Bromley Healthcare Community Interest Company

Inspection report

Bromley Healthcare
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Bromley Healthcare Community Interest Company (BHC) was established in April 2011 as a social enterprise organisation to provide out of hospital community health services in Bromley. BHC employs more than 1000 staff and over 75% of staff are shareholders in Bromley Healthcare CIC.

BHC provides community health services in four London boroughs. BHC received more than 87,000 referrals in 2020 – 2021 and had nearly 600,00 patient contacts.

BHC provides a rehabilitation/intermediate care ward with 30 inpatient beds at Queen Mary's Hospital, Sidcup; community health services for adults in the London Borough of Bromley; community health services for children, young people and families including health visiting in Bromley, Bexley, and Greenwich, school nursing services in Bromley and Bexley, and a specialist children's nursing team in Bromley. BHC took over the provision of health visiting services in Greenwich, at very short notice, eight weeks before the inspection.

In addition, BHC provides specialist dental services from several health centres in Bexley, Bromley and Greenwich. It also provides other services, such as dietetics in Bromley, Bexley and Lewisham, improving access to psychological therapies (IAPT) and sexual health services in Bromley.

BHC has very recently acquired a care agency with 55 staff providing 700 hours of care to people in their homes in Bexley and 200 hours in Bromley.

BHC has eight locations registered with the CQC (as of 6 September 2021). Five of these provide specialist community dental services.

We carried out inspections of three core services provided by BHC and a well-led review as part of our continual checks on the safety and quality of healthcare services. This was the first comprehensive inspection of the three core services and the first well-led review of the provider. The last inspection carried out by CQC was a focused inspection of community health services for children and young people and took place in October 2020 following the death of baby.

Our findings

We carried out inspections of three core services:

Community health services for adults;

Community health services for children, young people and families; and

Community health services for inpatients.

We did not inspect the provider's sexual health services on this occasion. CQC carried out a focused inspection of the provider's dental services in October 2021 as part of a dental services inspection project. This inspection is reported separately and was not rated.

Regarding this inspection report it should be noted that this inspection did not include a Use of Resources rating. Although Bromley Healthcare Community Interest Company is not a NHS trust the word trust is used erroneously in several places in the report as the word cannot be removed from the standardised inspection report template.

We rated Bromley Healthcare CIC as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good overall.
- We rated two of the provider's three core services as requires improvement and one as good.
- The provider had three overarching strategic aims but a lack of clarity and detail regarding how the strategy would be achieved and by when. The provider had begun to refresh the strategy for the next three years.
- Although there was a culture of high-quality care and leaders were clear that quality was not impacted by financial decisions, from our findings in the core service inspections there was some variation in the quality of care across some services. Specialist teams and services were found to have high quality care throughout. However, in district nursing and health visiting teams there was variation in quality.
- Assurance systems in some areas were weak. Although performance data was collected and some of it presented very clearly in the form of dashboards, other key details of service delivery were not routinely analysed leading to gaps in assurance. The provider did not have effective arrangements to ensure that all notifications were submitted to external bodies as required.
- Clinical audits were conducted mostly annually, but in some areas, such as record keeping, this was not frequent enough to drive improvements. The board had identified concerns about the quality of some audit design, which made it difficult to learn anything meaningful from the results. Where gaps had been identified following internal and external audits these were not always addressed effectively to bring about improvements, with the same or similar issues persisting at the time of our core service inspections.
- Focus on the development of black and minority ethnic and other staff groups with protected characteristics, and the equality, diversity and inclusion agenda more generally, was relatively recent and was developing. Indicators across several of the workforce race equality standards highlighted disparities between the experiences of black and minority ethnic (BAME) staff and white staff. Further understanding and strategies were required to improve the experience of BAME staff.
- The provider had arrangements in place for staff to implement the Accessible Information Standard, which applies to people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. However, many staff we spoke with did not know what the standard was. The provider did not monitor whether or not staff implemented the standard effectively.

Our findings

- Arrangements for the Freedom to Speak Up Guardian role had been in place since February 2021 but were yet to be fully established. The service had not been widely advertised or promoted with staff although details about the FTSUGs had been shared with staff via the chief executive's weekly briefing, and nurses' forum.
- Patient experience feedback was limited, especially during the pandemic. The provider largely relied on Friends and Family Test feedback and had not fully explored obtaining feedback in other ways. Patient and public engagement was taking place. For example, a children's community nurse ran a support group for carers and young people with sickle cell disease; the sexual health service was proactive in engaging patients through social media, focus groups and questionnaires; community paediatricians obtained feedback from patients on their experience of virtual consultations; and the COVID monitoring service had used a survey to gain feedback regarding long COVID symptoms from more than 440 patients. However, this work did not sit within an overall patient and public engagement strategy that included how BHC would engage specific patient and public groups who may provide valuable feedback but might not engage through the existing channels.
- The training and delivery of a quality improvement methodology and culture was at an early stage. BHC used a plan, do, study, act (PDSA) approach to quality improvement and a quality improvement lead had been appointed and commenced work with BHC in May 2021. Further work to develop a quality improvement approach and embed a quality improvement culture throughout the organisation was needed.
- Although the provider had carried out fit and proper person checks on directors, they had not made basic criminal record checks with the Disclosure and Barring Service in respect of non-executive directors.

However:

- There was a stable and full leadership team with capability in their roles. Leaders were visible and approachable across the organisation, although some leaders were very operational in their day to day roles and responsibilities. The non-executive directors (NEDs) had a variety of backgrounds with a bias towards commercial skills and expertise. The balance of NEDs on the board was being reviewed at the time of the inspection with consideration being given to the addition of a further NED with a clinical background.
- There was good financial stability and control and a highly skilled team delivering tender bids and winning appropriate contracts. The senior leadership team had a strong commercial skill set and were highly skilled at delivering this for the organisation.
- The provider was very responsive in its approach to health and care delivery as exemplified by the rapid mobilisation of the Greenwich 0-4 service and the setting up of a COVID-19 monitoring service at the height of the pandemic. The provider managed change effectively and minimised disruption when service provision changed.
- The provider had largely effective arrangements for identifying, recording and managing risks, issues and mitigating actions. Risks were recorded at service level and escalated up through clear channels to the corporate risk register where they were discussed and addressed. Risks identified by frontline staff matched those articulated by board members.
- Dashboards were available for teams and used by them to review performance. All staff said they were helpful and easy to use. Bromley Healthcare staff shared their information technology (IT) skills with the local care sector and supported GPs with IT during the pandemic.
- The provider had very positive relationships with external health and social care stakeholders. Senior leaders took an active role in local health care partnerships. Service staff worked effectively with NHS trusts and primary care clinicians to deliver high quality services to adults and children, such as the hospital at home service and rapid response.

Our findings

- The provider was committed to the development of staff and encouraged staff engagement and an open organisational culture. Senior leaders were very accessible to staff at all levels. A number of new staff well-being initiatives had implemented over the previous year, which were valued by staff.
- Senior leaders had clear oversight of incidents, safeguarding and complaints. Managers investigated incidents and complaints and shared the lessons with staff to minimise the risk of them happening again. Safeguarding procedures were robust throughout the organisation. Staff understood how to protect adults and children from abuse and the services worked well with other agencies to do so.

How we carried out the inspection

Our inspection teams comprised of eight CQC inspectors, one inspection manager, three specialist advisors with expertise in providing community health services and three experts by experience.

The well-led review team comprised an executive reviewer, who was a chief executive from an NHS combined mental health and community health services provider; CQC's national professional advisor for community health services, who was also a director of nursing in a community NHS trust; three CQC inspectors, an inspection manager and a head of hospital inspection.

During our inspection of the three core services, the inspection teams:

- visited an intermediate care/rehabilitation ward, looked at the quality of the ward environment and observed how staff were caring for patients
- visited six community team bases
- spoke with 21 senior leaders in the services including a matron, associate directors, team leads, and heads of service
- spoke with 56 other members of staff including nurses, nursing rehabilitation assistants, therapy rehabilitation assistants, occupational therapists, administrators, nursing associates, advanced nurse practitioners, district nurses, central coordination centre staff, health visitors, school nurses and nursery nurses
- spoke with 38 patients and six families who were using services or their carers/relatives
- reviewed 82 patient care and treatment records
- reviewed four safeguarding supervision records
- reviewed five patient and carer feedback cards
- observed seven telephone consultations with adult patients and four child clinic appointments with the consent of the parent or carer,
- observed five shift handover meetings, one multidisciplinary team meeting, one child development clinic and one infant feeding clinic
- sent an online survey to Bromley Healthcare staff eliciting more than 200 responses
- looked at a range of policies, procedures and other documents related to the running of the services

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Our findings

What people who use the services say

On the inpatient rehabilitation ward based at Queen Mary's Hospital, Sidcup, patients and carers told us that staff treated them with compassion, kindness and dignity. Patients and carers said staff were attentive, non-judgmental and were responsive to their needs. Carers told us that they were offered emotional support and advice when needed and that staff were very kind and caring with the patients. One patient commented that the ward felt like a hotel.

We spoke with six families using the community services for children, young people and families. Most people reported a positive experience and said their allocated health visitor had been caring. We heard positive feedback about the infant feeding team and how they supported mothers with breastfeeding. Families were very keen to resume face to face appointments.

Most patients using the district nursing service said that staff treated them well and with kindness, and were friendly, supportive and responsive when other professionals needed to be contacted. However, some patients told us that appointments were rushed, particularly with agency nurses, and sometimes staff would arrive without the correct medical supplies, or knowledge about their care needs. Patients and carers described unpredictable timing as a particular issue, with some experiencing missed or delayed visits. All patients we spoke with who used the specialist nursing teams were satisfied with the care they received and felt involved in making decisions about their care.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

We told the provider that it must take action to bring services into line with legal requirements. This action related to the provider and to three core services.

Provider wide

- The provider must ensure that systems and processes in place to assess, monitor and improve services are effective and performance data collected is routinely analysed to provide assurance, identify concerns and drive improvements in care. Regulation 17(1)(2)(a)(b)
- The provider must ensure that it undertakes at least a basic disclosure and barring service check for all non-executive directors. Regulation 5 (1)(2)(3)(a).

Community Health Services inpatients

- The provider must ensure that the number of patients with hospital acquired pressure ulcers continues to reduce. Regulation 12 (1)(2)(b)
- The provider must ensure that investigations into hospital acquired pressure ulcers record enough detail to provide assurance as to whether the pressure ulcers are avoidable or not and identify learning. Regulation 17 (1)(2)(b)

Our findings

- The provider must ensure that medicine administration records are completed clearly and accurately to reduce the risk of errors occurring. Regulation 12 (1)(2)(g)
- The provider must ensure that the placement and rotation of medicine patches is clearly recorded. Regulation 12 (1)(2)(g)

Community Health Services for adults

- The provider must ensure that it has effective systems and processes in place to assess, monitor and drive improvements in the quality and safety of services provided, including supervision. Regulation 17(1)(2)(a)(c)
- The provider must maintain regular oversight of the volume and impact of deferred visits in the district nursing teams in order to monitor and improve quality, safety and patient experience. Regulation 17(1)(2)(a)
- The provider must ensure that staff record patients' DNA CPR status consistently, including clear information on where to find the completed document, to ensure patients' dignity and that their wishes are respected. Regulation 9(1)(3)(g)
- The provider must ensure that care plans for all patients include details of patients' personal, psychological, social, cultural and religious needs, and how they will be addressed. Regulation 9(1)(3)(b)
- The provider must ensure that care records include all relevant information including the patient's name, and details of when any changes are made to the plan of care and by whom, to ensure that there is a clear plan of care in place that can be safely implemented by staff. Regulation 12(1)(2)(b)
- The provider must ensure that mental capacity assessments are completed where there is doubt over whether a patient has capacity to consent to treatment. Regulation 11(1)
- The provider must ensure that all patient deaths are notified to the CQC. Regulation 16 Care Quality Commission (Registration) Regulations 2009.
- The provider must ensure that all incidents resulting in patient injury which, if left untreated, are likely to result in a change of the structure of the body or cause the patient to experience prolonged pain, are notified to the CQC. Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Community Health Services for children, young people and adults

- The provider must ensure that the skill mix of the staff in the health visiting teams is fully explored to enable effective delivery of the mandated Healthy Child Programme and a robust workforce plan put in place. Regulation 18 (1)
- The provider must ensure that patient records are up to date and comprehensive in detail as well as ensuring the records include the details of both parents or adult figures or carers in a child's life. Regulation 12 (1)(2)(a)(b)
- The provider must ensure that staff follow the provider's own lone working policy. This includes staff ensuring they wear a personal panic alarm as set out in the policy. Regulation 17 (2)(b)
- The provider must ensure that there are effective governance systems in place to assess and monitor the quality and performance of the children, young people and family services. Regulation 17 (2)(b)
- The provider must ensure that there is a centralised record system in place for staff competency assessments to be recorded and stored. Regulation 17 (2)(b)

Action the provider SHOULD take to improve:

Our findings

Provider wide

- The provider should ensure that work continues to address disparities between the experience of white and black and minority ethnic employees and improve Workforce Race Equality Standard indicator scores.
- The provider should continue to review the quality of audit design and the frequency with which they are implemented.
- The provider should ensure that work to define a medium to long term strategy for the organisation continues.
- The provider should ensure that the role of the Freedom to Speak up Guardian is developed further and advertised more widely to staff.
- The provider should develop the quality improvement approach and embed a quality improvement culture throughout the organisation.
- The provider should look at ways to increase the amount of patient and carer feedback received by services, develop a clearer community engagement strategy, and be proactive in seeking the views of communities that might not engage through the existing channels, about service development and design.
- The provider should ensure that staff understand the Accessible Information Standard and how they can meet the needs of patients, carers and parents who have information and communication support needs and monitor implementation of the standard.

Community Health Services for inpatients

- The provider should ensure that medicines are appropriately disposed of after they are no longer in use.
- The provider should ensure that oxygen cylinders are secured to an appropriate anchor point.
- The provider should ensure that patients' medicine care plans are more person centred.
- The provider should ensure that staff are confident in identifying sepsis and receive face to face moving and handling training annually.
- The provider should ensure that the ward environment is more suited to patients with cognitive impairment and all bedrooms have clocks.
- The provider should ensure that staff escalate concerns about drug fridge temperatures promptly when they exceed the recommended limit.
- The provider should ensure that staff understand the Accessible Information Standard and how they can meet the needs of patients who have information and communication support needs.

Community Health Services for adults

- The registered provider should continue to recruit to vacancies in the district nurse teams to ensure improved consistency of care.
- The registered provider should ensure that records of completed staff supervision are kept.
- The registered provider should ensure that all staff involved in end of life care understand the five priorities as defined by the Department of Health and Social Care.

Our findings

- The registered provider should complete ongoing work to ensure that all staff working on their own, have access to a personal attack alarm.
- The registered provider should explore different ways of obtaining feedback on patient experience of the service.
- The registered provider should ensure that district nurses, including agency staff, bring the required equipment with them on home visits.

Community Health Services for children, young people and adults

- The service should ensure that the community children's nursing team are based in a space that is sufficient in size and can accommodate the clinical stock that the team require regular access to.
- The provider should ensure that staff understand the Accessible Information Standard and how they can meet the needs of patients, carers and parents who have information and communication support needs.
- The provider should ensure that there are clear plans in place to address the delays in the completion of educational health care plans (EHCPs) within the statutory six-week time frame.

Is this organisation well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they provided, were visible in the service and approachable for patients and staff.

The trust board consisted of the chair, chief executive, three non-executive directors and four other executive directors. The non-executive directors had experience as senior leaders in a range of organisations. The chair had a background in healthcare and as a non-executive director in a large mental health trust. Non-executive directors (NEDs) had experience in finance, management consultancy and had held senior positions in housing, health and a national home care provider. The balance of the NEDs on the board was more towards business and commercial experience. The recruitment of an additional NED with clinical experience when the next opportunity arose, was being explored.

Executive directors mostly came from a clinical background and the chief executive and other senior leaders were very involved in the operational aspects of service provision.

Board members visited services and teams and met with frontline staff. The programme of service visits had been reduced over the last year but there were plans to increase these. Executive directors had continued their visits to services throughout the pandemic, both virtually and face-to-face. Patients and carers spoke directly to the board about their experiences at board meetings, which had been held virtually during the pandemic.

Fit and proper persons checks were taking place. Bromley Healthcare (BHC) had a process for carrying out their duties in respect of the Fit and Proper Persons Regulation. We reviewed the fit and proper person checks completed for four board members, one executive and three non-executive directors. We found that pre-employment checks had been completed. Prior to employment, the provider carried out financial checks regarding bankruptcy, insolvency and their ongoing ability to hold director posts, for directors and non-executive directors. The provider made criminal record checks with the disclosure and barring service in respect of executive directors.

Our findings

However, the provider did not seek to obtain disclosure and barring service certificates for non-executive directors. For non-executive directors a signed self-disclosure regarding criminal convictions was obtained. As a regulated provider of health services for NHS patients, the provider is required to ensure that any directors are of 'good character' and confirm whether they have been convicted of any offence. Non-executive directors made visits to teams and services where they may have interacted with adults and children using services. There was a risk that without conducting thorough checks the provider could not be sure that the non-executive directors were of 'good character' as defined in fit and proper persons: directors, regulation.

Vision and strategy

BHC had clearly stated values and a vision for the organisation. It had a broad strategy to deliver high-quality care to people in local communities.

The stated key values of the organisation, as outlined in the quality strategy 2020-2023 were:

- We will treat others as we would like to be treated
- We will continually improve our services
- We will hit our targets

The overall aim or mission of BHC was 'to enable the best care possible closer to home.'

This was underpinned by three statements with supporting goals:

- Continually improve our services
- Treat others as you would like to be treated
- Hit our targets

The supporting goals linked to the key organisational vision and values were:

- Goal 1 Outstanding health and care closer to home
- Goal 2 Great place to work
- Goal 3 Sustainable for the future

The strategic goals had been developed as part of a board strategy workshop.

The organisational business plan 2021/2022 outlined the priorities identified under each goal with defined measures of success. Service level plans sat beneath the business plan, setting team/service level goals that contributed to the overall delivery of the plan.

The overall aim of the quality strategy was to ensure that:

- BHC provided high quality community healthcare which staff were proud of and were recognised for;
- patients and families received a service that met their expectations, sustaining BHCs reputation and increasing public confidence; and

Our findings

- demonstrated that BHC was able to listen and respond to the views of patients, families and the local community to drive service improvements

Beneath the strategy the provider had initially defined four quality improvement objectives, including actions, expected outcomes and measures of success year on year. These were:

- the reduction of avoidable acquired pressure ulcers
- to reduce the number of patients who fell whilst under BHC care and ensure appropriate interventions
- to improve the standard of clinical record keeping
- to reduce the number of medicines incidents causing harm.

Following evaluation of progress in year 1 of the strategy the provider judged that three out of the four priorities had been achieved with one indicator, reduction in falls, being partially achieved. All four priorities were carried over to 2021/22, as part of a three year quality improvement programme. However, during the core service inspections we carried out we identified concerns with record-keeping in district nursing and health visiting teams. We also identified concerns with the quality of medicine administration records on Foxbury rehabilitation unit, which increased the risk of medicines errors. This suggested that there was still more to do to bring about improvements in safety and quality.

Two further objectives were added to the quality priorities in 2021/2022 related to frailty/end of life care and dementia/ Mental Capacity Act.

There were working groups for each objective and they reported to the quality improvement group, which in turn reported to the quality improvement and performance committee and the BHC board. The record keeping working group had revised the record keeping audit tool ready for the next annual audit.

The provider had a document articulating the risks to delivering the strategy, existing mitigation controls, assurance evidence and actions that would begin to take effect in the next three to six months. The board rated its confidence in the mitigations and plans against each risk.

Board members, including NEDs, were clear about the overall strategic goals of the organisation. However, beyond the yearly business plan there was no clear plan as to how the strategy would be implemented in the medium to long term. The provider had begun work to review the existing strategy and develop an organisational strategy for 2022-2025**.** Lack of clarity in terms of the development of the local integrated care system and what the impact would be on BHC made long term planning more complex. The organisation's focus was more on the present and immediate future, ensuring that BHC was providing excellent services locally and had good relationships with partners.

The board had begun meeting to discuss organisational strategy going forward and develop a two to four-year strategic business plan. The board had broad plans to increase diversity and inclusion in the senior leadership group and board although there were no clear plans of how they intended to reach under-represented candidates during recruitment to senior leadership positions in particular.

Senior leaders considered that in order to be successful and sustainable as an organisation BHC needed to be better than other organisations, be innovative, be credible and one step ahead of changes in the landscape. This was a shared view across board members.

The provider had a well-defined and robust business model and had been successful in winning contracts. The organisation had grown by 10% in the last 12 months. The commercial director and commercial team reported into the

strategy and investment committee, a sub-committee of the board. A commercial team governance framework was in place and was used to manage bids and projects. Processes were either reactive (responding to tenders) or proactive (new business cases). A business analysis tool was used to support conversations at executive level and decisions to pursue opportunities for growth. Sign off of bids and business cases sat with the board. Leaders had an agreed vision to grow areas where they could deliver quality and areas of income generation that would allow BHC to reinvest in services.

BHC always involved commissioners in the development of new business cases. Business cases were assessed in terms of their financial appeal, fit to BHC's vision and values, complexity of delivery, risk, chance of success and capacity. BHC sought out partnerships where this was beneficial and carried out rigorous appraisals of possible partners before approaching them. BHC was regularly in discussion with commissioners around a range of business cases related to new or expanded services.

BHC was actively engaged with strategy development at south east London and One Bromley (local care partnership) levels.

Culture

The culture of the organisation was open and transparent and was centred on the needs and experience of people who used the services. Staff largely felt positive and proud about working for the organisation and their teams. We received positive feedback from staff at all levels during the core service inspections although staff survey results were less positive. Most staff felt able to raise concerns about the safety and quality of care without fear of reprisal. BHC had a strong emphasis on staff wellbeing, with many new initiatives introduced in the last year. BHC had begun work to promote equality and diversity in the organisation but this was at an early stage.

Local partners we met with described BHC as open and transparent and very focused on the needs of children and adults using the services. BHC was seen as easy to work with, collaborative, exceptionally responsive and solution focused with a 'can do' attitude.

The provider conducted a staff survey in October 2020. The survey had a 66% response rate, better than the average response rate for NHS organisations (47%).. Fifty-eight per cent of staff said they were satisfied with flexible working arrangements (NHS comparison 57%) and 75% said their immediate manager encouraged them at work, higher than the NHS average of 70**%**. The overall staff engagement score was 7.2: 76% were often/always enthusiastic about their job slightly higher than the NHS average (73%); 61% looked forward often/always to going to work, similar to the NHS average; and 79% said they would be happy with the standard of care provided by their organisation for a friend or relative needing treatment. This measure had improved from 64% in 2018. The NHS average for this measure was 74%.

Respondents were less positive in terms of the provider's focus on staff well-being. Thirty-three per cent said the organisation definitely took positive action on health and well-being, similar to the average for NHS organisations and 49% felt involved in deciding changes.

Eighty-four per cent of staff felt the organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age, although 11% reported experiencing discrimination from managers or colleagues. This was an increase from 7% in 2018.

Our findings

The vast majority of staff (93%) felt their role made a difference to patients/service users slightly better that the NHS average (89%); and 81% of staff were satisfied with the quality of care they give to patients/service users (similar to the average for NHS organisations).

The majority of staff (60%) said the provider treated staff who were involved in an error, near miss or incident, fairly. This had increased from 51% in 2018.

Three quarters of staff (78%) said that the provider took action to ensure that reported errors, near misses or incidents did not happen again, better that the NHS average (73%). This had increased from 65% in 2018, similar to the NHS average. A small percentage (9%) said they had experienced bullying and harassment from managers, a decrease from 12% in 2019 and 13% in 2018. This was slightly better than the NHS average of 12%. Fourteen per cent said they had experienced bullying and harassment from other colleagues, which was down from 19.0% in 2019.

We received more than 200 responses (around 20% of the workforce) to a survey we sent to Bromley Healthcare staff. Nearly 80% of respondents said they would recommend BHC as a good place to work. Eighty-eight per cent considered that the provider offered specific staff support to those with protected characteristics and three quarters said they could speak up about inequalities. A large majority felt they were valued by the organisation, although some staff commented that some communication with local managers was poor. Similarly, most staff said they felt listened to and they could contribute to improvements in services. When we asked staff what would make the experience of working for BHC better the most common themes were improvements in recruitment, staff support and career progression and better two-way communication with management, although many staff commented on these areas as strengths of the organisation. In relation to what they thought the provider did well the overwhelmingly most common theme was that BHC provided excellent patient care.

The senior leadership led actions to improve staff engagement and overall staff experience. During the last year BHC had focused on improving staff wellbeing with a range of new initiatives, which staff spoke positively about.

Black and minority ethnic groups accounted for 20% of the population in Bromley, 22% in Bexley, 42% in Greenwich and 48% in Lewisham. The makeup of staff employed by BHC was similar to local populations. However, the provider had work to do to improve the experience of black and minority ethnic minority (BAME) staff in the organisation. BHC took part in the Workforce Race Equality Standard (WRES) and reported on the standard indicators. The 2020 and 2021 measures for each indicator identified disparities between the experiences of white and BAME staff in the organisation on a number of measures. BAME staff reported more discrimination than the national average and high levels of bullying and harassment.

2020 and 2021 performance against WRES indicators (the 2021 results were still in draft at the time of the well-led review):

Indicator 1: the percentage of BAME staff within each banding against total staff. In 2020 the BAME workforce in BHC was 23% (208 staff). The majority of BAME staff were employed at bands 2, 3, 5 and 6. Twenty-five per cent of BAME staff were at bands 8a and 8b (24 staff in total). There were no BAME staff at band 8c or higher although the provider informed us that there were BAME staff working at equivalent grades in dental and community paediatric services on non-Agenda for Change contracts.

Indicator 2: the relative likelihood of white applicants being appointed from shortlisting in 2021 was 1.73, slightly worse than in 2020 (1.57).

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Indicator 3: the relative likelihood of BAME staff entering the formal disciplinary process compared to white staff in 2020 was 3.13, higher than the London trust average of 1.95 but this had improved to 1.73 in 2021.

Indicator 4: the relative likelihood of white staff accessing non-mandatory training and continuous professional development compared to BME staff was 0.93 in 2020 and 1.04 in 2021.This showed that BAME and white colleagues had similar access to non-mandatory training and continuous professional development.

Indicator 5: the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months was 34.6 for BAME staff (compared to the national average of 29% in 2020) and 24.1 for white staff.

Indicator 6: the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was 28.4 for BAME staff and 15.7 for white staff.

Indicator 7: the percentage of staff believing the organisation provides equal opportunities for career progression or promotion was 53.4 for BAME staff compared to the national average of 69%. For white staff the percentage was 89% compared to the national average of 87% for white staff.

Indicator 8: the percentage of staff personally experiencing discrimination at work from a manager/team leader or colleague was 27% for BAME staff (compared to the national average of 16%) and 6% for white staff (in line with the national average).

Indicator 9: BAME board membership (with voting rights) was 20% in 2020. This was similar to other London NHS providers.

BHC had a WRES action plan in place. This set out the 2021/2022 priorities mapped to the WRES indicators. Actions to address the disparities and poorer experiences of BAME staff included the roll out of unconscious bias training; network members to be trained in job evaluation; recruitment training; expansion of interview panels; transition to a 'just culture' approach (an approach that recognises that individual practitioners should not be held accountable for system failings over which they have no control); a focused survey undertaken with BAME network; the introduction of the freedom to speak up guardian and ambassadors; and a mentorship programme.

BHC, with partners at One Bromley (local care network), had established an ethnic minority mentoring programme. Twenty-seven mentors and mentees had been matched during the first phase. There were plans to roll out the mentorship programme to all staff over time.

The head of learning and development reported that 85% of staff had completed unconscious bias training by January 2021 and the training was integrated into organisational leadership training programmes.

BHC was not mandated to submit performance figures in respect of the workforce disability equality standard (WDES) but planned to submit information in relation to the key indicators for 2020/2021 by the end of September 2021.

The provider had established the first staff equality and inclusion network for black and minority ethnic (BAME) employees in July 2020. The BAME equality and inclusion network reported around 80 members. The chair of the group was not given protected time to carry out their duties, but was offered additional payment for their time. Staff had not had any difficulty taking time to attend the network meetings after some initial teething problems. The chief executive was the executive sponsor of the group and met with the network chair. The chief executive had been supportive of the group, and other senior leaders were seen as allies. The network chair was keen to secure more external support to help

establish the group. There were plans in place to hold a three-day conference aimed at empowering staff. The network hoped to be involved in delivering training to the new freedom to speak up ambassadors later in the year. The network reported into the people and culture subcommittee of the board and the network chair was a voting member of the subcommittee. The network chair noted that there were no ethnic minority staff at band 8c and above in the organisation and there was a desire for better unconscious bias staff training. The provider acknowledged this and informed us that there were some BAME staff working at equivalent grades in dental and community paediatric services on non-Agenda for Change contracts.

A staff lesbian, gay, bisexual and transgender (LGBT+) network was about to be launched in September 2021.

At end of March 2020 the provider employed 866 staff, 73% of whom were involved in direct patient care roles. Fifty-one per cent of staff were part time. BAME staff made up 24% of the workforce and 3.6% had declared a disability.

The overall staff sickness rate for 2020-2021 was low at 4% including staff absent because of COVID-19 but not including those isolating. In April and May 2021 staff sickness was 3.3% and rose slightly to 4.6% in June 2021, driven by an increase in COVID-19 related sickness.

The overall staff turnover rate for 2020-2021 was 14%.

The overall vacancy rate in 2020-21 was 8.3%. In the first quarter of 2021-22 it was 7% with a target of 5%. Vacancies were higher amongst health visitors (29% in Greenwich health visiting team - reduced from 41% when BHC took over providing the service) and district nurses (21% in June 2021 with 14 new band 5 staff appointed and due to start in September 2021). For children's OTs there was a 36% vacancy rate (2 whole time equivalent posts). The head of learning and development reported that BHC was developing a plan to retain older staff approaching retirement. The recruitment and retention of district nurses and health visitors was a high priority for the provider.

In terms of recruitment, the time to hire in 2020-2021 was 44.6 days. This was reduced to 39.3 days in the first quarter of 2021-2022, with an organisation-wide target of 40 days.

The number of staff with completed appraisals in 2020-21 was 92%. In the first quarter of 2021-22 it was 90% with an organisational target of 85%

Statutory and mandatory training compliance in 2020-21 was 88%. In the first quarter of 2021-22 it was 91% against a target of 85%. The areas where compliance was below target included moving and handling level 2 and basic/ intermediate life (BLS/ILS) support, both of which were face to face training courses. The pandemic had affected access to face to face training, limiting the numbers able to train at any one time. The learning and development team was working with national providers to ensure staff were trained as quickly as possible, despite a national backlog resulting from a shortage of trainers and social distancing constraints. Action plans were in place for the areas below target compliance. BHC had formed a close relationship with a local college to improve access to training.

The learning and development team approached a local university during the pandemic and were able to secure some face to face BLS/ILS training. The learning and development team anticipated that compliance with moving and handling training would have recovered by April 2022. Staff on the inpatient rehabilitation ward had been prioritised for training given the nature of their work. The provider reported that no incidents had occurred as a result of lack of training.

Our findings

Clinical supervision was not recorded centrally and was not part of the people key performance dashboard. The head of people reported supervision/one to one meetings were scheduled to take place four times a year. However, records were not kept centrally as to whether these meetings were taking place. Many staff we spoke with reported formal one to one meetings were taking place but records were not kept of the discussion. Staff reported good access to informal support. The provider later told us that staff should record professional reflection activity (supervision) on the appropriate IT system. This system recorded when supervision had taken place and for how long, for individual staff.

Two per cent of BHC's employees were doctors and dentists, 14% were allied health professionals and 30% were nurses.

The provider had a whistle-blowing policy that staff were aware of. The provider had received one whistleblowing in the last three years. Most staff we spoke with during the inspections said that they felt able to raise concerns with their line manager without fear of retribution. No concerns were raised by staff regarding bullying and harassment during the core service inspections although the staff survey reported it did occur.

BHC had introduced Freedom to Speak Up Guardian (FTSUG) arrangements in February 2021. There were two guardians in place, the head of people services and the patient experience lead. They had both received training for the role in December 2020. Three staff had been identified as FTSUG ambassadors and were due to receive training. The guardians planned to report on their work to the board on a quarterly basis.

At the end of quarter 1 2021/22 no cases were raised under the Freedom to Speak up policy. The initial launch of the service was described by a guardian as a 'soft launch' and it was not clear how aware staff were of the service, although details about the FTSUGs had been shared in various ways, such as through the chief executive's weekly briefing, and nurses' forum.

BHC had developed a range of ways of supporting staff health and wellbeing, including several new initiatives over the last year. BHC had introduced a programme of mental health first aiders. Sixteen mental health first aiders had been appointed and trained to support other staff.

During May 2021 BHC held the first annual 'health and wellbeing week', which focused on ensuring that BHC staff had a safe and healthy workplace where their mental health and physical health needs were respected and valued equally. The sessions were attended by about 360 members of staff and were well received.

Wellbeing activities included: a big walking challenge, resilience and mindfulness workshops, working parents and carers well-being session, online yoga, and menopause 101 (a session to highlight sources of support). BHC had also introduced Schwartz Rounds (a confidential, comprehensive forum where all staff, clinical and non-clinical, can come together regularly to discuss the emotional and social aspects of working in healthcare). Three sessions had been held since May 2021.

BHC had an employee assistance programme that provided mental health support via a 24 hours a day 365 days a year telephone helpline, face to face counselling, online cognitive behavioural therapy workbooks and additional support and training services.

Staff had access to support for their own physical and emotional health needs through occupational health. BHC had a contract with an external provider for occupational health and this was reported to be working well.

Our findings

BHC had developed a number of staff leadership development programmes tailored to the needs of different groups of staff. BHC had developed three core leadership programmes: 'how to be a great leader' aimed at band 6 & 7 staff; 'learning to lead' aimed at band 4 and 5; and 'refine and refresh your leadership' aimed at senior staff at band 8a and above. These programmes used a range of approaches including classroom teaching, coaching and action learning sets.

BHC had taken up space at a local college to deliver training and development courses. This helped raise the profile of BHC as an employer within the college.

As part of staff recruitment and retention strategies BHC had developed an overarching career pathway for adult nursing. It had introduced the band 5 readiness programme, a programme that supported band 5 staff to take up roles in community teams traditionally open to more experienced staff. Participants were supported to progress to a higher grade within the organisation through structured learning, development and support.

BHC had a people plan 'Building a culture for growth' 2020-2023. The plan was aimed at attracting staff, supporting their education, development and wellbeing and improving diversity at all levels of the organisation. BHC was working with One Bromley on workforce challenges via the workforce strategy group that reported to the One Bromley executive.

The themes and actions were:

- Looking after our BHC team – wellbeing initiatives.
- Belonging in BHC - including celebrating successes through 'team of the quarter', 'star of the month' and annual awards; regular communication through leadership briefings, team meetings and CEO updates; creating an inclusive culture and staff networks.
- New ways of working and delivering care – including making effective use of people's skills and experience. Laptops and smart phones rolled out to all clinicians.
- Growing our BHC team for the future – including the need to develop a clear plan for areas harder to recruit to and implementing effective annual appraisal.

A people plan tracker monitored progress with identified actions.

Governance

BHC had structures, systems and processes in place to provide assurance and deliver the organisation's services safely but these were not always effective. We identified safety concerns in all core services we inspected. Structures and processes included sub-board committees, specific area group meetings, service and team meetings. A governance review was undertaken at the end of 2020 resulting in a revised sub-committee structure aimed at strengthening oversight and governance.

The provider had structures, systems and processes in place to provide assurance and deliver the provider's key programmes. This included five sub-board committees:

- audit and risk
- people and culture
- quality improvement and safety

Our findings

- strategy, investment and development
- appointments and remuneration

Each committee was chaired by a NED or the chair and had clear terms of reference. Minutes from the sub-committees were shared at the board meeting and any areas of concern escalated. The non-executive directors were clear about their areas of responsibility and the committees they chaired.

The board met seven times in 2020 approximately every two months.

The executive directors had clearly defined areas of responsibility.

Senior finance business partners led on all financial matters with support from the chief executive who had a finance background.

Board members were knowledgeable about and understood the overall performance of services across the organisation. The director of nursing and quality led regular deep dives into services. However, while information systems collected relevant data related to service performance this was not always analysed on a regular basis and used to drive timely improvements.

The provider had plans to review governance and management structures in the organisation following some anticipated changes. The aim was to strengthen governance at a divisional level. Staff with a role to focus on quality were being introduced in district nursing.

The provider had dashboards providing key performance information to managers, teams, the provider senior leadership and board. At a ward and team level front line managers were clear about their responsibilities and felt they were given sufficient autonomy and support to perform their roles. Each team manager had access to dashboards containing essential performance information for their team. This helped to inform the management of their service.

Senior staff including the chief executive met weekly to review and discuss all serious incidents and complaints. Standard agendas were used to ensure essential information, such as learning from incidents and complaints, was shared with staff at team meetings. This helped the effective flow of information from service and team level to the board and vice versa. Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person

We identified safety concerns in all core services we inspected. Most of these had been known to the provider for some time but actions to address them had not been very effective. BHC did not keep robust oversight of deferred visits in district nursing and the effect on patient experience.

BHC had effective processes in place to respond to complaints. Patients and carers knew how to make a complaint. BHC ensured that people were able to raise complaints easily. Information providing advice on how to complain was available on the provider's website and was supported by leaflets that were given to patients by staff or information displayed on the inpatient unit. The provider's website signposted people to an independent advocacy service for help to make a complaint or express a concern about a service.

Our findings

The provider received 233 complaints and concerns in 2020-21. In the first quarter of 2021-2022 68 complaints were received. Following investigation 40% of these complaints were upheld. Seventy-five per cent of complaints were responded to within the agreed time frame, less than the target of 95%. In 2020-2021 25% of complaints were upheld and 85% responded to within the specified time frame.

The top three themes for closed complaints for 2020-2021 related to appointments, assessments and clinical treatment. Emerging trends and themes were monitored regularly and discussed at the weekly incident and feedback meeting. This meeting was chaired by the chief executive and attendees including the medical director, the director of nursing and quality and head of safer care. When learning was identified actions were taken and monitored to ensure that the learning was embedded to prevent issues reoccurring.

When a complaint was received, the complainant received a quick response, usually the same day, to understand if the complainant wished to receive a written or verbal response. When a written response was provided, this response addressed the areas of complaint and described actions the provider would take as a result of the complaint. We reviewed four complaint responses. Complaint responses expressed regret that the complainant was distressed. However, expressions of regret tended to be generic and did not always convey empathy specific to how the issues had affected the complainant.

Current themes coming out of formal and informal complaints included concerns about clinical assessments/ appointments, such as district nursing visits being deferred but patients not always informed.

There was a total of 52 concerns (informal complaints) reported in quarter 1 2021/2022. The top four concerns related to clinical treatment (13), communication (8), appointments (6), and staff attitude and behaviour (6).

Complaints were included in the safer care report that was shared with the quality improvement group and from there to the quality and safety committee bimonthly. The highlights of this committee were presented at board meetings. An incident review and feedback meeting was held weekly with senior executive team. Senior leaders reviewed all complaints at this meeting.

The provider also monitored compliments. The provider received 660 compliments in 2020-2021 and there was a total of 172 compliments in quarter 1 of 2021/2022. The highest number of compliments was received by Foxbury rehabilitation unit with 22. This was 13% of all compliments received.

Management of risk, issues and performance

The provider had processes for managing risks, issues and performance. Most areas of poor performance or concern were identified by the provider on risk registers and/or highlighted as a quality priority. However, actions to manage risk and improve quality and safety in some key areas, such as record keeping, had been ineffective. The provider was aware of the risks of decisions to not carry out mandated checks as part of the Healthy Child Programme but there was no robust workforce plan in place that considered skill mix in the health visiting teams more widely. BHC did not record whether staff in the children's community team were up to date with required clinical competencies. Records of investigations of hospital acquired pressure ulcers in Foxbury inpatient unit lacked detail.

The provider has a strategic risk register in place. In July 2021, the provider had nine open risks:

- Health and well-being of staff

Our findings

- Inequality impact of COVID-19 and long COVID
- Lack of ongoing diabetes consultant provision
- Failure to deliver digital strategy
- Mobilisation of Greenwich 0-4 service
- Pressures in children's services
- Risks associated with acquisition, mobilisation and running of a new home care service
- Sustainability of district nursing service (current level of district activity outweighing the capacity to deliver)
- Uncertainty arising from local arrangements and the development of the integrated care system

BHC also displayed these risks on a heat map. This showed clinical risks related to the mobilisation of the Greenwich 0-4 service and a high number of vacancies in district nursing as the highest risks - having a current risk of red (post mitigation). Two risks were rated as yellow and five as amber. BHC had taken over provision of the failing health visitor service in Greenwich from another provider in May 2021 at very short notice. BHC had inherited a high number of staff vacancies.

The board received performance information in the safer care report. Data in the report was presented in time series rather than using a red, amber, green rating. The previous year's data were included for some indicators, but not all, to allow comparison. The report included sections on incidents, pressure ulcers, falls, medicines incidents, serious incidents, infection control, central alerting system (CAS) alerts, NICE guidance and patient experience (complaints, concerns, compliments, FFT and care opinion).

The board was sighted on the risks affecting the organisation. Senior leaders, including NEDs were able to articulate the risks. The risks on the register matched those recognised by staff teams.

BHC had an annual audit programme. Although audits of key performance areas, such as record keeping, were taking place audit frequency was not always adequate to monitor and drive improvements in a timely way. We identified concerns about the quality of record keeping in community health services for both adults and children. Comprehensive audits of record keeping were carried out on an annual basis. In between it was expected that managers would review the record keeping of individual staff. This had been a quality priority for more than a year but there still significant shortfalls affecting safety and effectiveness.

An external audit of consent in 2020 had identified concerns about staff failure to complete and document mental capacity assessments in district nursing. During the core service inspection, we identified the same concern, there had been little improvement despite senior managers being aware of the issue.

BHC completed a total of 45 clinical audits in 2020/2021. Due to the COVID-19 pandemic this was a reduction on the number of clinical audits completed in 2020/2021.

The record keeping audit 2019-2020 had an assurance rating of 'significant assurance with minor improvement opportunities' and achieved 91%. Significant assurance was found in the documentation of user information, but only partial assurance that clinical information was recorded as it should be and how the record was written. This was largely reflected in inspections of district nursing and health visiting teams where we identified a range of short falls in clinical record keeping, suggesting little or no improvement since the last annual record keeping audit.

Our findings

Other audits included an audit of the appropriateness of antibiotic prescribing in rapid response - clinicians demonstrated adherence to National Institute of Clinical Excellence/British National Formulary guidance. BHC took part in national audits such as the National Audit of Intermediate Care. The results of the 2020-2021 audit were not available at the time of the inspection. In the previous year's audit, the results for BHC were positive. For example, patients waited an average of 0.2 days from referral to commencement of the service compared with an England average of 2.3 days. Patients spent an average of 19 days in the service compared with a national average of 26.6 days.

Quality improvement and safety committee meeting minutes from June 2021 noted concerns with clinical audit plans particularly with the construction of the audits and the appropriateness for the service being audited. For example, a catheter care audit was described as 'flawed', offering no assurance at all and a similar lack of assurance in pressure ulcer and falls audits. The director of nursing acknowledged that audits had not been well constructed in the past and this was an area of focus going forward.

The provider had systems in place to investigate and identify learning from incidents, complaints and safeguarding alerts and make improvements.

The provider reported no 'never events' and nine serious incidents in the last 12 months, seven of which were pressure ulcer related. One incident related to 24 children who did not receive vision screening when this was required. The provider contacted every family and apologised. One family went on to raise a formal complaint.

The provider had a process in place to manage the investigation of serious incidents. Serious incidents were investigated and any learning for staff or a service was identified. In the past learning from pressure ulcers led to the development of a heel campaign, where staff were reminded of the importance of heel care. The monthly pressure ulcer panel reviewed all serious pressure ulcers for causation and learning. The panel was attended by commissioner representatives. However, records of investigations of hospital acquired pressure ulcers, shared with us, lacked detail and provided little assurance that staff did everything possible to prevent patients developing pressure ulcers. Senior staff described a healthy reporting culture within the organisation.

Training was provided to staff on how to complete a root cause analysis of incidents.

All incidents were reviewed on a weekly basis by senior managers. This review involved identifying incidents which required a 72-hour report and a serious incident investigation. We reviewed six incident investigation reports. Serious incidents were investigated using root cause analysis and were thorough and comprehensive. Executive directors and the board reviewed and approved these investigation reports. Recommendations and actions arising from serious incident investigations led to an action plan, which was monitored so that actions to minimise repetition were completed.

The provider understood their responsibilities in respect of the duty of candour. During the core staff inspections staff understood the term 'duty of candour' and were able to provide us with clear examples of when they would offer support and apologise to patients and families. The chair reported that the board had oversight of the duty of candour through an annual report. Duty of candour was reported at quality improvement and safety committee meetings.

The provider monitored waiting times for services and advertised average waiting times on its website. Waiting times for the tissue viability service and adult physiotherapy were less than three weeks. The longest waiting times were for community paediatrics (16 weeks), children's occupational therapy (12 weeks) and children's audiology service (11 weeks). The provider was running additional audiology clinics on Saturdays to address the backlog.

Our findings

Referral to treatment times were monitored and reported on monthly. The provider was meeting or exceeding targets set in terms of patients receiving face to face crisis response assessment within two hours (94% against a target of 75%), patients receiving a rehabilitation/reablement response (beds or at home) within two days (78% against a target of 75%), and diabetes (meeting expected target of 95%). The provider was performing less well against expected targets in other areas such as reports for education, health and care (EHC) needs assessments completed within statutory time scale (54% against a target of 100%). The provider had negotiated with commissioners for additional resources to address backlogs. Additional doctors had been appointed to help complete EHC plans. There were 50 EHC plans overdue at the time of the inspection.

The provider carried out appropriate staff recruitment checks. The provider undertook disclosure and barring service checks for all staff and reported on this monthly. The provider had an effective system to ensure staff did not start working until all the necessary checks had been completed. We reviewed records of five randomly selected members of staff and found the records were thorough and the system worked effectively. The provider had a robust procedure of pre-employment checks before staff started working at the provider. These checks included a review of people's employment history, identification checks, references and a disclosure and barring service certificate (police check). When required for the role, the person's professional registration was also checked.

Systems were in place to ensure nursing and medical revalidation took place. Revalidation was monitored monthly. In the first quarter 2021-22 99.8% of staff had a valid registration. Other professional registration details were monitored for staff working throughout the organisation.

The organisation managed finances well. There was good financial stability and control and a highly skilled team delivering tender bids and winning appropriate contracts.

The provider had contracts with local health commissioners and three local authorities for the delivery of public health services for children, young people and families. The provider had been successful in winning and sustaining contracts. The commercial team had a clear strategy and approach to completing tenders for services where BHC considered they could deliver high quality.

BHC had an annual turnover of around £60 million. The July 2021 board papers reporting on financial performance in the first quarter of the financial year highlighted a profit for reinvestment of around £50k. This was in line with the year to date plan and original target of £150k profit (net) for reinvestment. Income was broadly in line with the financial plan. The key variance was the COVID-19 income, which was not budgeted for but offset COVID-19 related expenditure in the adult and rehabilitation services. Children and young people's services reported an underspend position of £45k, which predominantly related to staff vacancies. Dental services reported a breakeven position.

The provider had grown by 10% since September 2020 as Bromley Healthcare had taken on new services, including health visiting services in Bromley and Greenwich and a care at home service in Bromley and Bexley.

Agency expenditure decreased in June 2021 to 4.3% and for the previous year to date was 5.1%. This was lower than for the same period in 2020/2021 (5.7%)

The provider had robust arrangements for safeguarding adults and children. There was a clear governance structure for reporting to the board, with identified leads for child and adult safeguarding. The adult and child safeguarding leads gave regular support to staff and teams. Staff training requirements were mapped against intercollegiate standards guidance and competency framework to ensure staff were trained to an appropriate level. The safeguarding team disseminated any changes in policy to front line staff and ensured that learning from safeguarding adult and child

reviews were embedded in practice. The safeguarding leads monitored staff safeguarding supervision to ensure it was taking place. Compliance with safeguarding supervision in the health visiting and school nursing teams in Bexley and Bromley was high. In the Greenwich health visiting service safeguarding supervision was contracted out to a third party although there were plans to bring this in house later in the year. More than 90% of staff had completed Prevent training (Prevent is part of the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism).

The safeguarding leads worked closely with local multi-agency partners. For example, BHC was represented on the Bexley safeguarding partnership for children and young people. We received positive feedback from local authorities about the provider's involvement and engagement in local safeguarding arrangements and structures.

BHC had a modern slavery statement and provided training to staff on how to recognise modern slavery.

The provider was reviewing the use of all of its buildings and spaces in light of the COVID-19 pandemic. Each site had undergone a COVID-19 risk assessment and signage had been changed to ensure staff understood the capacity of each room in terms of social distancing. The facilities manager had spent time with clinical leads to understand how teams worked, integrating site layouts with service needs. The use of service waiting rooms has been staggered to ensure there was sufficient space for people waiting.

Yearly service line reviews included a review of estates to ensure that the premises the teams used met their needs. Any proposed changes took account of recommendations from infection prevention and control audits. Services also raised any estates concerns they had at monthly divisional meetings.

The provider set an annual plan that ensured all required health and safety checks and responsibilities were carried out. For example, the provider had external contracts that covered areas such as fire alarm testing, fire risk assessments, waste disposal and water/legionella testing.

The facilities manager tracked compliance with health and safety requirements. This was displayed in a dashboard, which the manager checked weekly. This information was reported to the health and safety sub-group.

An external contractor provided cleaning services to all BHC premises. Monthly cleaning audits were carried out involving the external contractor and BHC staff and any problems identified were escalated. There had been changes to the contract during the pandemic, which had resulted in increased cleaning of touch points and extra deep cleaning. The provider had set up a subgroup to ensure new national standards of cleaning due in 2022 would be implemented.

There were effective systems in place that enabled staff to log repairs and these were addressed in a timely manner.

The provider had effective systems in place to manage and monitor the prevention and control of infections and ensure appropriate and sufficient resources to enable compliance with good infection prevention and control practice. The provider had completed an infection prevention and control board assurance framework (IPC BAF), which demonstrated that appropriate systems and processes were in place. The IPC BAF was updated at regular intervals, as national guidance changed, and was last updated in June 2021.

The provider had appropriate plans in place for emergencies and other unexpected or expected events.

Our findings

NHS England (NHSE) use the Emergency Preparedness, Resilience and Response (EPRR) assurance process to be assured that healthcare organisations are suitably prepared to respond to an emergency. For 2019 the provider submitted and received an approved fully compliant rating for the EPRR. An action plan was developed following the assurance visit. In 2020 the organisation submitted a self-assessment to NHSE in relation to COVID-19 compliance. The EPRR submission for 2021 was due next in September 2021 and the provider was hoping to achieve substantial compliance.

In preparation for emergencies, the provider had secure computer system servers on separate sites. In the event one of the servers could not be accessed, another could.

A comprehensive staff cascade system was in place. In the event of an emergency, there was a clear process for contacting staff until sufficient staff could respond to the emergency.

The EPRR lead and accountable emergency officer attended relevant borough and south London emergency and resilience planning forums

Information Management

The provider had appropriate and accurate information, which was processed, challenged and acted on, although not all of the relevant service information was routinely analysed to give an ongoing view of service capacity and patient experience. BHC did not have effective arrangements to ensure that all notifications were submitted to external bodies as required.

The provider made good use of information technology (IT) in the delivery of patient care. Mobile staff had access to laptops and phones so they could be connected to the provider's systems away from their office base. The provider had rolled out over 700 laptops to staff during the pandemic. BHC also supported Bromley GPs to work from home and access secure systems. The IT team supported the dental services across Bexley, Bromley and Greenwich with dental radiology replacement. The provider had created performance dashboards for the community provider network and provider information technology support to Bromley GPs.

Communications equipment, telephones and access to the internet were secure and ensured patient confidentiality. Staff had shared access to patient records held by local acute trusts and GPs. This allowed more joined up working across south east London. There were plans in place to expand this to the whole integrated care system.

BHC supported their IT systems using an in-house team. Feedback from staff about the team was excellent. The IT team were managing their support calls and meeting targets: 93.7% at the end of quarter 1 of 2021/2022, higher than for the same period in 2020/21 (78.2%)

The providers of the electronic patient record system also managed staff support calls at above target levels: 97.5% year to date reported at end of June 2021, higher than for the same period in 2020/21 (66.4%)

The IT team worked with others to troubleshoot problems and enable more joined up working locally. The team had provided support to COVID-19 vaccine clinics and out of hours GPs.

The provider had plans to recruit a chief technology officer, who would lead the development and implementation of the organisational digital strategy.

Our findings

The provider had a five-year plan to improve business intelligence capability, upgrade the electronic clinical records systems and integrate more closely with One Bromley and other south east London providers, as well as continued development of mobile/agile working.

The IT team regularly checked cyber security systems to ensure they were effective. The team carried out yearly penetration tests on firewalls. An external review in October 2020 provided significant assurance in respect of cyber security systems.

BHC used data to try and improve services. For example, it reported at 'place level' on diabetes outcomes. In Bromley, there was a dashboard that could report against all patient outcomes of the nine care essentials for the diabetes population.

To support the ageing well workstream, the provider had been commissioned to improve community services data set data quality across south east London providers, improve the understanding of demand and capacity models and to produce a south east London consolidated dashboard bringing together the community providers' performance as well as to incorporate the social care and acute information.

The data in the dashboards was clearly presented. Some dashboards were generic, and others were service specific. Most dashboards were refreshed daily although for some services, such as rapid response this was more frequent. The provider worked with commissioners to be clear on contract metrics so that patient outcomes were measured and reported effectively.

The board were confident in data quality and integrity. Dashboards were shared at divisional meetings and sense checked. The latest nationally published data showed that in March 2021 the provider's community services data set data quality remained high at 84%. BHC had been supporting colleagues locally in improving compliance with the community services data set and improvements in data quality across south east London.

Some data was presented to the board as a time series to show variation over time, for example bed occupancy. The provider was considering developing statistical process control (SPC) charts to support robust statistical interpretation of measures presented over time and identify the difference between special cause or common cause variation and trends. SPC is a set of statistical methods based on the theory of variation that can be used to make sense of any process or outcome measured over time, usually with the intention of detecting improvement or maintaining a high level of performance. This would help measure the impact of any change and evaluate its worth.

However, although performance data was readily available not all of the relevant service information was routinely analysed to give an ongoing view of service capacity and patient experience. For example, the volume of district nursing visits that were deferred each day was not routinely reviewed, by senior leaders, for quality and safety purposes and to explore effects on patient experience.

BHC did not have effective arrangements to ensure that all notifications were submitted to external bodies as required. In the inspection of community health services for adults we found a number of notifiable incidents that were not notified to CQC.

The provider had good information governance systems and processes in place and there were effective systems to ensure the board had oversight of the information governance function Staff received mandatory training in information governance.

Our findings

The year 2020/2021 was the third year of use for the new version of the information governance toolkit. The data and security protection toolkit (DSPT) is based on the national data guardian's 10 data standards. The DSPT toolkit has mandatory or non-mandatory requirements, with organisations being required to meet all the mandatory requirements in order to pass. BHC met 97% of the mandatory requirements including training, against the 95% requirement. The DSPT was reviewed by the commercial director (senior information risk owner) and signed off by the chief executive prior to submission. More than 95% of staff were compliant with information governance training.

The information governance manager linked well with local counterparts and was well-informed about developments in information governance. They also worked closely internally with the Caldicott Guardian and were clear about areas of responsibility.

The information governance steering group meeting was held bimonthly. Staff training was a standing agenda item. Any information governance breaches were presented to the group. The information governance steering group was chaired by the senior information risk owner. Minutes from this meeting went to the audit and risk sub-committee and from there could be escalated to the board.

In the past a common theme of information governance breaches was two letters addressed to different patients being sent in the same envelope, but improvements in the mail system had reduced the risk of this happening. The information governance lead anticipated the key risks to the organisation and had put plans in place to address these.

There was an information governance page on the intranet that reminded staff of their responsibilities and provided guidance.

Engagement

BHC had positive and collaborative relationships with external partners and this had led to partnership working to deliver new and improved services for local people. BHC had worked to improve staff engagement over the last year and was focused on addressing the concerns of staff with protected characteristics. The provider engaged positively with patients and carers, but the amount of feedback received was limited and had decreased over the pandemic. Although BHC engaged with some local groups or communities, such as through a sickle cell support group run by a community children's nurse, and some individual services (such as the sexual health service) were very proactive in reaching out to their client group, BHC did not have a clear public engagement strategy showing how they would reach communities who had less of a voice in how services were designed and delivered.

The board regularly heard directly from patients and carers at board meetings.

A patient reference group had been established since 2018. It consisted of 10 patients and carers. The group met bimonthly. The group reviewed service template letters and leaflets. Changes had been made to the complaints leaflet in response to feedback from the group.

The patient experience lead conducted observation visits, called 'sit & see' visits, to Foxbury rehabilitation unit every month and engaged with patients and carers to obtain feedback about their experience. Staff also used an electronic tablet to help patients on the ward answer questions about their stay in hospital.

However, BHC mostly sought feedback from patients and carers through the friends and family test (FFT), which is an anonymous way for patients and relatives to give feedback about the service they have received. The FFT was reinstated in December 2020 after being suspended during the pandemic in 2020.

Our findings

The FFT asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The provider had an FFT response rate of 1.4% in 2020-21 and 1% in quarter 1 2021/2022. With many patient appointments being conducted virtually or over the telephone over the last year the response rate had declined.

Ninety-eight per cent of feedback received was positive. The highest number of returns were received from the hospital at home children's service (112) followed by the Foxbury rehabilitation unit (40). The provider received a total of 544 FFT responses of which six were very poor and mostly related to long waiting time for appointments. One related to a family being asked to wait outside in the cold for their appointment, due to the impact of COVID-19.

Senior leaders acknowledged the FFT response rate was very low and not where the organisation wanted it to be. The provider was taking a number of actions to increase the response rate, including sharing of approaches in monthly divisional meetings and a pilot had commenced in May 2021 whereby the care coordination centre would call a patient and text the survey following the call. If successful, there was a plan to roll this out to other services. The sexual health team was planning a survey specific to the needs of their client group.

The provider did not have an overall patient engagement strategy and took a largely ad hoc approach to reaching out to local communities, providing stalls at local events.

Since August 2016 all providers of NHS care have needed to follow the Accessible Information Standard (AIS) in line with section 250 of the Health and Social Care Act. The standard applies to people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. During the inspections the majority of staff we spoke with were not aware of the AIS and the provider did not check whether the AIS was being implemented effectively.

The provider told us that staff assessed and recorded patients' communication needs in respect of the AIS during their initial assessment. The electronic clinical records system had the ability to flag peoples' communication needs. The provider reported that all staff received training and an induction on the use of the electronic record systems. Staff used British Sign Language interpreters for appointments where appropriate. Documents in Braille were available to patients as well as easy read leaflets.

However, most staff we spoke with during the core service inspections did not know what the AIS was or the communication needs covered by the standard. Staff had not received training in the AIS. The provider had not sought assurance that staff knew how to identify, record, flag, share and meet people's communication needs and were implementing the standard in practice.

Interpreting services were available for people whose first language was not English.

BHC was working to improve staff engagement, particularly those staff with a protected characteristic. A BAME staff network had been set up and an LGBT+ network was due to start meeting in September 2021. BHC had implemented a number of staff wellbeing initiatives in the last year and had plans in place to improve staff survey outcomes and workforce race equality indicator scores.

The provider worked appropriately with trade unions. A trade union representative described how they had a good working relationship with the chief executive.

Our findings

BHC worked very well with local partners helping to deliver high quality integrated care across the London borough of Bromley. For example, the provider worked in partnership with a local acute hospital to deliver a hospital at home service for children and young people, providing acute paediatric care within the home setting.

BHC had worked with partners in the south east London healthcare sector as part of the community provider network since its inception in 2019. The development of the south east London integrated care system (ICS) was at an early stage. Engagement sessions had taken place and six work streams established. BHC was keen to engage fully in the ICS and had invited the ICS chair to the last board meeting. The chief executive had taken a leadership role in and acted as the chair of the ICS's diabetes and obesity programme board. Local partners told us that BHC was always represented at key meetings.

External stakeholders described the provider as open and transparent and said it kept stakeholders well informed about performance challenges and serious incidents.

An external review of the organisation's learning from COVID-19 commented that the provider had well worked with the system and community partners during the pandemic and had helped cement BHC within the ICS as a key system partner. The provider had set up a COVID-19 monitoring service with 48 hours' notice with local GPs.

Learning, continuous improvement and innovation

There were systems and processes in place for learning and continuous improvement, but quality improvements approaches were at an early stage.

BHC used a plan, do, study, act (PDSA) approach to quality improvement and a quality improvement lead had been appointed and commenced work with BHC in May 2021. Staff were encouraged to bring forward ideas for quality improvement initiatives, but this was not done in a systematic way. Staff were able to suggest ideas through the chief executive's online blog or email 'Ask Jacqui'. There was limited resource to support the embedding of quality improvement approaches in services. Most quality improvement activities were focused on the quality priorities of the organisation.

BHC provided opportunities for learning from serious incidents including deaths. Serious incidents were investigated thoroughly to identify learning. Where there were immediate lessons to be shared, these were communicated to all appropriate staff. Lessons learned were discussed at service line and team meetings.

BHC took part in accreditation schemes that recognised services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The Bexley health visiting team was Baby Friendly Initiative level 3 accredited, this is the step before the silver and gold award. The Bromley health visiting service had completed an assessment in 2021. There were plans for the Greenwich 0-4 service to undergo an assessment in May 2022.

BHC had collaborated effectively with local partners to develop new services for local people. The provider had developed a hospital at home service for children and young people. The service was launched in partnership with an acute hospital provider in January 2021. The aim of the service was to provide acute paediatric care to children and young people within the home setting, preventing unnecessary admissions to hospital, improving in-patient flow and enabling speedier discharges. BHC reported that 625 bed days were saved in the first four months of the service.

Our findings

During a challenging year, BHC quickly adapted to new ways of working. For example, they very rapidly established the Bromley COVID-19 monitoring service, at the request of local commissioners, to triage and monitor patients at home with suspected COVID-19 symptoms. Almost all patients gave positive feedback about the service.

The provider played an important role in the development of the multi-agency single point of access (SPA) integrated discharge to assess model of care in response to COVID-19. This led to improved outcomes with timely patient discharges and admission avoidance as services worked collaboratively with wider system partners to deliver quality care across pathways. The SPA had led to improved patient flow, a significant decrease in delayed transfers of care and decrease in length of stay for patients requiring supported discharge at the local acute hospital in Bromley from 20 to 15 days. Between March 2020 and March 2021 about 3,000 people were discharged in a timely way into the community. Nearly 12,000 bed days were saved at the acute hospital.

BHC rapidly mobilised, in a matter of weeks, to take over the Greenwich 0-4 health visiting service at the request of commissioners. The senior leadership had acted quickly to connect face to face with existing staff, put in place new systems and addressed serious concerns with the patient records system. They successfully migrated over 30,000 patient and family records in less than two months. The provider had a clear plan to take the service forward and improve quality and safety.

An external audit of 'learning from COVID-19' reported positively on the way the provider responded to the pandemic and received a significant assurance with minor improvements rating.

A quality improvement project focused on nurse-led case management for patients with frailty and multi-morbidity in Biggin Hill resulted in reduced hospital admissions and reduced GP consultations; reduction in the cost of medical and social prescribing; and an improvement in patients' frailty scores.

The rapid response team had developed into a highly effective service. The rapid response service accepted 94% of referrals compared with a national average of 74%. Seventy per cent of patient were seen within two hours with shorter overall waits (4 hours from referral to assessment compared with 4.2 hours nationally). Staff provided through initial assessments, which led to fewer follow up visits being needed.

BHC were commissioned to implement the south east London community provider data programme. BHC supported system partners/other community providers to submit a high-quality community data set (CSDS) extract every month. As a result, all four south east London providers were successfully submitting CSDS data with a greater focus on quality. The combined services dashboard helped with the visibility of data and performance across south east London.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Beckenham Beacon	Good Jul 2017	Good Jul 2017	Outstanding Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Bromley Healthcare Rehabilitation Unit (Foxbury)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Bromley Healthcare Central court	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jan 2021	Good Jun 2017
Overall trust	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Beckenham Beacon

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2017	Good Jul 2017	Outstanding Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Community health services for children, young people and families	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Overall	Good Jul 2017	Good Jul 2017	Outstanding Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017

Rating for Bromley Healthcare Rehabilitation Unit (Foxbury)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017

Rating for Bromley Healthcare Central court

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community health sexual health services	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Overall	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jan 2021	Good Jun 2017

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022
Community health services for adults	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022
Community health services for children and young people	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community health services for adults

Requires Improvement

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to relevant staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

At the time of the inspection, mandatory training completion rates amongst the three local district teams inspected were 79%, 85% and 90%, in the Hayes Wick and Five Elms, Orpington and the Crays, and the Beckenham and Penge teams respectively. Rates were at 97% in the Respiratory team, and 92% in the Diabetes, Rapid Response, and Tissue Viability teams. Staff were allocated time to complete mandatory training. Most of the gaps in training related to face-to-face training such as moving and handling, and first aid training, delayed during the Covid-19 pandemic. Managers had a strategy for ensuring that this training was now being completed as promptly as possible, including moving part of these training courses online.

New staff joining the teams received induction training, which was recorded. This included safeguarding, fire safety, and health and safety training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff told us they discussed safeguarding incidents in multi-disciplinary team meetings.

All staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give us examples of safeguarding incidents and told us they would raise this with the service's safeguarding lead, or their manager, and record it as an incident. They noted, however, that it could sometimes be difficult to find out the outcomes of safeguarding referrals.

We saw examples of staff liaising with the GP and social work teams for patients who were at risk of abuse. Staff knew how to make a safeguarding referral, and told us they could discuss concerns with colleagues, managers and the safeguarding lead.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

Community health services for adults

The service controlled infection risk well. Staff used infection prevention and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All patient areas were visibly clean and had suitable furnishings, which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE), regular hand washing and delivered care, bare below the elbows. Staff also had access to and wore face masks to reduce the risk of COVID-19. Staff told us they cleaned equipment after patient contact.

Staff told us that they had sufficient PPE, and that the provider had ensured supplies for them during the height of the pandemic, despite national shortages. Staff were aware of the provider's infection prevention and control policies. Staff disposed of clinical waste safely.

Environment and equipment

Staff carried out safety checks of specialist equipment. The service had suitable facilities to meet the needs of patients and their families. The service had enough suitable equipment to help them to safely care for patients.

Staff could obtain specialist equipment for patients when they needed to, by ordering this through patients' GPs. Equipment held by staff was serviced and/or calibrated twice a year.

We looked at the equipment available for each team, including a bladder scanner, blood glucose machines, thermometers, pulse oximeter, syringe pumps, blood pressure machine, and weighing scales for the diabetes team. All of these had been calibrated appropriately.

Each building we visited had a defibrillator, with pads in place and in-date first aid equipment with checklists in place to monitor them. We found one triangular bandage, which did not have an expiry date, and some expired alcohol wipes. We brought these to the attention of the appropriate staff, who took action to replace them.

Staff in each team carried out fire drills approximately every six months. Records were kept of any learning from the drills, such as delays in responding to the alarm.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on referral, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues including risk of falling, sepsis, and pressure ulcers. Staff shared key information to keep patients safe when handing over their care to others. We observed detailed handover meetings between staff, including all necessary key information to keep patients safe.

Records showed that staff in the rapid response team, diabetes and tissue viability teams carried out very comprehensive assessments of patients they worked with. Staff used a range of risk assessment tools including the

Medley Score when assessing skin integrity, for the prevention of pressure ulcers. They delivered appropriate interventions. They recognised when patients were at higher risk of sepsis and when the patient needed to go to hospital. Staff left sepsis information leaflets in people's homes. Staff referred patients on to other teams and services as appropriate.

District nursing records showed that nurses assessed risks using recognised tools, such as skin integrity assessments and frailty scores. District nurses handed over information about patients they had seen at the midday handover. They took photographs of patients' wounds and shared the pictures with the team to demonstrate how healing was progressing.

District nurses sought support from others in their team about how best to treat individual patients and the interventions they should provide.

Staffing

Despite nursing vacancies, the service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. However, a number of patient visits in district nursing were deferred each day as there were not enough staff to cover them. Some patients told us that visits were rushed. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of registered and non-registered nurses needed for each shift. The team managers could adjust staffing levels daily according to the needs of patients, as discussed at a daily situation report call between the district nursing teams, sharing their staff and agency or bank nurses as needed.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff told us they would block book regular bank and agency staff. Staff told us complex patients would be seen by regular staff only. Managers made sure all bank and agency staff had a full induction and understood the service.

At the time of the inspection there were significant vacancies in all the district nurse teams. In the Beckenham and Penge team there were 5.8 full time equivalent (FTE) vacancies. In the Hayes Wick and Five Elms team there were 6.2 FTE vacancies, and in the Orpington and Crays team there were 5.7 FTE vacancies. Vacancies were covered by bank or regular agency staff. The provider had ongoing recruitment in progress and 14 new band 5 staff were expected to start work in the teams in September 2021.

In July 2021 the overall turnover for the service for full-time equivalent staff (not including bank) was 1.5% and the sickness rate was 5.2%. Sickness rates had varied over the last 12 months, with the highest rate in January 2021 at 8%, the increased sickness rate in January related to the peak of the Covid-19 pandemic and the lowest in August 2020 at 2.7%.

The district nursing service was highly reliant on bank and agency nurses and attempted to block book these staff where possible to ensure continuity for patients. However, the cumulative effect of vacancies, staff sickness, staff having to isolate due to COVID-19 guidelines, and an increase in referrals was impacting the district nursing teams and leading to increased deferrals of patient appointments. The provider's standard operating procedure for community teams – district nursing dated February 2021 stated that the deferral of patients' nursing visits should only happen in 'extreme circumstances.' However, at the time of the inspection this had become routine. The impact of the Covid-19 pandemic was ongoing at the time of the inspection. However, the pandemic was not at a peak during this time.

In order to mitigate the risks of moving or deferring patient visits all higher risk patients were visited as planned. Only lower priority visits were deferred, where there was no risk to the patient from delaying the visit by a day. The electronic visit scheduling tool highlighted when a visit to a patient had been deferred, which alerted staff not to defer the visit twice in a row. The provider carried out an audit of more than 90 deferred visits that occurred in the first week of July 2021 and was assured that only low priority visits were deferred, and no harm had been caused to a patient by moving or delaying a visit. The director of nursing estimated there were on average 50 patient visits per day being deferred across the district nursing teams and was the result of an increase in referrals.

Some patients told us that appointments were often rushed, and that agency staff were not always aware of what was needed. Six patients said that staff would sometimes arrive at appointments without correct medical supplies to deliver their care. For example, one patient told us a nurse did not have the correct dressing. Only one person had made a complaint to the provider relating to this issue, and others appeared reluctant to do so.

The rapid response team had sufficient staff deployed to provide safe and effective care. The team consisted of five advanced nurse practitioners, an advanced clinical practitioner (with a physiotherapy background), two nurse practitioners and two band 5 nurses. There were no vacant posts. The rapid response team were able to see 92% of patients within their target of two hours. The team carried out up to 15 additional home visits a day from the district nursing teams, addressing more urgent issues such as blocked catheters.

Managers had introduced financial incentives for staff to book extra shifts, and carried out ongoing recruitment, with a number of new staff due to commence in September 2021.

During the COVID-19 pandemic the diabetes consultants were redirected to a local hospital. However, there was a diabetes specialist nurse available at all times, with over the phone consultant support as needed. The service also included a non-medical prescriber for prescriptions. Two nurses told us that they would like to have more medical cover for prescribing advice.

During the last year the rapid response team had benefitted from an additional doctor one day a week who supported the development of nurses in the team.

Records

Staff kept up to date records of patients' care and treatment. Records were stored securely and easily available to all staff providing care, but they varied in the level of detail included and some records contained conflicting information.

District nurses completed care plan templates for individual patients according to their needs. These were printed with standard interventions. In some cases, district nurses added handwritten details to the care plans. Four paper care plans in the Hayes Wick and Five Elms district nursing team did not have the patient's name recorded. Staff made amendments to some care plans in writing but did not sign or date them to indicate who had made the changes and when. Records on the system did not always match the paper records. The paper records were the only records available to some agency staff who did not have access to the electronic recording system.

One care plan we reviewed, related to a patient's individualised feeding regime using an enteral feeding tube. The paper care plan had been amended by hand on multiple occasions. Previous instructions on the volume and rate of the feed

had been crossed out and new ones added. Not all of these amendments had been signed or dated or were clear and this could have caused confusion for a district nurse unfamiliar with the patient. We found cases where staff would need to look through a number of pages of records to determine if a patient had a history of physical health problems such as hypertension.

We reviewed the district nursing records for 12 patients at the end of their life. We found inconsistencies in the recording of whether patients had a 'Do Not Attempt Cardio-pulmonary Resuscitation' (DNA CPR) record in place. In some cases, these were found at the front of the patient's paper notes, but this was not always the case. There was no clear way of telling from the electronic recording system whether there was a DNA CPR in place for any particular patient, or if there was one, where this could be found. We found seven patients where it was unclear if there was a DNA CPR in place or not. Staff suggested that they could contact the patient's GP surgery if needed to find out. However, lack of immediate access to this document might impact on respecting the wishes, and the comfort and dignity of patients.

District nursing staff completed initial assessments for patients at risk of pressure ulcers, including assessments of patients' mobility, skin condition, nutrition, continence, pain and consciousness. However, we found that body maps were not always completed.

In contrast the patient records for the rapid response team, diabetes, tissue viability and respiratory teams were maintained to a high standard. They included accurate, holistic and detailed records of patient visits/appointments. These were stored electronically including detailed records of physical health checks, diet, health promotion, and support with self-management of conditions. Care records covered reviews of patients' social circumstances, and psychological reviews. The specialist teams recorded care plans and interventions in letters to the patient's GP (with their consent) and copied to the patient.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Most medicines were prescribed by patients' GPs. Nurses in some teams, who were non-medical prescribers, were also able to prescribe medicines in line with standard operating procedures. When needed, nurses would administer medicines and had access to medicines within patients' homes including medicines for use when needed. There were four non-medical prescribers (nurses) across the district nursing teams, but they told us that they only prescribed medicines in exceptional circumstances. Many medicine charts across the district nursing teams did not have allergy/sensitivity information recorded (or none known if that was the case). The medicines for these patients were prescribed by their GP.

Staff told us that where possible they attempted to arrange all syringe driver appointments to be undertaken by two nurses, to ensure the risk of errors was minimised.

Patients and/or carers would collect medicines from their local pharmacy. Staff told us about some current national medicine shortages, for example for glycol morphine, which meant they had to be proactive in ordering these in advance, and sometimes having to visit a number of pharmacies to obtain the required medicines.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Community health services for adults

Staff knew what incidents to report and how to report them, in line with the provider's policy. Staff could give examples of incidents that took place and how they reported them. Staff would report incidents to their line manager and discuss issues at handover meetings. Staff told us they had monthly team meetings and weekly multi-disciplinary meetings where incidents were discussed, and learning was shared.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Staff told us that the most common reported incidents were pressure ulcers and they were clear about which of these needed to be reported. The safer care team held a pressure ulcer panel every Friday and learning was disseminated to the teams.

We reviewed nine incident reports. We saw evidence that changes had been made as a result of feedback, including improved recording of medicines used in catheter care, and greater focus on asking patients about bowel movements and pain.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers supported staff after any serious incident, and staff told us that they received a high level of support from team colleagues and managers allowing them to debrief after incidents including expected deaths.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

The service continually monitored safety performance and recorded information on electronic monitoring devices. Staff had access to dashboards that reported performance in key areas and identified any shortfalls. Measures included when patients were not seen for a prolonged period, completion of risk assessments and daily safety audits related to the administration of insulin.

In addition, staff carried out monthly audits of infection control and medicines charts. The provider carried out annual record keeping audits.

Is the service effective?

Requires Improvement

Evidence-based care and treatment

Staff provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies on the staff intranet.

At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers.

Community health services for adults

Staff in the specialist teams, rapid response, diabetes, respiratory, and tissue viability teams delivered detailed, high quality assessments of patients. Staff delivered evidence-based interventions in line with National Institute of Health and Care Excellence (NICE) guidance. The team managers highlighted any changes in national guidance and practice to the teams to ensure they delivered the most appropriate and up to date interventions.

District nurses completed care plan templates depending on the needs assessed. Treatments for wounds were individualised and changed as the wound healed. Pain assessments were carried out at every appointment in tissue viability. The specialist teams provided training for the district nurses in areas such as the use of high compression bandages and skin care.

A new patient record template for recording end of life care had been developed in March 2021 based on NICE guidance, incorporating the five priorities. However, although this was beginning rolled out to all teams, most staff we spoke with were not aware of the new template, and it was therefore not yet being widely used. This was confirmed in our inspection of end of life care records. The plan was that this would enable improved auditing of end of life care.

The tissue viability team provided advice on the provider's pressure ulcer panel for any patients receiving care from the local hospice service. The tissue viability team introduced a Leg Club for patients who had become socially isolated due to having leg ulcers, which was very successful.

In the diabetes team, staff regularly participated in audits, including handwashing, record keeping, hypoglycaemia and diabetic ketoacidosis (DKA) audits. The team had managed to work with 98% of those referred to the service, despite a surge in referrals for diabetes care. Staff said that working from home had increased telephone contact capacity.

In the respiratory team, staff worked with respiratory patients for long term management, in addition to short term new cases with urgent respiratory care needs. They were part of the COVID-19 monitoring service, set up during the pandemic, which was due to receive a nursing award.

Nutrition and hydration

Staff were aware of patients' specialist nutrition and hydration needs. They used special feeding and hydration techniques when necessary. Specialist support from staff such as dietitians was available for patients who needed it.

We did not see examples of food and nutrition charts, but staff told us that these were put in place when needed. Patient care records included references to checking on patients' food and fluid intake and recommending changes if needed. The diabetic clinic consultations included detailed consideration of diet and hydration, and regular weight monitoring.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Staff told us how they used non-verbal signs to monitor patients who could not verbally communicate.

Patients received pain relief soon after it was identified that they needed it or when they requested it. Some patients had access to syringe drivers for symptom control, specifically when patients were coming towards the end of life. Staff told us they would visit patients who were on syringe drivers daily to re-prime the drivers.

Staff administered and recorded pain relief accurately.

Community health services for adults

Patient outcomes

Staff used audits to monitor the effectiveness of care and treatment. They told us that they used the findings to make improvements and achieve good outcomes for patients. A new strategic internal audit plan was in place for 2021 to 2026 including looking at the quality impacts for patients of key risks to the service such as staffing levels, and inequalities caused by COVID-19.

The provider was a stakeholder in the National Wound Strategy and participated in developing better wound care alongside NHS colleagues.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held daily handover meetings with them to provide support and development. However, individual supervision meetings were not always taking place in line with the provider policy.

Staff were experienced, qualified and had the right skills to meet the needs of patients. Staff had access to a wide range of training including in catheterisation, motivational interviewing, caseload management, enteral feeding, positive behavioural support, and vaccination.

Managers gave all new staff a full induction tailored to their role before they started work, and supported staff to develop through yearly, constructive appraisals of their work. The provider's policy was that individual supervision should be provided quarterly and although staff described frequent informal supervision, they were unable to provide records of any recent formal management, clinical or safeguarding supervision. This meant that they could not be assured that staff were receiving regular supervision, and their learning and support needs were being met. The provider told us that staff should record professional reflection activity (supervision) on the appropriate IT system. This system recorded when supervision had taken place and for how long for individual staff. This would show whether the provider's policy was being followed. However, the provider did not state whether this information was actively monitored.

Staff had the opportunity to discuss training needs with their line manager and spoke positively about learning and development opportunities within the provider organisation. Band 5 nurses undertook a readiness programme over 12 weeks and completed competencies, which enabled them to achieve promotion. Some band 6 nurses undertook the specialist district nursing course every year. This course was due to become a two-year apprenticeship. A staff member in the diabetes team had just completed a Certificate in Diabetes Care, allowing them to practice as a diabetic nurse specialist. Staff in the team also attended online diabetes conferences and discussed the latest research. They offered district nurses training on diabetes.

Staff told us that they received specialist training for their roles, although not all had completed end of life care training. Online end of life care training was provided, but not all staff had received face to face training. Some staff told us that they had received training from the hospice they worked with, specific to end of life care, and some had received it in previous posts. Staff also told us they had training on holding 'difficult conversations' to assist patients with conversations about the end of life. The hospice provider had sent out bite-sized learning sessions online for the team to dip into. Most district nurses we spoke with were not able to list the five priorities for end of life care, but discussion with them indicated that they were providing care in line with the priorities. They had completed competency assessments and most staff had completed end of life care training commissioned from a local hospice. Staff were also required to complete competencies in a wide range of areas including end of life care before carrying out visits unsupervised.

Managers identified poor staff performance promptly and supported staff to improve. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

In the rapid response team, the team manager regularly went out on visits with staff and kept close oversight of care records. Staff met together with a community geriatrician to discuss more complex cases.

Staff in all the teams felt able to raise any concerns or questions they had with the team manager. Less experienced staff were supported to develop their skills, and staff said they were never asked to perform interventions that were beyond their limit of competence.

Multidisciplinary and partnership working

Staff held regular effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings were held at least weekly, in addition to monthly team meetings.

Staff worked across health care disciplines and with other agencies when required to care for patients.

The district nurses worked with a hospice provider to deliver end of life care. The hospice provider was usually responsible for planning the end of life care. They referred patients to the district nurses to address individual needs, such as the need for a syringe driver or to manage a complex wound. Staff attended Gold Standard Framework (GSF) meetings with GPs and local hospice staff to have oversight of end of life patient care. However, these meetings were not consistently taking place, especially during the pandemic. The provider kept details of the number of GSF meetings staff attended, ranging from one to six meetings per team each month. A nurse from the hospice was assigned to GP practices in the local area. Staff told us there were informal conversations happening between relevant staff, but these were not documented. Prior to the COVID-19 pandemic, the local hospice provider had also attended the district nurse multidisciplinary meetings.

Staff referred patients for mental health assessments when necessary if they showed signs of mental ill health or depression, working closely with the local mental health trust.

The rapid response team met together every two weeks with the community geriatrician to discuss more complex and challenging cases.

The district nurses described effective multidisciplinary and integrated team working. They referred patients on to other specialist teams as needed, and worked closely with the podiatry team, sometimes carrying out joint visits to patients. They also worked regularly with the falls, and catheter, bowel and bladder teams.

Seven-day services

Key services were available seven days a week to support timely patient care. Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The service had a night team who worked out of office hours.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Community health services for adults

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, they did not always record assessments of mental capacity for patients.

Staff could not locate capacity assessments for patients who lacked capacity. We found 10 patient records that did not include a mental capacity assessment, although it was clear from the progress notes, that staff did not think the person had capacity to make decisions about their care.

When patients could not give consent, staff made decisions in their best interests, but it was not clear whether they took into account the patients' wishes, culture and traditions, as these were not recorded.

When patients had capacity, staff made sure they consented to treatment based on all the information available. This was clearly recorded in patient records.

Staff had undertaken training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, managers were not taking sufficient action to ensure staff followed the Mental Capacity Act. An external audit of patient consent was conducted in 2020 including a review of 25 district nurse patient records. The audit report dated July 2020 found that five patients deemed as not having capacity to consent, did not have this documented and recorded on the electronic patient records. In these cases, it was documented that a decision has been taken by the organisation in the patient's best interests. Actions to address this finding were due to be completed by 30 September 2020, these included reviewing the recording template, and identifying staff training needs. However, our findings during the inspection were that this had not improved. The provider told us that all recommendations from the consent audit were completed within planned timescales.

Is the service caring?

Good

Compassionate care

Staff treated patients with compassion and kindness and were passionate about delivering care to patients. Staff were discreet and responsive when caring for patients, respecting their privacy and dignity. Most staff took time to interact with patients and those close to them in a respectful and considerate way. We observed district nurses speaking kindly and respectfully to patients in phone consultations, and about patients in handover meetings.

All patients using the specialist nursing teams were satisfied with the care they received and felt involved in making decisions about their care. We spoke with 12 patients and five relatives/carers using the district nursing service. They said that most staff treated them well and with kindness. They found the majority of staff friendly and supportive and responsive when other professionals needed to be contacted. Most patients and carers built a good rapport with the different nurses attending.

Community health services for adults

The provider used NHS Friends and Family Test (FFT) surveys to gain feedback from patients using their services. Due to the COVID-19 pandemic NHS England suspended the FFT from the end of March 2020 until 1st December 2020. Despite the suspension, 1625 patients completed the FFT cards for all services provided during 2020/21. Of the respondents, 1589 rated the service they received as very good or good (97.8%), which was, very similar to the results in 2019/20 (98%). Fourteen respondents rated services as poor or very poor.

Staff followed provider policies to keep patient care and treatment confidential. Staff told us they would only speak about patients care to carers and family members if patients gave consent.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

The administrator of the rapid response team made 'comfort' calls to patients to let them know the nurse would be coming to see them. They listened for any concerns that needed to be escalated.

Staff were able to describe how they understood and respected the personal, cultural, social and religious needs of patients, but this was not recorded in care plans we reviewed.

Emotional support

Staff told us they provided emotional support to patients, but these conversations were not always documented.

The Leg Club (provided by the tissue viability service with support from volunteers) had been hugely appreciated by patients who had been socially excluded. Patient told us that it was sorely missed when it had to close during the COVID-19 pandemic.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they had training on 'challenging conversations' which helped them to be confident in having difficult conversations with patients especially around end of life care.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff could give examples of supporting family members. We saw evidence of staff contact with patients' family members.

Staff described their emotional experiences of providing palliative care during the COVID-19 pandemic, when family members were unable to visit, leaving them as the only contact those patients had.

We observed a district nurse providing compassionate emotional support to a relative over the telephone and offering to make an unscheduled visit to prevent a patient from having to go to the emergency department.

Three patients we spoke with had problems with their mental health/anxiety and said that staff were very good at helping them to reduce their anxiety levels and were compassionate. However, one person told us that a lack of communication from staff attending meant they often felt treated like a medical condition rather than a person.

Understanding and involvement of patients and those close to them

Community health services for adults

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff told us they could use interpreters if needed. Staff could also give examples of how they communicated with non-verbal patients. Staff told us that some patients had letter boards or staff would write things down to aid communication. Patients' contact preferences were clearly recorded on the patient records. However, only four people we spoke with using the district nursing teams felt involved in making decisions about their care.

We found some detailed records in the patient notes from the specialist teams, for example the respiratory service included direct quotes about the patients' perceptions, details of social circumstances discussed such as benefits, and comments on hobbies such as using the gym and music.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback cards were left with patients and their carers but they received few responses (about 3% of cards were returned). Patients, carers and families could also call the service to give feedback.

Staff told us that end of life patients who had no family were supported in the community by carers and volunteers from the local hospice service.

Patient records included information about contacting the district nursing team including out of hours. We noted that there was a gap from 7am – 8am which was covered by the GP out of hours. This was not recorded on the information provided to patients.

Is the service responsive?

Requires Improvement 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The rapid response service provided home visits for patients referred by GPs, NHS 111, the London Ambulance Service, the local hospice and other health care professionals. The team assessed, diagnosed and treated patients at home, avoiding unnecessary hospital admission, and referred on to other appropriate services. The service aimed to respond to referrals within two hours. The service worked with patients over 18 years of age, registered with a GP in the London Borough of Bromley, who were housebound.

The district nurses held caseloads as a small team covering a specific geographical area in the primary care network. This helped with continuity of care and ensured visits could be scheduled closer together and so cut down on the amount of travelling time between visits. The teams had an estimated 500-600 patients on the caseload at any one time.

District nurse visits were scheduled using an electronic system. The system did not allow overallocation of staff. Visits were colour coded to identify high priority visits and ensure these took place. The system took account of mileage and travel times when making allocations. Coordinators manually adjusted the schedule to ensure as many visits as possible could be carried out.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia through external services. During the COVID-19 pandemic staff reported more patients experiencing mental health issues. They adapted their practice to provide support to people over the phone, refer to mental health services and inform the patient's GP. When patients did not meet the criteria for the local hospital psychology service (for example having needle phobia and diabetes) staff referred them to the local improving access to psychological therapies service, which Bromley Healthcare also provided.

Access to the right care at the right time

Patients could access the teams and services when they needed to and most received the right care promptly. However, some district nursing patients told us that sometimes their expected visits were cancelled on the day, which was frustrating.

District nursing patients were not given appointment times for general nursing care such as wound care. Patients who had specific needs such as support with syringe drivers, catheters, or insulin, would be give a timeframe for appointments in the mornings and/or afternoons. Patients told us this was difficult as they could be waiting all day for appointments causing them further disappointment when appointments were deferred.

Managers worked hard to minimise deferred appointments, but due to high staff vacancies and sickness or isolation due to the COVID-19 pandemic and an increase in referrals this happened on a regular basis. A central administration team called patients to inform them if their appointment would be rearranged. Text reminders were sent out to patients attending the specialist clinics, to reduce the risk of patients not attending.

The rapid response team had a target to respond to referrals and visit patients within two hours. They achieved this target more than 92% of the time (national target is 80%). Most referrals came from GPs, NHS 111, the London Ambulance Service and community matrons. The team had developed close relationships with local GPs. The service received between 350 and 420 referrals every month. The team worked closely with the rapid assessment therapies team and regularly made referrals for occupational therapy and physiotherapy support. The team would make follow up visits to patients if appropriate within five days of referral.

The rapid response service operated from 8am- 8pm seven days per week. Referrals that came in at the end of the day were passed on to the out of hours doctor service. The team had taken on 15 additional contacts with patients a day from the district nursing teams to support the delivery of the district nursing service. These appointments were shared amongst the team with urgent referrals prioritised.

In the Orpington and the Crays district nursing team on the day of our inspection, staff reported that 50 visits were being deferred until the next day as there was insufficient capacity within the team to complete the visits that day. Staff reported that this was higher than the average of 20-30 visits, which were deferred on other days. Efforts were made to avoid multiple deferrals for the same patient, which were flagged by the scheduling system. Patient care records showed informal complaints raised by two patients about visits not taking place and not being informed early enough in the day that a visit had been deferred. Staff apologised when visits were deferred. However, 15 of the 17 people using

the service we spoke with noted it would be helpful to know whether their visit would be morning or afternoon. Fourteen patients/carers said that they had experienced what they described as missed or deferred calls and had to contact the office to enquire if someone would be coming that day. They reported variable experiences in getting through to speak with someone.

The provider did not keep separate records of patients that were deferred due to a lack of staff capacity (rather than patient choice or for other reasons). When requested Bromley Healthcare provided data for July 2021 of 1845 visits that were deferred, moved by the patient, or brought forward. This was out of a total of 16,925 district nurse visits carried out in July 2021. This was higher than the figure for June 2021, which was 1240 visits moved, deferred or brought forward out of a total of 17,116 district nurse visits during that month.

Meeting people's individual needs

Staff made reasonable adjustments to help patients access services. The services had ramps and lifts for people who required adjustments. However, patients' individual needs were not always recorded within their care records.

Although staff gave us of examples of how they had supported patients with their religious and cultural needs, they routinely used a standard statement within patients' records for all patients which stated 'personal, cultural and religious needs acknowledged'. They did not record what specific needs the patient had in relation to this. As a result, not all staff may have been aware of a patient's specific religious or cultural needs.

Most care plans that we viewed were not holistic and did not include patients' wishes. For example, it was hard to find the preferred place of death for patients receiving end of life care. The care plans were not always personalised, some using unaltered standard statements and standardised care plans. There was no space for patients to sign or agree to care plans. Although care plans included an expected outcome and evaluation section, there was frequently no review or outcome date recorded.

Staff at the service referred patients living with mental health problems, learning disabilities and dementia to external services. The service had good links with services within the community. The service worked with GP services and local mental health trusts when caring for patients with mental health needs.

Most staff were not aware of the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Learning from complaints and concerns

There were systems in place for people using the services to give feedback and raise concerns about care received, although many patients and carers we spoke with said that they were reluctant to do so.

The services treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Staff included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns but most of those we spoke with told us that they would be reluctant to complain. In two cases patients said they were worried that this might impact negatively on the quality of the care they received. Patient care records included information on how feedback could be given to the service. Staff understood the policy on complaints and knew how to handle them.

Community health services for adults

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, creating a dashboard to ensure that all new patients and hospital discharges were prioritised and audited for appointments. Staff were also reminded to ensure that they checked that a person had lasting power of attorney for a patient before information was shared over the telephone.

Although NHS England advised healthcare organisations that they were not required to respond to complaints during the pandemic, the provider continued to respond to formal complaints within the 25 working days specified in their policy where possible. Patients were sent a holding letter if the expected timeframe was exceeded. The number of formal complaints received had reduced by 39% compared to 2019/2020. Despite the challenges during 2020/2021 compliments continued to outweigh the formal complaints and there was only a 3% reduction compared to 2019/2020.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the services. They understood and managed the priorities and issues the services faced. Staff told us the senior leadership were not always visible but were approachable for patients and staff. Staff knew how to contact senior managers and the chief executive and could give examples of when they had done so. For example, one staff member described how the chief executive had supported a move to change the staff culture to ensure that staff took the breaks they were entitled to.

Staff told us they had good rapport with their team leaders and senior managers, and said managers had an open-door policy. Staff felt managers were approachable and were involved with patient care. For example, they noted that senior managers had assisted in coordinating the flu vaccination campaign to allow the teams to concentrate on business as usual. Leaders had also introduced financial incentives to encourage staff to pick up extra shifts when needed and given staff vouchers and an extra annual leave day as a thank you for their work during the pandemic.

Staff were supported to develop their skills and take on more senior roles. The service had several development programmes available for staff across all bands. Some staff we spoke with were taking part in these programmes.

The manager of the rapid response team was very experienced and had the skills and abilities to run a high-quality service. They were visible and approachable to staff and gave hands on support covering the triage role and accompanying nurses on visits. They were committed and shared information, emerging evidence and new guidance with staff so that they remained up to date. They actively supported staff to develop their skills and take on more senior roles.

Vision and strategy for this service

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The provider's quality strategy 2020-2023 outlined Bromley Healthcare's commitment to ensuring and improving the quality and safety of the care provided with three key values: we will treat others as we would like to be treated; we will continually improve our services; and we will hit our targets.

Community health services for adults

The provider's business plan 2020-2021, included three goals: outstanding health and care closer to home, a great place to work, and sustainable for the future. Each service had a plan which sat below the overarching plan, describing how each team would put the plan into practice.

Culture within the service

Staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

Staff told us that morale fluctuated due to the demand on their role and pressures during the pandemic, but overall staff felt morale was good. Staff told us there was a positive culture within the service, they felt valued and worked well together as a team. Staff described the teams as supportive and respectful.

None of the staff we spoke with reported any bullying or harassment at work. Many staff we spoke with had worked for the organisation for a long time. A staff member told us that their manager had supported them when a patient was racist towards them, including sending a warning letter to the patient.

Staff described the provider as a supportive and flexible employer with many opportunities for career development. Two band 5 staff in the rapid response team were about to start the master's level course to become advanced nurse practitioners.

A wellbeing site was available for staff on the provider's intranet site with resources including yoga, resilience training, and support with the menopause. The provider had also introduced Schwartz rounds for staff, which involved conversations about the emotional impact of their work.

Governance

The service had governance processes in place, but these were not always effective. We found some gaps in oversight and auditing systems for the district nurse services, particularly related to record keeping, the monitoring of deferred visits that were a result of staff shortages, and the quality of staff supervision. However, staff at all levels were clear about their roles and accountabilities and were aware of key performance indicators. The provider had developed dashboards, which gave clear information about service performance.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, audits were not frequent enough, or detailed enough to pick up on the recording issues we found during the inspection. These included some staff amending care plans without signing or dating them, inconsistencies in the recording of DNA CPR records, lack of mental capacity assessments, and lack of individualised care plans. The annual patient records audits indicated high scores being achieved, most recently 88%, in Orpington and the Crays, and Hayes Wick and Five Elms, and 89% in Beckenham and Penge, which was out of keeping with what we found.

Data was obtained on the number of patients' visits deferred or missed each due to lack of district nurse availability or other reasons. The service had local oversight of this through daily situation report meetings held across the district nursing teams. However, the service did not routinely monitor trends in the number of patients whose scheduled visits did not take place, or how many times particular patients' visits had been deferred and for what reason. Following our inspection, the provider carried out an audit of more than 90 deferred visits that occurred in the first week of July, which

indicated that only visits that were rated as low risk had been deferred. However, the service was not conducting regular audits. Without regular review and monitoring of the volume and impact of deferred visits there was a risk that the provider would not identify changes in trends promptly and respond appropriately to ensure people received the care they needed.

The teams did not keep records of formal staff supervision, which meant it was not clear whether it was taking place four times a year as required. The provider had a system for recording supervision but there were no formal systems in place to maintain oversight of the content of staff supervision of their work.

The service had not submitted statutory notifications of all deaths of patients to the CQC as required. We identified 11 deaths within the service, through patient records, that had not been reported to CQC as required. Similarly, the service was not notifying CQC of all patients who developed an injury whilst under the care of the district nursing teams. We found examples of four patients who had developed grade 3 and above pressure ulcers whilst under a district nurse team, but which were not notified to CQC, as required under the CQC Registration Regulations 2009.

Managers advised that they were in the process of introducing a band 8 quality manager, and a band 7 quality lead post for each district nurse team. They anticipated that these new roles would address the gaps in oversight identified during the inspection.

The service held weekly multi-disciplinary team meetings where patients were discussed, and daily handover meetings. Staff would describe what actions were carried out for patients for example what referrals were made, and which observations were carried out. This was an opportunity for all staff to contribute in the care for each patient. The service also held monthly team meetings.

The service had policies in place which were accessible to all staff online. There was also a printed copy of the policies within the staff office. Staff we spoke with during the inspection stated they could locate the policies easily.

Staff told us that Gold Standard Framework meetings with the GP practices and hospice provider were very valuable in having oversight of patient care. These meetings had not been consistently taking place during the pandemic. Staff told us there were informal conversations happening.

Management of risk, issues and performance

Leaders and teams used systems to manage risk and performance.

The provider maintained a corporate risk register and separate service risk registers. These included risks related to the well-being of staff due to ongoing COVID-19 effects and vacancies. Staff identified and escalated relevant risks and issues and identified actions to reduce their impact.

One key risk in the service was demand outweighing capacity for the district nurse service leading to a reliance on agency staff, with staff vacancies hard to fill. Since the COVID-19 pandemic the service had seen a significant rise in demand for district nursing services, with no increase in resources. The service was looking at ways to meet demand and making the service sustainable in the future.

The district nursing service had an electronic diary system, which showed staff members' home visiting schedules, and this was visible to all staff. Staff told us the system was useful to monitor appointments, and also cap the number of visits scheduled for staff so they did not overwork. The system worked using colour coding, with higher risk/priority visits highlighted to ensure they were not missed.

The system recorded patients' appointments that were deferred due to staffing issues. However, senior managers did not maintain oversight of how this was managed at a local level. Staff told us patients were deferred depending on the level of risk, the system supported this, and the patients were informed. However, patients we spoke with told us they were not always informed of deferred appointments.

Between 1 August 2020 to 31 July 2021 the service reported 10 incidents when district nurse visits had been missed. Most of these were a result of no referral having been received to the district nurse team when new or existing patients were discharged from hospital.

Most staff used a lone working safety device when visiting patients on their own. When this was activated it rang through to a central point and gave the staff member's location. Some staff were issued with a safety device that they could operate in an emergency situation and summon help. However, three staff members told us that although it was the policy, they did not have access to these alarms. The provider was in the process of distributing alarms to all staff at the time of the inspection.

District nurses told us that as part of the electronic visit scheduling system staff logged when they were entering a home for a visit and when they left, so their whereabouts could be tracked. Staff at the base could see where district nurses were and the visits they had and had not made. Staff also used a telephone application to share information on their whereabouts with others.

Information Management

Paper records were stored in patients' homes and electronic patient records were only accessible with a staff key card. The issue of cyber security was on the provider's risk register with appropriate mitigations put in place.

Staff told us that they could find the information they needed easily. Staff were able to access the patients' GP health records and hospital health records. This meant they had a good understanding of each person's needs and could check on results of investigations in order to determine whether further input was needed.

Team managers had easy access to clear information about performance. Staff were positive about the IT equipment provided to them. They reported that phones and laptops enabled them to work efficiently and IT support was readily available. Regular bank staff were provided with a tablet to record their patient notes.

Staff engagement

Leaders actively and openly engaged with staff. The staff survey conducted by the provider in October 2020 had a high response rate of 66% of staff completing it. Of these 75% said their immediate manager encouraged them at work (better than the NHS average of 70% for the same period), and 58% of staff were satisfied with the opportunities for flexible working (similar to the NHS average of 57%). However, 46% reported feeling unwell as a result of work-related stress in the last 12 months. This was slightly higher than the NHS average of 44% for the same period.

The equality and inclusion group was formed in July 2020 as a staff network to support black and minority ethnic colleagues across the organisation. Staff we spoke with were aware of the network and viewed it as a positive development. The group undertook a survey of members' experiences in August 2020. There were 62 responses. Responses indicated that 39% of the survey respondents had experienced race/discrimination, but 47% of these kept quiet about the discrimination. The provider had implemented a range of strategies in response to this feedback including online unconscious bias training, training for freedom to speak up ambassadors, training for mental health first aiders, and mentoring.

The provider was looking to set up a LGBT+ network in September 2021.

Public engagement

The provider had a patient reference group, which met bi-monthly. It was led in partnership with Bromley Healthwatch and was chaired by the provider's chief executive. Recent group activities included reviewing and approving the district nurse equipment discharge leaflet and reviewing and revising the complaints leaflet now called 'Your Care, Your Feedback'.

Innovation, improvement and sustainability

The district nursing service had quality improvement objectives to: Reduce avoidable acquired pressure ulcers; Reduce the number of patients who fall whilst under our care and ensure the appropriate interventions have been completed; Improve the standard of clinical record keeping; and Reduce the number of Medicines incidents causing harm.

The Leg Club provided by the tissue viability service (with support from volunteers) was hugely appreciated by patients who had been socially excluded.

The Rapid Response Service were one of the seven national NHSE accelerator sites selected to implement the two-hour response to support a move to a two-hour response time for medically deteriorating community patients. This involved providing the rapid response team (advance nurse practitioners) with additional training and setting up a rapid access therapy team alongside them. A consultant geriatrician was recruited in late 2020 to oversee this project.

Community health inpatient services

Good

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included dementia awareness, National Early Warning Scores (NEWS2) and fire safety.

Although 86% of staff had completed their mandatory training, annual face to face moving and handling training was low as 45% of staff had completed their training. Managers told us that training rates were low due to restrictions experienced during the pandemic. The provider had followed national guidance in suspending most face to face training and offering limited updates for current employees remaining in unchanged roles, who had previously completed moving and handling training. The provider decided to move mandatory courses to online e-learning courses where possible during the pandemic, at the time of our inspection 90% of staff had completed their online manual handling training. Seventy-one per cent of staff had completed their basic life support training.

Managers recognised that online e-learning training on its own was not enough for manual handling training and from December 2020 staff were offered face to face manual training. Spaces were limited due to the need to follow national guidance on social distancing and priority was given to new staff that had not previously completed the training. The provider also told us that there were no incidents of staff reporting a workplace injury due to a lack of training received.

Although managers provided evidence that staff had received training in sepsis as part of their NEWS2 training, four out of five staff we spoke with told us that they had not had training on identifying sepsis.

Managers had identified in an annual audit that only 10% of staff providing face to face care had completed their wound management study day and/or pressure ulcer training within the last three years. Managers put in place action plans to address this, with a recommendation for at least 85% of staff to complete their face to face or online training and this was kept under review by the provider's pressure ulcer working group. From February 2021 staff were able to access a nationally recognised online training tool called 'react to red', a pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had a dedicated safeguarding lead that staff could access for advice. Staff had training on how to recognise and report abuse for adults and children and they knew how to refer safeguarding concerns to the local authority. Staff explained how they would escalate any safeguarding concerns. They were able to access a specific form in order to report any safeguarding concerns to the local authority.

Cleanliness, infection prevention and control and hygiene

Community health inpatient services

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean. Equipment on the ward was clean and had an 'I am clean' sticker on them displaying the last date it was cleaned. An external cleaning company provided cleaning services and the ward was cleaned daily. Staff were also expected to clean areas of high use, such as shared patient bathrooms. Commodes were cleaned after each use. We observed the ward being cleaned during our visit.

Staff adhered to infection control principles, including wearing appropriate protective equipment of masks, gloves and aprons. Managers completed audits to ensure that staff maintained appropriate standards of cleanliness and infection control. For example, managers completed hand hygiene audits, mattress audits and bathroom/commode cleaning audits. Staff managed clinical waste well and disposed of this appropriately.

Staff received training in infection prevention and control. Three carers told us that staff managed infection control procedures very well, especially during the pandemic and we observed staff asking a carer to wear personal protective equipment during their visit.

Staff adhered to national guidance and policies and procedures in reducing the spread of COVID-19. All patients were tested on admission and isolated in a single ensuite bedroom whilst awaiting a test result or remained isolated following a positive result until considered non-infectious as per national guidance. All staff were vaccinated against COVID-19 and completed tests twice a week.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Equipment was subject to regular portable equipment testing and checks. Patient equipment was ordered and reviewed at the daily handover meetings.

Patients had access to specialist equipment to aid their rehabilitation and meet their needs. We observed patients using a walking frame to mobilise. Staff had access to a hoist and pressure relieving mattresses for patients to use. Patients were able to use a dedicated room for physiotherapy activities and exercises.

Staff had access to emergency equipment and emergency medicines on the ward, which was in date and checked regularly. Staff could access a defibrillator and anaphylaxis kit located on the emergency resuscitation trolley.

The ward had a shortage of rooms for equipment to be stored in, which meant that some equipment had to be stored in the corridor, such as the emergency resuscitation trolley. One oxygen cylinder kept in the ward corridor was not secured to an appropriate anchor point to reduce the risk of harm to staff and patients. Managers told us that there were plans to expand the ward further into a corridor next to the ward, which would make storage easier.

Staff had completed their annual fire safety training and an external organisation was responsible in ensuring that annual fire safety checks had been completed. Twelve staff were trained first aiders within the service.

The ward complied with the guidance on eliminating mixed-sex accommodation. There were four shared bays compromised of five beds and 10 single bedrooms, four of which were single ensuite bedrooms. The shared bays were male or female only bays with a shared bathroom. Female patients that were in a single bedroom did not have to pass male bedrooms in order to access the shared bathroom.

The service was accessible for disabled people. Two bedrooms could accommodate larger patients and one bathroom was specially adapted for staff to complete therapy assessments, such as washing and dressing assessments with patients. Staff were able to assess and help patients develop their daily living skills using a therapy kitchen located on the ward.

The service could do more to make the environment more dementia friendly. The ward had some pictorial signs, such as a picture of a bed on the bedroom door but we did not see any other pictures on the ward. However, managers had planned to make the ward more dementia friendly as part of their Mental Capacity Act and dementia working group. Most patient bedrooms had clocks with the date, to help orientate patients but one bedroom was without a clock.

Assessing and responding to risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff assessed patients' risks within two hours of their admission and a therapist completed a more in-depth assessment within 24 hours of their admission. During the inspection we reviewed five patient risk assessments and found that patient risks were appropriately identified and managed. Patients had a falls risk assessment, and a bed rails risk assessment. A venous thromboembolism risk (VTE) assessment was completed for patients who required this. Staff assessed patients that were at risk of physical deterioration using a National Early Warning Score tool (NEWS2). We reviewed two patient NEWS2 charts and found that appropriate scores were recorded by staff and these were completed twice a day.

Staff used recognised tools to assess the risk to patients of developing a pressure ulcer, such as a Waterlow assessment tool and a Medley scoring tool. Pressure ulcer risk assessments (Medley tool) were reviewed on a monthly basis if a patient was scored to be a medium or high risk. An audit completed in March 2021, showed that 100% of patients in the ward had their Medley score reviewed monthly.

Staff had access to pressure relieving mattresses for patients. One patient required their position to be changed every two hours. Pressure area daily care plans were in place to reduce the risk of patients acquiring pressure ulcers. Staff liaised with the tissue viability service for support in ensuring that patient's skin integrity was maintained,

Staff completed moving and handling risk assessments for patients who required this. Patients identified as having a high risk of falls or mobility issues had a whiteboard above their bed, detailing the amount of support that they needed from staff to mobilise safely. Some patients also had a falls alarm, which would immediately inform staff if a patient had fallen. We observed staff supporting patients with their mobility.

Staff identified and quickly acted upon patients at risk of deterioration. Staff were able to access out of hours and weekend support where required.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. Agency staff could access the electronic patient record system.

Staff told us that staffing was a challenge during the pandemic, due to staff sickness and isolation but this had since improved. At the time of our inspection, there were no staff vacancies and the expected staffing establishment had been met. Staffing consisted of nurses, nursing rehabilitation assistants, physiotherapists, rehabilitation assistants, nursing associates and occupational therapists.

Managers could increase the staffing establishment and access extra staff when required. For example, staff were redeployed, or bank and agency staff were block booked to cover staff sickness and isolation during the pandemic. Staff who were on annual leave, off with sickness or self-isolating had their shifts covered by existing staff or regular bank or agency staff.

The service had enough medical cover. The ward was supported by a full-time consultant geriatrician. A GP also visited the ward three days a week to review patients. Staff could access a GP service out of these hours. In the event of a medical emergency, staff could access the rapid response team as the ward was located within an acute hospital.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up to-date, stored securely and easily available to all staff providing care. The service had both paper and electronic records. Risk assessments, observations, food and fluid charts and Waterlow assessments were kept in a paper record with the patient. Care plans and daily notes were recorded on the electronic system. Staff were able to access records easily, including agency staff.

Staff kept up-to-date handover records for patients. This included risks, mobility status, toileting needs, patient diagnosis, equipment needed, self-medication assessment, Deprivation of Liberty (Dols) status and discharge plans. Visiting professionals could make entries into patient records, including the GP that visited the ward regularly to review patients during the multi-disciplinary team (MDT) meeting.

The service was subject to an annual record keeping audit. The latest audit, completed in July 2020, showed that the service was 90% compliant with areas examined.

Medicines

The service had systems and processes to safely prescribe and administer medicines, but these were not always followed effectively by staff. Some prescription charts were poorly written and increased the risk of medicine errors. Records of medicine patch placement and rotation were not consistent.

Staff did not always clearly record entries on medicine administration records (MARs) to reduce the chances of misinterpretation and errors occurring. Where mistakes were made, these were often amended with scribbled writing over the top of the error. We found multiple examples where the dosing time of a medicine was changed but the dosage instructions on the MAR did not match this amendment. One MAR had multiple different doses for a single medicine on the same line of the record, it was not clear what dose had been administered on what day. This could result in a medicines error for patients.

Staff did not maintain a consistent record of the placement and rotation of medicine patches. Rotation of medicine patches is important to reduce the risk of sensitivities to the adhesive. A record of the placement of a patch is important to ensure the previous patch is removed before a new one is administered. There was a risk that a patient could receive a medicine patch at the wrong time or wrong dose.

Staff did not dispose of all medicines when they were past their recommended date of use. There was a risk of patients being administered out of date medicines. We found two liquid penicillin bottles and two eye drops bottles past their recommended date of use in the clinic room fridge. Staff told us that it was not being used and should have been disposed of as the patients had been discharged. We found ten medicines that were out of date that staff had not disposed of past their use by date. Staff were also using a cardboard box to dispose of undamaged empty medicine bottles, instead of a blue topped medical waste bin.

Staff completed daily checks of the clinic room and fridge temperatures but did not always escalate the temperatures when they exceeded the recommended limit, in line with the provider's policy. Medicines that required refrigeration were not kept at the recommended temperature. Records showed that the room and fridge temperatures had frequently been recorded outside of the recommended temperature range. Two patients' medicines were in the fridge at the time of our visit. Managers told us that a new fridge was on order and they were taking steps to lower the temperature of the clinic room.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients and carers said they were encouraged to say when they experienced any problems with their medicines. Patients kept their medicines by their bedside in a locked cabinet.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health at the weekly multidisciplinary team meeting. The pharmacist gave remote advice and checked patients' medicines, particularly when their prescription changed. Staff could access an out of hours prescription service.

The service appropriately managed and disposed of controlled drugs. All medicines were stored securely. Controlled drugs (CD) were in a locked CD cabinet in line with legislation and checked by staff daily.

Incident reporting, learning and improvement

The service managed patient safety incidents well. However, although hospital acquired pressure ulcers were reviewed at a weekly pressure ulcer panel and the provider told us these were fully investigated, the records of investigations into these incidents were limited and identified little learning for staff.

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. Staff told us that they knew what incidents to report and how to report them. Managers reviewed all incidents recorded.

The service had recorded two serious incidents in the previous 12 months, these were both injuries sustained from a fall. The manager investigated these incidents and lessons learned were shared with the staff team. Managers ensured that a falls action review was completed after each fall to understand how the fall had occurred.

There had been 51 incidents of pressure ulcers and deep tissue injuries acquired on Foxbury Ward, within the previous 12 months. Of the 51, 38 were category 2 (partial thickness skin loss) and one was category 3 (full thickness tissue loss). Of the category 2 pressure ulcers 28 had developed whilst the patient was on Foxbury and 10 had deteriorated to category 2 since admission. The category 3 pressure ulcer had developed while the patient was on the ward.

Following investigation of each incident the provider told us there had been no lapses in care in 50 of the 51 pressure ulcer incidents. The outcome was recorded as 'no harm caused by BHC' (Bromley Healthcare) for 50 incidents and one as

'minor harm caused by BHC'. We asked the provider for investigation reports for six pressure ulcer incidents where no lapses in care had been identified, including the category 3 pressure ulcer. The information about each investigation, sent to us by the provider, was very limited and insufficient to provide assurance that all six pressure ulcers were unavoidable. For example, three of the six did not mention whether the patient had been repositioned. One investigation gave no detail regarding any preventative care given for a category 1 pressure ulcer that deteriorated to a category 2 during the patient's admission to the ward. One of the six investigations identified any learning. The lack of detail recorded in the investigations made it difficult for staff to learn any lessons and improve the skin care provided to patients.

Although no lasting damage may have occurred as a result of the category 2 pressure ulcers, they were likely to have been very painful for the patient. A category 3 pressure ulcer involves full thickness tissue loss and may cause lasting damage. These developed while the patient was in the care of the provider.

However, the majority of pressure ulcers had occurred between September 2020 and February 2021. The last six months had seen a reduction by more than 50% in recorded pressure ulcer incidents (15 in total). The provider continued to have a focus on reducing avoidable acquired pressure ulcers as part of its quality strategy.

Safety performance

The service used monitoring results to improve safety. Managers monitored safety performance over time, including pressure ulcers, falls and completion of National Early Warning Scores (NEWS2). NEWS2 is a tool used to assess clinical deterioration in patients.

Staff completed appropriate safety tools for patients. For example, staff completed Waterlow assessments, falls assessments, bed rails assessments and a venous thromboembolism (VTE) risk assessment for patients. A VTE assessment was used to assess if patients were at risk of developing a blood clot. Staff used a Waterlow assessment or Medley tool to assess the risk of patients developing a pressure ulcer.

There had been 68 patient falls within the last 12 months, 11 of which were assisted/supported falls and 57 were unassisted. The provider had a quality priority to reduce the number of falls in the service and was taking action to address this.

Is the service effective?

Good

Evidence-Based care & Treatment

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. The service provided care and treatment based on national guidance and evidence-based practice.

Community health inpatient services

We reviewed five care and treatment records during our inspection. Staff had completed comprehensive assessments after patients had been admitted to the ward. This included risk of falls assessment, skin assessments, moving and handling assessments, body charts, dietary needs and mental capacity and communication assessments.

Staff completed National Early Warning scores (NEWS2) regularly for patients. We examined two NEWS2 charts and appropriate scores were recorded and signed by staff.

Staff followed national guidance in ensuring that appropriate prevention and management of pressure ulcers for patients by using a Waterlow assessment and a Medley assessment tool. Staff monitored patient's continence care and monitored constipation and bowel movements using the Bristol stool chart. We saw evidence that staff had completed a Rockwood Clinical Frailty Scale, which was a visual tool used to describe a patient's frailty upon their admission to the ward. This helped staff to identify what level of support was required for each patient in order to meet their rehabilitation needs. Staff completed a Montreal Cognitive Assessment tool (MOCA) to assess a patient's cognitive impairment.

Patients' recovery care plans were personalised, appropriately assessed patients' needs and detailed the views of patients, carers and relatives. The care plans addressed patients' personal care needs, mobility and falls prevention, self-medication if applicable and pressure area care. An audit completed in March 2021, showed that 100% of patients with a pressure ulcer had a care plan detailing frequency and type of dressings and review dates. Staff set goals for patients to work towards and outcomes they wished to achieve to become more independent, for example one patient's current goal was to be able to walk 50 feet with a walking aid.

However, patients' medicine care plans were generic and not person centred. Eight out of 10 care plans were very similar for each patient and did not specify what the individual needs were for each patient. For example, the plans did not detail how the patient preferred to take their medicines. Despite this, staff accurately described to us each patient's medicine requirements.

Therapy staff provided appropriate interventions, we observed physiotherapy staff engaging patients in exercise. For example, patients could take part in a weekly balance group, which was a variety of exercises completed sitting and standing to help improve their balance and mobility.

The occupational therapist completed personal care assessments for patients, this included assessments of patients' activities of daily living and toileting needs. The occupational therapist also completed home visits to ensure that their home environment was suitable to meet their needs once discharged, such as providing extra equipment.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff asked patients every two hours if they were in pain and ensured that patients had access to their call bell. They supported those unable to communicate using suitable assessment tools. For example, one patient used hand gestures as a communication method, staff told us that they also observed a patient's body language to see if they were in pain, such as facial discomfort. An audit completed in March 2021, showed that 100% of patients who had a pressure ulcer had a pain assessment completed in their records.

Nutrition and Hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

The service made dietary adjustments for patients' religious, cultural and other needs.

Staff used food and fluid charts to monitor intake for patients within the first three days of admission and longer for patients who required this. Staff visited patients every two hours to remind patients to drink their fluids. Staff used different coloured jugs to denote what fluid intake the patient had. For example, red lidded jugs were used for dehydrated patients who needed to be encouraged to drink more often and green lidded jugs were used for patients who required a normal fluid intake.

Staff were aware of patient feeding and hydration needs during mealtimes, including any identified allergies and these were discussed during handover meetings. Staff ensured that mealtimes were protected and assisted patients who required help with eating. We observed staff offering patients their preferred drink option.

Staff used a Malnutrition Universal Screening Tool (MUST) as recommended by the NICE Quality Standard for Nutritional Support of adults and national nutritional care standards to assess and improve nutritional care.

Staff had access to a speech and language therapist and a dietitian when required.

Patients and carers gave us positive feedback about the meals provided and the menu was on display on the ward.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Occupational therapists used the Barthel Index as a recognised tool to measure patient outcomes. The Barthel index consists of 10 variables that are used to measure a patient's daily functioning around activities of daily living (ADL) and mobility, including continence and dressing. Staff scored each variable, a higher number suggested that patients had more independence in that area. Staff completed this tool on admission and discharge for patients to assess a baseline of functioning and to monitor improvements in activities of daily living over time. Therapy staff provided appropriate interventions and exercises for patients, for example, we observed patients being supported to use appropriate exercise bikes.

Managers had oversight of patient outcomes and routinely collected information on patient readmission rates. Within the last 12 months, there had been a total of 516 discharges from the service. Of the 516 discharged patients 38 were readmitted to an acute hospital ward within seven days of their discharge from Foxbury Ward. Managers monitored readmission data monthly to ensure that the decision to readmit was appropriate and preventative measures had been considered.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff told us that they attended monthly clinical supervision, team meetings and received an annual appraisal. As of July 2021, 88% of staff annual appraisals had been completed.

Community health inpatient services

Staff received group clinical supervision and individual supervision on a monthly basis. Staff individual supervision rates on the unit were at 95% in July 2021.

Staff told us that they took part in non-mandatory training courses, such as resilience training and received training from other providers, such as training on end of life care provided by the local hospice. Staff also told us that the clinical lead presented topics for discussion in the staff meeting, such as continence care and caring for a patient with Parkinson's disease.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. For example, staff worked closely with the local acute hospital to refer patients for x-rays and staff liaised with social services in relation to patients' discharge. Staff were able to refer patients to the memory clinic. Staff worked closely with a GP who visited the ward weekly to review patients.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. Two carers told us that since using the service, their relatives had improved their independence in their mobility. The service had developed a leaflet for patients in continence care, this detailed where they could get advice and support for continence care.

Consent, mental capacity, deprivation of liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

There were five patients who were subject to the deprivation of liberty safeguards during our inspection. Managers had oversight of this using a spreadsheet and deprivation of liberty safeguards were discussed at handover meetings. Staff carried out mental capacity assessments when required, there was evidence of family involvement in these decisions. Records showed that mental capacity assessments were completed when required and were decision specific. Staff completed Mental Capacity Act training as part of their non- mandatory training and staff had completed a virtual Mental Capacity Act workshop in June 2021. Staff told us that where a patient's capacity was questioned, they ensured that the patient was not subject to a urinary tract infection, which can cause temporary confusion and delirium. One nursing associate told us that a lead nurse showed them how to complete a mental capacity assessment and observed them completing one as part of their training.

Do not attempt cardiopulmonary resuscitation (DNACPR) records were appropriately recorded, and family were consulted where necessary.

Is the service caring?

Good

Community health inpatient services

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We observed positive and compassionate interactions between staff and patients on the ward. Carers told us that the staff were very kind and caring with the patients and one patient commented that it felt like a hotel.

Patients could access call alarms as these were left in an accessible position. We observed staff responding to call alarms in a timely manner and one patient told us that staff would promptly respond to their call bell when it was pressed.

The service recorded patient feedback using the Friends and Family test (FFT). The FFT is a feedback tool that gives patients and carers the opportunity to feedback on their care and treatment whilst on the ward. The service has received 100% satisfaction between April and May 2021. The service also had a patient experience lead who visited the patients weekly to obtain patient and carer feedback and suggestions for improvement, which were fed back at the bi-monthly staff team meeting. Managers were then able to implement any suggested improvements, for example one patient asked for the toilet roll holders to be raised as these were too low.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. We saw evidence of family involvement in patient care plans and observed carers visiting the ward and speaking with staff in relation to a patient's discharge plans.

Carers gave us excellent feedback about the service their relative received, two carers told us that the staff had given their relative confidence in improving their mobility and strength since using the service. Three carers also told us that staff were very good at communication regarding their relative's care and treatment. The occupational therapist contacted relatives and carers to obtain the history of each patient, including their social circumstances and any communication needs they may have.

The service provided information leaflets to patients and carers, informing patients what they can expect during their stay on the ward. Carers and relatives were provided with a visitors' information leaflet, detailing the visiting procedures, an additional leaflet was provided to carers and relatives on the amended visiting procedure during the COVID-19 pandemic. Patients and carers were provided with a feedback leaflet, which informed them of how to provide the service with feedback, including how to access the local advocacy service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. Staff referred carers to a local service that provided support and advice for their wellbeing and health concerns.

Staff understood patients' personal, cultural and religious needs. Carers told us that communication was very good with staff. We observed staff providing support to patients who required this as mealtimes.

Community health inpatient services

Is the service responsive?

Good

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service worked closely alongside the rehabilitation home pathway service in ensuring that patients had the correct support to meet their needs once they were discharged. The patient group was appropriate to the service, most of the patients had sustained an injury following a fall in the community.

Staff discussed patients' progress at daily handover meetings. Discharge, pain management and physiotherapy goals were discussed at the weekly multidisciplinary team (MDT) meeting. We observed a handover meeting, where important information was discussed such as patient risks, mobility status and any actions required to work towards discharge. At the time of our inspection, there were two patients who were subject to a delayed discharge due to social circumstances.

Managers told us that they could access interpreters when required. The service made reasonable adjustments for those with a disability. One patient was unable to verbally communicate and used hand gestures to communicate with their paid carer.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Managers told us how the service was adjusted to meet a patient's needs. For example, staff used pictures as a communication tool with one patient who was unable to verbally communicate their needs with staff. Staff told us that they would contact carers and relatives to find out a patient's communication needs. Staff told us that they relied on non-verbal communication in addition to verbal communication, such as looking for facial expressions to see if a patient was in pain. However, staff were unaware of the requirements of the Accessible Information Standard.

Carers told us that they were able to keep in contact with their relatives during the COVID-19 pandemic, through staff facilitating telephone contact with patients.

The service was able to liaise with specialist teams in relation to end of life care. For example, staff told us that they referred patients to a local hospice and ensured patients had an appropriate package of care in place before they were discharged.

A chaplaincy service visited the ward, managers told us that this was vital support during the height of the COVID-19 pandemic, as they were able to visit patients on the ward, when carers and relatives were unable to.

Access to the right care at the right time

Community health inpatient services

People could access the service when they needed it and received the right care in a timely way. The service had clear admission criteria and would only accept patients who could engage in regular therapy sessions and lived within the London Borough of Bromley. Patients were admitted from their homes or from the local acute hospital and could be referred to the service via the single point of access. The single point of access is a triage service provided by skilled healthcare staff to assess and determine which community or inpatient service would be the most suitable to meet a patient's needs.

Staff planned for patients' discharge upon admission and held a meeting with family before a patient was discharged. The average length of stay was 22 days in the previous 10 months, which was better than the national average of 26 days. The service did not have a waiting list and was better than than the national average for referral to treatment time for patients (4.2 hours was national average and the ward achieved four hours). Seventy-one per cent of patients were assessed within two hours.

Patients could access activities for three days a week. Activities included a 'news and views' group and bingo. Patients were encouraged to cook their own food at the weekly breakfast club and could also access a weekly tai chi group. We observed one patient reading and another patient using their laptop on the ward.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients and carers were given an information leaflet on how to provide feedback and make a complaint if they wished to do so. Carers told us that they knew how to make a complaint if they wanted to. Over the last 12 months the service had received one complaint from a carer, which was upheld. Night staff had not communicated to the day staff that an appointment had been cancelled, resulting in an unnecessary trip. Staff were reminded to write down any important information in the handover book.

There was a suggestion box on the ward, we looked at five feedback forms from patients thanking staff for their care and kindness.

Is the service well-led?

Good

Leadership of service

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Staff were supported by a dedicated clinical lead and a matron for the ward.

Service vision and strategy

Community health inpatient services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The service had developed its own strategic goals linked to the providers' overarching goals and strategy. For example, one of the goals was to ensure that the service was a great place to work for staff. Managers of the service had implemented a staff news bulletin and a staff feedback box to meet this goal.

Culture within the service

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us that they knew how to raise concerns if needed. All staff we spoke with said that they felt valued and supported and morale was high within the team. Managers recognised the that the COVID-19 pandemic impacted on staff wellbeing, so introduced resilience workshops for staff in addition to offering counselling if this was required.

Governance, risk management and quality measurement

Leaders operated clear governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff attended monthly team meetings to discuss the performance of the service, such as staffing, provider updates, audits, complaints, incidents, patient falls and suggestions from the staff suggestion box.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Managers had access to the risk register and were able to tell us what the current risks were, such as financial risks if they need to use extra agency staff.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Managers were able to collect and analyse data for the service using dashboards and audits to measure performance of the service. For example, managers had oversight of completed National Early Warning scores (NEWS2) monitoring and any missing venous thromboembolism (VTE) assessments, or therapy or nursing assessments for newly admitted patients.

Managers also completed audits on patient falls, information governance, records and pressure care, which showed areas of good practice and areas of improvement. For example, the pressure care audit, completed in March 2021, identified that staff had completed 10% of their wound management study day and/or pressure ulcer training within the last three years and had identified a set of actions to improve this.

The service also took part in the National Audit for Intermediate Care, which aims to develop quality standards and patient outcome measures assessed against the agreed national standards. This audit identified areas where the service had performed exceptionally well. For example, the audit identified that the average patient length of stay on the ward was ward was better than the national average.

However, there was a lack of direct clinical and managerial oversight of how medicines administration and recording was taking place on the ward. Although the clinical pharmacist completed medicine audits and controlled drugs audits,

we found shortfalls in the recording on medication administration records (MAR) and medicine patches charts, which could potentially lead to patients receiving incorrect medicines. The clinical pharmacist, who was employed by the provider had been unable to attend the ward in person since the start of the pandemic. Staff told us that the service was part of an NHS England initiative called productive ward to try and reduce the number of errors occurring on the ward.

In addition, records of investigations were not detailed enough to provide assurance that hospital acquired pressure ulcers were unavoidable, and ensure all learning was identified.

Staff engagement

Managers of the service had launched a monthly staff e-bulletin to update staff on the latest developments to the service and reminders to staff, such as to complete their twice weekly lateral flow tests to test for COVID-19. It included any incidents reported on their incident reporting system, such as positive feedback received from patients and information on recent and upcoming staff training courses.

Staff were also given the opportunity to provide any feedback regarding the service at the bi-monthly staff team meetings in addition to learning about the latest developments to the service. Managers also sought staff views by using a suggestion box, which was shared in the staff team meetings.

Staff were supported to progress. Two staff told us that they were supported to become a trainee nursing associate through an apprenticeship scheme.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They understood quality improvement methods and the skills to use them. Leaders encouraged innovation. The service had a quality improvement project to reduce the patient length of stay within the ward, the aims of which were to optimise the speed of patients' rehabilitation for them to return home. The service was successful in reducing the average patient length of stay by 17% compared with the previous year, remaining below the national benchmarking average.

The service took part in an internal quality review. Managers found that the overall quality and standard of care was at the expected level for patients but made some recommendations for improvement, such as obtaining support from a community psychiatric nurse (CPN) as the service had benefitted from a CPN in the past.

The service had won an internal award for the staff commitment to excellence in healthcare practice during the COVID-19 pandemic in December 2020.

Community health services for children and young people

Requires Improvement

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Compliance rates within the community children's nursing team (CCNT) was 92%, Bromley 0-19 ream was 89%, Bexley 0-19 team was 90% and Greenwich 0-4 was 50%. The Greenwich health visiting team had transferred to Bromley Healthcare in June 2021 from another provider. The provider had put plans in place to support staff to complete their mandatory training going forward.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff had access to a safeguarding team who were always available during core working hours to respond to frontline colleagues needing advice. The safeguarding team attended Multi Agency Risk Assessment Conferences (MARAC) meetings as well as safeguarding meetings that involved vulnerable expectant mothers. Safeguarding school nurses in Bromley attended missing, exploitation and gangs affiliation (MEGA) meetings every two weeks.

Following a CQC inspection of the Bexley and Bromley 0-19 teams in November 2020, we recommended to the provider that they should review their safeguarding children's policy so that staff were clear on the provider's expectations. At the time of our August 2021 inspection, we found that the provider had updated their safeguarding children policy and had outlined staff roles and responsibilities.

Health visiting staff who held a caseload including vulnerable children and families received regular safeguarding supervision. Health visiting staff we spoke with across Bromley and Bexley told us that they received supervision every three months from the safeguarding team. The Greenwich 0-4 team had a pre-existing safeguarding supervision contract in place with another provider up until September 2021. From September 2021, Bromley Healthcare would be responsible for providing safeguarding supervision and staff would be required to follow their internal policies and procedures.

Following a CQC inspection of the Bexley and Bromley 0-19 team in November 2020, we recommended to the provider that they should ensure that safeguarding supervision record time scales for action plans were documented. At the time of our inspection, we found that the provider had made improvements to how supervision was recorded. We reviewed four safeguarding supervision records and found they were clear in detail and easy to follow. Each supervision record had clear time scales attached to the action plans. The safeguarding team had carried out an audit in June 2021 to review whether adequate changes had been made to how supervision was recorded. The audit found that improvements had been made and that the provider was assured. The safeguarding team planned to repeat the audit every three months until March 2022 to ensure the improvements were embedded.

Community health services for children and young people

Staff received mandatory safeguarding vulnerable children level three training and safeguarding vulnerable adults level two training. Following a CQC inspection of the Bexley and Bromley 0-19 team in November 2020, we recommended to the provider that they should consider providing additional training to staff working with non-mobile babies as a result of an incident. At the time of our inspection, health visiting staff across Bexley and Bromley 0-19 teams had received the training and a clear protocol had been put in place to support staff in how to respond to a non-mobile baby being injured or if they had suspicious bruising.

The service had an effective system in place to maintain oversight of the number of vulnerable children and families. At the time of our inspection, we found that Bromley and Bexley had their own systems in place to balance the number of child protection and child in need cases across health visitors despite staffing shortages. Bexley managed their safeguarding caseload using a 'corporate caseload'. This meant that vulnerable families could be allocated to a health visitor from any of the three teams dependent on workload. Within Bromley, the safeguarding caseloads were managed by the individual team lead. All staff could access the safeguarding allocations list.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Bexley and Bromley 0-19 teams performed consistently well in the provider's routine hand hygiene audit. Staff who used the clinic rooms at Phoenix Children's Centre allowed time between each family so that they could thoroughly clean the clinical areas.

Environment and equipment

Whilst the design and maintenance of the Phoenix Children's Resource Centre kept children, young people and their families safe, the buildings used did not always provide staff with a working environment that was comfortable and allowed them to carry out their jobs with ease. For example, four members of staff told us that poor connectivity and signal within the buildings could mean they were unable to access patient records and needed to go outside to make phone calls with families. At the time of our inspection, we identified the community children's nursing team (CCNT) did not have a permanent base to work from. The team were working in a temporary space using the dining room of the resource centre. We raised this with the provider who told us that there were plans in place to ensure the team base was appropriate.

Health visiting staff did not always ensure they followed the provider's lone working policy whilst working alone in the community. Despite the provider issuing staff with individual personal panic alarm devices, we found during the inspection that not all staff used the device when lone working. Staff had their own ways of ensuring their safety such as telling a colleague when carrying out a home visit or messaging the team via their mobile phone. The lack of adherence to the systems in place put staff at risk of not being able to escalate a concern when working alone. Staff working within the CCNT routinely used their personal panic alarm device.

Assessing and responding to patient risk

Staff ensured that most records of children, young people and their families were up to date and used tools to manage the acuity of families on their caseloads. Out of 28 patient records we reviewed we identified six records that lacked important information such as contact details for both parents or carers, and clear rationales for decision making. We found two examples in the Bexley 0-19 team of poor record keeping. One patient record did not demonstrate that the team had followed up a family who had not brought their child to any development reviews. In another record, a family

did not attend their child's two-year development review and no follow up appointment had been given. The record did not clearly detail the reasons why the child had been changed from an enhanced pathway to a universal pathway. An enhanced pathway is for children and families who are identified as needing further support, for example as a result of parental mental health concerns or domestic violence in the home.

Whilst staff ensured that the child's mother's details were consistently recorded and linked to their child's record, the health visiting teams did not always ensure that both parents were routinely added or linked to a child's record on the electronic care record system. We found that a child's parent or carer was assessed at the beginning of their care through a needs assessment but not always linked to the child. The safeguarding team told us that the details of a parent would be added if there was a concern. In one record we reviewed, we found that the father's details had not been formally recorded despite staff recording within the general notes that two father figures were involved in the child's life. The record did not clearly demonstrate whether the fathers were living at the child's home. Overall, the lack of consistent record keeping increased the risk of staff missing important information about a child or family that could lead to risks being unmonitored or not appropriately escalated.

The Bromley 0-19 team had not ensured that they had offered all children and their families a two-year development review. At the time of inspection, we identified two families that had not been offered a two-year development review in October 2020. Following the inspection, we asked the provider to review their patient record system to ensure no other families were outstanding. The provider identified a further 63 families who had not been offered a two-year development review in the month of October 2020, the month in which Bromley Healthcare took over as the provider of the service. The lack of two-year development reviews meant that children and their families would not be assessed as part of the Healthy Child Programme (HCP). The HCP is used by health visitors to assess and monitor the welfare and key stages of development in children, young people and families. This is a national mandated public health programme, requiring staff to screen, immunise, and review the development of children at specific points in their lives. The programme allows staff to identify risk of harm, disorder, ill health, or need for additional support.

Staffing

There was a high rate of vacancies for health visitors. This impacted on the ability of the teams to deliver the Healthy Child Programme (HCP) in full. Within the context of a national shortage of health visitors the provider had not fully explored the skill mix of teams, considering whether non-specialist staff or non-registered staff could deliver some of the mandated checks that were currently not being delivered.

Across all three boroughs, Greenwich had the highest health visitor vacancy rate of 30%, Bromley had a vacancy rate of 19% and Bexley had a 6% vacancy rate. The provider was sighted on the staffing issues and had put some controls in place to manage the gap in the long-term. Controls included offering flexible contracts to retired staff, new recruitment adverts and incentives to attract new applicants, retaining health visiting students once they qualified and employing agency health visitors. As part of the provider's long-term plan the head of health visiting for Bromley and Bexley was in the early stages of developing roles for band 5 community staff. The role would enable staff to work within a health visiting team before progressing to complete a specialist community public health nurse course (health visitor). The Bexley team had implemented Saturday working during August and September 2021 to ensure new birth visits were carried out in the timeframe required.

The impact of the staffing shortages had meant that health visitors had a heavier workload and were not able to carry out all mandated HCP checks on mothers, babies and children. Some checks were being carried out virtually to enable more people to be seen.

Community health services for children and young people

Since taking over the Greenwich 0-4 team in June 2021 the provider had not had enough staff to offer universal families a six to eight-week baby review as set out in the HCP. Following the inspection, the provider told us that the Greenwich 0-4 team planned to restart six to eight week baby checks for universal families from September 2021, virtually. However, by not seeing new mothers in their home setting there was a risk that their full needs would not be identified, including any mental health needs.

All three boroughs were unable to offer any antenatal contact with mothers at 28 weeks of pregnancy. This was because of staffing shortages. The Bexley and Bromley 0-19 teams had no plans to restore antenatal contacts. The provider explained that other healthcare staff were seeing mothers antenatally, which mitigated the risks of not carrying out the antenatal check to a degree. Bromley and Bexley 0-19 offered the six to eight week baby checks virtually.

Whilst the health visitor shortages were largely out of the provider's control, the provider did not demonstrate how they were going to restore the HCP in full, balance face to face and virtual contact and review the skill mix of teams. National guidance from Public Health England, pubished in 2021, suggests the whilst health visiting services should be led by a registered public health nurse/health visitor, the skill mix within the team should be led by local needs and underpinned by a robust workforce plan. Although the teams included some community staff nurses and nursery nurses the contribution of these roles to the delivery of the HCP had not been fully explored.

Quality of records

Following our last inspection in November 2020 we recommended to the provider that they should ensure that patient records were completed in a timely manner and kept up to date. At the time of this inspection, whilst we found that records were stored securely and accessible to all staff, we did not find that records were clear and up to date. Staffing shortages meant that staff had increased workloads and were not always able to record their work as soon as possible after an appointment. We found an example of where a staff member in the Greenwich 0-4 team had not recorded three separate appointments and subsequently went on sick leave. The lack of contemporaneous record keeping increased the risk of important information not being shared and potentially missed.

Medicines

The service worked with community GPs, special schools and acute hospitals to ensure medicines were managed safely. Staff located at the Phoenix Children's Centre told us that no stock medicines were stored on-site, and staff did not individually prescribe medicines. Children who attended special schools had their medicines prescribed by their paediatrician. The hospital at home team administered medicines that were stored at the child's house. We observed a nurse safely administering medicines to a child at home.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. During the inspection, we reviewed a sample of incidents from April to June 2021 and found that the provider had investigated incidents such as child deaths and medicines errors. The provider had investigated an unexpected child death within Bexley in early 2021. The investigation identified a need for system wide learning and further training for staff in areas such as safer sleep and motivational interviewing. The provider had ensured that they had put in place safer sleep training for all staff in August

and September 2021 and communication skills training was planned to be delivered at a professional development workshop in September 2021. All staff across Bromley and Bexley had also undertaken additional training following an incident involving a non-mobile baby. The CCNT had ensured they had made changes to practice following medicines errors at two specialist schools over the past 12 months.

Staff understood the term duty of candour. Providers of healthcare services must be open and honest with patients and other 'relevant persons' (people acting lawfully on behalf of patients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to provide examples of when they would offer support and apologise.

Is the service effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care. Health visitors and school nurses delivered most aspects of the Department of Health and Social Care's national Healthy Child Programme. Bexley and Bromley were carrying out some aspects of the HCP virtually for universal families but were gradually returning to face to face work. All three boroughs were carrying out all mandated contacts face to face for families under an enhanced care pathway. Health visitors used the Ages and Stages Questionnaire, third edition, which is an evidence-based assessment tool that encourages parents as experts to provide information about the development of their child across five developmental areas. School nurses followed the national child measurement programme in primary schools.

Nutrition and hydration

Staff assessed, monitored and managed patients' hydration and nutritional needs, where needed. Most children and young people were seen in clinics or visited at home. Staff ensured that special feeding and hydration techniques were used when needed, such as enteral feeding tubes (the use of a feeding tube placed into the gastrointestinal tract). Health visitors were able to refer children to specialists such as dietitians and the speech and language therapy (SLT) teams for advice about diet, eating and drinking, and swallowing difficulties.

Parents and carers had support and training in order to ensure they felt confident in caring for their child in the community. The children's community nursing team provided training to parents and carers on managing enteral feeds at home and were supported by dietitians in the community. Dietitians were available to provide advice to young people, parents and carers about food allergies, tube feeding and diabetes. Health visitors and nursery nurses held baby weighing clinics and provided advice on feeding and introducing solids. Each borough had an infant feeding team that supported parents and carers with young children who have feeding problems such as tongue tie and faltering growth.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The Bexley 0-19 team had been accredited up to stage three of the UNICEF Baby Friendly Initiative, which aims to support breastfeeding and parent infant relationships. This meant they were making progress in achieving key stages in the programme.

Community health services for children and young people

The service had arrangements in place to monitor the health and treatment outcomes of children, young people and their families. Team leads used a dashboard to monitor their team's performance and maintain oversight on the delivery of the mandated Healthy Child Programme (HCP). This included antenatal contact, new birth visits, six to eight-week reviews, one year and two-year developmental reviews. At the time of our inspection, both Bromley and Bexley 0-19 team were meeting most of their targets including new birth visits. Both teams had performed over the target of 90%. However, both teams had not met their target of 90% for two-year development reviews. Bromley had completed 80% of reviews and Bexley had completed 72% of reviews. Both teams had performed better than the national average of 71%. The Bexley team had employed a part-time administrator to book in all outstanding two-year reviews.

The Bromley 0-19 service had introduced a new national measure to identify and support early language needs in children. The Early Language Identification Measure (ELIM) is a recognised tool produced by Public Health England (PHE) and the Department for Education, which is designed to support children's speech, language, and communication development as part of the two-year development review. The Bromley team had designed a package of support for different care pathways including a referral to a speech and language therapist. The nursery nurses had received the ELIM training in order to begin using the tool.

Competent staff

Whilst the service made sure staff were competent for their roles, leaders did not always ensure they held a central register of when staff competency assessments had been completed. Staff in the community children's nursing team (CCNT) were responsible for holding their own training certificates and completed competency assessments. At the time of our inspection, we were only able to review the records of three staff members due to records not being available on-site. The lack of a centralised record system meant that the team lead was unable to monitor the skills and competence of the nursing team who carried out specialist procedures such as nasogastric feeding. Staff holding responsibility for their completion certificates increased the risk of important information being unavailable if documentation was lost and meant managers did not have clear oversight of the competence of staff.

Managers appraised staff's work performance and held management supervision meetings with them to provide support and development. The CCNT team had a completed appraisal rate of 100%, the Bromley 0-4 rate was 87% and the Bexley 0-19 rate was 90%. Staff holding a safeguarding caseload received three monthly safeguarding supervision. Safeguarding supervision provided staff the space to consider the impact of their decisions and actions on the safety and wellbeing of children, young people and adults. All staff we spoke with told us that they found these supervision sessions helpful. Most staff also told us that they had received management supervision.

The provider recognised that within health visiting there were no specialist roles available. The provider was keen to introduce specialist roles such as a specialist perinatal health visitor and domestic violence worker once the current staffing vacancies had reduced. During the COVID-19 pandemic families experiencing domestic violence were signposted to online guidance.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. We reviewed two records from CCNT and found examples of good practice where staff had worked closely with other agencies including a specialist palliative care team. The team carried out joint visits with other specialities when required, such as tissue viability.

Community health services for children and young people

Staff had set up ways of working with professionals to ensure complex situations were discussed and monitored. For example, a health visitor was allocated to each GP practice within the borough of Bromley and Bexley. Health visitors told us that they routinely held MDT meetings with GPs to ensure high risk children, young people and families were reviewed. The care records we reviewed demonstrated that health visitors attended regular meetings with GPs. The Greenwich safeguarding team worked closely with children's social care in order to ensure the team maintained close oversight of vulnerable families and children.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives. Throughout our inspection we observed staff engaging families in health promotion work that included healthy eating, sleeping habits and immunisations. This is in line with the Healthy Child Programme (HCP). The provider was not offering face to face well-baby clinics due to the COVID-19 pandemic but had a dedicated page on their website which signposted parents and carers to the teams' contact details. The Greenwich 0-4 team did not yet have a website available for parents and carers to refer to. At the time of our inspection, the provider told us that the website would be available soon.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. Staff received Mental Capacity Act training and understood how to support parents and carers to make their own decisions for their baby or child. In the records we reviewed staff were required to record the capacity status of the patient and if a young person, whether they were Gillick competent and consented to the care. Gillick competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Staff were also required to gain consent from families to share medical information with other professionals.

Is the service caring?

Good

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. During the inspection, we observed staff to be warm and friendly towards children, young people and their families. We observed a nurse putting a child at ease whilst administering their medication.

Children's services used a survey called the Friends and Family Test (FFT) to gather feedback from those who used the service and their parents or carers. Staff told us that prior to the COVID-19 pandemic they routinely encouraged families to share their experience whilst attending an appointment. However, since COVID-19 this had stopped and ways of feeding back had changed. Some staff believed families could feedback online, via comment cards or the provider's website. A few members of staff were unsure of the feedback systems in place.

Emotional support

Community health services for children and young people

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. We spoke with six families who had used one of the provider's health visiting services and most reported that they had a positive experience and their allocated health visitor had been caring. Families told us that they recognised that the service had changed as a result of COVID-19. One family told us that they requested to change health visitor due to the health visitor's poor attitude.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. We saw evidence of good practice within the patient records of the community children's nursing team. Staff demonstrated that they worked closely with families and supported them to develop their skills to carry out specific procedures at home such as nasogastric tube management. We saw evidence of wider holistic care being delivered, for example staff linking families in with 'remember my baby' photographers. This is a service for families who are experiencing or have experienced a baby loss.

Is the service responsive?

Good

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. Each health visiting team we visited was commissioned separately and as a result, there were some differences in the way services were planned and delivered. Service managers held regular meetings with commissioners to ensure services were meeting the local population needs with the funding that was available. The senior leaders of the Greenwich 0-4 team had held a meeting with GPs based in Greenwich to ensure they were aware of the history of the service as well as the mobilisation plan.

Services adapted opening times in order to ensure they could reach more children, young people and families. The health visiting teams were open during core working hours, Monday to Friday 9am to 5pm. However, the Bexley team had started working on a Saturday morning during August and September. The hospital at home team were available seven days a week to support timely care for children, young people and their families at home. The team delivered the service Monday to Sunday, during core working hours and into the evening. Following the inspection, the provider told us that an on-call service was available 24 hours a day, outside of the service's usual working hours.

The provider understood who their local population were and provided services that met their needs. Since February 2021, the CCNT delivered a hospital at home service. The service was designed to support children and young people to be discharged home early and enable them to carry on their care within their own home. Data taken from February to June 2021 showed that the service prevented 803 admissions of children to hospital. The service had been shortlisted for a Royal College of Nursing award and a Laing Buisson award.

Meeting the needs of people in vulnerable circumstances

Whilst the services were inclusive and took account of patients' individual needs and preferences, staff were not clear on how they would implement the Accessible Information Standard. Since August 2016 all providers of NHS care have needed to follow the Accessible Information Standard (AIS) in line with section 250 of the Health and Social Care Act. The

standard applies to people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. Out of the 26 members of staff we interviewed, we found that 15 members of staff were not aware of the standard and gave examples that would not apply as part of the standard. For example, using a language interpreter or making a referral to a speech and language therapist in the first instance. Two members of staff understood how they would support children and their families with communication needs including the use of a British Sign Language interpreter. Overall, staff did not have a clear understanding of how they would support a child, young person or family with an information or communication need, which meant that a family may receive information in a way they cannot understand, and not receive the communication support they need.

Access to the right care at the right time

Whilst most people could access the health visiting and community nursing services when they needed it, there were significant delays in assessments for children and young people who received care from the children's therapy services. The teams were not always able to complete education health needs assessments (EHCP) within the six-week statutory timeframe. The provider had 52 assessments overdue as of the week ending 13 August 2021. Delays were higher in the children's occupational therapy team due to a lack of capacity within the wider team. The provider told us that funding had been agreed from September 2021 until March 2022 to help address the backlog of assessments and recruitment had begun. The provider had this as a key risk on their strategic risk register.

The provider had referral arrangements in place for children and young people transferring between services. GPs were able to refer mothers and their children directly to the health visiting team that looked after their patients. Health visiting teams also accepted maternity concern referrals from midwives and hospital maternity teams. There was a system in place with the child information service (CHIS) who monitored databases for families who had moved into the area. The health visiting teams had protocols in place to guide staff in how to respond in the event a vulnerable family moved out of the area, including who they should notify.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Between April 2020 and March 2021, the provider had upheld two complaints relating to the children's physiotherapy service. The complaints received were related to the waiting time for a face to face consultation. Due to the COVID-19 pandemic, the team was carrying out virtual appointments only in accordance with national government guidance. The provider took 25 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

Families we spoke with told us that they felt confident to raise any concerns directly with the service and gave examples of when they had done this.

Is the service well-led?

Requires Improvement

Leadership

Community health services for children and young people

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. At the time of when the COVID-19 pandemic started many health visitors were redeployed as requested by the government. This meant that the service was not able to carry out their usual duties but ensured it prioritised vulnerable children and families. School nurses continued to work throughout the pandemic but were unable to carry out all aspects of their role due to schools being closed. Leaders were sighted on most of the local issues affecting teams such as staffing issues.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The provider had long term plans in place but was keen to ensure in the short-term that staff wellbeing was a priority and as a result all staff had been offered a wellbeing assessment. Other strategic objectives included the recruitment and retention of staff. One of the ways the provider planned to achieve this was by tri-borough advertising in order to balance the staffing numbers across the teams. The provider had plans to carry out a training needs analysis specifically for the teams who worked with five to 19-year olds to understand where additional training could be required.

Culture

Whilst many staff felt respected, supported and valued, others felt overworked because of the workload. At the time of the inspection, all members of staff told us that the staffing shortages had impacted on their workload and on them professionally. For example, some staff told us that they did not have time for personal development.

Staff were focused on the needs of children, young people and their families receiving care despite a challenging environment due to staffing vacancies. We observed staff providing welcoming and friendly care to children, young people and their families. The service promoted equality and diversity in daily work and had plans to advertise for specialist roles once the teams were more established. The service had an open culture where patients, their families and staff could raise concerns without fear.

Governance

Whilst some governance processes were working effectively within the service, we identified several areas for improvement. At the time of the inspection, we identified that the assurance systems in place that monitored child development reviews were not working effectively. Leaders had not identified that the Bromley 0-19 team had not offered a two-year development review to children who were eligible. Following our inspection, the provider told us that they were working to ensure all families identified were offered a two-year development review.

There was no centralised record system in place for staff competency assessments, which meant that senior leaders did not have oversight and assurance that staff in the CCNT had achieved the competencies they needed.

The provider had not ensured that staff understood lone working arrangements despite them issuing staff with personal panic alarms and having a lone-working policy in place.

Community health services for children and young people

Although senior leaders acknowledged that some elements of the healthy child programme (HCP) could not be delivered in full due to a lack of staffing, the provider did not provide sufficient assurance that they had a clear plan in place in the short-term to be able to restore the HCP in full. At the time of our inspection, the provider did not demonstrate that it had explored all possibilities to assess whether the current staffing skill mix could be utilised more effectively to deliver aspects of the HCP.

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Team leads and senior leaders met on a monthly basis to discuss performance as well as incidents, complaints and audits. Information relating to quality and performance was reported up to the executive team who then reported to the provider's board. We reviewed a sample of local team meeting minutes from January 2021 to July 2021 and found that teams regularly discussed performance, incidents and complaints.

Management of risk, issues and performance

Leaders and teams used systems to identify and manage risk and performance but did not always fully explore ways to mitigate risks safely.

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. Key risks relating to children's services were logged on the provider's risk register. Health visiting key performance indicators (KPIs) demonstrated that the service maintained a high rate of new birth contacts and six to eight-week baby reviews. However, during the COVID-19 pandemic these were mostly virtual meetings. Vulnerable families cared for on an enhanced pathway received face to face consultations.

At the time of our inspection, the Greenwich 0-4 team were not carrying out any six to eight-week baby checks for universal families because of a health visiting staffing shortage. This milestone contact was mandated in law. The provider had taken over the service from previous provider with a high health visitor vacancy rate of 41%. The provider had agreed a plan with local commissioners to how and when the checks would be restored. Following our inspection, we raised concerns to the provider about the timescales because of the risks to children and their families. The provider confirmed that they would restart the six to eight-week baby checks for universal families from the beginning of September 2021, but the contact would be virtual.

Although team leads told us that audits formed part of the provider's assurance framework, we found that record keeping audits were not performed regularly enough to maintain standards and drive improvements. For example, the Bexley 0-19 team had carried out their last record keeping audit in 2019. The audit identified that patient notes were not always written contemporaneously. The Bromley 0-19 team carried out their last audit in January 2021 following our November 2020 inspection. The audit identified that staff needed to give equal consideration to fathers and single sex partners. At the time of the August 2021 inspection, we found that this had not improved, and that mothers' details only were mainly recorded.

Following the inspection, the provider told us that the annual record keeping audit for 2020-2021 had been paused in response to the Covid-19 pandemic. The next record keeping audit was due to start in November 2021.

Information management

The service collected reliable data and staff could find the data they needed, in easily accessible formats to understand performance. Although some key pieces of information had not been closely analysed and had led to several

development reviews being missed, the information systems generally worked well and were secure. At the last inspection in November 2020, we found that the provider had not submitted required statutory notifications to the Care Quality Commission, without delay. At the August 2021 inspection, we reviewed a sample of incidents from April to July 2021 and found that the provider had submitted the required notifications relating to those incidents.

All members of staff had access to up-to-date information about young people's care and treatment. In teams where patient record systems were not shared with external colleagues such as children's social care, staff ensured that documents were handed over using appropriate systems. Team managers had access to information about the performance of the service. For example, incidents and staffing.

Engagement

Leaders and staff actively and openly engaged with patients and staff. Most staff told us that their team leads involved them in decisions and asked them how they could improve the service. Staff encouraged families to feedback about their experience but recognised this had been difficult due to families not being seen face to face during the pandemic. The provider had a dedicated website for both Bromley and Bexley 0-19 services that provided information and resources for parents and carers. The provider was developing a similar website for the Greenwich 0-4 team.

Staff had access to up-to-date information through the trust's internal communication systems. Staff were sent a regular newsletter that shared service updates, team performance, training dates as well as organisation news. The 0-19 teams held professional forums, which gave an opportunity for staff to reflect and enhance their development.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The service lead for the CCNT was in the early stages of writing a business case for a community asthma service working alongside the local acute hospital and primary care. Children's therapies and the CCNT had identified the need to improve the system in place for children who were transitioning from a children's service to an adult's service and who required specialist care and support. This included children who used a catheter or had a tracheostomy. A working group had been created to address the issues. The Bromley 0-19 team had a new parent programme in place that was being delivered at children's centres between September 2021 and March 2022. The programme involved teaching sessions that covered aspects of caring for a baby such as infant feeding, weaning and breastfeeding.