

London North West Healthcare NHS Trust

R1K

# Community health services for adults

## Quality Report

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2015  
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# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/unit/team)</b>	<b>Postcode of service (ward/unit/team)</b>
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This report describes our judgement of the quality of care provided within this core service by London North West 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 London North West Healthcare NHS Trust and these are brought together to inform our overall judgement of London North West 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?	Requires improvement	

# Summary of findings

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# Summary of findings

## Overall summary

The trust provides variety of services within the community including community nursing services provided by district nurses, community matrons and specialist nursing services. This includes long-term condition management and coordination of care for people with complex needs or multiple conditions, wound care, medicines management and acute care provided at home. Furthermore rehabilitation and reablement following illness or injury, community outpatients and diagnostic services and prevention and health promotion services. The community health service for adults provides services to a population of 828,000 people in areas of North West London. Community teams were based in 50 locally based sites, including health centres, GP practices and community hospitals, which span across London Boroughs of Brent, Ealing, and Harrow. The trust provided overall 1,350,700 community appointments in 2014/2015. It included over 447,000 of

home visits made by district nursing teams and nurses working at night, 90,000 of musculoskeletal and physiotherapy team interventions, 75,500 podiatry appointments, 20,500 interventions by nutrition and dietetics team and 7,000 provided by the continence and bladder and bowel management teams. The trust employed about 1,950 community healthcare professionals providing out-of-hospital, community-based healthcare services.

On the week of the inspection we visited nine locations across the three boroughs where community teams were based. We accompanied community teams on home visits and spoke with 34 patients and some of their relatives and carers. We also spoke to 91 members of staff which included managers, doctors, nurses, healthcare assistants, allied health professionals such as physiotherapist, podiatrists, and dieticians among others.

# Summary of findings

## Background to the service

Overall, the services provided by London North West Hospitals NHS Trust for community health services for adults require improvement because;

The community health service for adults provides services to a population of 828,000 people in areas of North West London. Services are provided in patients' homes, in residential and nursing home settings, in clinics, in reablement centres, and in community venues throughout London Boroughs of Ealing, Brent and Harrow. Services included; district nursing service for housebound patients, falls service, which offered advice and help for people who have lost their independence or confidence after a fall, 'enable service' which aimed to provide a seamless, community rehabilitation service for patients with neurological conditions, diabetes services, nutrition and dietetics, and wheelchair service, which provided an assessment and equipment provision for those who had permanent walking or seating difficulties. Furthermore; cardiac services and support for Harrow residents, specialist adult bladder and bowel services, community nursing support and specialist advice to those infected or affected by HIV, podiatry, speech and language therapy or tissue viability service among other services.

We found staff did not feel fully engaged and that they could influence changes within the organisation. They were not fully aware of the trust's vision and the direction

organisation was taking in order to develop community services. The trust did not have cohesive workforce strategy. Each of the three borough teams, as well as some of the teams, working within the same specialities, were working in isolation and the trust failed to utilise opportunities linked to working in a larger, integrated care organisation.

The trust had set targets for mandatory and statutory trainings but these were not met by the adults community teams. Staff were not routinely informed of trends and patterns of incidents and complaints in order to share learning. We observed significant use of temporary staff among some of the teams, the trust was planning to suspend use of agency staff but had failed to assess local risks related to it. There were long waiting times to access some of the community services, including tissue viability services, as they had limited capacity to respond promptly to referrals. There was a suitable service provision at night, and during weekends. Services were able to respond to urgent referrals.

Patients' feedback was positive, they told us they felt listened to and that staff understood their needs. Nursing and therapy staff showed respect for patients and their families and a commitment to promoting the dignity of patients. Staff communicated well with patients and provided them with information on how to manage their condition and options of treatments available.

## Our inspection team

Chair, Dr Richard Quirk, Medical Director, Sussex Community NHS Trust

Team Leader: Robert Throw, Interim Head of Hospital Inspection

The inspection team was made up of a CQC inspector and specialist advisers.

## Why we carried out this inspection

This inspection was part of a scheduled programme of inspections

# Summary of findings

## How we carried out this inspection

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

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

Before visiting the trust we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 19 and 23 of October 2015. During the visit spoke with a range of staff who worked within the service, such as managers, nurses, and therapists. We observed how people were being cared for and we talked with parents and reviewed a small number of treatment records of people who use services.

## Areas for improvement

### **Action the provider MUST or SHOULD take to improve**

Ensure all staff working within the community health services receive adequate training.

The trust should harmonise adults community health services and systems used across various locations to ensure continuity and allow for shared learning from complaints and incidents across the organisation.

The trust should develop workforce strategy and business development plans to ensure adults community health services are not reliant on use of temporary staff.

The trust should ensure prompt access to adults community health services including tissue viability service, speech and language therapy and continence services among others.

The trust should engage staff in community adults health services development and reconfiguration so they can influence changes within the organisation.

London North West Healthcare 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**

We rated safe as good because:

The service had a good level of safety performance with lower incidents of falls and other safety incidents than the England average.

Incidents were reported and investigated investigated and root cause analysis had been completed with learning points identified and shared with staff.

Staff were able to identify and respond to safeguarding issues, and reduce the risk of patients suffering harm.

The trust had set target of 80% for health and safety, basic life support, fire safety and equality, diversity and human rights training, and 90% for other mandatory and statutory trainings completion. This target was not met by the adults community teams.

Not all staff were routinely informed of trends and patterns of incidents in order to share learning, prevent reoccurrence and encourage practice improvement.

Although the average vacancy rate for adults community services was better than the hospital average the rate

recorded for Harrow's district nursing teams was significantly higher, which translated into significant use of temporary staff. The trust was planning to suspend use of agency staff but had failed to assess local risks related to it.

### Safety performance

- The trust maintained mostly good record of safety performance. The trust had reported that between July 2014 and February 2015 0.2% of all patients receiving care experienced a fall, which caused harm to them. It was better than the England average of 0.7%. Between March and July 2015, it has increased to 0.3% at the trust; however, it was still better than the average for England (0.6%).
- The rate of the catheter and new urinary tract infection reported by the trust between July 2014 and February 2015 was 0.03 % this was better than the England average of 0.3%. Between March and July 2015 0.15% of patients experienced this problem, this continued to be better than the England average of 0.3%.
- The trust had launched a use of urinary catheter care passports in June 2015. It included information relating

## Are services safe?

to the management of patient's catheter (do's and don'ts), daily and weekly care information and a daily checklist, as well as clinical management information and information related to resolving potential problems.

- The trust had reported, between July 2014 and February 2015, that 1.35% of all patients had developed a new pressure ulcer. This was worse than the England average of 1% during the same period. Between March and July 2015, the rate for the trust was 1.45%, which was also worse than the England average (1%).

### Incident reporting, learning and improvement

- There was no never events related to delivering adults community services. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures were implemented.
- 153 incidents were reported for the adults' community services provided by the trust through the strategic executive information system (STEIS) in 2014/15 (July to June). 43 of those incidents related to grade 4 pressure ulcers, 108 grade 3 pressure ulcers and two regarding slips and falls. The incidents were adequately investigated and root cause analysis had been completed with learning points identified.
- Incidents, related to community adults services, recorded on the trust's electronic incidents reporting system were reported correctly. Each of the incidents was graded accordingly to the risk level and actions taken in response as well as lessons learned were noted. Most of incidents was reported within two days from occurrence with many being reported on the same day. Staff stated they were encouraged to report incidents and received some feedback from their line managers; they had access to an online reporting form and told us they were confident using it. Staff were able to give us some examples of where practice had changed because of incident reporting.
- We noted that it took long time to record incidents through the system. For example, staff took on average 72 days to report incidents between January to July 2015. 43% of these incidents took longer than 100 days (34 out of 79 incidents reported in January to July 2015) and seven took longer than 200 days.
- The trust had introduced triggers within the electronic incident reporting form to remind managers of the required actions under the duty of candour when a

moderate or serious incident was reported. Staff were trained on duty of candour as part of the risk management training at induction and the mandatory update training.

### Safeguarding

- Staff we spoke to were able to describe safeguarding procedures and potential scenarios where safeguards needed implementing. We saw suitable referrals raised with the local authority when required. The chief nurse was the executive lead in safeguarding; there was a named lead nurse for adults and children. The hospital had policies for safeguarding children and vulnerable adults. Staff we spoke with were aware of the policies and procedures concerning safeguarding.
- Staff safeguarding level 1 and 2 training for adults was part of mandatory training and was routinely provided to all staff. Similarly safeguarding children level 1 training was provided to nearly all staff including administrative and clerical staff. Safeguarding children level 2 was mandatory for all nurses and allied health professionals. Staff working in Ealing was also provided with level 3 training, this included managers, learning disability nurses and members of the nutrition and dietetics support team. Records indicated that safeguarding adults level 3 training was provided only to staff managing Ealing community services.
- The average safeguarding training completion rate for adults community services was 91% in 2014/2015. It varied between 55% among additional clinical services staff group (Brent and Harrow district nursing teams and Brent adult services) and 100% within many of the adults' community teams working in Ealing.

### Medicines

- Emergency medication, emergency equipment and resuscitation trolleys were available in community centres, and these were routinely checked.
- In general, we found that medicines were correctly stored and administered.
- We observed patients were encouraged to self-medicate and nurses monitored use of medicines and observed individual's regime and any changes to inform potential dose alteration. When changes to medicines were required, community nurses would communicate this with patient's GP on their behalf.

### Environment and equipment

## Are services safe?

- Equipment was tested and in date to ensure it was safe to be used. It included blood pressure monitoring devices carried by community nurses and scales, which were calibrated before being used by nutrition and dietetics team members.
- Teams discussed the need for bespoke specialist equipment and complex equipment such as profiling beds to enable patient's independence. There was a system for servicing of beds and hoists and wheelchairs.

### Quality of records

- The clinical records kept were a combination of electronic records and paper records. Paper records, which included care plan, were kept at patients' home. Electronic records were available only to authorised people; computers and computer systems used by staff in community centres were password protected. Staff were provided with portable devices, which should allow access to records from a remote location. In addition, they could use a workstation at the community centre.
- District nurses were provided with reminder cards that prompted them on documentation to be completed at initial assessment on mobile device. It included pressure ulcer risk assessment, manual handling assessment, photographs with measuring scale and wound evaluation chart, care plan and general assessment and observations forms. Ealing community service completed a record keeping audit in July 2015 of 50 randomly selected computerised records. This audit indicated overall positive findings; electronic records were completed within 1 day from the initial visit, there was sufficient information recorded such as correct addresses and contact details, name of the next of kin, and learning disability status. It indicated there was suitable evidence and record of care and treatment episodes. Developments areas were also highlighted through the audit, which included improvements in keeping accurate record of verbal and over the telephone conversations and a formal record of patients consent.
- Community team members were to ensure up to date care plans were available to patients. We accompanied nurses on home visits and observed that not all patients care plans, printed and kept at patients' home, were up to date. For example some patients supported by district nurses in Brent did not receive a copy of the most up to date care plan. We saw that patients in Ealing had up to date copies of their care plans available at home.
- Some patients' records were unavailable on the new electronic patients record system introduced in September and October 2015. It included patients' individual risk assessments such as dementia screening assessment, malnourishment risk assessment or skin integrity risk assessment. Staff told us it was due to the migration from one electronic patients' record system to another. Where staff were able to present us with a suitable and up to date patients' risk assessments, these were comprehensive and mostly updated regularly. Nurses told us that all assessments were reviewed monthly and if one could not be located on the new system, it would be completed within one month.
- Many of the staff expressed their frustration linked with occasional inability of accessing the new system from patients home and the fact that some of the records they had input through the system were not available to them.
- In clinics, staff used desktop computers or their portable devices, which were also used to record assessments during patient home visit. Some community staff were reluctant to use portable devices in patients' homes as they felt it interfered with their rapport and formed a 'barrier' in between them and a patient.

### Cleanliness, infection control and hygiene

- Clinical areas we visited appeared clean, and we saw staff washing their hands and using hand gel between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited. Personal protective equipment, such as gloves and aprons, was available for staff use in community centres. Staff who visited patients in the community carried protective equipment with them. We observed appropriate infection control practice in the nursing care of a patient who had dressings changed by community nurses.
- There was an infection prevention control nurse allocated to each of the boroughs where adults community services were provided.
- There were monthly hand hygiene audits carried out for services provided in the community centres. We observed that results of these were positive. For

## Are services safe?

example, podiatry service in Harrow had achieved 100% compliance in 2014/2015. Similarly, hand hygiene audits carried out in Brent community centres indicated compliance with the 90% target set by the trust.

- The trust also carried out cleaning audits in the community clinics. We noted that outcomes of these were positive with compliance scores varying between 91% and 98% for centres located in Ealing. Services in Brent recorded 92% to 97% compliance (April, May and June 2015).
- There were also environmental audits carried out to establish whether waste had been managed correctly, including sharps disposal. Any action points raised were recorded and implementation of improvements was monitored by infection control specialist nurse.

### Mandatory training

- All staff were required to complete mandatory training in health and safety, fire safety, fraud awareness. Infection prevention and control, information governance, basic life support, conflict resolution and equality, diversity and human rights. The trust had set target of 80% for health and safety, basic life support, fire safety and equality, diversity and human rights training, and 90% for other mandatory and statutory trainings completion. Records indicated that this target was not achieved. Only 67% of all staff working in adults community services had completed health and safety training, 68% fire safety training and 73% other mandatory trainings.
- Mandatory and statutory training completion rate varied among various staff groups and adults community services teams across 2014/2015; 70% for nurses, 74% for administrative and clerical staff, 83% for allied health professionals, and 83% for medical staff. It was recorded at 77% for Harrow team, 68% in Brent and 82% among Ealing adults' community services teams.

### Staffing levels and caseload

- The average vacancy rate adults for community services was better (8.8%) than the hospital average (15%). However, some teams were experiencing recruitment challenges. The vacancy rate of 64% was recorded for Harrow South Central district nursing team followed by the Harrow West and Harrow East district nursing teams (37% and 26%) Ealing rapid assessment and response community team also recorded high vacancy rate of 39%. There were no vacancies among bladder and

bowel health community team in Ealing, diabetes services in Brent and Ealing, immunisation team in Brent, physical disability team in Harrow and learning disability services in Ealing among some other teams.

- The average use of temporary staff at the trust was 17% (bank and agency). The community adults services recorded better figure of 11% (2014/2015). The highest use of agency and bank staff was recorded for Harrow district nursing teams (South Central 81%, West 40%, and East 37%), rapid assessment and response community team in Ealing (45%) and 'twilight' district nursing service in Ealing (38%) and Harrow (23%). No temporary staff use was recorded in diabetic community services in Brent and Ealing and bladder and bowel health team in Ealing, also none for Harrow's community falls team and physical disability team. Most of the agency staff supporting community teams had been working within the same team for numerous months. They were very familiar with the practice and local procedures.
- It was noted on the community health services' risk register that capacity of district nursing service was not sufficient to meet demand, leading to risk of clinical incidents, staff sickness, increased staff turnover, and a reduction of staff morale. The trust noted that it could also lead to complaints, and failure to meet contractual obligations. The trust worked with local clinical commissioning groups to review service and reflect operational capacity and staffing levels. There were various recruitment initiatives taken up across the three boroughs in 2014 and 2015 but this had not brought a significant change to staffing levels.
- The trust told us that they were working towards removing the need to use agency staff from November 2015. Staff told us, including team leaders and local managers, there was no risk mitigation plan and that they felt it was impossible to achieve and patients safety might be compromised if agency staff were no longer used. Many of the permanent staff worked also as banks staff. and covered additional shifts when required. They did not feel there was capacity to cover all shifts within the staff employed by the trust.
- Overall district nurses and staff working within nutrition and dietetics teams, as well as those working in contraception and sexual health services complained of unmanageable workloads. Records indicated that there was lack of unified approach across the teams as staff, working within the same specialities in various

## Are services safe?

locations, held varied number of cases in their caseloads. The trust had failed to establish a benchmark for a 'safe workload', informed by the best practice guides and a clinical risk, to ensure patients safety and staff wellbeing.

- Where district nurses were unable to visit patient on the day, due to staff shortages, visits were rescheduled to the following day. Although, this activity was risk assessed and patients who required medication administered or other urgent intervention were still seen. There was no record to indicate the scale of the issue and inform service improvement.

### Managing anticipated risks

- The National Institute of Health and Care Excellence (NICE) guidelines recommend use of a validated measurement tool such as photography or transparency tracing when assessing wounds. This is to allow repeat views of a wound that can be compared objectively over time. Guidelines used by the trust gave clear instructions regarding use of photography. These guidelines prohibited use of personal cameras and mobile telephones staff were able to use portable devices they were provided with the trust. However, occasionally they were unable to trace or take a photograph of the wound, as they could not access patients' record from their home. Staff were still able to measure the wound and keep paper record of the size.
- We observed nurses carrying out baseline assessments such as measurement of temperature, blood pressure and pulse, these were consistently recorded, and standardised assessment tools that monitored nutrition and skin integrity were used across the community teams.
- Community nurses supported by occupational therapy team undertook moving and handling assessments in patient's homes. It helped to mitigate the risk of injury to patients and carers through unsafe handling or ineffective transfer technique.

- Patients were provided with emergency contact numbers and informed how to access out of hours support. Any issues were discussed during staff handover meetings led by a matron or a team leader so all teams were aware of risks and symptoms of patient's potential health deterioration.

### Major incident awareness and training

- There was a policy in place, which advised staff how to respond to local emergency (major incident); it was updated in January 2015. The objectives of the trust was to provide continuing support and care for the community. The plan had been developed taking into consideration the risks and hazards identified in the community and the local risk registers and clearly set out command and control structures, and how the service would work with external providers to ensure continuity of care.
- Major incident awareness training was one of the mandatory courses provided to staff. The trust aimed to provide this training to a minimum of 80% of all staff. Some teams and staff groups achieved 100% compliance with this training; it included teams working in Clayponds Community Centre. However, others working across the three boroughs had not achieved this goal and overall major incident awareness training completion rate for adults community services was 62%. The worst training completion rate was recorded among learning disability nurses working in Ealing (20%), Brent's district nursing team (48%), Ealing's district nursing team (54%), Ealing's nutrition and dietetics team (56%), and staff working in Harrow's short-term assessment, rehabilitation and re-ablement service (STARRS: 56%), Brent's community adult services also recorded compliance rate below the required 80% (62%).
- Staff were aware of how to act in the event of fire and of individual staff responsibilities.

## 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.

We rated effective as good because;

Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Patients had access to appropriate pain relief and community nurses monitored whether patients were adequately fed and hydrated.

The trust participated in the national audits of intermediate care to inform care delivery.

We observed good multidisciplinary working and that staff shared information with others involved in patients care effectively to achieve best treatment outcomes.

We also noted many staff were not appraised and that teams in each of the three boroughs were working in isolation. It did not allow full integration and knowledge sharing. There was poor integration of services within the sexual health speciality.

### Evidence based care and treatment

- The electronic patient record keeping system included tabs, which linked the user to clinical guidelines. These were attached to the assessment templates and were based upon best practice and NICE guidelines.
- Staff working in the community were observed to complete a review, which included baseline recordings, nutritional intake, respiratory assessment, clinical assessment for wound infection, and checked compliance with medication regime. Staff were also taking note of patients' social needs and considered how this affected their emotional and physical wellbeing.

### Pain relief

- Community nurses considered pain relief during home visits. We observed a home visits with palliative care patients where options for pain relief were discussed with the patient and their family. We observed a home visit where a patient's self-management of pain was discussed including use of a patch to enable a patient to have more sustained relief from pain.

- District nurses were supported by community palliative care team and a long-term pain management teams. We observed that they communicated with GPs on patient's behalf when increase in pain control medication was required to accommodate for rapid response.

### Nutrition and hydration

- Community nurses monitored whether patients were adequately fed and hydrated. They offered advice during home visits related to food and drinks intake.
- We accompanied dietician with home visits and observed that detailed nutritional assessment had been undertaken. They provided patients with an advice tailored to individual preferences and accommodated for patients likes and dislikes.

### Technology and telemedicine

- Community teams did not provide telecare support as this was organised by another provider and coordinated by the local authority. Integrated community care team helped to coordinate a process with obtaining a suitable equipment to enable patients discharge from the hospital into their home or a preferred place of care.

### Patient outcomes

- Patients care was well organised with individual patients being discussed during multidisciplinary team meetings, held at individual GP practices. Nurses told us that despite dealing with large caseloads they did not feel pressurised to discharge patients and were able to deliver required care.
- Community nurses felt able to increase the level of care in response to patient's changing needs. They obtained agreement from patient, their GP, patient's relatives and consulted the matron or a team leader before doing so.
- The trust participated in the national audits of intermediate care including the most recent one organised in 2015. This audit informed the provision of intermediate care services, its outcomes were not available at the trust level and we were unable to compare how the trust compared with other providers.

### Competent staff

## Are services effective?

- In general, nurses, healthcare assistants, and other staff providing community services were competent and knowledgeable when spoken to. Staff working in Ealing told us they were provided with numerous development opportunities and career development, which made their job interesting. Others working in Brent and within the sexual health speciality teams complained that development opportunities were limited and they had access only to statutory and mandatory training.
- The trust reported that only 51% of all staff had up to date appraisal in July 2015. There was variation among the three boroughs teams with Harrow community services reporting worse, 36% appraisal rate, Brent 44%, and Ealing performing slightly better than the trust's average with 56% of staff being appraised.
- There was a competency framework for new staff to the service, completed within the first 3–6 months.
- The trust had introduced a new electronic patient record system across the three boroughs in September and October 2015, prior to introduction of this system all staff were provided with training on how to use it.
- Staff told us they had regular team meetings, which provided them with an opportunity to express their views, share experiences, discuss challenges in their day-to-day work and learn from one another.

### Multi-disciplinary working and coordinated care pathways

- Shared pathways, such as diabetes community pathway, worked well and patients told us that, when external agencies were involved, communication was effective.
- We observed nurses sharing their professional opinion with GPs and other health professionals. Community nurses were allocated to 'localities' and had GP practices allocated within these, it helped to develop effective partnership working. They attended regular meetings with GPs; frequency of these was determined by number of patients registered with any particular GP practice, which were supported by the community team.
- To avoid inconvenience to patients, various specialist teams organised joint visits and joint assessments when more than one team, or health professional, was involved.
- However, we observed that each of the three borough teams was working in isolation and we did not observe

cohesive integration. Staff told us that they had started working towards developing new ways of working together and had organised workshops, involving teams from different localities, to discuss their ideas related to the subject. They said they had limited opportunities for coordinated working since the North West London Hospitals and Ealing NHS Trust had merged in September 2014. The district nursing workshop in October 2015 was looking at standardisation of work across teams.

- There was poor coordination and lack of integration of services within the sexual health speciality. Genitourinary medicine (GUM) teams and contraception and sexual health teams were working in isolation and were not using opportunities for joint working in order to improve patients' experience. Similarly doctors and nurses failed to communicate effectively to ensure service coordination. We observed good coordination between GUM and HIV services. There was an allocated pharmacist to the HIV community service.

### Access to information

- Across September and October 2015, the trust had migrated patients electronic records from one electronic patient's record system to another, with an aim for more accessibility and improved information sharing opportunities. The new system allowed staff to view patients' GP's clinical record, as well as the record completed by other health professionals involved in patients care. Nurses felt it was very useful and helped to plan care and treatment more efficiently.
- We observed that nurses were not always able to access the system remotely. Access to clinical information was problematic due to connectivity to electronic patient record keeping system and staffs unfamiliarity and occasional discomfort with the use of technology in community environment. Some records and risks assessments had not been transferred into the new system and staff was required to use an old system in order to access the information. Other information was missing. For example in Brent district nursing team reported that patients records collated over 10 days have not been uploaded into the new system, this included individual risk assessments. The introduction of the new system had been staggered; with two weeks gap between each borough, and staff felt it was better managed at later stages, and that the lessons had been learnt from the early stages. We observed that

## Are services effective?

additional technical support was available to staff to help to resolve any issues. Senior managers and directors were aware of the issue, access to information was listed on the divisional risk register.

### **Consent, Mental Capacity act and Deprivation of Liberty Safeguards**

- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005. Nurses were able to describe how they obtained patients consent and procedures for making 'best interest' decisions in situations where patients consent was questioned.
- Staff were observed explaining treatment plans and obtaining verbal consent to simple procedures being carried out. In meetings, staff discussed examples of consent protocol being followed.
- Ealing community service completed a record keeping audit in July 2015 on 50 randomly selected computerised records. This audit indicated that improvement was required in formal recording of the patients' consent to treatment. Action plan developed in response required team leaders to perform random monthly checks to ensure improvement.

## Are services caring?

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

We rated caring as good because;

Patients' feedback was positive, they told us they felt listened to and that staff understood their needs.

Nursing and therapy staff showed respect for patients and their families and a commitment to promoting the dignity of patients.

Staff communicated well with patients and provided them with information on how to manage their condition and options of treatments available.

### Compassionate care

- In all the care we observed, nursing and therapy staff showed respect for patients and their families and a commitment to promoting the dignity of patients. The needs of patients with complex needs were considered with compassion. On home visits, patients were given reassurance and clear explanations from nursing and therapy staff. We observed some staff had stayed with patients for longer than the allocated visit time to provide answer to all questions and ensure they were comfortable before leaving them. However, a few patients mentioned that district nurses seemed often rushed and did not have time for a conversation; they were “concentrating on performing their tasks”.
- The hospital started using the NHS Friends and Family Test in January 2015 and patients' feedback gathered through it was positive. This is a single question survey asking patients whether they would recommend the service to their friends and family. As indicated by responses gathered in 2015 (January to July 2015), the trust performed slightly better than the England average (95.5%), with the average 97% of patients saying they would recommend the service to their friends and family. Records indicated that community nursing services, and rehabilitation and therapy teams were among mostly recommended teams with 99% and 100% positive responses received.
- Patient consultations took place in private rooms when at community health centre settings. In patients home, we observed staff paying attention to the environment

and who can overhear conversations. Staff felt able to ask others present to leave the room if privacy was required for an examination or private conversation to take place.

- Ealing community rehabilitation services had organised patient satisfaction survey between May and September 2014. Findings of the survey indicated that 83% of patients strongly agreed staff was compassionate and caring and 93% thought they were treated with respect and dignity, as well as in a thoughtful and courteous manner.

### Understanding and involvement of patients and those close to them

- District nurses involved patients in their care. We observed that they communicated well and provided them with simple information on how to manage their condition and options of treatments available. Patients were involved in planning of their treatment and nurses acted on patients wishes. When patients asked questions these were responded to appropriately and where further information needed to be obtained by a nurse patients were informed when, and how they would be provided with the information. Most patients had an up to date copy of their care plan at home, as well as additional information on how to manage their condition and contact details for services which could offer additional support.
- Ealing community rehabilitation services' patient satisfaction survey indicated that when patients phoned the service their query was dealt with appropriately, and staff was able to respond to their questions (97%). 73% strongly agreed they were involved in their care as much as they wanted to be. 78% strongly agreed that they were provided with information which helped them to manage their condition better at home.

### Emotional support

- Patients told us they felt listened to and that staff understood their needs. We observed a therapy visit where patients and their relatives were provided with

## Are services caring?

compassionate emotional support. Staff offered referrals to counselling service and asked if any other support was required to address patients and their relative's emotional or social needs.

- Staff, during their handover discussions, shared information related to patients emotional and social needs and discussed best ways of approaching issues and how to access additional support.

## Are services responsive to people's needs?

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

We rated responsive as good because;

The service understands its patients population and makes reasonable adjustments, for example adapting to prayer routines when making appointments.

We noted staff were aware of patients' individual needs and of the diverse population they were providing services to. There was a suitable service provision at night, and during weekends. Services were able to respond to urgent referrals.

Staff were not routinely informed of trends and patterns to complaints, including these received by other teams, in order to share learning and encourage practice improvement.

Services were able to respond to urgent referrals within 24 hours, it included district nurses who were working day and night across the three boroughs.

### Planning and delivering services which meet people's needs

- Capacity of the community teams was stretched; staff reported that over the number of years they have observed increasing complexity of patients referred to community teams. Integrated community team helped to discharge patients from accident and emergency and hospital by proactively liaising with the local authority, community district nurses, and GP practitioners, to allow early discharge and coordination of services in the patient's home.
- Suitable services were provided at night by the 'twilight team', there was also an appropriate provision during weekends. It meant that patients who required daily or urgent support were seen without delays.
- Podiatrist services in Brent reported very high, above 60% non-attendance rate in August and September 2015. Staff were not clear why it was so high. In response the trust introduced an automated messaging service to remain patients of their podiatry appointment, alongside other initiatives, which resulted in slight improvement in nonattendance in October 2015.
- There was limited availability within the tissue viability service in Brent and Harrow due to increased work

pressures. Although community nurses seemed confident in regular pressure ulcer management, records indicated that there was long (up to seven days) waits for the service.

- We observed that there was sufficient seating in all of the community health centres we visited. Health centres were also accessible to people with limited mobility.
- Ealing community rehabilitation services' patient satisfaction survey completed in September 2015 indicated that 45% of patients, of those still receiving services at the time when survey was conducted, did not know when their next visit would be. District nurse and allied health professionals told us that patients were usually given a two hours time slot within which they should be expecting a visit. Where specific request, related to time preference, were made by patients these were accommodated for.

### Equality and diversity

- Staff told us how they accommodated religious and cultural diversity and how it had informed individual care plans including consideration of Ramadan, understanding of patients and families belief systems in relation to medication and pain control, and awareness of prayer routines when planning visit times.
- Staff told us they had access to a translation service should they need it. When required, staff used face-to-face, or over the telephone interpreting services. This meant that patients, for whom English was not the first language, could engage fully in their consultation.
- We observed that teams were diverse with staff being able to speak multiple languages. It was taken into consideration when caseloads were allocated to ensure effective communication. We observed that staff also communicated with a help of relative during a routine wound care visits.

### Meeting the needs of people in vulnerable circumstances

- The trust reported that interpreting and translation services were mostly delivered to Romanian and Polish populations. There was an interpreting service run by

## Are services responsive to people's needs?

the 'language service department', when staff required a face-to-face interpreter they filled a request form, which was available on the intranet to allow staff to book required interpreter.

- In a handover meeting, staff discussed care needs of patients and relatives. They paid attention to social needs and discussed external agencies involvement whenever appropriate. We observed staff confidently communicating with patients with variety of needs including those who did not speak English, patient with Alzheimer, a patient who had mental health illness and a person with learning disability.

### Access to the right care at the right time

- Services were able to respond to urgent referrals within 24 hours, it included district nurses who were working day and night across the three boroughs.
- Records indicated the service with longest waiting times in Brent was the speech and language therapy community service with waiting times between 23 days (Kilburn Square Clinic; May 2015) and 7.7 days (Wembley Centre for Health; May 2015). Patients of Hillside Primary Care Centre were waiting for up to 22 days, to see a podiatrist for routine appointment in June 2015. The respiratory service responded within 10.6 days to see a patient at home (June 2015). Tissue viability nurses were able to respond within a maximum of seven days (January 2015) with most referrals being responded to within one day (February to June 2015; visits at patient's home and nursing homes).
- In Brent, there were quick response times within the physiotherapy service with average 2.6 days in January 2015 to June 2015. Occupational therapy services were able to respond within four days, bladder and bowel management teams took 3.4 days, diabetes services less than two days, musculoskeletal service 4.9 days, and nutrition and dietetics took on average three days during the same period.
- For services provided in Harrow there were long waiting times, of up to 26 days (nursing home; February 2015), for podiatry services, including on average 17 days wait for a visit at patient's home (January to June 2015). Furthermore, there was stretched capacity of the tissue viability service with a response time of up to 6.4 days (May 2015; patients home).
- In Ealing long, 17.2 days, waits were recorded for referrals to continence team, 9.7 days for community

diabetes service, and approximately eight days for learning disability services and podiatry (January to July 2015). Community physiotherapy service took 7.6 days and musculoskeletal therapies 3.6 days. Tissue viability nurses were able to respond within 2.4 days.

- Patients referred to participate in a diabetes groups experienced wait of up to five months due to limited capacity of the community team. It did not follow NICE (National Institute for Clinical Excellence) guidelines on education in type 2 diabetes.
- Records indicates that some patients (207) were waiting for over three months to access a routine community physiotherapy service.

### Learning from complaints and concerns

- There were posters in community centres waiting areas informing patients how to complain, make a suggestion, or express a compliment. There were also feedback cards available and comments boxes in reception areas. The trust's website directed patients, who had any concerns, and their families, to the patients' advice and liaison services (PALS) and explained complaints process. The PALS officer, whenever required, contacted matrons and team leaders to resolve or investigate issues.
- Staff were trained on duty of candour as part of the risk management training at induction and the mandatory update training.
- Patients who received service at home were provided with a file, which included a complaint leaflet and a contact details for PALS department. They were also provided with contact details for a team leader and a matron should they want to discuss any concerns directly with them.
- Staff told us that complaints related to rescheduling of visits and of staff running late were not recorded as these were dealt with informally by a team leader or a matron. This meant that the service was unable to fully monitor patterns in order to improve the service. Where complaints were appropriately recorded, we saw that they were responded to and staff were aware of them. However, staff were unable to give examples of complaints, which were received in other boroughs and related to the same speciality. They were not routinely informed of trends in order to share learning and encourage practice improvement.

## Are services well-led?

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

We rated well-led as Requires improvement because;

Staff did not feel fully engaged and that they could influence changes within the organisation. They were not fully aware of the trust's vision and the direction organisation was taking in order to develop community services.

The trust did not have cohesive workforce strategy. Each of the three borough teams, as well as some of the teams working within the same specialities, were working in isolation and the trust failed to utilise opportunities linked to working in a larger, integrated care organisation.

We also noted local teams were well managed by experienced and knowledgeable team leaders and managers. Staff were very motivated aiming to deliver patient centred services.

### Service vision and strategy

- The trust had developed divisional business plan for each of the locations where community services were provided. It included strengths and weaknesses analyses and highlighted potential risks related to finances, re-tendering and staffing levels, among others. These plans had also included key divisional objectives such as quality improvement, finance stability, or partnership working. Each of the divisional objectives was linked to the strategic goals set by the trust's senior management team.
- At the time of the trust merger (September 2014) the trust had introduced "stronger together" phrase to reflect changes introduced to the organisation and encourage partnership working. It also supposed to bring out positives of the cooperative work of joint organisations. Staff at focus groups told us they did not feel this phrase reflected their work reality. They felt the trust had not used all the opportunities that were linked to working in a larger organisation. They also said the trust focus was on financial viability and care quality was not treated at equal importance. Many members of staff told us they did not feel they worked in the "integrated care organisation" as suggested by the trust's executive team.

- The trust's vision was to provide "compassionate, responsive and innovative clinical care". We found staff we spoke to were not aware of this vision.
- The trust did not have cohesive workforce strategy for community teams which would address staffing recruitment problems, use of temporary staff, pressures experienced by individual teams and long waiting times in accessing some of the services. They had not analysed service delivery levels and individual staff workloads in order to review staffing levels and commissioning arrangements.

### Governance, risk management and quality measurement

- There was a general manager overseeing adults' community services activity in each of the boroughs where the trust provided services. They were line managed by one (out of two) of the community services directors and a director of community services. There were speciality leads in each of the locations, which included diabetes service lead, podiatry team lead and district nursing team leads among others.
- District nursing teams were divided into smaller teams, which allowed them to develop close working relationship with local GPs and other providers such as nursing homes. For example, there were South Central, East, and West district nursing teams in Harrow.
- Each of the teams had prepared quarterly reports that monitored training compliance, local risk registers, incident patterns and result of any regular audits carried out (i.e. hand hygiene audit). This allowed to monitor and compare overall performance and establish trends within individual teams.
- Each of the three borough teams was working in isolation and we did not observe cohesive integration. Staff were constrained by boundaries of each of the boroughs and service delivery contracts, which slightly varied across the three boroughs. The district nursing workshop organised in October 2015 was looking at standardisation of work across the three teams, which

## Are services well-led?

included revision of processes for caseload allocation, and referrals management with a potential introduction of a single point referral system for all teams. There was a senior manager allocated to service standardisation.

### Leadership of this service

- Local leadership was praised by staff as visible, accessible and responsive. We found that local managers had appropriate knowledge and experience to lead services and they were well aware of issues and challenges their teams faced. Staff felt empowered by their local team leaders and managers.
- District nurses and allied health professionals told us the director of community services was not sufficiently visible, and that other senior trust managers were rarely seen around community centres. Staff did not feel they could freely approach them and openly discuss issues. There was a general feeling that community services were "not treated equally" with services provided by acute divisions. Many of the staff told us the service had "struggled to find their voice" at the senior trust management level. They said they struggled to communicate the importance of community services delivery. They felt there was no integration within the trust between the community and the acute service delivery side.

### Culture within this service

- District nurses, healthcare assistants and allied health professionals were focused on providing a good experience for patients. They were mostly patient focused. We observed that most local teams worked efficiently and staff were supportive to one another. We observed all staff being well motivated. However, they complained of high caseloads and increasing work pressures which were linked to staffing levels and increasing complexity of patients' needs.
- Local managers showed a caring approach towards staff. All staff showed receptiveness to advice from their colleagues and were supportive of one another. Nurses told us they had mostly good relationship with local managers and if they had any concerns they were able

to address concerns directly with them. However, many said they had limited influence over changes introduced to the service by the trust and they did not feel listened to by senior management team.

- The sickness rate for adults community services was slightly worse (5%) than the hospital average (4.4%).
- Staff providing adults community services in Harrow told us they were uncertain of their future with the trust as the service was out to tender in 2015. At the time of the inspection, it was unclear if the trust would continue to provide the service in the borough. It was also a cause of anxiety and reason for some temporary measures being put in place, such as use of temporary staff, due to uncertainty of the future.

### Public engagement

- Patients' views on service delivery were being sought through the friends and family test results of which were very positive with average 97% of patients saying they would recommend the service to their friends or family. Responses were collected by the trust since January 2015.
- Ealing community rehabilitation services had organised patient satisfaction survey between May and September 2014, 41 patients responded to this survey. All patients rated overall care received as excellent or very good.

### Staff engagement

- Staff did not feel fully engaged and that they could influence changes within the organisation. They indicated that the trust had implemented changes "from the top down" and failed to consult them when changes were introduced. The trust told us they were looking to reorganise governance and management arrangements and it was organised from the top level, after new executive directors were appointed. Local leaders and managers told us the trust had failed to look at individual caseloads and service delivery levels, to inform changes and adjust governance structures and line management arrangements accordingly.