Camden

Services provided and their rating:

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Community End of Life Care

Areas of good practice:

- The Transforming End of Life team were piloting documentation which incorporated five key enablers to improve communication between patients, families and clinical staff. This included the amber care bundle, advanced care planning, coordinate my care (CMC), rapid discharge checklist, and excellent care in last days of life which was being trialed at UCLH. These were all tools and approaches to guide the support given when the person may not have long to live. The transform project will run for five years to educate mentor and train clinical and medical staff in end of life care. It is anticipated that the documentation will also roll out across the community.

Camden, Islington ELiPSe palliative care services.

- At UCLH there was UCLH trust guidelines in place for pain control in palliative care which the hospital palliative care team coordinated. There were also guidelines for pain control for the community teams to coordinate, these included the setting up and use of an anticipatory syringe driver for palliative care patients by trained staff.
- The Camden, Islington ELiPSe and UCLH and HCA Palliative Care Service for the period November 2013 to December 2014 92% of patients died in their preferred place of choice.
- The Camden, Islington ELiPSe and UCLH and HCA palliative care service also had in place an educational and clinical governance programme. All staff were expected to attend the weekly sessions which were held each Wednesday.
- In 2014 the Islington ELiPSe team and the Camden palliative care team together with a social care housing provider won the Linda McEnhill award for outstanding end of life care for making positive difference.
- The Camden, Islington ELiPSe and UCLH and HCA palliative care services risk register was used to highlight any issues of immediate risk and these were reviewed on a monthly basis.
- The operational policies for the Camden, Islington ELiPSe and UCLH and HCA palliative care services set out the governance framework for the services.
- We found that key performance indicators were monitored on a monthly basis across all the Camden, Islington ELiPSe and UCLH and HCA palliative care services which showed that the teams were consistently achieving or exceeding in their targets in the community.
- In response to concerns from a group of people with a learning disability the Islington ELiPSe team and the Camden palliative care team worked with the group giving them advice, information and support about the decisions they could make regarding their care at end of life.

Community Health Inpatient Services

Areas of good practice:

- St Pancras Rehabilitation Unit had introduced weekly observations of staff practice. Ward managers visited and observed the practice of staff on other wards. The ward managers relayed their findings to the clinical lead at the St Pancras community in patient weekly clinical indicator team meetings.
- At St Pancras all wards had a white quality board which made patients and visitors aware of each ward’s performance with regard to safety issues such as patient falls; hospital acquired infections; and acquired pressure ulcers. The quality board displayed how many days had elapsed on the ward since a patient had

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experienced any of the above. They also display "you said- we did", where patient feedback and the response to the feedback was published.

- At St Pancras staff told us the clinical director had visited the unit and chaired staff meetings to discuss safeguarding.
- Patients in South Wing, St Pancras received comprehensive and individualised continence assessments.
- Quality governance meeting minutes, 26 January 2015, recorded how practices on Oakwood ward, St Pancras had been changed during the afternoon handover, with healthcare assistants staying on the ward to assist patients. An aspect of these meetings was also to monitor the implementation of best practice guidelines from the National Institute for Health and Care Excellence (NICE).
- Records confirmed incidents of patient falls had reduced as a result of the measures. This meant people’s risk of falls was reduced as a result of the trust’s quality monitoring processes.
- Staff at St Pancras held a multi-disciplinary workshop in February 2015. As a result of the workshop nursing and therapy staff had created an integrated assessment tool to identify patients care goals.
- The trust was involved in a project with University College London Hospitals NHS Foundation Trust (UCLH) and the National Hospital for Neurology and Neurosurgery (NHNN). The project involved staff at the Oakwood ward, St Pancras, working together with UCLH and NHNN to help support stroke patients in Camden and Islington return safely home as soon as possible.
- The response letters to complaints about St Pancras included details of the rights of patients to contact the Parliamentary and Health Service Ombudsman if they were dissatisfied with the outcome of the community in patient units’ complaints investigation.

Areas for improvement:

- Based on a suggestion from the CQC, we now have bedside lockable cabinets for our patients and guests who would prefer to manage their own medication. Of our 53 beds in the units, we currently have 51 lockers available.

Community Health Services for Adults

Areas of good practice:

- Camden integrated primary care teams had a weekly governance meeting where learning was shared. The CQC saw the notes of a recent meeting and saw findings from an inquest in another locality had been shared and this had proved a useful learning process. They were given an example of learning from an inquest that highlighted every team should have spare suction equipment and this had been provided.
- Integrated primary care team in Camden reported 98% of staff up to date with training
- The Camden respiratory team had a risk register for patients who were not on the “domiciliary care” pathway, who were isolated and with a poor support network. This was to alert the team the patient may require more support.
- Camden respiratory team had just started a national pulmonary rehabilitation audit that was to run over 12 months to compare teams across the country. They also demonstrated a range of outcome measures including a tool where patients self-rated their health. Further they measured performance using key performance indicators including number of patients where an admission to hospital had been avoided.
- The Camden Neuro-Therapy team have a ‘neuro navigator’ whose role it was to facilitate the transfer of patients between services to best meet the patient’s individual needs. Carers and families were an integral part of the process and had the contact details of the ‘neuro-navigator’.
- The Camden integrated primary care team managers told the CQC that there was an open referral process including self-referrals with a separate pathway for nurses and therapists in the team. Referrals for all integrated primary care services went to a central access point at St Pancras and were triaged by the team there. Patients were then allocated on a geographical basis to the most appropriate team.
- The Camden integrated primary care team said there was a clear pathway for discharge from hospital. Generally this would involve referral to the Camden rapid access team which worked closely with care link the reablement team and their interventions would usually last five days. Referral could then be made to the integrated primary care team which offered interventions for around six weeks although we were told this could be flexible around patient need. If the patient required an on-going care package social services would be contacted two weeks prior to the expected discharge.
- Camden integrated primary care team told us shared goals with the patient were identifed and this process began with the initial screening process which considered the patient’s motivation for treatment. We reviewed one set of notes and saw good documentation of involvement of family and need for interpreter. A falls exercise booklet had been translated for the patient and a shared goal had been identified with the patient. It was noted the patient was unable to sign the document and the reason why.
- Camden respiratory services went to screen and diagnose people with possible respiratory problems, for example going to supermarkets, GP surgeries and events

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to undertake tests. The number of patients screened between January 2013 and September 2014 was 1229; 50 referrals were made for further screening and 133 new diagnosis made. CQC were told screening had also occurred in mental health in-patient wards and hostels for homeless people. Clinical research from this work was presented to the American Thoracic Society in 2014.

- Camden respiratory and neuro-therapy teams had a range of positive initiatives to ensure vulnerable people had access to good quality and effective care. For example taxis were provided for the patient and carer to attend the pulmonary rehabilitation class. The class included group and individual exercises, education sessions and a question and answer session with the consultant. Sessions with a nurse, clinical psychologist, dietician, occupational and physiotherapists were available. British Lung Foundation packs were given to patients and leaflets were available in different languages with access to interpreters if required. Patient feedback had informed the timing of sessions.

Areas for improvement:

No ‘must do’s’

Community Health Services for Children, Young People and Families

Areas of good practice:

- An audit was undertaken by the Camden Multi-Agency Safeguarding Hub (MASH) team to ascertain what impact the MASH had on interagency working. The results showed the majority of health visitors and school nurses found positive benefits of working with MASH.
- Evidence based treatment evidenced by the Mosaic centre in Camden where an audit had taken place to see if NICE guidance was followed in the care pathway for children with cerebral palsy. This showed the need to improve record keeping which was being addressed.
- The child development centres all demonstrated examples of exceptional multi-disciplinary working. In Camden the ‘single point of referral’ meant that all children referred for developmental assessments would have access to the most appropriate professional and team including multi-agency teams where needed. Camden had established a new Alliance Provider model for children’s services working in partnership with other local NHS trusts. CNWL is the operational lead. This arrangement is now formalised as Camden Integrated Children’s Services to meet the needs of children with developmental concerns and disabilities.
- In Camden the ‘my child’ and ‘early bird’ programmes were supporting children and families where the child had complex needs. These were enabling the child to receive a better quality of care as a result of the professionals and carers working together. Early Bird was also cited as a programme which addressed the needs of both home and school settings by training parents and carers to give consistent support to their child with autism.
- In Camden a health visiting duty desk had been set up so parents and professionals could have access to advice and support from a qualified health visitor.
- The children and families services had adapted to make services more integrated and accessible. Examples included the Saturday clinics for looked after children in Milton Keynes, the health visitor duty desk in Camden and the school nurse drop in clinics in Hillingdon.
- The Camden child development centre had a programme called ‘my child’ which was delivered by a team who worked with children from 0-5 years old, who had complex needs. The team provided sessions where families could talk about their child’s diagnosis and assisted them to set goals and priorities for therapy.

Discussions from the Quality Summit to be taken forward in partnership with commissioners and other stakeholders:

- Overview and Scrutiny Panel would like to encourage opportunities for shared learning with C&I NHS Trust.
- Camden CCG is keen to support Camden Senior Management Team and divisional management but want Exec Board reports to reflect Community Health Services as much as mental health. Work to get more practice level engagement between CNWL executive and GP. Healthwatch also wanted the needs of community health patients and carers to be more prominent. Supporting housebound patients to have their voice heard.
- Aspiration for sexual health services to become more localised. Requested CNWL to get more direct feedback from patients so that they don’t need to go to Healthwatch.
- Work to increase FFT numbers.
- Coordinate my care - lacking information to support OOH care working more collaboratively on information.
- Use the experience on children’s services integration and build and sustain integration in other areas. Support around frailty integration.

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- More work around joint commissioning with local authorities.
- CEPN education and training - to get more involved and to identify someone to join the Islington CEPN. To get CNWL’s palliative care service involved.
- Use the contract review meeting in a more strategic manner.

Action:
- Recovery College - build on new work
- (engagement with carers and users)
- Sustainability
- Nurse recruitment, skills development and retention
- Learning peer reviews and challenging practice and care across services and
- across divisions
- Sharing learning across CHS services across CNWL
- Working across LETBs and
- Managers.

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Continued Internal Quality Assurance:
As part of the Trust’s internal initiatives to monitor and drive continuous improvement across CNWL a quality inspection was undertaken between 23rd-25th November 2015. This involved volunteer staff from CNWL, commissioners and individuals from patient user/carer groups.

The inspections were carried out across a number of services. Overall the exercise confirmed that the Trust’s other internal assurance processes were working well and no serious safety issues were identified during the course of the inspections. The visits reinforced the positive attributes raised by the CQC visit in February and particularly the caring approach of staff.

As well as many positive comments the main continuing issues that arose from the visits were:

- How we use our building as clinical resource and as staff bases. We need to pay additional attention to the use of Reception areas as this impact on the patient experience. We also need to look after our staff and make sure they have a working space which is appropriate and can play a potentially significant factor for staff morale.
- All our community teams have very recently moved to a new electronic patient record system (SystmOne) and not surprisingly this was an area of concern for staff. It is anticipated that these concerns will be relatively short lived as the new system beds in.
- Although concerns about staffing were less prevalent in community services they did spread across boroughs. Specific concerns were raised about growing difficulties in recruitment and in some cases how CNWL is struggling to compete with other providers to recruit.