Central London Community Healthcare NHS Trust

RYX

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1968304531	Colville Health Centre	Colville Health Centre	W11 1PA
RYXY9	Edgware Community Hospital	Edgware Community Hospital	HA8 0AD
RYX02	Soho Centre for Health and Care	Soho Centre for Health and Care	W1D 3HZ
RYXX4	St Charles Centre for Health and Wellbeing	St Charles Centre for Health and Wellbeing	W10 6DZ
RYXY9	Violet Melchett Clinic	Violet Melchett Clinic	SW3 5RR
RYXY8	Central London Community Health Services – HQ	Central London Community Health Services – HQ	SW1E 6QP

This report describes our judgement of the quality of care provided within this core service by Central London Community Healthcare 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 Central London Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Central London Community Healthcare NHS 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

Overall rating for this core service Good

Overall we judged community health services for adults as good.

The service had identified and reported incidences of pressure ulcers as an area to improve and had responded appropriately particularly through training, communication and distribution of resource packs to residential home staff. Incidents were reported consistently across teams and feedback facilitated learning and change of practice.

We reviewed patient records within community sites, patients' homes and during our observation of patient care. Initial assessments, risk assessments, care plan reviews and consent information were fully completed. The service maintained a risk register of identified risks in community settings and staff demonstrated awareness of key risks to patients and arranged further support when required.

Staffing levels required to achieve safe staffing levels in community and specialist nursing teams reflected the skill mix of staff as well as the number and needs of patients. Although we were told staffing deficits meant staff worked excess hours and extended shifts to cover work allocated to their team.

The service used National Institute of Health and Clinical Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. The tissue viability service had developed examples of innovative practice and had taken part in international research and the development of NICE guidance. We found staff understood their individual roles and responsibilities in the delivery of evidence based care and used nationally recognised assessment tools to screen patients for risks. Recognised assessment tools supported by national guidance were used to support the review of patients.

Multi-disciplinary, patient–centred care was evident and involved a range of specialist staff involved in joint visits to the patient. External partners included GPs, housing and social services, police, the prison service, and mental health.

Referrals to community health services came from a variety of services including GPs, practice nurses, district nurses, patients being discharged from hospital wards and complex cases in nursing homes, residential homes, and police and prison services.

We saw patients were consented appropriately and correctly and consent was obtained before care was delivered. We reviewed consent information as part of our review of records and found this was obtained and recorded appropriately.

During our inspection, we observed patients and relatives being treated with dignity, respect and compassion. Staff were very considerate towards patients, their relatives and other people. The promotion of self-care was of particular relevance to the care of patients and we observed patients' independence was promoted during visits from the service.

Managers worked with commissioners of services, local authorities, other providers, GPs and patients to co-ordinate and develop services responsive to the needs of patients. We found patients could access community health services promptly in the areas we visited. Indicators for community services showed that patients were assessed promptly for care and treatment, and this was consistently within the expectations of patients and commissioners.

Information for patients about services included information about how to make comments and compliments or raise concerns or complaints and information about the Patient Advice and Liaison Service (PALS). Patients we spoke with were aware of the complaints procedure. In community locations we saw copies of the PALS leaflet were available.

The trust board placed emphasis on developing a vision and strategy, ensuring clear accountabilities and effective processes to measure performance and address concerns, leadership, culture and values. Clinical Business Unit Managers and Team Leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive and provided leadership.

Summary of findings

Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. There was good team working. Staff were enthusiastic and felt involved in the decision making process. They felt they had the time to spend with patients and provide the care required.

Community services had commenced engagement with the public through the NHS Friends and Family test had set up and actively engaged with a number of patient representative groups. The trust had developed a number of initiatives to ensure effective engagement with staff.

We saw the tissue viability service had developed innovative practice and had taken part in international research and the development of NICE guidance. The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients.

Summary of findings

Background to the service

Central London Community Healthcare NHS Trust provided a number of services across London, which included: adult community nursing services; children and family services; specialist services to help manage long term conditions; rehabilitation and therapies; palliative care services; offender health services and NHS walk-in and urgent care centres.

The Trust provided healthcare in the boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, and Westminster. The Trust worked closely with the Barnet Clinical Commissioning Group and the three CCGs which make up North West London Clinical Commissioning Groups.

Community services for adults covered services provided to adults in their homes or in community based settings. The services were focused on providing planned care, rehabilitation following illness or injury, ongoing and intensive management of long-term conditions, coordination and management of care for people with multiple or complex needs, acute care delivered in people's homes and health promotion.

The core services included community nursing services and integrated care teams, including district nursing, community matrons and specialist nursing services as well as:

- community therapy services;
- community intermediate care;
- community rehabilitation services;
- community outpatient and diagnostic services.

During this inspection we met with in excess of 120 managers and staff representing a range of roles and seniority. We included qualified nursing staff, specialist nurses, allied health professionals (physiotherapists, occupational therapists and speech and language therapists) health care support workers, team leaders and managers. Interviews were conducted on a one to one basis, in small groups of two or three staff within a service, or in group discussions arranged as focus groups.

Inspectors spoke with more than 35 patients in a number of settings. We visited clinics, and we accompanied district nurses to observe patients receiving care at home as well as to talk with patients and their relatives about their experience of the service. We also received feedback from patients who had completed comment cards.

Our inspection team

Our inspection team was led by:

Chair: Paula Head, Chief Executive, Sussex Community NHS Trust.

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Specialist Dental Adviser , Community Paediatrician, Palliative Care Consultant, General Practitioner, Community Matron, Intermediate Care Nurse, District Nurses, Health Visitors, Physiotherapists and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

Summary of findings

How we carried out this inspection

What people who use the provider say

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 7 to 10 April 2015.

Good practice

- The service responded proactively to reported incidences of pressure ulcers through training, communication and distribution of resource packs to residential home staff. The tissue viability service had developed innovative practice and had taken part in international research and the development of NICE guidance.
- Staff understood their individual roles and responsibilities in the delivery of evidence based care and used nationally recognised assessment tools to screen patients for risks.
- Multi-disciplinary, patient–centred care was evident and involved a range of specialist staff involved in joint visits to the patient. External partners included GP's, housing and social services, police, the prison service, and mental health.
- The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should:

- Review arrangements to support adequate staffing of all community nursing teams to ensure patients are not placed at risk.

Central London Community Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The service had identified and reported incidences of pressure ulcers as an area to improve and in response, the trust had developed Pressure Ulcer Prevention and Management training as an e-learning module, introduced objective structured examinations and distributed resource packs to residential home staff.

Staffing levels required to achieve safe staffing levels in community and specialist nursing teams reflected the skill mix of staff and the individual needs of patients. Staffing deficits meant staff said they were working excess hours and working extended shifts to cover work allocated to their team.

Foreseeable risks and planned for changes in demand due to seasonal fluctuations including disruptions to the service due to adverse weather were managed through emergency plans including plans to meet the needs of vulnerable patients in severe winter weather, heat waves and during power cuts.

Detailed findings

Incident reporting, learning and improvement

- There were no Never Events reported in community hospitals or other settings in the community between February 2014 and January 2015.
- Between February 2014 and January 2015 the trust reported 174 serious incidents in community hospitals or other settings in the community; of these 131 occurred in patients' homes (131).
- The majority of incidents (145) were grades three or four pressure ulcers.
- The service had identified and reported incidences of pressure ulcers as an area to improve and had

undertaken communication and training initiatives within care and residential homes. Pressure ulcers assessed as grade three severity or above were referred for investigation as a serious incident and a root cause analysis was undertaken.

- We reviewed a sample of investigation reports submitted by the service. Root cause analysis (RCA was completed as part of the investigation of incidents. RCA's identified learning from incidents and lessons learned from incidents were shared across teams.
- In response to incidents of pressure ulcers, the trust had developed Pressure Ulcer Prevention and Management training as an e-learning module, introduced objective structured examinations and distributed resource packs to residential home staff.
- The speciality reporting the most incidents was 'Community Nursing', which also had a higher proportion of incidents (19%) causing moderate harm to the patient compared to other specialities (nutrition and dietetics (11%), rehabilitation (6%), palliative medicine (3%), thoracic/respiratory medicine (10%).
- Incidents were reported using an electronic incident reporting system and we saw these were consistently reported across teams. Staff used the reporting system appropriately to record and report incidents and staff received feedback which facilitated learning and change of practice. Learning was supported by sharing the results of pressure ulcer audits and dissemination to staff.
- Individually and within focus groups staff explained they found the reporting system accessible. All grades of staff were encouraged to report incidents and staff told us issues were escalated and learning identified. Feedback following investigation was given individually and in team meetings.
- We reviewed a sample of investigation reports submitted by staff and saw root cause analyses (RCA) had been carried out as part of the investigation process. RCA's identified causes, lessons learnt and actions to prevent reoccurrences.
- Safety alerts were reviewed for relevance by clinical leads and identified for dissemination to staff; alerts relevant to the service were displayed on staff notice boards.
- Arrangements had been made to train staff in the duty of candour as part of mandatory training.
- Some staff we spoke with were able to explain their understanding of the requirements of duty of candour, although others were unaware of the requirement.

Safeguarding

- The service had a safeguarding policy in place. Staff were able to explain and demonstrate they understood the policy and how they used this as part of their practice.
- Staff received training in safeguarding as part of their mandatory training. Safeguarding adults (level one) training was included in the corporate induction training. Staff received further training annually including update training, at a level appropriate to their area of work.
- We reviewed evidence within community based settings and saw that compliance with mandatory safeguarding training was 80% to 95% against a trust target of 90%. In areas where compliance with training was below the target level, relevant staff had been booked on the next available training date.
- Staff we spoke with could describe the different types of abuse, and how they reported and alerted potential safeguarding issues. Safeguarding issues were reported to the safeguarding lead for further investigation. If safeguarding concerns were identified, the clinical lead was invited to attend the safeguarding strategy meeting with other members of staff involved and learning was shared with the team.
- Patients we spoke with felt safe and expressed confidence in the staff that worked with them. Information about safeguarding for patients in the community including contact information was displayed on staff notice boards.

Medicines

- Medicines were observed to be prescribed, supplied, stored and administered appropriately. Controlled drugs were handled appropriately, with the involvement of the GP as necessary.
- Training in the administration of medicines was undertaken by appropriate staff groups. Training in prescribing was supported for staff who expressed an interest where this was appropriate to their role.

Good

Are services safe?

- We saw Patient Group Directions (PGDs) were in place where appropriate, for example the administration and/or supply of Enoxapirin and for the administration of Lidocaine in Musculoskeletal clinics.
- We reviewed drug administration records in twelve patient records held in community based settings and patients' homes. Patient group directions were checked for patient administration of medication including pain relief. Staff were aware where medication errors had occurred, these were reported as incidents and were followed up so that learning points were identified.

Environment and equipment

- We found there were adequate stocks of equipment, and for some items of equipment, patients were offered a choice. In urgent instances, equipment could be supplied to the patient the same day. A limited emergency stock of equipment was available for supplies out of hours.
- All equipment viewed was regularly cleaned, electrical tested and service records of equipment were available. Medical devices were recorded on the trust's asset register showing service due dates.
- We saw processes were in place for planned maintenance, the return of used equipment and the procurement of replacement equipment.
- Resuscitation trolleys in community sites were clean and well stocked and daily checks of equipment were completed and recorded.
- Medical device alerts were displayed on staff notice boards.

Quality of records

- We reviewed a sample (18) of patient records within community sites, patients' homes and during our observation of patient care. Initial assessments, risk assessments, care plan reviews and consent information were fully completed.
- Records of actions taken and the administration of medication were documented appropriately.
- Community based staff completed and updated records when they visited the patient in notes kept within the patients' home or community setting. On return to their base, this information was also recorded in the patient's computerised records management system.
- The trust was in the process of moving to a computerised records management system linked to GP practices which enabled information sharing.

Cleanliness, infection control and hygiene

- The service had infection prevention and control policies in place.
- We observed staff during visits to patients in their own homes, care homes and clinic sessions. Staff demonstrated they had a good understanding of infection prevention and control. Staff followed trust guidelines for hand washing and wearing clothing bare below the elbow.
- We saw staff cleaned their hands and used hand gel prior to and after care was given, used gloves and aprons appropriately and cleaned reusable equipment. All locations visited adhered to schedules for cleaning and appeared visibly clean, tidy and sharps boxes were available.
- Cleaning audits were undertaken (January 2015) to identify risks and issues. Any lapses were identified and action taken. Hand hygiene audits were completed monthly with scores ranging from 93% to 100% compliance.
- Information about infection control was displayed on staff notice boards in community based settings and included guidance about correct waste disposal, hand hygiene techniques and methicillin-resistant staphylococcus aureus (MRSA) screening.
- We were informed that each team included an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.
- Aseptic Non Touch Technique (ANTT) validation audit showed 95% compliance. eLearning in ANTT techniques had been re-launched in 2014 and was mandatory for all staff carrying out invasive procedures.

Lone working

- The Trust had a lone working policy in place and implemented procedures to reduce the risks to staff working alone. Patient records identified and alerted staff to addresses which were considered to represent a higher risk to staff working alone.
- Lone worker risk assessments were completed by community teams and reviewed regularly. Staff worked

with a colleague when visiting patients in the evenings when a patient had been identified as a higher risk and also stayed in touch by mobile phone and sent a text message to colleagues to say they had reached home safely.

- The Trust was in the process of rolling out lone worker devices, based on risk assessment, enabling staff to alert colleagues if they encountered a situation in which they were vulnerable. The devices enabled staff to discretely allow the control centre to listen to interactions with patients in potentially higher risk situations.
- These devices also allowed the control centre to locate and track staff through global positioning systems (GPS) and to send assistance if required.

Mandatory training

- We reviewed the trust records for training and this showed the percentage of mandatory training completed by type of training. Although we found records of mandatory training for some community locations were not up to date at trust level due to delays in recording, overall a very high proportion of mandatory training was completed.
- For example the completion of health and safety training was shown to be 87% for nursing staff, 85% for nursing and healthcare assistants, 90% for physiotherapists and 96% for occupational therapists.
- Mandatory training for community based staff included resuscitation, infection control, information governance, fire safety, equality and diversity, moving and handling, health and safety, conflict resolution, safeguarding adults and safeguarding children.
- Locally maintained records for each member of staff in community locations included mandatory training attended. When we spoke with staff in community locations and reviewed their local mandatory training records, we found that training had been undertaken in most instances, or arrangements had been made to attend training.

Assessing and responding to patient risk

- We observed nursing team handovers and saw that concerns were identified and escalated appropriately. Staff demonstrated confidence in being able to escalate their concerns about deteriorating patients. Senior clinical staff provided advice and a daily review of the patient waiting list took place to continually assess the capacity of the team to respond to the needs of vulnerable patients.
- Services maintained a risk register of identified risks in community settings. For example, where patients had been assessed as presenting a higher risk to visiting staff, this was noted on the patient's records.
- Community based staff demonstrated awareness of key risks to patients and arranged further support when required such as the supply of additional equipment, or referral to further specialist assessments.
- Risk assessments were completed for each patient at the initial visit and included skin integrity, nutrition, falls risk, pain assessment, and activities of daily living. The service proactively responded to identified risks by assessing the urgency of the need and developing treatment plans to respond to priority patients.
- We observed nursing team handovers and saw that concerns were identified and escalated appropriately. Staff demonstrated confidence in being able to escalate their concerns about deteriorating patients. Senior clinical staff provided advice and a daily review of the patient waiting list took place to continually assess the capacity of the team to respond to the needs of vulnerable patients.
- These also showed that support and training had been identified regarding the use of different aspects of the malnutrition tool and the trust 'Multi-factorial Risk Assessment Tool'.
- Feedback was presented in staff meetings and incomplete or untimely assessments were monitored and staff responsible questioned in order to offer individual training and supervision.
- The tissue viability team were also involved in providing support. Tissue viability specialist nurses facilitated training days for community based teams and provided telephone support.
- We reviewed the completion of patient risk assessments as part of our review of patient records. Risk assessments were fully completed and the information was up to date.

Staffing levels and caseload

Good

Are services safe?

- Staffing levels required to achieve safe staffing levels in community and specialist nursing teams reflected the skill mix of staff and the need to travel within the areas covered as well as caseload numbers.
- A "complexity tool" to measure the complexity of caseloads was also used to provide support for planning caseloads. Caseload allocations were reviewed periodically to reassess the frequency and appropriateness of visits to patients with long term conditions.
- Staff from community locations we visited identified to us that the shortage of staff in their team was an issue and they said they were working excess hours and working extended shifts to cover work allocated to their team.
- Data provided to the trust board confirmed vacancy rates across the trust at 19% for qualified nurses and 9% for allied health professionals. These were confirmed by specific vacancy rates for district nurses of 22% for West London CCG and 25% for Hammersmith and Fulham CCG.
- However, data provided by the trust showed an average fill rate for registered nurses of 93% and for care staff 117% during the day. At night the average fill rate for registered nurses rose to 97% and for care staff fell to 113%.
- Specialist nursing teams we spoke with informed us that staffing levels were sufficient for current contact levels, although increases in referrals as well as the complexity of cases, required regular review.
- Sickness absence rates of 4% for qualified nurses and 2% for allied health professionals were reported (March 2015).
- Staff shortages were identified on the trust's risk register and staff told us they escalated issues related to staffing levels which were then sorted at a local level. Feedback was received from incidents reported and these were discussed at team meetings.
- Identified staffing shortages were escalated to team leaders when the revised roster was planned, which in turn were escalated to Clinical Business Unit Managers. The service used a trust bank service to obtain cover for peaks in community nursing workload. Bank staff had received a trust induction and had access to trust policies and procedures.
- The trust had set a 70:30 bank to agency staff ratio as a target to move the trust to a position of less reliance on agency staff. The trust is not yet meeting this target and the trust had continued to make the bank more attractive and work was underway to provide weekly payments to bank staff working in Barnet in order to increase and maintain the size of the bank.

Managing anticipated risks

- Foreseeable risks and planned for changes in demand due to seasonal fluctuations including disruptions to the service due to adverse weather were managed through emergency plans including plans to meet the needs of vulnerable patients in severe winter weather, heat waves and during power cuts.
- Updates to emergency plans were shared with the governance team and minutes of emergency planning meetings were shared with staff. Community staff we spoke with were aware of these emergency arrangements.
- Health and safety risk assessment tools were available on the staff intranet and we saw clinical and team leads regularly reviewed actions to be taken and followed up any outstanding actions.
- Patients with additional support needs had been identified and this enabled staff to identify those who required a visit in an emergency situation, such as oxygen users, diabetic patients and those with electrical equipment.

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

The service used National Institute of Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients.

The tissue viability service had developed examples of innovative practice and had taken part in international research and the development of NICE guidance.

Multi-disciplinary, patient–centred care was evident and involved a range of specialist staff who may also be involved in joint visits to the patient. External partners included GPs, housing and social services, police, the prison service, and mental health.

We saw patients were consented appropriately and correctly and obtained before care was delivered. We reviewed consent information as part of our review of records and found this was obtained and recorded appropriately.

Detailed findings

Evidence based care and treatment

- The service used National Institute of Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients.
- We saw evidence of references to and use of national guidelines within a number of services, e.g. 'Liraglutide starting and stopping following NICE guidelines', 'Home enteral tube feeding (HEFT)' and 'NICE Guideline Pressure Ulcer CG029'. Specific pathways and guidance were used for certain long term conditions which staff accessed on the trust intranet.
- The tissue viability service had prepared local wound formulary guidelines for wound dressing and care which reflected NICE guidance. A pressure ulcer leaflet for staff to give to patients was also based on NICE guidance. The respiratory team used local guidance which drew on NICE Chronic obstructive pulmonary disease (COPD) guidelines for pulmonary rehabilitation.
- The tissue viability service had developed examples of innovative practice and had taken part in international research and the development of NICE guidance. The service was in the process of updating NICE guidance for national use at the time of our inspection. The service had taken an innovative patient centred approach, focused on the needs of patients and support for the patient's self-management of their condition.
- Staff understood their individual roles and responsibilities in the delivery of evidence based care and used nationally recognised assessment tools to screen patients for risks, and referred to relevant codes of practice, for example infection control procedures.
- We saw patients' assessments were completed using templates available on the trust's computer system which followed national guidelines for measuring harm reflected in the NHS Safety Thermometer.
- Records we reviewed confirmed that assessments were completed and updated at relevant and appropriate intervals for skin integrity, nutrition, falls risk, pain assessment, and activities of daily living were included in assessments.
- We observed that when administering care and treatment and in handovers the use of pathways and guidance was followed. Staff we spoke with understood how NICE guidance was applied and supported local guidelines. When we observed staff administering care to patients we saw that assessment guidelines were used correctly.
- The falls service followed national and international best practice in developing assessment guidance and screening tools used by occupational therapists followed NICE guidance to measure effectiveness.
- Patients were supported to exercise at home and in small group sessions to improve cognition and minimise the risk of falls for older patients. The service followed NICE guidance which indicated that patients aged 75 years and over could access treatment directly.
- Staff received the minutes of meetings where guidance was discussed and which included changes to practice which might affect their area of work. Audits were used in the service and informed the development of local guidance and practice.

Good

Are services effective?

Pain relief

- A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. We found care plans indicated if a review was required.
- Our observation of staff administering care and treatment and our review of patient records confirmed that patients were assessed appropriately for pain symptoms. We observed there was attention to pain during the patient examination and pain relief was offered immediately.
- Patients received treatment which applied pain relief effectively and pain management plans were discussed with the patient to ascertain their pain levels and to provide advice.
- Specialist nurse teams referred patients directly to the pain service. Community nursing staff liaised with GPs to ensure patients were taking medication as prescribed to control pain symptoms.

Nutrition and hydration

- We observed that assessments using a recognised assessment tool supported by national guidance were completed appropriately to assess the patient's nutrition and hydration needs.
- The service monitored monthly the proportion of patients assessed for nutritional requirements at their first visit and we saw care plans were in place for nutrition and hydration.
- Community and specialist nursing staff referred patients to a dietician where the need for additional support and advice on appropriate treatment was required.
- Information leaflets about nutrition and hydration were available for patients which provided dietary advice to improve nutritional intake and help prevent weight loss.
- Clinics for patients with diabetes were attended by a dietician to provide practical advice for patients about healthy food choices and to work with patients to change their eating habits.
- The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients. The service participated in international research and publication.

Patient outcomes

- The trust had completed a number of audits in 2014, for example compliance to malnutrition screening, falls guidance and compliance with NICE guidelines on managing pressure ulcers.
- Audits showed a drop in the number of pressure ulcers recorded (43) in December 2014 against previous months. Audits detailed the ongoing response to incidents of pressure ulcers i.e. pressure ulcer competency and training, quarterly deep dive into pressure ulcers reported to the Quality Committee and review of the Pressure Ulcer policy across the Trust.
- The tissue viability team were also involved in providing support. Tissue viability specialist nurses facilitated training days for community based teams and provided telephone support.

Competent staff

- Trust data showed 74% of community and specialist nursing staff had received annual appraisal and staff development in the last twelve months. We reviewed the trust report of appraisal rates for each service and location and these varied between 75% and 95%.
- This data also showed 80% of nursing/healthcare assistants, 78% of physiotherapists and 85% of occupational therapists had received annual appraisal and staff development in the last twelve months.
- We saw that remaining staff had dates arranged for their annual appraisal and they confirmed to us that development was identified at these meetings.
- All new staff completed a trust induction, complemented by induction and job shadowing locally. The trust provided all staff with training to support and enhance competencies in particular skill areas relevant to the service.
- Data provided showed 84% of nurses, 90% of nursing/healthcare assistants, 88% of physiotherapists and 76% of occupational therapists had received training and development within the last twelve months.
- Staff told us training and development was supported throughout the trust, training needs were identified as part of appraisal, and through one to one meetings. Staff were supported to complete education and skills development.

Good

Are services effective?

- Staff confirmed Clinical Business Unit Managers and Team Leaders provided clinical supervision for staff across teams every four to six weeks.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary, patient–centred care was evident and involved a range of specialist staff who may also be involved in joint visits to the patient. External partners included GPs, housing and social services, police, the prison service, and mental health.
- In some community locations, staff in specialist services shared accommodation with community matrons and district nursing staff. Staff told us they felt the joint arrangements were an advantage in supporting joined up working between community based teams.
- Community nursing teams worked closely with GP practices and with social services in supporting care and treatment for patients in community settings using multidisciplinary teamwork to support the coordination of care pathways.
- GPs were kept fully informed of specialist assessments and community teams worked closely with practice nurses and specialist teams were available to provide advice.
- Specialist nursing staff provided support for community clinics and professional advice for community nursing colleagues to support multi-disciplinary working and the use of best practice for patients. For example, a dietician attended community clinics to provide advice for patients.
- We observed visits to patients' homes and saw that district nursing staff contacted appropriate specialists for advice and to arrange support for the patient. Nursing staff told us they felt well supported by other professional staff who provided multi-disciplinary support.
- Multi-disciplinary team meetings were held to address the needs of patients with complex care needs. We saw there was co-ordinated working between the specialist musculoskeletal service and other specialists in orthopaedics, physiotherapists and podiatry and maintained links with occupational therapists and with the falls team.

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, practice nurses, district nurses, patients being discharged from hospital wards and complex cases in nursing homes, residential homes, and police and prison services.
- District nurses were able to refer patients urgently for assessment to the rapid response service in order to prevent a hospital admission.
- All referrals followed agreed pathways of care and staff confirmed there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- Staff working in specialist services confirmed referral pathways were followed and they received few inappropriate referrals.
- Patient transfers to other services followed agreed pathways. An example of this was where musculoskeletal specialists working with the pain clinic service referred patients to physiotherapy specialists working with hospital departments and then liaised with the falls team and occupational therapists to arrange appropriate support for patients.
- Discharge arrangements from hospital were supported by community teams. Community nurses liaised closely with acute hospitals prior to discharge of patients.
- Patients discharged from the community nursing caseload and admitted to hospital were supported by the district nurse who liaised with the ward to support their admission. The community nurse visited the ward to check that patients needing support due to be discharged to a home setting were comfortable to return home and to arrange for intervention from the community team.
- We found integrated arrangements for discharge liaison between hospital and community settings were effective. Discharge care plans were prepared for patients and recorded on the trust's information system. The discharge pathway could involve self-care with GP support with access to a range of other support services.

Access to information

- We reviewed information on the trust intranet that staff used to support their work and saw the information was clear and accessible. This also enabled staff to access practice and information about patient care and treatment through external internet sites.

Good

Are services effective?

- Staff received corporate emails with team briefings, newsletters and other updates about particular themes on a regular basis.
- In community locations, information displayed in the staff area was up to date and relevant. Themes were used to draw attention to particular issues relevant to staff. Staff briefings included information about other services within the trust and other organisations nationally.
- The use of information across community teams was enabled through the recent introduction of common systems in the trust and GP practices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw patients were consented appropriately and correctly and consent was obtained before care was delivered. We reviewed consent information as part of our review of records and found this was obtained and recorded appropriately.
- We observed that Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) courses attended were included in the member of staff's individual training log. We did not see overall figures for staff attendance.
- However, staff we spoke with demonstrated a clear understanding of the Act, of their responsibilities and of DoLS procedures. Mental capacity assessments were undertaken if nursing staff had a concern that the patient might not have capacity to consent.

Good

Are services caring?

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

Summary

During our inspection, we observed patients and relatives being treated with dignity, respect and compassion.

Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed. We observed staff also providing emotional support to carers and relatives.

Patient's management plans were discussed and at all contacts with patients, questions were answered and advice was given to patients directly, carers and relatives.

Detailed findings

Compassionate care

- During our inspection, we observed patients and relatives being treated with dignity, respect and compassion. We observed caring, compassionate care being delivered. Staff were seen to be very considerate towards patients, their relatives and other people.
- Staff had a good understanding with patients and had built up good relationships with patients they knew.
- When delivering care and treatment, staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records.
- We observed telephone calls made by staff to speak with patients. Staff consistently demonstrated good communication skills and a caring approach to the patient. Patients were advised in a caring, competent and compassionate manner which maintained their dignity.
- Throughout our inspection we found the approach staff used was consistently appropriate to the setting and demonstrated compassion and consideration for the patient.
- We observed care and treatment being delivered by tissue viability specialist nurses who respected and maintained patients dignity and administered care sensitively and with compassion.
- All patients, carers and relatives we spoke with were very positive about the care and treatment they received.
- Letters and comment cards received from patients were displayed in community locations we visited and showed consistently positive comments. The trust had recently introduced the Family and Friends Test as a means of receiving patient and family feedback, results showed 95% of patients agreed they were treated with dignity and respect.

Understanding and involvement of patients and those close to them

- We observed care and treatment being delivered in community locations and saw staff demonstrated good communication skills during the examination of patients, giving clear explanations and checking understanding. We observed staff listened to patients, explained their symptoms and identified patients' needs.
- Staff answered questions from patients directly and explained what the patient could expect to happen next and likely outcomes. Further visits were arranged where more information was required to support and involve the patient in their care and treatment.
- Staff in a focus group told us community nursing teams involved the patient, family and carers in decision making. Patients were involved in decision making about their care and treatment. We observed district nurses give advice to patients on medication and using assessment, clinical specialists set goals with the patient's involvement and planned with the patient so that their needs were addressed to help them achieve their goals.
- We observed home visits by community nursing staff where patients were involved in their own care plans where appropriate and able to do so. Nurses used their relationship with patients and carers to support the patient and determine if information was understood.
- Staff in community clinic settings used a management plan from the patient's previous visit and gave positive feedback and more information and explanation of mobility and walking aids. The management plan was discussed with the patient and a patient information leaflet provided where appropriate.

Emotional support

Good

Are services caring?

- Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed. We observed staff also providing emotional support to carers and relatives.
- Staff explained patients had access to 24 hour contact with the community nursing team if required. Patients and relatives were referred to specialist services to provide support where appropriate.
- A bereavement service had provided a leaflet which gave practical information for people who were bereaved. The brochure was available in other formats and languages other than English.

Promotion of self-care

- Staff told us the promotion of self-care was of particular relevance to the care of patients in community settings. We observed that patients' independence was promoted during visits from the service. Patient leaflets and verbal advice about self-care were available. Information leaflets were provided to patients for health promotion and self-management of long term conditions.
- The physiotherapy service supported exercise regimes for patients in community clinics and we observed a clinic session where the patient exercises regime was reviewed and improvements discussed. The patient's progress was discussed with them and encouragement was given to the patient regarding their progress with exercise.
- Patient's management plans were discussed with them and equipment needs reassessed. At all contacts with patients, questions were answered and advice was given to patients directly, carers and relatives.

Good

Are services responsive to people's needs?

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

Summary

Managers we spoke with across a range of community services were aware of the issues in their area to develop services responsive to the needs of patients. They worked with commissioners of services, local authorities, other providers, GPs and patients to co-ordinate and integrate pathways of care.

Training in caring for patients living with dementia was available to staff and staff had undertaken a dementia awareness training session.

We saw most services were meeting referral to treatment targets. Referral to treatment times achieved were reviewed on a monthly basis. Latest data supplied (9 April 2015) by the Falls service showed the referral to assessment target (30 days) was being met in one clinical commissioning group area (West London) but not in Central London (49 days) and Hammersmith and Fulham (36 days).

The trust categorised complaints as either simple or complex depending on the nature of the complaint and had set a target of responding to 90% of simple complaints in 25 working day and 100% of complex complaints within the agreed timescale.

Detailed findings

Planning and delivering services which meet people's needs

- Managers we spoke with across a range of community services were aware of the issues in their area to develop services responsive to the needs of patients. They told us they worked with local commissioners of services, local authorities, other providers, GPs and patients to co-ordinate and integrate pathways of care.
- Community services included specialist nurses and therapists for particular conditions, for example, diabetes and respiratory, tissue viability, continence, falls and stroke teams. For patients who required support for mental health or social care needs, arrangements for care and treatment was facilitated with mental health or social services.
- Community nursing teams attended the needs of patients who were assessed as predominantly housebound or their needs were identified as best being met in their own home.
- Patients who were more mobile were able to travel to local centres for a range of community clinics.
- The falls team provided a service for patients over 65 years who had suffered a fall and attended the emergency department after calling an ambulance. The service also accepted GP referrals.
- We found there were good working relationships with local acute hospital providers so that patients benefited from joined up care when admitted to hospital. Managers and team leaders also liaised with residential and nursing homes in arranging care and support which avoided the patient's admission to hospital.
- When we observed care being delivered, we found that as well as following plans of care, community nurses were prepared to consider varying their approach to treat particular persistent conditions, for example leg ulcers.
- Service specifications were in place which included expected outcomes for patients. Staff told us that generally they had developed a good understanding with commissioners, other providers and stakeholders.

Equality and diversity

- Leaflets for services stated that the information was available in other formats and languages other than English.
- Staff confirmed translation services were available for people whose first language was not English and were able to provide examples where the interpreter service had been used.
- Staff said they asked what the patient's cultural needs were as part of their initial and ongoing assessment. This was confirmed by patients we spoke with.

Meeting the needs of people in vulnerable circumstances

- Training in caring for patients living with dementia was available to staff. We were informed that all staff had undertaken a dementia awareness training session.
- The trust had designated dementia champions.

Good

Are services responsive to people's needs?

- Physiotherapists in the specialist musculoskeletal service provided services for patients living with a learning disability and for patients with long term conditions such as cerebral palsy. For patients who used mental health services, community nursing services undertook joint visits with mental health staff.
- Staff explained two members of staff attended visits with some patients, depending on the assessment of their need, e.g. patients living with a learning disability with complex needs, such as dementia patients.
- Posters with information for patients were displayed in community settings in different languages.
- Information was included in leaflets about other formats and other languages, with contact details in other languages.

Access to the right care at the right time

- The service used a single point of access to help ensure patients got the right care at the right time and where possible to avoid admissions to hospital. We found patients could access community health services promptly in the areas we visited.
- Quality indicators (e.g. referral to assessment, referral to treatment) for community services showed that patients were assessed promptly for care and treatment, and this was consistently within the expectations of patients and commissioners.
- We saw most services were meeting referral to treatment targets. Referral to treatment times achieved were reviewed on a monthly basis.
- Latest data supplied by the Falls service (9 April 2015) showed the referral to assessment target (30 days) was being met in one clinical commissioning group area (West London) but not in Central London (49 days) and Hammersmith and Fulham (36 days). The Clinical Lead for Falls and Bone Health explained the reasons for this and actions that had been identified and implemented.
- Staff explained they would work across areas to meet targets for responsiveness. Patients we spoke with confirmed they had experienced only a short waiting time to access the service and they appreciated care closer to home.
- We were told triage decisions were informed by the schedule of nursing visits already planned, and the rapid response service was used when the number of unplanned calls exceeded capacity.
- We observed that between visits, the community nurse team leader adjusted the visiting schedule to meet the patient's needs and communicated with the GP practice about any changes to their schedule.
- The Rapid Response service provided intermediate care to prevent hospital admission, early discharge support or to supplement other services. In order to prevent admission to hospital, a health integrated team included generic staff based in social services.

Learning from complaints and concerns

- The trust categorised complaints as either simple or complex on an individual basis depending on the nature of the complaint and the difficulty involved in effectively investigating it, to provide the complainant with a response which thoroughly addresses their concerns.
- The Trust met the national target for NHS Trusts and responded to 100% of complaints within a time limit agreed with the person making a complaint in 2014. The trust had recently set itself a more challenging target of responding to 90% of simple complaints in 25 working days and achieved compliance of 66% at the time of our visit. The trust had developed further training and guidance to increase compliance with this internal target.
- Data submitted by the trust showed 94 formal complaints were made to Central London Community Healthcare NHS Trust in the last 13 months (January 2014 to January 2015), of which 20 were upheld in full, 28 were partially upheld, 31 were not upheld, 1 was withdrawn and 14 were still under investigation.
- Of the 94 formal complaints, 25 were related to concerns about clinical care, 22 were related to staff attitude/ behaviour and 12 were related to problems with booking and availability of appointments, 6 complaints were about care of prisoners.
- From the data submitted 23 informal complaints were made to Central London Community Healthcare NHS Trust in the last 13 months, of which 13 were resolved and 10 were withdrawn.
- Of the 23 complaints, 3 were related to staff attitude, 3 were related to concerns about quality of district nurse care, 3 were concerns about possible confidentiality breaches

Good

Are services responsive to people's needs?

- Information for patients about services included information about how to make comments and compliments or raise concerns or complaints and information about the Patient Advice and Liaison Service (PALS).
- Patients we spoke with were aware of the complaints procedure. In community locations we saw copies of the PALS leaflet were available.
- Staff in a focus group were aware of the trust's complaints policy and of their responsibilities within the complaints process. Apart from formal complaints patients were directed to the trust's PALS. Staff were aware of complaints that patients had raised about their service area and of what was done to resolve the complaint.
- Action to be undertaken following the investigation of a complaint was identified and the action proposed was discussed with the patient. The completion of actions was monitored. Line managers fed back learning from the investigation of complaints at team meetings. Staff could describe how services had changed as a result of action taken.

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

Trust board minutes demonstrated the emphasis placed by the board on developing a vision and strategy, ensuring clear accountabilities and effective processes to measure performance and address concerns, leadership, culture and values. Clinical Business Unit Managers and Team Leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive and provided leadership.

Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. They felt they had the time to spend with patients and provide the care required.

Community services had commenced engagement with the public through the NHS Friends and Family test. The trust has set up and actively engages with a number of patient representatives groups such as the Quality Stakeholder Reference Group, the Patient Experience Group, the Compassion in Care Board and the Achieving Excellence Together Steering Group.

The tissue viability service had developed innovative practice and had taken part in international research and the development of NICE guidance. The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients.

Detailed findings

Service vision and strategy

- Trust board minutes (February 2015) demonstrated the emphasis placed by the board on developing a vision and strategy, ensuring clear accountabilities and effective processes to measure performance and address concerns, leadership, culture and values.
- Managers in community services had developed a vision and strategy for the service and linked this to the trust's vision and strategy. We found that most staff we spoke to were aware of this. Staff in a focus group said the vision and strategy was publicised in the trust and it was relevant to staff.
- Managers and staff told us they felt there was a clearer vision for the community services and a strategy of improvement and changes to services delivery. Staff teams we spoke with said they had been engaged and included in developing the vision and strategy for their team, which adapted and interpreted the trust vision for the service and an annual plan for their service. The vision and strategy for their service centred on safe and effective care for patients, closer to home.

Governance, risk management and quality measurement

- The trust had a risk management policy in place and community services maintained a risk register. The register was reviewed regularly and staff were aware of the risks in their service area, of the action taken to mitigate risks and the role of the corporate risk manager.
- We reviewed the minutes of community locality meetings which evidenced that risk registers were reviewed and assessed according to perceived high, medium and low risk. Ongoing locally managed risks were discussed and trust wide risks were also linked to clinical governance meetings. Items to be added to the risk register were recorded.
- The board reviewed a range of audits to improve performance and support safety and minutes of clinical governance meetings evidenced that an annual plan for clinical audit of the service was in place and progress was reported monthly.
- Patient Reported Experience Measures (PREMS) were used to show the effectiveness of the service and there had been a significant increase in the number of PREMS received (1621 in December 2014). The trust achieved

this through telephone interviews, face to face interviews and paper questionnaires with patients and service users, feedback from patients and from a group that represented patients' diversity.
- Clinical Business Unit Managers and Team Leaders told us regular locality and team meetings were held which were also attended by specialist nurses. Our review of documents showed that these meetings were recorded and included case discussion. Actions taken were documented and reviewed in subsequent meetings.

Leadership of this service

- Clinical Business Unit Managers and Team Leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive and provided leadership.
- Staff in specialist nursing teams felt their line managers were supportive and accessible. Although they did not often encounter senior management, they felt they knew how to access them if required.
- Staff were positive about the clinical leadership they received and about the practical ways in which their clinical role was supported by the trust. We observed clinical leadership provided for staff during handovers and staff were supported appropriately, for example by Clinical Business Unit Managers and Team Leaders.
- Health care assistant staff felt comfortable in their role and well supported in their development.

Culture within this service

- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. There was good team working. They were able to put forward ideas and discuss them as a team.
- Staff said the trust was good to work for, with an open, no blame and patient focused culture; they felt they had a positive culture.
- Staff were enthusiastic and felt involved in the decision making process. They felt they had the time to spend with patients and provide the care required.

Public engagement

- From January 2015 community services had commenced engagement with the public through the NHS Friends and Family test. We saw responses in a range of community settings which were all positive. The trust routinely gathered information under the test and reported this outcome to the Quality Committee. The trust received 1621 responses In December 2014 and this showed performance had improved against national targets.
- The trust has set up and actively engages with a number of patient representatives groups such as the Quality Stakeholder Reference Group, the Patient Experience Group, the Compassion in Care Board and the Achieving Excellence Together Steering Group.
- The trust had recently joined the national 'Sign up to Safety' campaign and held a number of engagement events in each borough during February and March 2015. These involved patients, carers, members, partners and staff in developing the trust campaign to improve patients' safety.
- Some services used comment cards to capture feedback from patients. The notice board in community locations displayed thank you cards demonstrating that patients and relatives had taken the time to write and thank staff.
- The trust had recently introduced the Family and Friends Test as a means of receiving patient and family feedback, 1621 responses were received in December 2014.
- Results showed 95% of patients agreed they were treated with dignity and respect, 82% of patients would recommend the service and 90% of patients rated their overall experience as either excellent or good.

Staff engagement

- The trust has developed a number of initiatives to ensure effective engagement with staff. These initiatives include:
  - Clinical Fridays - Chief Nurse and senior quality team work alongside clinical staff on the frontline;
  - Non-Executive Directors and Executive Directors visits - regularly visit front line services to discuss with staff their work and their general feelings about the Trust and the future strategy;
  - Spotlight on Quality - weekly communication to all staff highlighting the latest developments/ lessons learned etc. in quality;

Good

Are services well-led?

  - AGM Workshops - Non Executive Directors led small workshops with staff and the public to discuss key issues around standards of care, integration and access to services;
  - Mission, Vision and Strategy - refreshed in consultation with staff;
  - Quality Inspections - All staff were asked if they would like to join peer review quality inspection teams (QITs);
  - Achieving Excellence Together - campaign focussed on improving the quality of care and morale of staff within district nursing services across the organisation.
- The 2014 NHS Staff Survey showed improvements in staff saying they are '…able to do my job to a standard I am personally pleased with' (81% agree or strongly agree) and 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (65% agree or strongly agree).
- The trust had undertaken a staff survey on a quarterly basis; this showed 81% of staff agreed they were "…satisfied with the care I give to patients/services users".

Innovation, improvement and sustainability

- The tissue viability service had developed examples of innovative practice and had taken part in international research and the development of NICE guidance. The service was in the process of updating NICE guidance for national use at the time of our inspection. The service had taken an innovative patient centred approach, focused on the needs of patients and support for the patient's self-management of their condition.
- The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients. The service participated in international research and publication.