The Whittington Hospital NHS Trust

RKE

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

This report describes our judgement of the quality of care provided within this core service by The Whittington Hospital NHS 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 The Whittington Hospital NHS Trust and these are brought together to inform our overall judgement of the trust.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community services for adults as good overall because;

- All community staff were aware of the trust's incident reporting processes and there were mechanisms in place to learn from incidents. District Nurses (DNs) were aware of their duty to report pressure ulcers. Community services across the trust were described to us as high demand in relation to capacity. The DN service had a high staff turnover rate but there were a number of measures in place that managed the safety issues that arose from this. Staffing pressures and low team morale were more acutely felt in some teams and this had an effect on the service.
- Current evidence based guidance, standards and published best practice were identified and used in the delivery of care. The trust had done much to improve staff competency through a number of positive initiatives although some essential items needed further development. We found good and widespread examples of multidisciplinary working and clear understanding of care pathways among the community teams.
- We found compassionate and respectful care was present in all interactions we observed, in what were busy teams working in what were challenging environments.
- The trust's integrated care approach was designed to meet the wide ranging needs of different patient groups. Community services were provided by staff groups who were generally culturally and ethnically representative of local populations. The DN services were observed to be very supportive of the older patients they visited and understood the needs of working with this patient group.
- The trust's vision and values around providing integrated patient centred care were reflected by the community staff we observed and spoke with. Community staff felt well supported by the managers of community services.
- There were governance processes and lines of reporting to the executive team on quality for all three directorates with community services, with risk and quality issues discussed in local team meetings.
- All staff reported that meeting demand with current capacity was a challenge, which was only set to increase with further development of integrated community services within the trust. Community staff generally felt there was a lack of understanding of their role by both trust leaders and their professional counterparts who were hospital based.

Summary of findings

Background to the service

Community services for adults were located within three of seven hospital directorates, known within the trust as Integrated Clinical Service Units (ICSUs). They were managed alongside inpatient services within these directorates:

1. The Medicine, Frailty and Networked Services (MFNS) ICSU managed: specialist nurse for long term conditions, continuing healthcare Islington, ICAT-support to eight nursing homes and GPs in Islington, care home specialist nurse, the community rehabilitation team (CRT) Islington, Intermediate care rehabilitation Haringey, Haringey integrated learning disability service (health element) and wheelchair services.
2. The outpatient and long term care (OPLTC) ICSU managed; IAPT, Nutrition and Dietetics, Podiatry, Musculoskeletal physiotherapy and Clinical Assessment and Treatment service, health centre managers, bladder and bowel specialist nurses, community central booking service, self-management and smoking cessation and tissue viability and lymphedoema service.
3. The emergency and urgent care (EUC) ICSU managed district nursing, virtual ward, rapid response, primary care, alcohol and drugs services and Hanley Road GP Surgery.

How we carried out this inspection

As part of this inspection, we visited a number of health centres and community team bases at: St Ann's Hospital, Crouch End Health Centre, Hornsey Central Neighbourhood Health Centre, City Road Health Centre, Holloway Community Health Centre, Hornsey Rise Health Centre, Islington Outlook and the Partnership Primary Care Centre.

60,000 face to face patient contacts took place within the community each month.

We met with a number of community teams: The Integrated Care Ageing Team, (ICAT) who worked to meet the need of the frail elderly. The Diabetes Team who offered home visits, a service at outpatients and a telephone service. Sexual health services where there were four community clinics. The Integrated Community Respiratory (CORE) team, providing support and management of people with Chronic Obstructive Pulmonary Disorder (COPD). Four of the eight district nursing teams. The Community Rehabilitation Team (CRT) working with individuals who have complex disabilities or neurological impairments. The musculoskeletal team.

We spoke with a large number of healthcare professionals including physiotherapists, podiatrists, dietitians, speech and language therapists, clinical psychologists, occupational therapists, district nurses, geriatricians, consultants and junior doctors. We also spoke with a number of senior clinicians, service managers and senior managers.

We spoke with 20 patients in a number of settings where care was provided. This included health centres where community teams were based. We visited patients in their own homes and observed care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Ensure that at the Holloway physiotherapist team base, there is a medicines management standard operating procedure and a control and audit trail of medicines.

Ensure that agency nurses have the basic equipment such as glucometers and sticks and the basic equipment to carry out tasks such as take blood pressure readings.

Summary of findings

Ensure that district nurses are aware if the trust's dress code policy.

Ensure that infection control issues raised by the use of computer tablets by staff are subject to infection prevention and control procedure or direction.

Ensure that infection control issues raised by a dog that regularly visited a health centre is subject to infection prevention and control procedure or direction.

Ensure that the reported lack of training and competency around picc lines and midlines for intravenous drug administration, are considered in the district nurses training needs analysis.

Ensure that compliance with clinical supervision is improved, specifically in district nursing and sexual health services.

Trust and trust nursing leadership should be more visible in the community in order to better understand the pressures and challenges of the community staff.

The Whittington Hospital NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- We rated the safety of adult community services as good because;
- All community staff were aware of the trust's incident reporting processes and there were mechanisms in place to learn from incidents. However, due to the high workloads of district nursing (DN) teams, nurses told us that some incidents may not have been reported.
- Community staff were aware of safeguarding procedures, what constituted abuse and how to escalate concerns. DNs were aware of their duty to report pressure ulcers. Specific patient risks were assessed and managed.
- Insulin administration had been difficult to manage due to the capacity of the DN teams. A pharmacy technician was employed within the DN service. However, due to high caseloads and pressure on staff, they were not able to do all of this work and spent most of their time administering medicine.
- We observed full and concise record keeping in all patient files we saw. This included on home visits, podiatry and physiotherapy.
- Agency nurses lacked some basic equipment. An equipment audit showed nurses were not carrying some items of equipment in their bags which was being addressed through practice development. Otherwise, equipment needed to provide care and treatment to people in their home and in centres was appropriate and fit for purpose.
- The trust's infection prevention and control team had not assisted with guidance on potential infection control issues such as community nursing staff not wearing uniform, a dog's access to a health centre and no decontamination taking place between patients where computer tablets were widely used. We observed good hand hygiene among DN teams, however, elsewhere we found variable standards and attitudes to hand hygiene.
- Community services across the trust were described to us as high demand in relation to capacity. The DN service had a high staff turnover rate but there were a number of measures in place that managed the safety issues that arose from this. Working alongside GPs, self-management was encouraged among other community teams. Staffing pressures and low team morale were

more acutely felt in some teams than others. We found some instances of high stress and sickness rates. Sexual health services were working at almost half their staffing capacity to the detriment of the service and clinics were closed on a weekly basis.

Safety performance

- Nursing quality indicators for the service measured quality in three categories: patient safety, patient experience and staffing. The indicators were broken down by individual DN team and measured each item against a target rate. Items reported on included pressure care, missed visits, complaints, a 48 hour visit target, training and vacancy rates.
- The DN service also produced a monthly document called 'how we are doing' which included a report of the number of pressure ulcers recorded by each DN team graded 2, 3, 4 or ungraded. Documentation provided showed there were 23 reported pressure ulcers for October and 16 for November 2015.
- Community matron caseloads with individual care plans showed 100% across all teams in both trust boroughs. The DN also stated that the team had recently improved the collection of regarding pressure ulcers and falls. Safety thermometer information did not specifically refer to falls. 'Patients with no acquired harm' was recorded and was consistently above the trust target of 95% although this accounted for both inpatient and community.

Incident reporting, learning and improvement

- A DN told us that incidents were recorded in case notes and discussed in team meetings and handovers. Learning or changes in practice as a result of learning from incidents were discussed in team meetings and disseminated to all staff.
- There were mechanisms for escalating and reporting concerns within the DN service. Incidents were reported immediately if there was a concern through the team manager. If the team manager was not available the first point of contact was the lead district nurse or service manager. Otherwise issues and risks would be reported at the 2.30 pm handover. A DN manager felt the safeguarding lead was available and accessible for conversations about safeguarding issues and thresholds of reporting. It was the responsibility of all team members to raise concerns, report incidents and safeguarding issues. There was a single point of access through a central referral system with a cut off time of 4 pm for triage, which was carried out by band 6 DNs.
- Data showed that between September 2014 and September 2015, 249 pressure ulcers were reported by the DN service. Pressure ulcers graded two or above were reported as incidents. Pressure ulcers acquired prior to discharge and detected in the home were included in this figure.
- The DN service manager told us there was a good focus around managing patient safety and learning from incidents, especially around pressure care. All DNs had an electronic tablet and completed skin integrity risk assessments when required, which linked to the online incident reporting system. DN groups told us in discussion that any grade 2 pressure ulcer or above was recorded as an incident, with one ulcer equaling one incident (multiple ulcers for one individual count as multiple incidents). Lessons learned from incidents were fed back either to the group or on a one to one basis as appropriate. The service manager and DN leads (band 8a) saw all incidents that were reported from the community.
- During a home visit observation, we saw a letter to carers regarding responsibility for checking and escalating concerns regarding skin integrity and equipment issues.However, DNs were still accountable and if patients developed pressure ulcers, it was reported as an acquired pressure ulcer. Communication with carers was reported as a challenge and work was described as ongoing to make this better.
- It was reported by DNs that some incidents, including pressure ulcers, may not have been recorded on the trust's electronic reporting system by junior staff due to the pressures on staff time. Time was reported by staff as enormously pressured and staff found this difficult given reported levels of over working.
- On observation of a home visit with a DN there was discussion of learning from a medication incident, regarding an increased dose of insulin. This was recorded as an incident on the trust's electronic reporting system. The medication policy was followed and the nurse suspended from drug administration until

their competencies were re-assessed. There was a root cause analysis and lessons learned were shared at the monthly trust DN forum. The nurse completed a reflective piece of development.

- Escalating concerns and requesting police welfare checks when access to people's homes could not be gained, were areas of focus for the community services following significant incidents in the last year. Situation Background Assessment Recommendation (SBAR) teaching sessions had taken place with a focus on escalation during handover and carrying out efficient handovers. Incident reporting was communicated in local team meetings and regular DN forums.
- Managers of the community rehabilitation team (CRT) gave us a recent example where an incident involving lone working had resulted in learning being shared with all the staff teams. The lone working policy had been reinforced to the teams and staff were asked to ensure they had emergency police contact devices on them when out in the community. Staff we spoke with could not recall the incident referred to by the manager but told us that if there was an incident it was recorded in patient notes and on the trusts electronic reporting system, depending on severity. Any learning taken from incidents was discussed in team meetings and disseminated throughout the team.
- Physiotherapists told us they used the trusts electronic reporting system but outcomes were not always reported back. The team could not think of an example of learning.
- Podiatrist teams told us they had recently had a diabetes training day in relation to best practice to recap on lessons learned from providing the service. Staff also noted that recent training was attended on using the trust's reporting system. Staff had also requested support in understanding the criteria for a Serious Incident. Specific points of learning from incidents for podiatry were shared at team meetings and one to one sessions were available if staff had concerns. An action from this had been an arranged diabetes study day for staff. We also viewed two incidents on RiO (the IT reporting system). One incident related to a staff member carrying out a debridement on a pressure ulcer which they were not qualified to do, and the other incident related to the patient's family member feeling care provided by the service was insufficient. Both investigations were on going with no further identified information.
- On a patient visit with a member of the CORE team, we observed that staff notified the consultant for the service if there was a problem. In sexual health services, staff were trained in incident management. There was a dedicated person for reporting and feedback.

Duty of Candour

- In information the trust provided prior to our visit, they stated that Duty of Candour (DoC) training was provided on induction to all clinical and non-clinical new staff including junior doctors. The RCA Investigation report and action plan templates prompted DoC responsibilities to be documented. A DoC section was embedded in the incident reporting form. This mandatory field is completed in all incidents resulting in moderate harm and above. There were also template letters within the electronic reporting system for staff to access.
- The DN service manager told us the trust policy on the Duty of Candour (DoC) had been re-issued in April 2015 and the trust governance team had put together a training package for the community teams. The trust's electronic reporting system now prompted staff regarding the DoC and the culture of candour when recording an incident. This included whether teams had informed patients, carers and relatives. We were also told managers checked that DoC was being carried out when reviewing incidents.
- During home visits with another DN, they were able to demonstrate they understood the Duty of Candour. They stated that families, carers, and patients were informed of incidents and provided with support and further information where necessary. Regarding a culture of candour, a minor incident was witnessed in a patient's home. The DN explained to the patient what had happened in an open and transparent way. The incident was then discussed on return to the office, and was to be shared at handover and also discussed with manager to decide on whether any further action needed to be taken such as reporting it on the trust's electronic reporting system.

Good

Are services safe?

- Teams of physiotherapists and podiatrists demonstrated an understanding of the DoC in conversation and during observation. We were given an example of learning from an incident that had demonstrated incorporating the trust's DoC. Trust incident logs for two serious incidents demonstrated a compliance with the trust's DoC, which had been implemented within ten days of the incidents.

Safeguarding

- The DN service manager told us the safeguarding lead for the trust was very accessible and the team could call on them for assistance with complex cases. It had been recognised recently that training had become very 'online', so as a response, face to face training had been carried out that included case study work. The service manager told us that the community teams within the directorate had a focus on completing safeguarding referrals if there was any doubt.
- Observations of home visits with DNs demonstrated awareness of what constituted potential abuse and their duty to report abuse. They were aware of the responsibilities of the trust safeguarding lead who they felt was accessible. A home visit observation with a DN demonstrated incident reporting from people's homes. For instance, raising a safeguarding alert for a grade 3 pressure ulcer was discussed. Another DN we spoke with told us that staff had mandatory safeguarding training and there was a safeguarding lead within the service. The DN also stated that safeguarding concerns would be recorded in the case notes and escalated when identified.
- Out of hours staff told us they would call the social services duty social worker if concerned about a potential safeguarding issue. Learning from safeguarding was fed back at monthly DN forums.
- In the diabetes team, we saw an example of positive practice and a linking in to the local authority safeguarding team. There was also an appropriate response and ICAT referral for cognition and frailty.
- In sexual health services there was a child protection lead.
- Community rehabilitation team physiotherapists told us that safeguarding was part of mandatory training and must be completed. They stated that management ensured mandatory training was completed.
- Podiatrists were able to describe the process for escalating and reporting safeguarding concerns. Staff stated that safeguarding training was mandatory and included conflict avoidance.

Medicines

- Medication administration record (MAR) charts used with allergy boxes were seen and had been completed. There was a signature sheet at the front of the chart. During a home visit, we witnessed a request for medication go in to the GP practice via staff computer tablet. A recording of the list of medications was updated in the person's home. The DN utilised the referral sheet and transcribed this on to the MAR chart. Authorisation came from a letter for administration as part of this referral.
- The DN professional development and quality lead told us the medicines management policy was on the trust intranet and within two weeks of starting staff had to have signed to state they had read it. DNs told us they completed medicines competencies, some via e-learning. The pharmacist had recently delivered a training session on polypharmacy.
- We were also told by staff that insulin administration had been difficult to manage due to the capacity of the DN teams. During observation of home visits with a DN, they reported that health care assistants (HCAs) were authorised to administer insulin following competency sign off, however, this was not patient specific. For instance, specific staff being authorised to administer to specific patients only. A pharmacy technician was employed within the DN service to do medicines reviews. However, staff told us that due to high caseloads and pressure on staff, they were not able to do all of this work and spent most of their time administering medicines which was a priority of the service. We were also told by DNs that there had been occasions when patients had missed medication or, more often, the service had been late in administering it.
- The 'How we are doing' monthly report included a record of the number of medication incidents by each

DN team. Documentation provided showed 15 reported medication incidents for October and seven for November 2015. The DN service carried out over 19,000 home visits in October and 17,000 in November 2015. DNs reported to us that due to pressures of high caseloads not all incidents were being reported. Incident reports were supposed to be completed for all medicines incidents, but DNs told us that on occasions, nursing staff did not get time to complete them. If an agency nurse made a medication error it was reported to be escalated to the nurse agency in writing.

- In the diabetes team, nurse prescribers had clear boundaries regarding who did what. For instance, there were specific prescribing roles for GPs, nurses and the hospital depending on clinical responsibility. The service was currently training more nurse prescribers.
- ICAT had a pharmacist in their team. Medicines rationalisation was discussed during observation. Joint reviews were carried out by the pharmacist and doctor.
- At the Holloway physiotherapist team base, the treatment room was in a secured area of the building but the medicine cabinet was not attached to the wall or floor. Although there were no CDs, or high risk drugs here, there was no medicine management standard operating procedure, no control of medicine stocks, and no audit trail on medicines. Patient Groups Directives (PGDs) were under review and a copy of the revised version was yet to be signed off.

Environment and equipment

- Equipment for DNs was provided through an external agency.
- One identified problem with a patient's bed was documented in their case notes for further action and the DN stated they would establish if this could be addressed. During a home visit observation, we witnessed equipment being ordered for patients. We were told these were usually delivered within five days but staff could access same day deliveries when required. One patient was advised equipment needed had not been ordered and would be delayed by three months.
- While observing home visits with a DN, a patient told us that an agency nurse who visited them two days ago did not have equipment to take blood pressure readings. A DN told us that some agency staff did not have some basic equipment such as glucometers and sticks. Delays in receiving ordered basic nursing equipment were reported and nurses ended up borrowing from one another. Equipment went missing when agency workers left, compounding the issue.
- Patients with equipment were not discharged from DN caseloads but kept on with limited input if supported by home carers. There was a letter to carers regarding responsibility for checking and escalating concerns regarding equipment issues. Annual checks or services of equipment were also provided by an external agency.
- Sharps boxes were located in patient's homes where needed, rather than being carried in nurse rucksacks. Manual handling risk assessments were completed in all patient held home records.
- The DN service manager told us that the reporting process for upkeep and repair of premises was through trust estates, who it was reported, responded to defects and repairs in a timely manner. Health centres we visited were generally in a good state of repair.
- The dress code audit showed 100% compliance had been reached in half of the 12 criteria audited in July 2015. Messages about responsibility were reiterated by team managers with a plan to re audit in March 2016. The audit of essential items to be carried in a rucksack by DNs was reported on in November 2015. It showed that only three of 14 items that were classed as essential were being carried by all DNs audited. Attack alarms were carried by only 58%, insulin syringes by 56% and nursing assessment packs by 62%. Mobile phone, gloves and hand gel were carried by 100%. Comments included that some nurses' glucometers had been lent to agency staff and not returned. Recommendations and an action plan had been made with a plan to re-audit in March 2016.
- Nurses in the diabetes team had examples of insulin pens to be used as needed.
- The CRT service was sharing the building with a social services team, which had its benefits as the CRT used the therapy equipment available. The management also stated that if equipment or an item in the building was noticed to be in disrepair, this was reported to the estates team and resolved quickly. A sticker on one of the exercise machines stated that the last date of

equipment check was November 2011. We enquired about this, and were shown an email from the service personnel who had checked the equipment. This showed that the equipment had been checked and was in date.

- A CRT staff member stated that the team were very happy with the equipment provider and that they could get items ordered quickly and easily. The equipment provider also had a second-hand equipment sales department which the CRT used to get items at lower prices. While observing a home visit, staff checked the functionality of equipment the patient was using, such as a hand brace and walking stick, and enquired if the patient needed any further items or improvements to their home to facilitate rehabilitation.
- Physiotherapists from Holloway Community Health Centre had access to a local gym and exercise service. The equipment store was also viewed and items were stored in a clean and tidy way. All equipment had been tested and was in date.
- With the podiatrist service from Holloway Community Health Centre, we found that staff had checked equipment in the podiatry room. The chair, box of sharps, resuscitation equipment, and PAT testing had all been checked and found to be in date. Curtains and disposal of waste were also found to be satisfactory.

Records management

- We observed full and concise record keeping in all patient files we saw. This included DN home visits, podiatry and physiotherapy.
- On visits with DNs, we observed that case notes for patients were stored in the patient's house. Information relating to the care of the patients was recorded in the case notes on visits by the DN.
- Care notes from CRT physiotherapist visits were written on a printout of goals from the visit, to be written up when back in the office. The patient did not have a copy of their care plan. Staff documented upcoming appointment dates on an appointment card kept in the patient's home.
- The respiratory team used computer tablets in the community and were able to upload and send attachments to GPs.

Cleanliness, infection control and hygiene

- Community infection control audits were shown by location on the Whittington Health Infection Prevention and Control Dashboard for quarter one, April to June 2015, showed that community services were audited for environment, hand hygiene, personal protective equipment (PPE) and low use outlets (flushing of low-use water outlets to prevent the build-up of stagnant water). Outcomes were red/amber/green (RAG) rated and showed 76% green 14% amber and 10% red. Red and Amber ratings were exclusively focused in the environment and the low use outlets sections. Red rated areas were required to re audit in three months and amber within six to eight months.
- We generally observed good infection control measures on home visits. Hand hygiene was observed by DNs most home visits. We observed personal protective equipment (PPE) such as gloves and aprons used for procedures such as a catheter change and stoma bag change. However, gloves only and no apron were used for an abdominal wound dressing. Shoe covers were available but not used.
- Bare below the elbows was observed. DNs were not in uniform. DNs we spoke with were not aware if the trust's infection, prevention and control (IPC) team had been consulted about this practice but there was a trust dress code policy. The policy stated below knee for female dress although we witnessed two DNs not observing this.
- Computer tablets were widely used by community teams and all DNs. At no time were these decontaminated between patients. There was no standard procedure for their routine decontamination. One DN told us that hand washing before and after procedure and before handling the tablet was practiced but there was no specific infection prevention process or direction given by managers or the trust regarding their use. With the respiratory team there was a tablet app which allowed patients to sign on the tablet. This raised an additional infection control issue where patients had handled the tablets.
- We also found variable infection control practice among other community teams. For instance, good hand hygiene was observed during a new patient assessment at Hornsey CORE team but there was no evidence of hand sanitation during pre-assessment with a patient

with the Holloway physiotherapist team. This was however, observed post assessment. Another patient told us there was a lack of hand hygiene prior to their appointment.

- Hand sanitisation and infection control on equipment was observed during a CORE team visit.However, a watch was not removed prior to patient examination. There was also repeated use of mobile phones during visits but no observed sanitisation.
- On home visits with a physiotherapist from the CRT, we observed staff washed their hands following patient contact in their homes. However, sanitiser was not available at the centre where patients were also seen. Following a therapy group, all machines were cleaned with disinfectant wipes.
- We also encountered a potential infection control issue relating to a dog that visited the centre. The team had not consulted the trust's IPC team regarding managing the risk of infection in relation to this.
- The podiatry service from Holloway were observed wearing gloves and aprons during patient contact but no uniform. Chairs were swabbed between patients.

Mandatory training

- Trust compliance for mandatory training was set at 90%. A mandatory training compliance report for DNs showed mandatory training items RAG rated. Only five of 13 subjects were rated green. Six were amber while two were red. Child protection level 2, moving and handling and resuscitation were all amber rated while information governance and fire safety were rated as red. The DN professional development and quality lead monitored training across the trust's DN teams and the directorate. They told us that an electronic staff record would soon be available which would be capable of identifying non -attenders and low attendance staff.
- A DN stated that staff were required to complete mandatory training before working with patients and to ensure that they were up to date. Mandatory training was completed by both e-learning and occasional classroom work. If mandatory training was not completed it was raised by the line manager for the service.
- Staff members of the CRT felt that mandatory training was well monitored and that managers informed staff when training needed to be completed or updated.
- We reviewed the mandatory training records for physiotherapist and podiatry teams we visited and found mandatory training met trust targets.

Assessing and responding to patient risk

- The DN service maintained a 'patients of concern' database, which had criteria for inclusion. This included complex wounds, complex pressure area, pressure sores, non-healing wounds over six weeks, palliative care needs, continuing care funded, patients refusing care, safeguarding alerts, and other complex needs.
- Being included on the 'patients of concern' database meant that care was reviewed more regularly by DNs and reviewed by a service manager monthly. Where risks were higher and cases more complex, other services could be called upon such as the community nurse specialist team, diabetes team, respiratory team, heart failure team and bladder and bowel team.
- Risk assessments were found in initial documentation. On home visits with DNs, we found manual handling risk assessments in all patient files we saw. Risk assessments were completed at the initial assessment period based on referral information and care plans. During visits, we observed visiting DNs asking patients if there had been any falls, skin breakages, loss of bladder control or significant changes in weight.
- Patient assessment documentation was found to not be fully completed in two of three cases we checked. There was an incomplete wound assessment chart and incomplete skin bundle.
- DN care plans were individualised and used input from specialised services. However, DNs told us it was a challenge to get these completed and returned to patients' homes and there was no standard timeframe for this to happen.
- With the CRT, team members stated that carrying out risk assessments on potential patients and assessing potential risk to staff was an important part of the initial assessment period for new admissions. Risk assessments regarding mobility for patients were provided by referrers, which informed physiotherapy if patients could use the exercise machines available at

the service. On a visit with a CRT occupational therapist (OT), we observed care given to a patient on the 'early supported discharge stroke pathway'. The pro forma care plan stated key risks in brief, at the beginning of the plan, which identified categories under the specific headings of suicide & self-harm, harm to others, self-neglect, drug and alcohol, access to the home. Care plans also contained key medical information, basic details and contact information, current difficulties and goals. The care plan was evaluated in the case notes with regular updates.

- The diabetes team undertook daily triage with a target of assessment within two weeks. The team held weekly meetings where complex cases were discussed. Monthly meetings took place with a consultant in attendance, who was reported by staff as always available by phone and email to assist with complex cases.
- Both ICAT) held monthly governance meetings where they worked on issues of patient risk that arose. For instance, a recent issue was working with anticoagulants in care homes. Contact was maintained with the local authority where safeguarding was an issue, and all incidents were reported through the trust incident reporting system.
- With the CORE team, initial visits were risk assessed. Patients would often be seen on the ward prior to the home visit to mitigate risk. The trust had a lone working protocol and emergency policy which all staff interviewed seemed to be aware of.
- Management reminded staff to stick to the lone working policy to manage risk. The service kept a handwritten record of where each practitioner was going on visits. Staff were required to notify if they would be delayed. They also had a code they could use if they were at risk without putting themselves in further danger. Initial visits in the community could be carried out as a double visit both to provide more comprehensive assessment and mitigate risk. GP and other working partners can inform the service of risks.

Staffing levels and caseload

- Information provided by the trust prior to our visit highlighted recruitment and retention in community nursing as a challenge. Senior managers told us that DN was a very high volume service and managing demand was 'key'.
- Across each trust borough (Haringey and Islington) there were four DN teams covering 8.30am to 5.30pm and a twilight team who worked from 5pm to midnight. The twilight shift consisted of up to eight staff working alone up to midnight out of two bases. The overnight DN team worked 10pm to 8am and consisted of two staff and a driver. There was also a 24/7 messaging service. This left a half hour gap where there was no service. Calls continued to be taken but by a call handling service who passed messages on to day staff. Incidents that occurred during this half hour gap would be delayed in response.
- Nursing quality indicators for the DN service were provided for July to October 2015. Sickness rates were measured against a target of 3%, which had been achieved in only 11 of the 40 monthly team reports. South Islington teams reported the highest rates. Islington South West, recorded a 11% sickness rate in August 2015.
- Nursing quality indicators for the DN service for July to October 2015 showed vacancy rates were currently running at 51 across the whole DN service.
- In partnership with NHS Elect, a 'length of stay' piece of work had been undertaken in order to assist managing demand. Peak days in patients' care were identified with regard to patients avoiding service dependency. Work was also carried out around units of work, which were divided in to 15 minute units. Assessments were then carried out around numbers of units needed for each patient with work allocated on this basis. This provided a way of looking at demand in terms of how much capacity the service had to manage the workload, better known as the 'community activity tool'.
- Senior managers told us there had been a lot of recruitment over the last year. Local advertising, recruiting newly qualified nurses from Portugal and maintaining a 'grow your own' focus by mentoring, rotating and developing their own nurses were identified as recruitment streams. Vacancy rates for DNs were measured monthly and had varied from 2% to 14% in 2015.
- Part of the retention of staff initiatives was the mentorship programme for pre-registration nurses. Documentation we examined demonstrated this was

taking place in two cohorts with the first beginning in September 2015 and the second in January 2016. So far there were nine nurses undertaking the course out of the twelve places offered.

- As well as bank staff, agency staff were used to fill posts and absence. In order to maintain consistency of practice, one single agency provided all temporary nursing staff. This meant there was one agreed induction package. Trust processes could be used and managers met with the agency for regular quality monitoring. Within bank staff, there was a temporary staffing manager to manage contracts and practice of bank staff.
- DN teams generally consisted of two band 7s, three band 6s, twelve band 5s, one band 4, three band 3 and two part time band 2s. Caseload numbers were considered high demand which were reported as at its highest for a team as 556. the equivalent of 14 units of work in the morning and four to six units in the afternoon.
- Trust DNs stated that management of caseloads could be a challenge, particularly when there was high turnover of staff. At the Hornsey Rise DN service for instance, it was reported that the team had two band 7 (one agency), 1.5 whole time equivalent (WTE) band 6, 13 WTE band 5s and two WTE band 3s. Home visits were undertaken through walking and public transport which limited productivity. Staff who were unable to drive would manage patients closer to the team base, while drivers worked further into the community.
- It was widely understood among DNs that staffing pressures and caseload pressures were felt more acutely at the City Road Medical Centre DN service, which were reported to us as 'not safe', meaning patients remained unallocated on a daily basis. Visits were categorised into three priorities; priority one was for medication which was not to be missed. Two was for wound care and three for reassessment. We were told there were days when priority one patients remained unallocated due to staffing issues. Every morning there was a teleconference across two boroughs to discuss workload. This included the unallocated visits chaired by a lead district nurse who moved workload across teams. If priority one work remained unallocated it was escalated to the service manager and head of nursing who would deploy resources accordingly. Help for unallocated patients was regularly sought from other DN teams. For instance, community matrons from other bases helped out, thus covering large geographical areas. To staff's best knowledge all priority one patients were seen on the day but medication administration would be late. The service was meant to have capacity for each nurse to carry out 14-16 units in the morning and 4 to 6 in the afternoon. Senior managers told us the unit allocation took into account time for travel to visits. However, nurses told us that walking and taking public transport added to the length of each visit. DNs were regularly working well beyond their shift times to ensure vulnerable patients were seen.
- On the day of our visit, there was one band 5, and two band 6s with one in charge, one band 4 and one band 3 on duty at City Road. There were also two band 5 bank staff, one band 6 agency nurse and an agency matron. There was also shift a coordinator, who would usually be in the office, but had gone out to see a long term conditions patient as they were the only person on duty today with skills to see this patient. Time owing was accrued, staff worked through lunch breaks and stayed late in the office to get lists and administrative tasks completed, especially for coordinators, who were reported as working up to 7pm to allocate patients. Staff accruing time owing were not able to take this back. This was reported as leading to low morale and affecting the staffing further because people were leaving.
- With the sexual health services there were seven nurse vacancies out of a staff of 16. We were told that four had been appointed but had not yet started. Staff told us that because of a shortage of staff, patients were not being streamed properly. Staff reported severe shortage of staff which resulted in fatigue and stress, with a service prone to mistakes and a high sickness rate. The manager was on sick leave. Clinics were reported as being closed on a weekly basis due to staff shortages. Staff felt disconnected from the trust and did not feel like part of the trust's other community services.
- The diabetes team had recently reformed with a more appropriate skill mix. There were more than 200 new patients per month who were offered one hour appointments.
- The ICAT MDT met every morning to review caseloads and appropriately escalate work across the team.

Good

Are services safe?

- The Holloway physiotherapist team stated that caseloads were manageable but this balance was easily affected by sickness and annual leave. Staff were not encouraged to work over contracted hours and those who did were helped to find ways of avoiding working additional hours. There were currently three vacancies in the community integrated physiotherapist service. Staff stated in interview that there was pressure on the service due to demand and capacity.

  Senior managers told us that physiotherapists were seeing 95% of referrals within six weeks, which was a challenge due to a high throughput of physiotherapist staff. Movement of junior staff, moving on to more senior roles every couple of years was pre-empted and recruitment.

  Demand and capacity work for podiatry, physiotherapist and the ICAT service had been carried out. In order to ease pressure on services, podiatry patients were encouraged to self-manage their conditions and work with GPs around self-management. There was a 'self-management team', which linked in with community teams generally, to look at how consultations were structured to further aid self-management.

- CRT managers stated that the team were capable of meeting demand with current staffing, but that this could be a challenge once referrals and caseloads increased as the trust became more community orientated. There were some longstanding staff and staff turnover was not high compared to other areas of the trust or community nursing. Within the MDT, the staff team was stable, with one vacancy currently filled by a locum in the early support to discharge (ESD) service.

  CRT staff members also stated there was a stable staff team with some longstanding members, although it could be difficult to get cover for some specialist nursing positions. For instance, the team had a specialist multiple sclerosis nurse post, where maternity leave was being not covered.

- In the respiratory team reported that there had been some difficulty in recruiting to a band 7 post, which had caused some pressure on the team. The post had been advertised but there were very few applicants, possibly due to only being a 0.5 WTE.

Managing anticipated risks

- An adverse weather protocol was in place. If staff could not get in to work other staff (who may live nearer) would be called in. Complex cases were prioritised and families and carers contacted to establish if they were able to help.

- In the CRT team base, a dog belonging to a member of staff walked freely around the centre. Patients with limited mobility and at risk of falls regularly visited the centre. Risks were not anticipated. There was no plan in place or limitation on the dog's access to the centre.

Major incident awareness and training

- There was a major incident on call management system. The DN service manager and head of nursing participated in the trust's silver on call rota and also received ongoing training and support. During a major incident they were allocated to manage flow and demand in the community and were answerable to the gold on call team.

Good

Are services effective?

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

Summary

- We rated the effectiveness of community services for adults as good because;
- Current evidence based guidance, standards and published best practice were identified and used in the delivery of care. Staff utilised computer tablets in the community to complete assessments, communicate with key professionals such as GPs and share essential information.
- The trust had done much to improve staff competency through a number of positive initiatives although some essential items needed further development such as the low number of staff, including district nurses and sexual health staff receiving clinical supervision. Also the mentorship programme's current low uptake. We found good and widespread examples of multidisciplinary working and clear understanding of care pathways among the many community teams.
- In order to integrate patient care, staff from all community teams had to navigate their way around a number of information systems belonging to different care providers. Even the trust had more than one system.

Evidence based care and treatment

- Alerts on published and best practice guidance came from the trust to the DN professional development lead. There was a DN forum every six weeks and a standing agenda item was professional development, that covered guidance, training, audits and lessons learned. We were provided with a recent policy relating to DN practice regarding insertion and management of urinary catheters. The policy referenced a number of publications including NICE guidance CG139 and guidance on clinical procedures dated 2015. The DN professional development and quality lead told us that care planning referenced a number of recent DH publications on good practice. We also viewed a protocol on insulin administration via pen device, which was based on 2015 NICE guidance and published NMC guide. New DN staff were provided with a competency workbook outlining nursing procedures that was based on a number of published best practice guides.
- DN staff told us that new policies from the trust and guidance for evidence based treatment were regularly disseminated to staff and discussed further in team meetings. From our observations of home visits with DNs, we found that evidence based practice was incorporated in to plans of care to include core care plans such as prevention and management of pressure ulcers and the use of SSKIN principles (a five step model for pressure ulcer prevention) within documentation. We also witnessed evidence based practice for the prevention of pressure ulcers.
- With the ICAT team, education was given as part of the service to GPs, community matrons and care home staff during half day sessions.
- The CRT used an assessment of function for dementia. The Montreal Cognitive Assessment was also used which was sensitive to picking up dementia. Pathways included early supported discharge for mild to moderate stroke. There was also a standard rehab pathway used for transfers, cognition and mobility. These were focused on goals and community access and lasted an average of four to six weeks. Staff stated that information on new policies within the trust and national guidelines for practice were disseminated throughout the team by email and raised in team meetings. During a visit with an OT from the CRT, we observed the 'repeatable battery for the assessment of neurological and psychological status' (RBANDS) assessment being carried out.
- Community podiatrists stated they would be updating their understanding of new NICE guidelines for diabetes as part of continuing professional development. In Haringey, high risk patients could be retained on a permanent basis, while in Islington there was a slightly lower assessment criteria. In the diabetes team, type II diabetes was their main remit and worked to best practice.

Good

Are services effective?

- With the Hornsey CORE team, staff stated that 64% of starters completed 75% of their pulmonary rehabilitation course, compared to the national average of 50%.

Pain relief

- Observations of home visits with DN service showed patients were asked about pain. There was a pain assessment tool for staff to use which was part of the standard DN documentation pack. Plans of care included pain management and 'as required' analgesia was administered with a verbal report from the patient.
- During a CRT visit to the patient's home, we observed a discussion on pain management and the discussion was recorded by staff member.

Nutrition and hydration

- During home visits with DNs, we observed that the Malnutrition Universal Screening Tool (MUST) was utilised, along with alternative weight measurement (mid upper arm circumference). Patients were asked if they had any significant changes in weight since the last visit and if they were eating well or had any problems with keeping food down.
- On a CRT visit to a patient's home, it included a discussion on appetite which was recorded in the notes. Staff members provided hydration to patients using exercise equipment during therapy sessions.
- There was a trust dietitian and nutrition service available which could be accessed in the community. The service was provided in GP surgeries, health centres and also had a large home visiting service (which patients need to be registered with a GP in Islington for). This was predominantly an adult service in Haringey.

Technology and telemedicine

- DN staff were observed utilising computer tablets to complete assessments, staff tracking, consult British National Formularies (BNFs) and look at maps. They were also used to send requests directly to GP practices via email for medication and prescription requests.
- The CORE team had discussed the use of computer tablets and the potential issues regarding the transmitting of sensitive information for patients. This had been cleared by governance of the trust for use. All patients could be shared with the team and visit information for patients was available to view.
- Community podiatrists were being provided with computer tablets to facilitate community working. Patients were able to use the devices to provide consent.

Patient outcomes

- Nursing quality indicators for the DN service measured quality in three categories: patient safety, patient experience and staffing. The indicators were broken down by individual DN team and measured each item against a target rate. Items reported on included pressure care, missed visits, complaints, a 48 hour visit target, training and vacancy rates. This was then processed and made available as a monthly report.
- With the Hornsey CORE team, the respiratory consultant had been embedding skills and improving confidence through regular reflective practice sessions. The service recently completed an audit of bed day savings over the course of the year. Findings were presented to the British Thoracic Society along with feedback from patient satisfaction and the Family and Friends surveys. A copy of the article was viewed.
- The ICAT team aimed to improve patient outcomes and reduce the number needing hospital admissions.
- Within the physiotherapy service the pain of patients with biomechanical medical problems was monitored and outcomes explained to patients.
- Staff records for the podiatry service indicate an 8-12% DNA rate for the service.

Competent staff

- A competency workbook had been produced by the professional development and quality lead. It was designed for new DN staff and began at the two week induction. It was intended to travel with them around the community teams and documented their learning and development based on published guidance. It outlined best practice for a number of nursing procedures including bladder care and continence management, wound care and medication.

Good

Are services effective?

- When a member of staff joined the DN service there was an intensive two week induction period. DN staff were required to read the standard operating procedure and medicines management policy and sign to state this.
- DN staff told us that new policies from the trust and guidance for evidence based treatment were regularly disseminated to staff and discussed further in team meetings and monthly DN forums, which were trust wide. DNs stated that team members could request and access additional training if it was of value to the service. A training needs analysis was provided by the DN professional development and quality lead that looked at specific nursing skills needed for the service. It identified the nurses and their bands and DN nursing base alongside course titles that included non-medical prescribing, physical assessment and diagnostic, diabetes and tissue viability. One issue reported by DNs was a lack of training and competency around picc lines (PICC is a peripherally inserted central catheter) and midlines for intravenous drug administration, which was not present on the needs analysis.
- DN agency staff received induction from their agency based on what the trust wanted covered. A single agency was used by the trust to maintain and monitor quality and consistency.
- Current DN compliance with clinical supervision was low. Documentation demonstrated that 10 of 65 were completed for the year. The DN professional development and quality lead indicated that clinical supervision was a 'work in progress' and that they were currently rolling out training to all band 6 nurses and above to facilitate this roll out.
- Carers and patients both stated they felt DNs were well trained for their roles.
- We found physiotherapist appraisals were up to date. Staff had approximately half a day of CPD time a month.
- With the diabetes team, medical emergency response (MERIT) and DESMOND training had enhanced the skill set and competency of staff. (DESMOND is the acronym used for Diabetes Education and Self-Management for Ongoing and Newly Diagnosed).
- Within sexual health services there were low appraisal rates of 30%, but 100% for medical staff.
- At the ICAT service staff told us there was an induction programme that they found helpful.
- CRT staff stated that they had good access to training and the service provided good access to non-mandatory courses if they would benefit the service. Staff felt there was good access to supervision and there was opportunity for reflective practice. The senior OT (band 7) supervised three rehab assistants within the CRT. Also CRT were getting a locum to clear waiting times who they would also supervise.
- In the respiratory team there was funding available for external courses for staff but this was subject to a cost improvement programme.
- We observed excellent physiotherapist handling skills during a new patient assessment. Staff interviewed stated there was a lot of in-house development for staff, as well as access to external courses. The team had four study days ring fenced per year. Staff had access to one to one supervision support and a group meeting every four to six weeks. Training and learning opportunities were built into the roles.

Multi-disciplinary working and coordinated care pathways

- DNs were aware of 'keyworker' responsibilities for coordinating patient care. There was evidence of multidisciplinary working between DNs and long term conditions teams. Social workers and DNs shared assessment documentation, allowing for holistic assessment of health and social care needs. DN staff were observed utilising computer tablets to send requests direct to GP practices via email for medication and prescription requests. DN team managers had access to healthcare gateway. A DN stated that multidisciplinary working was good within the service and that the DN team could access specialist support when needed. The DN also stated the team had good working relationships with other services both within the trust and externally.
- DNs told us the service could be better coordinated with providers of home care services. Patients stated that carers had made decisions relating to their care that were not coordinated with the DN service and could have an adverse effect on patient care. For instance, we found that a carer had been putting more than one continence pad on a patient at a time.

Good

Are services effective?

- The diabetes team told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples in podiatry patient records that stated there had been a shared assessments with the diabetes team and assessments were reviewed during treatment. The ICAT team felt they had good links with other community teams. We observed this in practice.
- The CRT team had access to a large multidisciplinary group within the team, encompassing nursing, medical physiotherapy, psychology, speech and language therapy, and occupational therapy. In addition, to this there was a core of professionals that supported the work of the ten integrated care clusters that the trust encompassed, with the aim of joining up care in the community. The CRT were able to provide a MDT assessment including physiotherapy, OT and speech and language in their own homes, which formed the basis for then deciding care goals with the patient. For instance, physiotherapist and speech and language therapists (SALT) attended the same appointment based on patient need. A staff member stated they would like to have better communication with GPs regarding collaborative working.
- Patients referred to the CRT could be provided with an individualised package of care, which fell into five different care pathways separated by the rehabilitative needs of the person (with some cross-over between pathways). The team had an approach of using the outcomes of the rehabilitation to decide length of time with the service, as opposed to deciding a length of stay on admission. On a visit with an OT, we observed care given to a patient on the 'early supported discharge stroke pathway'. They told us other pathways included early supported discharge for mild to moderate stroke. There was also a standard rehab pathway used for transfers, cognition and mobility. These were focused on goals and community access – and lasted an average of four to six weeks.
- The community integrated physiotherapist service offered different packages of care depending on the type of treatment needed. General rehabilitation included physiotherapy, occupational therapy, and speech and language therapy. This could be accessed by open referral to a single point of access. We observed some good multidisciplinary working within the CORE team, and good communication between the community service and associated acute services. There was evidence from patient records of multidisciplinary coordination between consultant and physiotherapist. We also observed the multidisciplinary community ulcer clinic discussing recent discharges from the hospital.

Referral, transfer, discharge and transition

- During a home visit observation with a DN we observed a single point of access for referrals which were received by email. There was a triage nurse who took referrals in to the DN service, where risk and priority were assessed.On observation of home visits, we saw evidence of referral, transfer, discharge and transition with adult and end of life patients who required timely discharge from inpatient areas to the community for preferred place of death.
- A CRT staff member stated that patients fell into different urgency levels at assessment which allowed patients with higher needs to receive more support. This was corroborated by the management of the service. The CRT management team felt the team had an approach of using the outcomes of the rehabilitation to decide length of time with the service, as opposed to deciding the length of stay on admission. The service offered quick access to assessment to new referrals based on need. This may have meant however, that when the service saw more referrals and caseloads increasing, that the team would be under further pressure to see patients who fell into the higher priority of need, which could mean patients with less complex needs may wait to get the rehabilitation they require. The team was working on a report to establish how long each type of appointment took, including assessments and home visits. This information was then compared to the current staffing levels, so as to make a case for increasing the resources available to the team to meet the expected demand. The management team stated that if commissioners wished to keep the current model of working at CRT this needed to be addressed.
- Self-referrals had to be referred back to the GP to access the CATS service. It took approximately two to five days for initial triage, and then a further five to six weeks to first appointment. The team stated that the triage process was robust, using settled and experienced clinicians (band 7 or above). Patients we met with stated they had been waiting three to four months for initial appointments.

Good

Are services effective?

- Referrals to the podiatry service were via self-referral or clinician (patients must be registered with a Haringey GP). A similar referral process was in place for Islington.However, the Haringey service had a lower bar for referral.
- Among physiotherapy teams, all appointments were 20 and 45 minutes. There were referral pathways via GPs, and physiotherapy colleagues. The team was currently working towards a fully integrated service. The routine musculoskeletal physiotherapy and the musculoskeletal CATS had two separate referral routes and although based on the same site were two separate services.
- For the musculoskeletal physiotherapist service, initial appointment times were 45 minutes unless capacity dictated the need for 30 minute 'blitz' appointments.
- The CORE team received referrals via hospital staff, by seeking out patients on the wards, and from GPs. The hospital based members of the CORE team monitored admissions daily in order to pick up appropriate patients. CORE followed up with patients coming into or going out of hospital to establish if support was needed.

Access to information

- In order to integrate patient care, staff from all community teams had to navigate their way around a number of information systems belonging to different care providers. Even the trust had more than one system.
- The ICAT teams had access to the GP's electronic patient record system (with the consent from patients). They also added to paper notes at the hospital. Staff had laptops with 4G connectivity for use in people's homes. 'coordinate my care' was also used from wards to care homes for ACP.
- The CRT used the local authority's information system, and the trust's notes based system, although hospital information remained paper based. Cases could be joint worked and information shared. This meant for instance there could be a need for social workers to know or be involved in a case. Funding for major equipment was through the local authority so teams talked to each other regarding this.
- When patients were discharged in to the community notes tended to get archived quickly, at which point they became hard to retrieve and thus difficult to access. Referrals usually contained hospital assessments which were scanned and forwarded.
- Comprehensive patient held records were available in patients' homes. DN handover took place at 2.30pm daily, allowing for communication of information regarding patient discussion, concerns and incidents.
- On observation of home visits with a DN, we observed that patients were provided with information on pressure ulcers which related to their care. Patients also had access to copies of their care plans in their homes. Leaflets could be seen in the main reception area of the service back also.
- In the CRT, we observed that information on treatment for the visit to the patient's home was printed off by the staff member and brought with them. However, the patient did not have a copy of their care plan in their home. The staff member discussed alternative methods of recording notes and stated that use of laptops or tablets in the community would be difficult. The staff member also stated that information sharing amongst working partners and communication with other providers involved in the patient's care was robust.
- Information on injection therapy was observed to be provided by a physiotherapist to a patient in leaflet form. We also observed a clinician providing appropriate verbal information explaining the reason for tests given to the patient. Another patient stated that explanation of findings were generalised and needed more information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- On home visits with DNs, we found patients had given consent for procedures and also their consent for CQC attendance at the visits. DNs asked for consent from patients prior to any care action. Discussion on care was observed to be collaborative and patient-centred.
- At the ICAT service, staff told us there was an induction programme that included MCA and DoLS training.
- In the CRT, we observed staff members on a community visit discussing treatment decisions with the patient.

Good

Are services effective?

Staff were supportive and made suggestions to meet the needs and treatment goals of the patient. Staff also stated that the capacity of patients was regularly monitored, and revisited in treatment if needed.

- In the respiratory team, the computer tablets used in the community had an app which could record patient consent. Consent was often being sought verbally but was not always being recorded. Consent was sought from the patient on the home visit.
- We observed consent being sought and given for assessment and treatment during a new physiotherapist patient assessment. Another patient we met stated they felt the request for consent was vague and could have been improved.
- Podiatry patient records stated that consent to treatment had been obtained. Staff had asked one patient for consent to obtain their medication list.
- Senior managers told us that level two safeguarding training was mandatory and included capacity. Continuing healthcare teams worked a lot with capacity issues as they linked in with pressure care, learning disability and tracheostomy care. We were told that staff had additional training on capacity and liberty, and court of protection work. The safeguarding lead for the trust did additional bespoke training for DNs to deal with self-neglect issues. We were told there was a journey to go on with capacity and knowing who to contact in cases.

Good

Are services caring?

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

Summary

- We rated caring in community services for adults as good because;
- We found compassionate and respectful care was present in all interactions we observed, in what were busy teams working in what could be challenging environments. Patients, carers and family were involved in the care and we observed staff taking the time to enable patients to understand information being presented to them. We observed an understanding of the emotional impact to the patient of their condition.

Compassionate care

- On home visits with DNs, we observed that staff took time to interact with patients, showing compassion and sensitivity to patient needs. Privacy and dignity was observed to be maintained with all patients we saw, in what was sometimes challenging environmental situations, whilst taking in to account patient choice. We also observed that staff took time to interact with patients on visits. Patience, caring and compassion was demonstrated. Privacy and dignity was maintained. Discretion and sensitivity to patients' needs were shown. Patients were given verbal updates on their progress from the DNs. Empathy was shown with both patients and carers. We observed compassionate and supportive care. DNs were respectful of patients' homes and treated both patients and carers with dignity. Carers and patients fed back that the staff were generally supportive and respectful.
- The CRT management team believed staff built up relationships with their patients throughout rehabilitation and the feedback they received from patients and carers was generally positive. They felt the team were compassionate and understanding to the needs of the patient group. Patients and carers we met with, stated that staff were friendly, well trained, and welcoming. Observations on community visits to patients' homes and of a therapeutic group found staff to be supportive, encouraging, and respectful of patient dignity. Staff were seen to inform patients with communication issues of any moving or handling plans before proceeding with movement, and were careful to minimise risk to the patients.
- When observing a follow up physiotherapist appointment, we observed the patient was treated with dignity and respect. They were given multiple opportunities to ask questions about their treatment that may have arisen during the discussion. We also observed an assessment which they stated was at the pace of the patient and conducted with empathy. At another patient assessment, we observed that expectations of treatment were discussed. The patient was treated with dignity and respect.
- In the CORE team, we observed a caring attitude by staff towards the patients visited in the community. A patient commented that the CORE service was brilliant and very reassuring. The patient was observed to be treated with respect and dignity.
- We observed podiatry patients being treated with dignity, respect and provided with compassionate care. Staff discussed transportation needs with one patient who had difficulty accessing the service.
- Friends and family scores from the quality dashboards for the community from February 2014 to August 2015 showed that 351 of 398 were likely (148) or extremely likely (203) to recommend the service.

Understanding and involvement of patients and those close to them

- On home visits with DNs, we saw evidence of good communication with patients regarding their progress and management of their condition. There were information leaflets in all patient held records. We also saw evidence of shared care, in accordance with patients' wishes and choice for care provision from members of the family, thus enabling the patient to maintain some independence. For instance, one patient was visiting their son that weekend so medication administration was being discussed with them so that

arrangements could be made. We also observed patients being asked if they needed any help to understand the information provided to them on the visit.

- On a visit with an OT from the CRT, we observed kind and compassionate care. There were good interactions with the patient and good conversation. They worked at the patient's pace when carrying out an assessment and engaged the patient well in the lengthy assessment that could have been a stressful process for the patient.
- There was plenty of information available in the main reception area of the CRT for visitors to access regarding treatment, diagnosis, and the trust. Observations on community visits to patients' homes and of a therapeutic group found that communication between staff, patients and their carers seemed positive, with any treatment decisions made collaboratively.
- While observing the respiratory team on a home visit, a patient was included in discussions on assessment, outcomes and treatment by staff. Questions that the patient had relating to care were listened to and noted for further action. We observed the patient's query being actioned on return to base.
- Feedback from a patient stated the CORE service was brilliant and very reassuring. They stated the team had saved them an admission to hospital.
- Subjective and objective physiotherapist assessments we observed felt rushed and lacking in non-verbal communication.
- When observing foot care and self-management, progress and issues were fully explained to the patient.

Emotional support

- The CRT were aware of the emotional impact on carers and were able to provide support to the families of patients where it had been identified as needed. This was used particularly for carers of patients with Motor Neurone Disease. Observations of staff and patient interactions found staff to be understanding of the emotional impact of treatment and the expectations of patients. The management team of the CRT stated their psychology staff could provide emotional support to the staff team as well as the patients.
- The principle podiatrist told us they were able to provide emotional support to the MDT in one to one sessions or regular MDT meetings.
- On a visit with an OT from the CRT, we observed an understanding of the emotional impact to the patient of their condition. Interactions with the patient demonstrated kindness when enquiring about their health and progress.

Good

Are services responsive to people's needs?

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

Summary

- We rated the responsivness of community services for adults as good because;
- The trust's integrated care approach was designed to meet the wide ranging needs of different patient groups. Teams had developed closer working relationships with commissioners in order to better meet local need. However, there were some inconsistencies between services that were provided to patients in different boroughs due to the commissioning of services not being joined up.
- Community services were provided by staff groups who were generally culturally and ethnically representative of local populations. The DN services were observed to be very supportive of older patients they visited and understood the needs of working with this patient group.
- The DN service was in high demand, felt most acutely in the Islington teams where there was a higher instance of unallocated or missed visits. However, the DN service was largely managing to meet the needs of its patients. For other community adult services, the trust was not managing to meet most of its targets of referral to treatment and referral to face to face initial appointment.

Planning and delivering services which meet people's needs

- The trust's integrated care approach was designed to meet the wide ranging needs of patients by providing a variety of services within the community to meet the needs of different patient groups. The most recent of these was a pilot that had been running since September 2015 for a community team to meet the need of the frail elderly. This had just been confirmed as a permanent service.
- The trust provided us with information prior to our visit and stated that a move to outcome based commissioning models for both diabetes and the care of older people living with frailty had been a key change. In response to these changes, the trust had successfully bid for the role of lead provider for these programs, and would be taking the lead in developing the clinical models for both areas. The trust also stated that as an integrated care organization they aimed to work closely with commissioners on integrated pathways.
- The CRT service appeared to be well tailored to the needs of the patients. Those referred to the service could be provided with care, which fell into five different pathways. Therapy groups provided many different exercises opportunities to meet the needs of those attending. Community visit therapy exercises met the rehabilitation aims of patients. The team was working on providing different age groups of patients with different therapeutic activities and the CRT had developed a closer working relationship with the commissioner for the service, who the team felt was now learning the needs of the patient group and responding positively.
- The commissioning of services was discussed on a home visit with a DN. The service was not commissioned to provide personal care for end of life patients and this was not done as routine. This was only if the visit required this as there could be a gap in care.
- Respiratory team members stated that due to differences in commissioning arrangements between the two boroughs they worked in and the geography of the trust, it was difficult to provide the same service to patients in different boroughs.
- The CORE Service stated that the trust could better meet the needs of their patients. The team wanted to encourage GPs to do spirometry with patients. This was currently an ongoing discussion with the CCG. The team would like to have a clinical psychologist embedded in the Haringey service, and would also like to establish smoking cessation services throughout both boroughs. The team stated that improving links with trust end of life care would also be beneficial to the service. In order to better support colleagues in the community, the CORE service stated it would like to use teleconferencing for team meetings.

Good

Are services responsive to people's needs?

Equality and diversity

- Community services were provided by staff groups who were generally representative of the local populations. For instance, there was a good cultural diversity amongst the podiatry team to meet the needs of the community. The service also had access to translation services. The IAPT team could offer psychological intervention in ten different languages due to the diversity of their staff group.
- The Hornsey physiotherapist service had two Turkish speaking physiotherapists who provided support in the community to the large Turkish population in the borough. The service also offered Turkish triage for patients.
- Patient information leaflets were available in the standard DN patient folder. It had information on making a complaint available in different languages.
- There was plenty of information available at the services we visited however, there was a lack of information available in other languages. For instance, in the main reception area of the CRT, and the health centres we visited, there was plenty information regarding treatment, services and the trust. The information was not seen to be available in other languages. Multi-lingual signage was not observed at service sites.

Meeting the needs of people in vulnerable circumstances

- In information the trust provided prior to our visit, they stated that they had introduced dementia champions across clinical settings and promoted the 'This is Me' document to aid communication of individual needs. They stated they had introduced dementia identifiers and a dementia webpage on the intranet. They also told us they had signed up to 'Johns Campaign', providing carers' passports and allowing carers to stay with their loved one should they wish to assist/feed/care any time day or night.
- The CRT used an assessment of function for dementia. The Montreal Cognitive Assessment was also used which was sensitive to picking up dementia. Staff told us that if working with dementia, they would look at working to specified goals. The service were aware of other support networks available when working with people with dementia. Referral to the memory clinic was also available as was the dementia navigator and Age UK.
- The CRT service provided a bus to pick up patients with mobility issues to attend appointments or groups at the CRT base. Equipment and occupational therapy could also be provided for in patient's homes.
- The DN services were observed to be very supportive of older patients they visited and understood the needs of working with this patient group.
- We observed podiatry staff discussing a patient's needs with the patient and discussing care planning at the first assessment. Staff discussed transportation needs with one patient who had difficulty accessing the service.
- In sexual health services there were out of hours clinics every weekday and a Saturday morning clinic. SHOC-sexual health outreach on call service, for female sex workers in Enfield and Haringey provided a street outreach service, a weekly sexual health clinic and a drop in two days a week. This was an integrated service with medical and nursing staff.

Access to the right care at the right time

- 60,000 face to face patient contacts took place in the community each month, with just under a third being district nursing contacts.
- The DN service carried out over 19,000 home visits in October and 17,000 in November 2015. Nursing quality indicators for the DN service showed the service averaging 506 unallocated visits for the year so far with the South East Islington team accounting for a clear majority of these. For instance, in September the team accounted for 417 unallocated visits. This meant there was a need to cover this service shortfall with cover from other teams and matrons. 'How we are doing' reports included the number of missed visits recorded by each DN team. Documentation provided showed there were a total of ten missed visits in October and November 2015, nine of which were in Islington.
- Nursing quality indicators for the DN service were provided for July to October 2015 and showed that the DN service were meeting the 48 hour target from referral to visit in 95% of cases. This was against a trust target of 90%.

Good

Are services responsive to people's needs?

- The trust measured the percentage of patients waiting less than 6 weeks to attend face to face initial appointments (from the date the referral was received to the initial attended face to face contact). Data submitted, from March to July 2015, showed that an average of 80% of face to face contacts were within this six week period. Podiatry teams averaged 70% and CRT 75%.
- In information the trust provided prior to our visit, they stated they had responded to an increased demand in a number of ways. In relation to emergency activity, there were a number of initiatives in place to reduce demand. They told us there was an ambulatory care unit in place that worked to prevent emergency admissions and redirected patients away from A&E, as well as other community based initiatives to help keep people out of hospital.
- Within the CRT, referrals were triaged into three different groups based on urgency and priority. Priority one was seen in one to four weeks, priority two was seen in four to eight, and priority three within eight to twelve.
- The CRT were getting a locum OT to assist the senior OT and three rehab assistants to help clear waiting times. They told us that the expectation was that they saw three patients a day but with travel and other duties this was not always possible. Most people were seen for a six to twelve week period but the service was able to see people for a lot longer in order to get patients to where they want to be.
- The podiatry service referral to treatment time (RTT) was around six weeks, which was being reviewed, as the team would like to offer treatment in three weeks.
- The CATS service currently had an 18 week RTT time but with an aim of a six week RTT time.
- The CORE team's RTT was approximately one to two days and was facilitated by use of computer tablets which allowed for the quick sharing of data.
- Among physiotherapy teams the RTT was currently running at three months to a first appointment and three weeks for follow up appointments. For the musculoskeletal physiotherapist service, RTT was approximately six weeks. Initial appointment times were 45 minutes unless capacity dictated the need for 30 minute 'blitz' appointments. The team had a Turkish triage clinic to meet the needs of the local population where routine physiotherapist appointments were seen within 7-10 working days, however acute cases such as neck or back, needed to be seen within three days.

Learning from complaints and concerns

- Nursing quality indicators for the DN service were provided for July to October 2015 and showed the service averaging seven complaints a month.
- The DN service manager told us that all complainants were offered a chat with the lead DNs or the service manager, to talk through their issues and that most complainants took up this offer. The service were in regular contact with PALS, who regularly spoke with the service manager or clinical lead regarding who would lead on complaint investigations as well as action points.
- Patient information leaflets were available in the standard DN patient folder, were visible in the main reception area of DN bases and detailed the complaints process and who to contact. There was information specific to both the trust and the DN service and contained the PALS number and information in different languages.

Good

Are services well-led?

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

Summary

- We rated the leadership of community services for adults as good because;
- The trust's vision and values around providing integrated patient centred care were reflected by the community staff we observed and spoke with. Community staff felt well supported by managers of community services.
- There were governance processes and lines of reporting to the executive team on quality for all three directorates with community services, with risk and quality issues discussed in local team meetings.
- Community staff generally felt there was a lack of understanding of their role by both trust leaders and their professional counterparts who were hospital based. All staff reported that meeting demand with current capacity was a challenge, which was only set to increase with further developed integrated community services within the trust. Low morale, high sickness and turnover were issues for some DN teams, while staff in another directorate felt under pressure from their leadership.

Service vision and strategy

- Senior managers were not able to present us with business plans. They told us these were in the process of being produced for each ICSU. They were to be presented to the board at the time of our inspection but were cancelled due to an anticipated junior doctors' strike. The management of the CRT stated they were happy with their directorate's business plan which identified the proposed areas of growth for the trust directorate until 2017.
- DNs reported to us that the trust's vision and values were to provide integrated patient centred care. They felt holistic assessment used by health and social care reflected this. Trust values were displayed in nursing areas of health centre DN bases.
- The values of patient centred rehabilitation were reflected in the attitudes we observed of the CRT staff. The CRT were aiming to develop a more integrated support service. A staff member stated there was good communication and relationship building with other services.
- The respiratory team stated they felt involved by the organisation as a whole. The team were generally aware of the vision of the service to reduce admissions for ulcer care.

Governance, risk management and quality measurement

- Each hospital directorate (ICSU) with community services had a dashboard for governance and quality. Each ICSU had a quality board which reported in to the executive team.
- With incident learning and practice, teams did their own investigations which fed in to the trust quality committee which was shared trust wide.
- The DN professional development and quality lead presented an audit programme topics for 2015/16. These were: essential nursing equipment, dress code, infection control, use of topical negative wound therapy pumps and incident of cellulitis in new patients. Three had been completed while the record keeping, use of topical negative wound therapy pumps and incident of cellulitis in new patients were still to take place.
- Governance, risk and quality issues were also discussed at DN team meetings and DN forums. 'How we are doing' statistics were reported on monthly by DN services. This covered the number of patients on each DN team caseload, the number of home visits undertaken, the number of not recorded as completed on the electronic record system, the number of patient surveys completed, the 2 hour and 48 hour KPI reporting times, place of choice of death, pressure ulcers, medication incidents, missed visits and other incidents.
- There were weekly team meetings within the CRT which fed into the directorate's monthly meetings. This group was still being established and had met three times so far. The agenda for that meeting was about

performance and the quality of services, updates on what was happening in the trust and information for staff. The trust directorate had also established a monthly quality, governance and risk meeting, however this had yet to meet and the agenda was yet to be finalised.

- The respiratory team were unclear from discussions how they accessed trust clinical governance meetings. The team had carried out an audit of the use of Handbase (the case-note management app used on tablets) approximately three years ago to establish if it was useful, but this has not been audited since.
- A recent audit demonstrating a reduction in the number of admissions had been published in "Podiatry Now" journal. The CORE team recently completed an audit of bed day savings over the course of the year. Findings were presented to the British Thoracic Society along with feedback from patient satisfaction and the Family and Friends surveys.

Leadership of this service

- Community services for adults were located within three of the seven trust directorates, known within the trust as Integrated Care Service Units (ICSUs). They were managed alongside inpatient services within these directorates.
- The Medicine, Frailty and Networked Services (MFNS) ICSU managed specialist nursing of long term conditions, continuing healthcare, support to nursing homes and GPs, and community rehabilitation. The Out Patient and Long Term Care (OPLTC) ICSU managed: nutrition and dietetics, tissue viability and lymphoedema services, podiatry, musculoskeletal physiotherapy, clinical assessment and treatment, health centre managers, bladder and bowel specialist nurses, IAPT, self -management and smoking cessation. The Emergency and Urgent Care (EUC) ICSU managed: district nursing, virtual ward, rapid response, primary care and alcohol and drug services.
- Responsibilities for service directors, clinical leads and heads of nursing for the directorates was for both inpatient and community services, in keeping with the integrated ethos of the trust.
- DNs reported that clinical leadership and managerial support as positive. The executive team were reported as not visible within the community. An executive member came out to the community on a monthly basis but DNs felt that the director of nursing should be more visible in the community to better understand the pressures and challenges of the DN service.
- Physiotherapists felt the staff team were well supported by their leadership within the community.

Culture within this service

- Senior managers told us they had been a clinically led integrated care organisation since 2011, which had a philosophy of 'local care for local people'. The culture of the trust was all about integrated care, with learning shared across the integrated ICSUs.
- Across community services for adults, senior managers, clinical leads, service managers and healthcare professionals were all acutely aware of the high demands placed on community services across the trust which was only set to increase as the culture of integrated care and earlier discharge was further embedded. Staff told us that patients were returning to the community, from hospital earlier and with more need. Services needed to adapt to meet this need. They felt that the culture of the trust was changing as a result and there was now real motivation to implement a more integrated model of care in the community. It was felt that the trust leadership could drive this further by placing more value on community services through funding, as acute still seemed to be prioritised. Healthcare professionals from all disciplines told us there was a lack of understanding from hospital based staff of the nature of community working and what it entailed. For instance, DNs reported that acute staff did not know what working in the community entailed. Therapists told us their hospital counterparts lacked an understanding of their role. Simple procedures and visits took a lot longer and all community professionals took on a more holistic case management role and, as an integrated trust, this needed to be better understood.
- All staff felt that meeting demand with current capacity was a challenge. All the staff we met also cared about the work they did with patients but were aware of the effect this had on staff morale. DN teams were aware that this was most acutely true of the City Road DN service, where morale was lowest. This was due to the

available capacity not meeting the high demands of the service. There was a high sickness rate and a high turnover of staff. There was a daily list of unallocated patient visits allocated out to other teams. Staff regularly worked beyond their allocated hours. Training was often cancelled to accommodate capacity issues. For instance, recently wound care training had been cancelled.

- Within the OPLTC directorate, it was reported that demands on the service had led to members of staff feeling pressured and feeling bullied by leadership, and not willing or able to speak up. Staff members wished to maintain confidentiality but felt intimidated. Physiotherapists told us morale was variable but generally good. The teams were not aware of any incidents of bullying or harassment, or of incidents of stress related illness. Podiatrists told us they felt supported by their managers however, there was a general feeling that morale was low due to the changes to the service. One staff member stated feeling that the service was well led and there were good access to mentors, but also stated morale was low.
- At sexual health services we received inconsistent messages from staff. One consultant told us everything was all well and that leadership was good at all levels. All other staff unanimously told us there were major problems with the leadership at several levels and morale was very low.

Public and staff engagement

- Friends and family scores from February 2014 to August 2015 showed that 351 of 398 were likely (148) or extremely likely (203) to recommend the service.

Innovation, improvement and sustainability

- The trust provided us with information prior to our visit and stated that a move to outcome based commissioning models for both diabetes and the care of older people living with frailty had been a key change. In response to these changes, the trust had successfully bid for the role of lead provider for these programs, and will be taking the lead in developing the clinical models for both areas. The trust also stated that as an integrated care organisation they aimed to work closely with commissioners on integrated pathways.
- Senior managers told us there had been innovation in working across the trust directorates and stakeholders regarding learning good pressure care management. There had been a safeguarding element to pressure ulcer care with local authorities, in order to tie in to reporting processes. Trust tissue viability nurses went in to care homes and the care homes nurse was able to identify themes or trends among care homes. Skin bundles had been introduced across care homes and Haringey CCG were introducing something similar.
- Two Turkish speaking physiotherapists were specifically employed to deliver a service to the Turkish community. This came about through identifying a high demand on interpreters within the community service.
- Integrated care service teams (ICAT) had been piloted in the boroughs of Haringey and Islington. It was a GP led multidisciplinary service whose primary function was to work with the top 2% of GP patients at risk and who placed huge demands on GP services. Matrons in the teams had access to GP and hospital records to establish which patients were in need of the service. They also worked to get people home from hospital by working with packages of care and nursing teams in the community. They had been piloted for nine months and shortly before our inspection a decision was taken to formally establish them.
- The Hornsey physiotherapist team stated that they were proud of their falls clinics, which provided support for patients twice a week for twelve weeks. The service has also been working with Transport for London (TFL) to practice transferring patients on and off buses.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found examples where health care assistants (HCAs) were authorised to administer insulin following competency sign off which was not patient specific and not delegated appropriately by a nurse, or the prescriber with specific instructions about which patients the HCAs can administer insulin to. Specific staff are required to be authorised to administer to specific patients only. 12,2(g).