North East London NHS Foundation Trust

RAT

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RAT	Trust Head Office		

This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust.

Summary of findings

Ratings

Overall rating for the service	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

Summary of findings

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Overall summary

Overall, we rated community health services for adults at North East London NHS Foundation Trust (NELFT) as requires improvement because:

- There were major staffing shortages and recruitment challenges across all staff groups and localities. High percentages of bank and agency staff were used to run services and this was affecting continuity of care for patients. There was extensive recognition amongst all staff of heavy and unsustainable caseloads across services, particularly in district nursing.
- There was inconsistency in the completion of healthcare records, including in risk assessments, diagnostic tools, progress notes and medication charts. A system to effectively monitor and audit the quality of patient records was not in place.
- There was inconsistent measurement and analysis of patient outcomes across services and localities. Some local areas had clear patient outcome measures in place but others had limited systems for monitoring outcomes. There were examples of large backlogs of incomplete patient outcomes recorded from visits, which staff stated was due to a lack of staff capacity.
- The service had only recently made Mental Capacity Act (MCA) training mandatory, meaning that many staff had not been trained and did not have an understanding of the MCA and Deprivation of Liberty Safeguards.
- Inspectors observed a lot of variation in referral to treatment (RTT) times for accessing services across different localities, and the trust did not have a system in place for effectively monitoring RTT, particularly in district nursing.
- As community health services for adults worked with many Clinical Commissioning Groups (CCGs), services were delivered in many different ways between boroughs, meaning some areas could not provide services which were available in other parts of the trust.
- Although the trust was moving towards delivering a more standardised model of care across the different boroughs, there was still a lot of variation in how services delivered care in response to the needs of local health economies.
- There was no clear, documented vision for the service as a whole, and it was not clear how community health services for adults were represented at board level. Staff stated they felt more connected to their local area than to the wider Trust, and did not have much communication with similar teams in other areas.
- Community health services did not have an effective structure in place for clinical governance or risk management, and services did not have a robust system of audit in place or effective means for measuring quality.

However:

- The service had robust systems in place for identifying and reporting safeguarding risks, and staff recorded and investigated incidents appropriately.
- Permanent staff were meeting trust targets for mandatory training. Staff told us that they were given appropriate training to develop the skills required to undertake their roles.
- There was evidence of good treatment across community health services for adults which was delivered in line with national guidance and best practice. There was good provision of evidence-based advice and guidance to staff, and the trust had established several groups across services, such as the clinical excellence networks, to identify and disseminate best practice amongst the teams.
- Inspectors found good examples of a caring culture despite staff pressures. Staff were welcoming and professional, and we saw staff communicating with patients with empathy and in a polite and caring way. Feedback from patients regarding nursing staff was universally positive, and results from satisfaction surveys were encouraging.
- Staff worked in partnership with patients and their family members when delivering care, and helped patients to access the information they needed to support treatment and wellbeing.
- The service had a robust system in place for collecting and responding to complaints, and managers fed back findings from complaints in team meetings to support learning for staff.
- There was good understanding of the different cultural needs and backgrounds of patients and staff, and the

Summary of findings

Trust had set up an award-winning Ethnic Minority Network to promote diversity and inclusion within the culture of services. Services offered good access to translation services, with patient literature available in many community languages and in accessible formats.

- The service had established single points of referral across localities to offer easier access to patients, and the rapid response teams/community treatment teams provided an alternative to hospital admission for patients needing emergency treatment.
- Inspectors saw some good examples of local leadership across community health services for adults, despite challenging circumstances. The staff we met told us that they felt cared for, respected and listened to by their colleagues and local line managers.

The executive team and local trust leads were also visible across services and were available to meet with staff through a number of initiatives.

Summary of findings

Background to the service

North East London NHS Foundation Trust provides community healthcare services to a diverse population of over 2.5 million people in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. It also extends into Essex and provides services in the boroughs of Basildon, Brentwood and Thurrock. The trust employs around 6,000 staff.

Services for adults in the community are managed on a locality basis, aligned with the seven boroughs that the trust works with. Within each locality, the trust provided district and community nursing services, specialist nursing (such as diabetes and tissue viability), Community Treatment Teams (an alternative to hospital emergency services and admissions), and therapies. Services in Waltham Forest, Barking and Dagenham, Essex, and most recently Redbridge had moved to an integrated care model, joining nursing services with mental health and, in most areas, adult social care. This had been implemented to varying degrees across the services, with an overall ambition to provide integrated care services across all adult community health services.

Our inspection team

Chair: Helen Mackenzie Director of Nursing Berkshire Healthcare NHS Foundation Trust

Head of Inspection: Natasha Sloman, Care Quality Commission

Team Leader: Max Geraghty, inspection manager, Care Quality Commission

The team that inspected community health services for adults comprised one CQC inspector and a number of specialists, including: district nurses, a community matron, a community safeguarding adults and children lead, a sexual health consultant, and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at two focus groups.

We inspected a selection of the trust's services across localities. During our inspection we visited the trust's sites at :

- Brentwood Community Hospital
- Gray's Court Community Hospital
- Integrated Care Team, Phoenix House, Essex
- Anthony Wisdom Centre, Essex
- Harold Wood Polyclinic, Havering
- Harold Hill Health Centre, Havering
- Seven Kings Health Centre, Redbridge
- Hainault Health Centre, Redbridge
- South Woodford Health Centre, Redbridge
- Woodbury Unit, Waltham Forest

Summary of findings

- Hurst Road Health Centre, Waltham Forest
- Langthorne Health Centre, Waltham Forest
- Oliver Road Medical Centre, Waltham Forest

We also attended home visits with district nurses, rapid response, tissue viability nurses (TVNs), and diabetes. We spoke with more than 30 patients and their family members. We observed care and treatment and looked more than 30 sets of patient records. We also spoke with more than 70 staff members, including community and specialist nursing, health care assistants, GPs, consultants, allied health professionals, administrative staff, local senior management, and clinical leads. In addition, we reviewed national data and performance information about the trust.

What people who use the provider say

Good practice

- The community treatment team worked closely with local acute hospitals to reduce emergency admissions to hospitals for patients, who were treated in their own homes. The service has been highly commended and has won a national patient safety award in partnership with London Ambulance Service.
- The rapid response service in Waltham Forest had identified by Waltham Forest Clinical Commissioning Group to have contributed to a reduction in acute hospital admissions to Whipps Cross hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that staff consistently record medicines administration in case notes so that it is clear what medication has been given to a patient.
- The trust must implement a system for monitoring and frequently auditing the completion of risk assessments in patient records across community health services for adults.
- The trust must ensure community services for adults are meeting minimum targets for supervision and appraisals for all staff.
- The trust must develop an effective system of governance for adult community health services, which includes means for measuring and comparing quality or performance across services through audit. This to include the quality and completion of patient records across the services and referral to treatment (RTT) times for universal and specialist services across all localities.

Action the provider SHOULD take to improve

- The trust should provide agency nursing staff working in the community with a means of completing patient records and outcomes from their patient visits.
- The trust should review how services report the results from pressure ulcers assessments to ensure the data can be compared across community health services.
- The trust should take steps to ensure safeguarding practices and performance are frequently audited in line with trust safeguarding policies.
- The trust should provide staff with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) to meet the minimum trust targets for training in these areas.
- The trust should review the lone working policy for staff and ensure the implementation of the policy is standardised across the trust.
- The trust should take steps to improve the information sharing process between different disciplines working in integrated care teams.
- The trust should improve opportunities for staff to share information with similar teams working in different localities across the trust.

Summary of findings

- The trust should develop a clear strategic vision for community health services with clear shared for the directorate and individual goals for services.

The trust should take steps to ensure actions identified in audits, incidents and complaints are completed within deadlines.

Action the provider COULD take to improve

North East London NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- There were major staffing shortages and recruitment challenges across all staff groups and localities. Community health services for adults were using high percentages of bank and agency staff to run services and this was affecting continuity of care for patients.
- Many staff told us that they were carrying heavy and unsustainable caseloads. This was across all universal and specialist services.
- There was inconsistency in the completion of healthcare records across services, including risk assessments, diagnostic tools, progress notes, and medication charts. The service also did not have a system in place to effectively monitor and audit the quality of patient records.
- There were examples of patients not being adequately risk assessed, which meant their risk was not managed effectively.
- There was a lot of variation in how lone working policies were implemented across services. This meant that staff could not all be accounted for when out in the community and this might put them at risk.

However:

- The service had robust systems in place for identifying and reporting safeguarding risks. The service had good access to advice and support through the safeguarding team.
- The service reported and investigated incidents appropriately. Learning and changes in practice from incidents was disseminated across teams.
- The service was meeting the trust targets for mandatory training.
- All of the locations we visited were clean and tidy and there were good infection control systems in place.

Safety performance

Requires improvement

Are services safe?

- We found a good attitude across teams for reporting serious incidents, however the London Borough teams output for reported incidents differed from the Essex reports in level of detail. This made it difficult to compare incident data across the trust.
- Staff reported no never events in the 12-month period leading up to our inspection. Never events are serious incidents that are wholly preventable, as guidance available at a national level and systems implemented by all healthcare providers should prevent them from happening.
- Staff reported 267 serious incidents (SIs) within London Boroughs in the year preceding our inspection. Pressure ulcers accounted for 98% of the recorded figure; with 38% (103 cases) related to ulcers that patients had developed while being cared for by community health services for adults. Sixty per cent (160 cases) were inherited ulcers, which patients had on referral to the service. The remaining four SIs reported related to suspected falls and patient death.
- Staff were aware of the need to accurately record incidents, and felt that they were encouraged to do this by their managers. Staff told inspectors that an adequate reporting system was in place and that they received training in how to use it.
- Serious incidents in Essex were all related to pressure ulcers in the year preceding our inspection (105 cases at least Grade 3 or above). However, staff did not identify the number of inherited pressure ulcers in records as with London Boroughs. This meant that it was difficult for the trust to compare performance on this area across all of the service as a whole.

Incident reporting, learning and improvement

- The staff we spoke with stated that they knew how to access the electronic incident reporting system (Datix). When asked by inspectors, staff across disciplines displayed a good knowledge of when incidents should be reported and the process for doing this.
- Managers had systems in place to share learning and lessons from reviews of incidents locally, such as in team meetings and in emails to all staff in their locality. Staff could give examples of where they reported incidents and times they had received emails about other incidents that had happened across the trust. Team leads also discussed incidents in monthly Quality and Safety Group meetings and then disseminated from these into their teams. Inspectors observed minutes from these meetings in district nursing bases at the trust. Staff stated they discussed incident reports in weekly team meetings.
- The trust had effective processes in place for investigating incidents that staff reported. The trust had a serious incident team which investigated issues raised on Datix and, with input from the others involved in the incident, identified learning to be shared and potential changes to practice. The community safeguarding team also viewed every incident submitted for their input and advice.
- Several groups were set up to examine incidents, which occurred repeatedly to identify learning and suggest changes to practice. These groups had developed new ways of working to support improved care for patients. For example, nursing staff working in care homes had a nursing home group three times a year to discuss repeated incidents for their patients, such as pressure ulcers. Due to monitoring pressure ulcer incidents, the group organised tissue viability nurses (TVNs) to deliver training to care homes where they had noted that referrals were high. Nursing staff stated this helped to reduce pressure ulcers and helped staff identify tissue damage at an earlier stage.
- Staff stated that although they learn about incidents locally, they often do not hear about incidents in other areas of the trust. Staff in London Boroughs stated they do not often know what the issues are in Essex and there were limited opportunities for joint discussion across the trust. Staff in some specialist nursing services, such as the diabetes teams, stated they did not receive information relating to incidents or have opportunities to discuss incidents frequently.

Duty of Candour

- Managers and allied health professionals demonstrated a good working knowledge of Duty of Candour (DoC) and were able to describe the process they would follow when informing patients and family members.
- Most of the frontline nursing staff we spoke with were able to describe what DoC was, but when asked were unable to identify what action they would need to take to comply with the trust policy. Qualified nursing staff generally demonstrated good knowledge of what DoC was, however some of the healthcare assistants (HCAs) we spoke with were unsure of what this meant.

Requires improvement

Are services safe?

- The trust had made training in DoC available to new staff as part of their induction training before beginning their roles; however, it was not part of the mandatory training courses to be completed.
- Inspectors observed an example of a patient record where a relative had raised a complaint about care received, which did not evidence DoC. The managerial response to the relative's complaint was in the case notes, but lacked any information on following the DoC process for the trust.

Safeguarding

- Robust safeguarding structures and policies were in place, with support and advice available to all staff from a specialist safeguarding team within the trust. The staff we spoke with stated that the safeguarding team were available to support raising alerts to the safeguarding authority, joint visits to patients, and staff attending local safeguarding meetings if needed. Each local nursing team had a link nurse to the safeguarding team, who attended quarterly safeguarding meetings, which looked at themes or prevalent issues (e.g. radicalisation, domestic violence). Staff stated that the support available from the safeguarding team was valuable and reassuring when they had to raise concerns. The trust established a joint safeguarding children and adults duty desk, which provided advice and guidance five days per week.
- The safeguarding adult policies and procedures that inspectors viewed were robust, clear and concise. The policies followed national and local guidance, including the Health and Social Care Act, and provided information on what constitutes good practice. The trust had recently reviewed the harmful practice policy to include process for domestic violence, female genital mutilation (FGM) and child sexual exploitation (CSE). Staff we spoke with knew were knowledgeable about safeguarding policies and procedures.
- Ninety-three per cent of staff completed the Enhanced Safeguarding adults training,which is above the trust target of 85%. Also 95% of staff completed the Safeguarding Children level 2 training.
- The adult safeguarding team and the children safeguarding team had a positive working relationship. The Safeguarding Adults and Safeguarding Children reports for the trust, which were developed by the safeguarding teams, were jointly presented to the Local Safeguarding Boards across London and Essex to help identify common issues.
- When trust staff completed an incident report on Datix, they also had to note if they considered contacting the safeguarding team. The safeguarding team was aware of any new reported incidents and would contact the relevant staff member; if they felt safeguarding concerns had not been appropriately raised.
- While the safeguarding policies we observed referred to regular audits of safeguarding practice and Mental Capacity Act (MCA) assessments in patient records, service managers stated they were unaware that the trust had carried out any audit of safeguarding. Inspectors also did not find evidence of regular audits to measure performance for safeguarding.

Medicines

- Inspectors observed policies in place to manage the storage and administration of medication. Pharmacy technicians carried out quarterly quality audits at all locations where medicines were stored or prescriptions used and fed the results back to the nursing teams.
- The trust held a quarterly medicines group for district nursing staff, with one district nurse (DN) attending from each locality. This meeting was to share information and common issues, as well as changes in practice, and attendees relayed any outcomes from this meeting to their teams.
- The pharmacy team worked closely with staff to facilitate quick access to medication and support when needed. The team worked with certain community pharmacies across London and Essex to ensure that they always stocked medicines that certain patients may need urgently (e.g. palliative care, diabetes). The team also developed a standardised referral form for syringe driver administration, for use by GPs and nurse prescribers, which provided better information to the teams when prescribing. District nurses stated that the pharmacy team were available to support intravenous (IV) antibiotic administration in people's homes and provided guidance on which referrals to accept and which to check with a pharmacist.

Requires improvement

Are services safe?

- Non-medical prescribers we spoke with stated there were no delays in obtaining or administering medication. Patient Group Directions (PGDs) were in place to allow nurses to administer medicines without waiting for a prescription.
- Inspectors on visits in the community observed nursing staff explaining the appropriate use of medication to patients for self-administering, advice on how to store medication, and how to re-order when the patient was running low.
- The pharmacy team supported staff in a wide range of community services, and were in the process of addressing regional variation across the trust. The pharmacy team were working to standardise procedures for recording, prescribing and administering medication across all boroughs, which historically provided individual services. However, they anticipated that this could be a long process to complete due to the longstanding variation across services. The pharmacy team also planned to give community nurse prescriber's access to the Summary Care Record (SCR), which would allow them to see the medication history of the person they were prescribing for, however this was not in place yet.
- Inspectors observed in patient records in Redbridge that medication charts were not in use for recording administration. This meant it could be more difficult for staff visiting the patient to identify what medication had previously been given to a patient and when. Staff confirmed that medication charts were not being used to record administration of medication and this was being recorded in the progress notes.
- The trust did not have a process in place to allow consultants working for another trust to prescribe in services jointly run with North East London Foundation Trust (NELFT)**.** For example, Barking & Dagenham, Havering, and Redbridge NHS Foundation trust (BHRUT) had set up a joint Diabetes service with NELFT and provided two diabetes consultants for a twice-weekly clinic in Havering. Staff for this service stated that the BHRUT consultants were unable to prescribe within this service, and had to write to GPs asking them to prescribe to patients. This meant that patients could experience delays in receiving their medication.

Environment and equipment

- Equipment needed for patient care in their homes could be ordered quickly by staff following assessment. Staff stated that equipment (e.g. mattresses) was generally delivered in a timely fashion and if there were delays, nurses would follow up with the suppliers. Inspectors examined a sample of patient records at district nursing bases and found examples of equipment requests completed effectively and with the necessary information required. Inspectors also noted discussions with patients in the community regarding what equipment they would need to support healing and improve mobility.
- The Tissue Viability Nurses (TVNs) and district nurses across the trust were provided with a range of equipment to facilitate comprehensive assessments and better treatment for pressure ulcers. TVNs and district nurses used a pack containing a camera for recording pressure ulcers, mirrors, and patient information leaflets with guidance on how to promote healing for open wounds. Following assessment by TVNs and district nurses, equipment could be ordered to help patients manage, such as alternating pressure-relieving mattresses or negative pressure vacuum pumps to help facilitate wound healing. Staff also had training in the appropriate use of the equipment, such as the alternating mattresses.
- Specialist nursing teams found it challenging to locate venues to run the education sessions for patients in the London area. Type 1 and Type 2 Diabetes education sessions would need to be run over four weeks; however it was difficult to find a venue which was cost effective and large enough to meet demand, and staff told us this impacted on the number of people that can attend sessions.
- District nursing staff across Redbridge Health & Adult Social Services stated they did not have enough access to computers at the new integrated care bases. The teams had moved to new bases recently, and shared office space with adult social care and mental health teams. This meant staff could not always find a computer to work at when it was busy, which could affect completion of patient records in a timely way and access to emails.
- Redbridge Health and Social Care Services had moved into shared bases in the week prior to our inspection and staff found the environment was not fit for purpose and not properly cleaned. The teams reported that they did not have chairs, desks, areas to store confidential information, storage for equipment, IT access or working telephones. Staff stated that they had returned

to their old base to use IT facilities, as they could not access the systems they needed for patient notes at the new base. The team stated that the rooms were very dirty and the nursing staff had to clean the space themselves as it had not been prepared, and some building work had not been completed. Staff stated they felt the moves was rushed as they had one week's notice and that the environment had not been properly prepared for them, which they found stressful.

- Allied health professionals (AHPs) reported it was a challenge to transport large pieces of equipment for assessment and treatment without the use of a car across the trust localities. Many staff stated they travel by public transport in the Outer London areas while working, but this means they cannot bring some equipment with them on community visits. Allied health professionals stated they do not have access to trust cars to transport equipment for assessments, which can affect what they can use in assessment and treatment with patients.

Quality of records

- Ninety five per cent of staff had completed information governance (IG) training, against a trust target of 85%. Inspectors observed administrative and nursing staff working with the record-keeping systems and found them to be comfortable using it. Staff received training on how to use the electronic records system (ERS) as part of their trust induction.
- All patient records observed by inspectors were stored securely in locked filing cabinets or kept on password-controlled computers. Staff we spoke with showed a good understanding of data protection.
- Two different ERS systems were used across the trust to manage patient records, which had limited compatibility. Staff in London Boroughs used one system (RiO), and Essex-based services used another system (SystmOne). The two records systems were not compatible so staff from each area could not share information easily through these systems. District Nursing teams (as part of Integrated care teams) for community health services in Waltham Forest and Redbridge also had different systems from their colleagues in adult social care, which meant records for the same patient would have to be held on different systems. Staff that worked across both London and Essex, such as some therapy staff, stated they would have two logins, one for each system.
- Although the Trust had two ERS, there was a lot of variation in how patient records were kept across the Trust on these systems. Some London boroughs had moved to a "paper-light" system, using electronic records and only maintained paper records in the patient homes, while other boroughs maintained some paper copies of patient records at district nursing bases as well as in patient homes. As some systems had a backlog of records that had not been updated by teams, this created differences in the quality of notes in patient homes and those recorded on the system. The nursing and managerial staff we spoke with were unaware if there was any work being done to standardise practice for maintaining records across the Trust.
- Agency staff did not all have access to logins for the ERS. This stopped agency staff from completing updates to patient records on the ERS following visits. Agency staff wrote their progress notes on paper copies and administrative staff then used the paper copies to complete the patient records and update the activities log on the ERS. However due to the high use of agency staff across services there was a backlog of patient records which had not been updated adequately as admin staff did not have the capacity to complete them. This meant that patient records were not up to date for use by other staff and would not be accurate if used for quality audits.
- Nursing staff and managers we spoke with across district nursing teams stated that they do not have the capacity to complete patient records or record the outcomes of visits due to staffing. Staff stated that as they are short-staffed and agency staff cannot complete their records, as they have no logins, they have had to prioritise patient care over the completion of patient records. This had contributed to a large backlog of incomplete records and outcomes in patient files.
- The trust did not have formal governance or audit structures in place to monitor the quality of patient records across the service. The Trust ran an annual healthcare records audit to assess data quality using a sample of paper and electronic records from services across the Trust, however there was no evidence of other structures in place to establish quality at a local level more regularly. Managers and directors we spoke with stated they had performed local audits in the past, but did not know of any other records audits in place at a Trust level.

Requires improvement

Are services safe?

- Inspectors observed examples of patient notes in London Boroughs that had not flagged patient risks on ERS. The London ERS allowed referrers or other staff to red flag patient records that had a significant risk. Inspectors noted examples where patients flagged as a risk at referral, had not continued to be flagged on to the trust ERS. This meant that some high-risk patients were not recorded as such in their patient record. Staff stated that they would record the risk in the notes or hand this information over verbally to other staff. Staff were also unsure of any existing audit in place to monitor use of the flagging system.

Cleanliness, infection control and hygiene

- In the 2015 Patient-Led Assessment of the Caring Environment (PLACE), the trust scored 99% for cleanliness, 2% higher than the national average. PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50% members of the public.
- Staff we spoke with stated that they use the Aseptic Non-Touch Technique (ANTT) on community visits to minimise the risks of exposing a patient to infections. ANTT requires that staff use only sterile equipment and fluids during treatment procedure. Inspectors observed staff using sterile equipment in line with this guidance.
- Inspectors observed positive hand hygiene practices in patient's homes by nurses across the trust. Additionally, community health centres and other clinical areas patients attended had hand sanitisers available in service entrances and throughout the public areas.
- Good practice was in place to prevent cross contamination between patients homes. Staff delivering care in patient homes were observed to have the required cleaning materials for cleaning equipment and wore personal protective equipment during the visit. Staff cleaned any equipment they used before moving on to the next patient. Staff we spoke with also stated that an infection control nurse was available to staff to support community visits if risk of cross contamination or infection was a concern, and could provide advice if necessary.
- Inspectors noted sharps boxes in district nursing bases and in patient homes to safely dispose of needles and other sharp objects. When staff had used a sharps box in patient homes, safe disposal of sharps was recorded in the case notes.
- Toilet facilities at health centres and other clinical areas were clean and had been regularly signed as checked by staff.

Mandatory training

- As of April 2016, compliance rates in mandatory training for community health service for adults was 92%, against a trust target of 85%.The service had achieved a 99% compliance rate for training staff in Safeguarding Children 1 and 96% in Safeguarding Adults and Safeguarding Children Level 2, while the lowest compliance score was Immediate Life Support. The trust had recently introduced the MIDAS performance management system for staff to monitor their compliance, which staff said helped them to remain informed when their training would soon expire.
- New staff recruited by the trust were required to complete a week long trust induction which covered many areas of mandatory training before beginning their employment. Mandatory training was a mix of both classroom learning and computer-based learning. The staff we spoke to were positive regarding their e-learning experience, as it did not require missing shifts with their service.
- Many staff had not had training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS), and could not describe what DoLS was. The trust made training for the MCA and DoLS mandatory for all adult community health staff in November 2015. The Trust reported 75% compliance for training in these areas, with a lot of variation in completion rates across different localities (as low as no staff in some services). Many staff stated in discussions they had not had this training yet, and were unable to explain aspects of DoLS or the MCA. Senior adult community health service staff stated they had prioritised the rollout of the training to staff more likely to need it, which meant others had not yet had the training as the time of inspection.

Assessing and responding to patient risk

- Inspectors observed a lot of variation across the trust in the quality of completion of risk assessments in the patient notes. This meant that inspectors were unable to determine if staff had completed risk assessments or if they were just not being recorded in the patient records. For example, in district nursing for Waltham Forest inspectors looked at ten sets of patient records and observed Waterlow assessments (which estimates

risk for the development of a pressure sore) were recorded as completed in four sets of patient records, while the Malnutrition Universal Screening Tool (MUST) was completed in one set of ten patient records. This variation in performance of recording risk assessments was consistent across other areas of the Trust we visited, and could have an impact on monitoring the development of care and patient safety.

- District nursing teams were able to access rapid response teams quickly in the event of an emergency. Staff stated that they had direct access to make quick referrals to rapid response teams (an urgent care team which worked in the community with patients to prevent admissions to emergency services).
- Inspectors observed handovers at district nursing bases and found the communication to be effective and important information easy to transfer. The meetings had MDT input (tissue viability, physiotherapy) available when discussing patients and progress, and risks were discussed as part of handover. District nursing bases used a standardised template for recording handover, which facilitated the easy transfer of information.
- Inspectors found insufficient governance structures in place to monitor the completion of risk assessments and the quality of notes taken following assessments. District nursing staff stated that there were no processes in place for measuring performance in relation to risk assessments. Staff stated that the trust and managers rely on staff feeding back to them about patient needs and rely on risk to be managed, but do not have effective systems in place to monitor this.

Staffing levels and caseload

- We found high vacancy rates across all services within community health services for adults, leading to sustained use of agency staff for long periods. The trust reported an overall vacancy rate of 19% in the three months between August and October 2015 for community health services for adults, with a staff turnover rate of 17% in the same period. Directors confirmed vacancy rates of between 15% - 40% in some areas, with district nurses for services in Waltham Forest, Essex and Redbridge particularly difficult to recruit. The trust managed staffing shortages by increased use of bank and agency staff to fill shifts. In many cases, agency staff used by the trust had been filling shifts as regularly as permanent staff.
- Staff we spoke with felt that the agency staff did not always have the required competencies to meet the needs of patients. Agency staff were required to complete a competencies checklist before working and regular staff carried out a dual visit with agency staff to do a competency check. However, staff stated that when agency staff did not have the competencies required this put more pressure on the permanent nursing staff to take on the more complex patients. Agency staff were also unable to outcome their community visits on the ERS, which had resulted in a backlog of patient records waiting to be updated.
- Service managers stated the process for organising agency staff was difficult and caused delays in filling shifts. Managers stated each request for agency nursing cover needed to be signed off by the Locality Integrated Care Director (ICD), however before this request could be submitted staff were required to seek an available member of staff from another team. Managers stated that although requests were rarely turned down, this process result in delays in filling shifts.
- Key staff indicators (sickness and turnover) were provided for the Trust from October 2014 for October 2015. Over this period, the Trust had 5% sickness rate across community services against a target of 4%. This was highest in Havering integrated care teams One, Three, and Five (7%, 13%, and 7% respectively), and Redbridge integrated care team Three (7%). District nursing staff stated in focus groups that staff sickness rates and turnover had been high and put more stress on the remaining teams.
- Staff stated that there were long waiting times before new recruits could start in post, sometimes as long as six months. Staff, including Allied health professionals and managers, stated there were long standing issues with HR in signing off references and confirming applicants to available roles. Staff stated this had resulted in people accepting roles, but leaving before they start as they accept an offer of employment elsewhere that started sooner. Assistant directors for localities stated that this had improved since the introduction of 'TRAC' (employment monitoring system), and that Human Resources had been going through a reorganisation. Managers in Waltham Forest had developed their own recruitment team to address some of the blockages holding up new recruits from starting.

Requires improvement

Are services safe?

- District nursing staff across the trust stated that many of them did not wish to join the staff bank roster, as it was not equitable for them to do so. Staff stated they were not paid for their band when filling bank shifts, which they felt created tension when agency staff would be paid much more. Assistant directors stated that in their boroughs some staff have come off the bank roster due to the pay issue.
- Frontline and senior staff stated that it was difficult to retain staff in some areas of the trust due to differences in pay from the Inner or Outer London weighting. Barking & Dagenham staff qualified for Inner London weighting, while Havering, Redbridge and Waltham Forest qualified for outer London weighting (Essex staff did not receive additional weighting). This meant that there was a pay discrepancy amongst staff doing similar work based on the locality they worked in, and it was difficult to retain staff who were willing to travel slightly further for a better salary.
- Staff and managers we spoke with stated they have been working together across the trust in relation to addressing the recruitment issues. In Essex and Waltham Forest the teams had run a number of recruitment events within the localities to attempt to attract local people to roles (an idea was suggested by staff in consultation) and the teams were also developing links with local universities to raise awareness of available posts amongst students who would soon be qualifying.
- Staff across the trust recognised the difficulty in meeting the capacity of the caseload while staff vacancies rates were high. Frontline staff, allied health professionals and managers all stated working extended hours and days off to meet the needs of the population. Staff stated that they would often have to prioritise patient visits, which meant missed appointments for patients with less complex needs due to lack of capacity. Staff stated they felt this was a risk to patients as they were not receiving the treatment required to improve their health, and could deteriorate between appointments. District nursing staff in bases we visited saw between 10-15 patients a day, with a caseload of between 90-110 patients across an individual team, which staff stated was difficult to complete over a single shift and unsustainable in the long-term.
- Staffing shortages in community health services for adults were identified on the trust risk register and senior managers were aware of the challenges the vacancies presented. Staff we spoke to stated they were encouraged to record staff shifts that were not filled by either bank or agency staff on the incident reporting system.

Managing anticipated risks, major incident awareness and training

- Staff we spoke with were able to identify major incidents that had been included in the major incident policy and the trust lead for major incident planning. Inspectors observed that staff were able to quickly find the major incidents policy on the Trust intranet, and staff we spoke with stated the policy and procedures for adverse events were well planned.
- The rapid response teams across the trust had good lone working procedures in place to protect staff. Triage nurses on shift for rapid response services were able to identify where all staff were in their area. This facilitated getting the nearest staff member to patients as quickly as possible, as well as monitoring the safety of staff. All staff checked out at the end of the day through the triage nurse.
- The trust had a lone working policy; however, there was a lot of variation across localities in the lone working process for district nursing, some of which did not keep staff safe. District nursing staff in Essex had a system that identified community staff on maps, and admins in the nursing bases would contact team members by phone if they were not back when planned. However, in Barking & Dagenham and Havering, staff stated there was no formal process in place for lone working but staff had a phone and could contact the base if needed. In Waltham Forest, the district nursing administrators were aware of the location of any planned visits for staff, however they did not know the process for monitoring lone workers on unplanned short-notice visits. This meant the manager was unable to monitor the risk to staff attending emergency or unplanned visits. All staff we spoke with stated that if they felt there was a risk to working alone, a colleague would be available to attend with them.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement because:

- There was inconsistent measurement and analysis of patient outcomes across services and localities. Some services and localities had very clear patient outcome measures but other services had limited evidence of measuring and monitoring patient outcomes. There was also a large backlog of incomplete outcomes, which staff stated was due to a lack of staff capacity.
- Community health services for adults were not meeting targets for supervision and appraisals set by the trust, and there was a lot of variation in compliance across different localities.
- We found long-standing issues with human resources processes, which meant delays in getting new staff into post and delays in renewing Disclosure and Barring Service checks for existing staff.
- The trust had only recently made Mental Capacity Act (MCA) training mandatory for staff, meaning many staff did not have this training. There was a lot of variation in understanding of the MCA and Deprivation of Liberty Safeguards.

However:

- There was evidence of good clinical practice in place, which was delivered in line with national guidance. There was good provision of evidence-based advice and guidance to staff, and the trust had established several groups across services to identify and disseminate best practice, such as the communities of practice (COPs) and the clinical excellence networks.
- There was effective internal and external multidisciplinary team (MDT) working and practitioners worked with other staff across services.
- The trust had developed a robust process for managing and treating pressure ulcers across the service. This had resulted in a decrease in the number and severity of pressure ulcers reported.
- The trust had single point access systems for some services.
- The rapid response team provided an alternative for patients needing emergency treatment, and could deliver joint appointments with other specialist services.

Evidence based care and treatment

- The trust had a good intranet, which was easy to navigate. Staff could access policies and corporate information and there were protocols, policies and guidance available.
- We reviewed a sample of trust policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) guidelines. Staff stated they felt the trust policies were comprehensive and included the appropriate national guidance and current best practice.
- Inspectors on home visits in the community with staff observed best practice being implemented in the delivery of care. Staff were following NICE guidelines in practice while delivering care and recording patient records. For example, nurses were observed discussing antibiotics with patients and taking a mucous sample for microscopy, in line with NICE guidelines for Chronic Pulmonary Disease. Care plans viewed by inspectors also followed NICE guidance, for example, the use of intravenous therapy (IV). Patient notes we observed detailed consent of patient, flushing of the line, observation of site of IV and patient comfort.
- The trust had developed groups to identify best practice and new ways to improve delivery of care. The trust started Communities of Practice (COPs) which were groups of staff taking a lead role for a specific area of care (e.g. frailty, mental health and learning disability) and identifying good evidenced based practice for dissemination into the teams. Allied health professionals also informed inspectors of Clinical Excellence Networks (CENs), where therapeutic staff discussed issues arising across teams and localities, and identified research to be shared. Staff we spoke with stated that COPs monitored completion of training in some areas across the Trust (for example, frailty monitored completion of dementia training) and gave examples of changes to practice from these groups.

Requires improvement

Are services effective?

- Newly diagnosed patients to diabetes services were offered educational sessions for patients with a yearly refresher (DESMOND). This was in line with NICE guidelines for type 2 diabetes. Sessions included specialist input from dietician and proper use of pumps for patients on insulin. Patients diagnosed with a learning disability receive a separate group (or one to one if needed) with visual education, involving carers, and cookery demonstrations.
- The pressure ulcer policy did not reflect recent changes in best practice. The Tissue Viability Nursing (TVN) leads we spoke with were aware that the Pressure Ulcer Policy needed updating, as the policy did not reflect changes to reporting patient harm in grade 4 pressure ulcers following an NHS England review.

Technology and telemedicine

- The Trust had established a working group to manage the use of tablets,laptop computers, and apps across community health services for adults. However, this is currently limited to some London boroughs and had issues with connectivity in areas with poor Wi-Fi reception. Waltham Forest had recently begun a trial with electronic devices for district nurses, which if successful will be expanded to other areas. In Essex, staff stated they were working overtime to complete notes at bases due to lack of connectivity in the community. The Trust was establishing the need for new mobile devices to support clinical work.

Patient outcomes

- The trust was monitoring the incident of pressure ulcers across localities and had a plan to reduce the incidents of ulcers, which the Clinical Commissioning Groups monitored. This included an update to the policy for pressure ulcers and an audit for the quality account report that highlighted pressure ulcer prevention across North East London Foundation Trust inpatient units and district nursing teams. The Trust also introduced an audit to measure compliance against the East of England SSKIN (a five-step model for pressure ulcer prevention) as this was a target for commissioners. Staff were able to identify the Pressure Ulcer Prevention policy when asked and were aware of standard operating procedures relating to pressure ulcers. Due to these changes, some areas (e.g. Waltham Forest) had seen decreases in the number of pressure ulcers in the last three months. Tissue viability nurses were available to train staff, as well as care home workers, in the use of SSKIN to facilitate better home care of pressure ulcers.
- Patient outcomes were assessed using nationally recognised outcome measures, but staff capacity and caseload pressures resulted in variability in the recording and analysis of patient outcomes across service and locations. This meant the reliability of these outcome measures was impacted. Inspectors noted inconsistency in recording outcomes for pressure ulcers and tissue viability, nutrition and hydration, pain scores, and cognition.
- Managers in Essex ran daily reports to check if patient outcomes were being recorded in the notes, however many teams reported a backlog of incomplete outcomes on the electronic records system. Managers stated that this gave them the opportunity to maintain quality of patient notes and ensure staff where accurately recording treatment. However, staff we spoke with stated that due to the vacancies, the teams did not have the capacity to complete their outcomes on the electronic records system, as they were prioritising patient care. As some agency staff did not have logins for the ERS, administrative staff were filling in their outcomes; however, they also did not have the capacity to keep agency staff outcomes up to date. This meant there was a large backlog of patient outcomes not being filled in across the trust.

Competent staff

- There were effective induction processes for newly appointed staff. Staff completed a four-day trust induction, which included completion of some mandatory training modules. Local induction included orientation tours of local workplace, allocation of a mentor, and shadowing before beginning in post. Newly recruited staff told us they were well supported and happy working at the trust.
- Permanent staff we observed appeared competent and comfortable in their roles. Inspectors shadowed home visits in district and specialist nursing and observed care was being delivered in line with best practice. Staff stated they felt their teams were experienced and had a good range of skills. If there were concerns regarding staff competencies, staff would be shadowed and supported on visits by a more experience member of the team to help improve their skills.

Requires improvement

Are services effective?

- Student nurses stated they were provided with a management placement for three of their 12 months with the team, which was intended to help retain and attract staff. The Trust supported newly qualified nurses through preceptorship, who received a mentor as part of their induction, and the Trust had specifically recruited a Practice Facilitation Manager to support student nurses development. Assistant Directors and support workers stated that the trust had introduced the Care Certificate qualification for healthcare assistants.
- Tissue viability nurses have developed an eLearning package for staff, with questionnaire testing which must be completed and passed by practitioners. Many of the competencies for new staff were completed in leg ulcer clinics supported by a senior tissue viability sister. Inspectors noted that TVN staff were able to demonstrate robust knowledge of wound healing, pressure ulcer prevention and wound dressing.
- There was good provision of emotional support and wellbeing for staff across the service. Staff stated they could access support through the mental health teams if needed, colleagues provided informal support and advice, and they had access to a health and wellbeing service which could provide counselling
- The trust provided leadership training to staff with management responsibilities. This included management training, leadership workshops and quality improvement training.
- Agency staff often did not have the required competencies to meet the needs of patients. Staff stated agency staff that would come in would often not have the required competencies to provide anything other than very basic patient care, which put further pressure on permanent staff to manage the caseload. Some agency staff in district and specialist nursing teams had received training to improve their competencies (i.e. wound care training for agency staff working in tissue viability). Agency staff were required to complete a competency checklist before starting and were shadowed by a senior member of the team before being allowed to work alone.
- The teams reported a lot of variation in completion of supervision across the Trust. The Trust had set a core service target of 85%, with an overall completion rate between April 2014 and March 2015 of 80%. Completion of supervision was lowest in Barking & Dagenham Orchard's Health Centre (33%). The trust informed the inspection team that appraisals information could not be broken down by core service. The Trust had an appraisal compliance rate of 80% against a target of 85% for the last 12 months. Managers and staff in Essex stated they met the compliance target, and this included monthly group supervision. Data on supervision and appraisals was collected by local managers and provided to the local clinical commissioning groups. Most staff we spoke to stated they received one-to-one supervision every 4-6 weeks, and that they felt supported to raise issues if they needed to. Staff stated that the impact of vacancies meant that there was less time to complete appraisals and supervision.
- Staff stated that there had been longstanding issues with Human Resources across the trust. HR had been not been completing Disclosure and Barring Service (DBS) checks in a timely manner when staff needed to reapply, while staff stated in the previous month before the inspection there had been problems with receiving holiday pay. Staff also stated there were long delays between accepting an offer of employment and starting the job, sometimes as long as six months, and people who had accepted positions had left for other roles because of the delays in starting. Assistant Directors stated that since the introduction of the TRAC system for monitoring and signing off references for staff, this had improved, but they also agreed there were delays with HR. In Waltham Forest, they had set up their own HR support team to help alleviate delays.

Multi-disciplinary working and coordinated care pathways

- Staff in London boroughs had good access to support from mental health colleagues. The trust delivered the mental health provision for London boroughs alongside community health services. Mental health nurses could provide joint visits for patients with mental health problems, and work together with district nurses when developing treatment plans. District nursing staff we spoke with gave examples where they had involved mental health colleagues, including therapy staff such as psychologists, in patient care. Staff stated in interview that there were opportunities to move between physical health and mental health within the Trust, and within Havering they had just finished a mentoring program for their first registered mental health nurse.
- There was effective internal and external multidisciplinary team (MDT) working and practitioners

worked with other staff across services. There were many examples of MDT working across community health services for adults. The rapid response nurses worked closely with therapy teams to offer joint assessments when needed. Staff in Redbridge had developed a positive working relationship with social services. In Waltham Forest, the district and specialist nursing teams was expanded to include physiotherapy, occupational therapy and psychology. However, there was a lot of variation in what MDT services were available in different localities across the trust, meaning patients across the trust did not have the same access to services.

- District nursing benefitted from the input of MDT colleagues to deliver more comprehensive care. Staff in district nursing we spoke with stated that co-location of services allowed easier access to MDT colleagues, and they gave examples of where nursing had worked together with therapy colleagues to improve treatment options for patients.
- Some trust localities had a much larger availability of MDT input. Staff in Waltham Forest, Essex, Barking and Dagenham had established their integrated care teams and had weekly MDT meetings, while integrated care had only very recently been introduced in Redbridge. This meant more established teams had made closer links with MDT colleagues to deliver services jointly.
- District nursing and rapid response teams had a good working relationship with local palliative care nursing teams. Staff in district nursing stated they had good support available from MacMillan Centre nurses, and had worked jointly with them in the past. Staff stated that although district nursing did not see many palliative patients, they were supported to make referrals (where palliative services were not provided by the trust) and get support when needed. Rapid response across the trust and palliative care teams aimed to provide a joint response to urgent patients within a 20-minute target. Patient records we observed on a rapid response visit to a palliative care patient detailed the involvement of other services and professionals involved in the care.
- Specialist nursing teams in Waltham Forest, Havering and Redbridge had developed a wound care pathway to support ease of access for patients. Tissue viability nurses (TVNs) monitored compliance of the pathway to formularies (approved medicines) and Electronic Prescribing Analysis and Cost (ePACT) data, and raised issues identified to teams. TVNs also monitored anti-microbial usage and reported to managers any inappropriate ordering or application. The Trust has also developed a cellulitis tissue viability pathway for patients in Essex.
- Staff stated in interview that there was a lot of variation in working with mental health colleagues. In London boroughs district nursing staff had a lot of joint working with mental health for high-risk patients and teams were more closely integrated. However, in Essex there was not much joint working as the mental health provision for this area was managed by another Trust (South Essex Partnership University NHS Foundation Trust). Staff we spoke with stated there was also some confusion as to what care the mental health nurses could provide, as district nurses were often contacted by mental health colleagues to complete basic care for patients (e.g. Catheter care), which a mental health nurse (RMN) should be able to deliver.
- The Trust employed multiple sclerosis (MS) specialist nurses who worked in collaboration with a neurologist from Whipp's Cross Hospital and managed patients from diagnosis. The nurses provided input into patient's care and were available to support colleagues through advice and joint visits if the patient deteriorated. MS nurses and the neurologist held weekly clinics and served three boroughs in London (Barking and Dagenham, Havering, and Waltham Forest). The team were managed by Havering neurology team, and could also provide specialist Parkinson's Disease support through a specialist nurse. These services were not available to Redbridge due to commissioning arrangements.
- Respiratory teams were well established across the Trust providing home visits and community support. Teams accepted referral from GPs, rapid response teams and district nursing, and attended monthly MDT meetings at local hospitals to discuss patients. Some respiratory teams had links with hospices, which could provide counselling to carers and patients. The teams could provide patients with classes on managing anxiety and pulmonary rehabilitation depending on their diagnosis.

Referral, transfer, discharge and transition

- Staff stated that most referral pathways started with referral by GPs and hospital-based staff. The trust used a single point of access referral system in some boroughs

for access to specialist community health services, such as tissue-viability, diabetes, and therapeutic services such as physio. Patients could access these services through a single point of contact, where clinical leads triaged referrals into the appropriate service.

- Nursing teams had positive relationships with local hospital services. Staff stated they had developed relationships with hospital services in their locality to support transitions from inpatient care into the community. Nursing staff stated they attended multi-disciplinary meetings at hospitals to support transfer of patients between services.
- The rapid response team accepted and triaged all referrals, with the most urgent appointment receiving visits within twenty minutes of referral. There were no therapists within the team but the rapid response staff did have priority access to rehabilitation teams and could offer joint assessments on the same day. The service sees 500 plus patients a month. Response can be provided within 20 minutes, with less urgent patients potentially referred to another service.
- Discharge paperwork from the trust was well completed and informative. Inspectors examined a sample of records for patients across the trust who had been recently discharged and found examples of notes being completed comprehensively for handover back to the GP. Risk assessments and notes relating to hygiene, nutrition, tissue viability, and cognition had all been completed.
- There was a lot of variation in how localities managed the relationship with GPs to facilitate referrals. In Waltham Forest, district nurses attended MDT integrated care meetings based at GP practices, which was led by community matrons. This allowed the opportunity to share information and discuss patient transfers. In Essex, GPs provided information on patients through the ERS.
- Referrals to the diabetes team across the trust were triaged into need for continued clinical appointments, educational sessions or community treatment. Services accepted referrals for type one and two diabetes, and can offer individual appointments or clinics.
- In Redbridge referrals came through a central triage centre, which staff stated had some historical issues with inappropriate referrals as there was no clinical input. District nurses confirmed a nurse is now involved in triaging referrals, where originally it had just been run by clerical staff, which led to incorrect or inappropriate referrals. Staff stated they were not consulted on the implementation of the central triage centre before it was introduced. After being received referrals were triaged following referral into urgent (appointment within four hours) and non-urgent (appointment within 24 hours).

Access to information

- Teams providing urgent care had access to local hospital systems to facilitate quick treatment. Rapid response teams in Waltham Forest had access to Barts Health NHS Foundation Trust electronic record systems (ERS), so they could view discharge summaries, results of tests, and other health information for patients quickly. Rapid response teams in other areas of the trust had similar relationships with local hospitals providing emergency services.
- In Essex, staff were provided with training to use the ERS and could communicate with other healthcare providers through the system. Staff were trained to use the ERS as part of induction, and all GP services locally could access the ERS (although some GPs were not set up to share information through the system with community services).
- The trust used two different ERS: one for London boroughs and a separate system in Essex boroughs. Most staff could only access information recorded on one ERS. For example, staff in Waltham Forest using the London ERS could access Redbridge or Havering information, but could not access the Essex ERS and vice versa. Therapies staff that worked in both areas had dual logins. Staff that worked in integrated care teams also had different ERS to their colleagues in social services. The staff we spoke with told us that the separate systems created some barriers to effective and timely sharing of patient information across teams and localities.
- We observed health professionals using the ERS and saw they were comfortable and adept at using the system. However, some staff in London boroughs told us there were problems with slow access to their system. The trust were aware of this. Staff in Redbridge stated accessing patient information could be difficult on the computers at new integrated care bases.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we observed had good practices in place relating to consent on community visits. Records viewed

in patient homes by inspectors suggested that consent was being recorded on visits, and staff were observed seeking consent from patients before being given any treatment. Nursing staff also sought patient's consent to take photographs of wounds for monitoring purposes. Inspectors observed staff requesting consent to take photographs of pressure ulcers to monitor progress and recording the consent for photographs in patient's records.

- Managers provided reminders to staff on how to access support and information on Mental Capacity Act (MCA). Inspectors observed a monthly team meeting, which included a discussion on MCA process, written information and consequences of actions. The team managers reinforced the available resources (safeguarding team, social worker) to provide support and advice in relation to the MCA. Nursing staff in rapid response teams discussed MCA knowledgably.
- Staff did not feel comfortable carrying out MCA assessments, even if they have had the training. Staff we spoke with stated that although they had the MCA training they would not feel comfortable carrying out an assessment of capacity and would ask another professional to do so or ask for support from the safeguarding team. Most staff we spoke to stated they had not completed a MCA assessment while working for the trust and were unaware of the role of clinical staff in completing such an assessment. This meant that staff may not be identifying patients that did not have capacity to consent to treatment or make decisions
- Inspectors found a lot of variation in understanding of MCA and DoLS, even from those who have completed the relevant training. Some staff stated they felt the training had not provided enough knowledge of Deprivation of Liberty Safeguarding (DoLS) and they did not understand why it was used, although inspectors observed the slides from training did contain this information. Some staff were also confused about the difference between the Mental Capacity Act and the Mental Health Act when asked.
- The trust had only recently made MCA training mandatory for community health service staff. The trust had now made MCA training part of the trust induction training, but Assistant Directors stated that there were staff who had not had the appropriate training. The trust had prioritised training for staff who delivered more urgent treatment, for example, rapid response teams, and these staff discussed MCA knowledgably with inspectors when asked.
- Staff inconsistently completed records for MCA assessments across the Trust. For example, staff in Redbridge stated that while they would record consent on RiO, they would not complete decisions using the best interests' paperwork when an assessment had been made. Patient records observed from the same area show consent had been gained (also for photos), but no formal MCA recorded, even when confusion had been noted as part of diagnosis.

Good

Are services caring?

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

Summary

We rated caring as 'good' because:

- Staff across community health services for adults were welcoming and professional. We saw staff communicating with patients with empathy and in a polite and caring way.
- Feedback from patients regarding nursing staff was universally positive, stating that staff were supportive, respectful and well-trained. Results from the Friends and Family Test (FFT) were positive.
- The feedback from patients stated staff placed an emphasis on supporting them to live as independently as possible, rather than just providing care. Staff were observed to promote self-care to patients where possible.
- Inspectors observed staff working in partnership with patients and their family members when delivering care. Staff delivered information to patients in an accessible way and ensured patients were involved in their own care.

Compassionate care

- The services users and family members that we spoke with were very happy with the care they had received from staff. Some patients stated that staff were "absolutely wonderful", "always going the extra mile", "a lovely team that works really well together" and "respectful of me and my family".
- Patients we spoke with in district nursing stated they could not get by without the support they received from the nurses, and felt staff were interested in helping them live as independently as possible.
- In the four months prior to our inspection, the Friends and Family Test (FFT) showed an average of 95% of patients would recommend the service if they needed similar care.
- The trust's overall score for privacy, dignity and wellbeing in the 2015 PLACE score was 86%, the same score as the national average.
- Inspectors observed the staff taking collaborative approaches to care, ensuring that patients were involved in decision-making and treatment outcomes were explained. Inspectors also noted involvement of family members where possible in the care of the patient.
- Rapid response teams appeared to work well with patients with learning disabilities. Inspectors observed a visit by the rapid response team to patient where staff introduced themselves calmly and explained the purpose of their visit clearly to the patient and carer. Staff supported the carer and the patient well during the visit to decrease anxiety, and inspectors felt that the practice was well adapted to meet the needs of the situation.
- Staff stated there was an emphasis within teams to use lay terms rather than medical terms with patients to help them understand their treatment. Inspectors noted on home visits that staff asked patients if they had any questions during visits, and staff provided information in an accessible manner to the patient.
- The district nursing team in Essex promoted self-care to patients where they could to facilitate greater independence. Nursing and therapy staff provided joint assessment visits of patient's mobility and activities of daily living, and provided any equipment to the patient they might need to self-care.

Understanding and involvement of patients and those close to them

- Inspectors observed staff working in partnership with patients and their family members when delivering care.
- As part of the diabetes provision staff were able to provide educational courses to patients and family members on how to manage the illness. This course was also available in other languages to meet the needs of the local population, and the diabetes team could offer information leaflets in many different languages. The diabetes team could also provide accessible information for patients with learning disabilities.
- Information leaflets developed by the Trust were visible in public areas of health centres and community hospitals. Inspectors observed leaflets which provided information on clinical services offered by the trust in

the local area (e.g. Diabetes Services, Speech and language therapy), information on self-care (e.g. preventing pressure ulcers) and additional support services (e.g. domestic violence, financial support).

Emotional support

- Inspectors observed examples of district nurses discussing coping with illness with patients and advising on what additional support is available. Staff in London Boroughs could provide information on mental health services, which could be accessed within the Trust. Staff in Essex would provide information on another trust locally, which provided the mental health services in their area.
- Staff considered the emotional support patients would need when discussing caseloads with colleagues. Inspectors observed examples of district nurses in handover discussing the emotional state of a patient ahead of a home visit. Staff we met with stated they try to be understanding and empathetic on home visits so they recognise the social and psychological needs of the patient, as well as the physical health needs.
- Staff stated that they had benefitted from therapeutic input since moving into integrated care teams. District nursing staff that we spoke with working in integrated care models (Waltham Forest and Redbridge) stated discussions they have had with mental health and psychology colleagues regarding patient care have been helpful. Staff stated that mental health colleagues were available to provide joint visits if district nursing staff felt it would improve the treatment patients received.
- District nursing teams had a good relationship with the local Marie Curie services, which provide support for end of life care to patients and their families. Staff stated they could access night sitters to remain with patients in palliative care, and the teams could provide information on bereavement services if needed.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

- Inspectors observed a lot of variation in referral to treatment times for accessing specialist nursing services across different localities. The trust did not have a system in place for monitoring referral times to treatment in district nursing.
- Although the trust was moving towards a more integrated care model and standardised practice across the different localities, we found teams were often unaware of what similar teams were doing in other parts of the trust, and there was still a lot of variation in how integrated care was delivered.
- There was a lot of variability in terms of what resources were available to meet the needs of the population in each health economy. As community health services for adults worked across different Clinical Commissioning Groups (CCGs), there was a lot of variation in how services delivered care and the resources available.

However:

- The trust set up an award-winning Ethnic Minority Network to promote and embed diversity and inclusion within the culture of services, and was the first NHS trust to develop an Ethnic Minority Strategy.
- The Trust had a robust system in place for collecting and responding to complaints. Information from complaints was feedback to staff in team meetings.
- There was good access to translation services, with good provision of patient literature in community languages and different formats. There was good understanding of the different cultural needs and backgrounds of patients.
- District nursing services across community health services for adults were responsive to the needs of patients and offered tailored clinics in areas with high demand.

Planning and delivering services which meet people's needs

- Community health services for adults was moving towards providing an integrated model of care to all patients across the Trust. This provided one-stop shops for nursing, mental health, therapy, and social services. The trust had rolled out this model to staff in Barking and Dagenham, Redbridge, and Waltham Forest, with further plans to introduce the models into other areas of the trust. Staff we spoke with stated that while there were problems to be worked out in the systems and structures of integrated teams, they believed it was the way to deliver services and had benefitted from the multidisciplinary support available to them though mental health and social services.
- Staff we spoke with recognised the importance of delivering services to meet the needs of a diverse healthcare population, which had a lot of variety across the area served and unique challenges to meet. Staff we spoke with also recognised that the issues faced by staff in one health economy within the trust did not always reflect similar experience in other geographical areas, and felt it was important to tailor services to meet the needs of local people using their services.
- The trust commissioned rapid response and community treatment teams across the Trust to alleviate pressure on local emergency services. These teamsprovided an alternative to hospital admissions, by offering urgent appointments delivered to patients in their own homes. Staff and managers stated that this service allowed patients who would normally present at Emergency Services to receive treatment in the community. The rapid response team accepted and triaged all referrals, with the most urgent appointment receiving visits within twenty minutes of referral.
- A positive working relationship existed with the local commissioners of services across the trust; however, there was a lot of variability in terms of what resources were available to meet the needs of the population in each area. Managers and local directors that we spoke with felt commissioners supported moving towards an integrated care model, however the trust covered such wide geographical area, that teams were required to work with different commissioning groups. As the commissioning groups worked separately and had different priorities, this created difference in what services were available within different areas. For example, district nursing teams in Havering, Redbridge

and Essex ran leg ulcer clinics for patients to attend, while this service was not available in Barking and Dagenham. This meant patients in Barking did not have the same ease of access as patients in Essex.

- Although the trust was moving towards a more integrated care model and standardised practice across the different localities, we found teams were often unaware of what similar teams were doing in other parts of the trust. Staff we spoke with stated that they were aware of working going on within their local area, however did not have much opportunity to meet with similar staff in other areas to share learning or practice.

Equality and diversity

- Translation services were accessible for patients and family who had difficulty understanding English. This included direct access to interpreters and telephone translation services in clinics and therapy sessions. The trust advertised translation services on posters in different languages throughout health centres and community hospitals.
- Leaflets developed by the trust were available in different languages to reflect the demographics of East London and Essex. Some service literature contained pictorial demonstrations to remove language barriers.
- The trust set up an Ethnic Minority Network to promote and embed diversity and inclusion within the culture of services, and was the first NHS trust to develop an Ethnic Minority Strategy. Staff we spoke with felt positive about the diversity and representation of staff within the Trust, stating that it reflected the local population well. The Ethnic network won the Employee Race, Ethnicity and Cultural Heritage Network of the Year at the Inclusive Networks Awards in autumn 2015.

Meeting the needs of people in vulnerable circumstances

- District nurses were responsive to the needs of end of life care patients in the community. Inspectors observed an assessment of a patient with respiratory symptoms, and observed a positive discussion between the patient and the nurse regarding additional support required by palliative care team. The nurse involved displayed good communication with the palliative care team and the GP to support further assessments of the patient's health.
- Clinics in areas where they had identified high numbers of patients requiring regular care allowed community staff to see more patients during shifts than if they offered individual appointments. For example, in Essex the district nursing team had set up weekly clinics in nursing homes to provide easier access to care. The Essex district nursing service also ran a leg ulcer clinic 5 days a week, which was available to patients at a subsidised cost.
- The trust had a process in place for auditing the quality of care received by patients with a learning disability. The trust had learning disability services for adults available across London Boroughs and Essex, and used the Green Light self-assessment toolkit to audit the support available for people with autism spectrum disorders and other learning disabilities. The trust also had a learning disabilities lead, who could provide support and advice to staff, and a Community of Practice (COP) for reviewing and improving mental health and learning disability (LD) care.

Access to the right care at the right time

- The rapid response teams were able to provide urgent support to patients in the community that otherwise would be admitted to hospital. Rapid Response were on call and available through the Single Point of Access team five days a week. Rapid Response provided more staff on Fridays, bank holidays, and other days where managers anticipated the service may see increased demand. Staff stated this helped to alleviate pressure on teams and allow more access to care for patients.
- The trust provided patients with an incorrect contact number for the new base for district nursing in Redbridge, potentially delaying their time to treatment. As the Redbridge nursing team changed bases to join integrated care colleagues, the teams provided the new contact telephone number to patients on printed cards or by phone call. Staff were informed after moving that the number provided was incorrect, and patients had been unable to reach the team. Staff stated this raised concerns that patients would have been unable to reach support if needed and referrals would not get through. The assistant directors stated there had been problems with telephones during the move, but these problems had been quickly resolved and patients informed.
- Inspectors observed a lot of variation in referral to treatment times for accessing specialist nursing services across different localities. This difference was affected by the number of available services within the locality, the interventions offered, and if regular clinics were available. For example, Diabetes services in Waltham

Requires improvement

Are services responsive to people's needs?

Forest had a waiting list of three to four weeks for non-urgent cases, (but more severe cases could be seen with no waiting list), while diabetes services in Essex could be seen more rapidly as there were more clinics available across the area.

- Although rapid response could provide a quick intervention to patients needing urgent care, the team did not have sufficient specialist input to support complex cases. Staff we spoke with stated the team did not have the clinical expertise to manage Multiple Sclerosis (MS) and respiratory illnesses. This meant patients experienced delays receiving treatment and would be admitted to hospital, as they could not be supported in the community.
- The trust does not have a system in place for monitoring referral times to treatment in district nursing. The trust stated they do not routinely record referral response times to visit patients in district nursing, as these are dependent on clinical risk assessments. This made it difficult for the trust to establish if they were meeting targets for providing access to treatment for patients in a timely way. Staff we spoke with stated that district nursing services did not have waiting lists, and the team would arrange a visit for a patient as soon as possible.

Learning from complaints and concerns

- Inspectors observed comment and suggestion boxes located in community health centres and hospitals. Inspectors also observed posters and leaflets on how to make a complaint and these were provided in different languages.
- The trust recorded 1,717 compliments in the 12 months leading up to the inspection. Of these, 981 compliments related to "Unplanned Care, Essex", services that prevented unplanned emergency admissions for patients.
- Complaints are reviewed in team meeting by staff to identify recurring issues and themes. Staff stated in discussions with inspectors that managers fed back on complaints they received either through team meetings or in supervision, depending on the nature of the complaint. Following complaints, staff members had sometimes completed a reflective learning tool to help reflect together on key learning. However, staff in some areas stated that although complaints were reviewed in team meetings, they did not often hear back regarding outcomes or changes to practice.
- Trust data demonstrated that community health services for adults received 34 formal complaints in total from May 2014 to December 2015. Seven of these were fully upheld and 16 were partially upheld. No complaints were referred to the Ombudsmen. Six of the 34 complaints received related to the Integrated Community Teams in Essex.

Requires improvement

Are services well-led?

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

Summary

We rated well-led as requires improvement because:

- There was no clear, documented vision for the service as a whole and operational staff were not clear about the strategic direction.
- There was not a structure in place for effective governance or risk management. Community health services for adults did not have a robust system of audit or means for measuring quality or performance across services.
- Staff in some areas did not feel consulted as part of the move to integrated care services. Staff felt that the move was not well planned and that their concerns following the move had not been listened to.
- Action plans that had been developed following audits had not been actioned or monitored.
- It was not clear how the service was represented at trust board level, nor was it clear to inspectors who was ultimately accountable for adult community health services within the trust.
- Many of the staff we spoke with told us they felt more connected to their locality than to the wider trust. Staff did not have much connection to teams doing similar work in other areas of the trust.

However:

- The staff we met told us that they felt cared for, respected and listened to by their colleagues and line managers. We saw examples of good local management in place despite challenging circumstances.
- The executive team and local trust leads were visible across services and were available to meet with staff through a number of initiatives.

Service vision and strategy

- The trust ran "communities of practice" (COPs) to provide multidisciplinary strategic leadership and develop new ways of working on specific areas of healthcare such as frailty and mental health and learning disability. The COPs comprised of a clinical lead, operational lead and nursing lead, as well as other interested staff, to coordinate corporate strategies, develop new care pathways and lead audit and evaluation. Staff we spoke with stated that information on new practice regularly came from COPS into the teams.
- The majority of staff interviewed were not clear on the values of the trust. Staff in general had an understanding of the trust strategy to move towards integrated health care and felt this was a positive step, but most staff were unaware of the Five Values (People first, Prioritising quality, Progressive, Professional and honest, and Promoting what is possible).
- The trust did not have a cohesive strategic plan for the future of community health services that included progress for all localities. The trust had a plan to move adult community services towards a model of integrated care, however there was a lot of variation across the trust in how this had been implemented. Some services had moved to fully integrated models (such as Waltham Forest and Redbridge), however other boroughs were waiting to see the outcome of other integrated care models before moving forward (such as Havering). Inspectors saw no evidence of a single strategic document for the development of these services.

Governance, risk management and quality measurement

- Assistant Directors attended monthly performance, quality, and safety group meetings with set agendas to discuss performance data, finances, serious case reviews, new guidance, and operational reports from each service. Staff in local teams stated they met every four to six weeks to discuss Key Performance Indicators (KPIs), serious case reviews, and commissioning targets.
- Some boroughs had established their own governance structures to meet the needs of the service. In Waltham Forest, the district nursing team had set up local audits to measure quality. The team locally audited ten sets of patient records quarterly to assess the quality of records

and how performance could be improved. The team also ran a quarterly infection control audit. The staff discussed results in team meetings and used the information to improve the delivery of service.

- The trust ran an annual healthcare records audit to assess data quality across the trust, however there was no regular ongoing monitoring for the quality of health records. Staff stated the trust completed the annual healthcare audit for both paper and electronic records by collecting a sample from each team and analysing the quality of the samples. The trust made results available each December and this was provided to teams for information. However, inspectors did not find evidence of any further ongoing monitoring of healthcare records at a service-wide level. Assistant Directors we spoke with stated that they had done some local audits in the past but could not identify any further robust systems of audit or clinical governance in place across community health services for adults.
- Inspectors observed actions identified in audits were not completed by teams in time to meet deadlines. Inspectors observed that staff in Redbridge had conducted an audit in response to a serious incident from October 2015, with action from the audit due to be completed in January 2016. Actions included ensuring staff had read a policy and completion of an additional audit. Inspectors were unable to find evidence that actions identified in the audit had been completed or were being monitored. Staff stated that the clinical audit effectiveness group manages re-audit and monitoring the completion of actions, however there was no evidence of action in relation to this audit.

Leadership of this service

- Nursing staff were aware of initiatives to meet with the trust Chief Executive and his team. Staff we spoke with stated they had the option to have breakfast with the Chief Executive ("Breakfast with John") and there were also opportunities to meet with the executive team at trust induction. The trust had also developed regular communication from the executive team through a weekly staff email, which shared information on recent developments within the trust, and the Chief Nurse's regular blog. Staff also stated they felt the directors of community services in their localities were accessible when needed and often visible around services.
- Assistant Directors for the Trust across the different localities had set up a monthly meeting amongst themselves to discuss issues and share learning and expertise across teams.
- Staff stated they felt they could access support from assistant directors within their locality when they needed to. Staff stated they felt services locally were well managed, that senior managers had run a positive recruitment campaign to attract new staff and the assistant directors often stayed late to support the team.
- There was lack of clarity around the representation of community health services for adults at trust board level. It was also not clear who was ultimately responsible for leading the service across the trust. The operational and leadership team were not consistently able to identify the structure of the service at board level, and who had overall responsibility. Trust governance documentation highlighted that integrated care directors were responsible for locality-based management, supported by associate directors. However, it was not clear if there was a director level position within the trust with ultimate accountability.

Culture within this service

- The services we visited had highly dedicated staff, often working in challenging circumstances, who were very willing to go beyond the requirements of their roles to meet the needs of the service. Staff we spoke with were passionate about the care they delivered and there was a culture of working together as a team and trying to support colleagues.
- The staff we met told us that they felt cared for, respected and listened to by their colleagues and line managers. Staff stated they were good informal support available from teammates, and there was a strong culture of teamwork amongst the staff across disciplines. The staff we met with were also positive regarding support from local line managers, particularly Band seven nursing and from the Assistant Directors. Frontline staff stated that the local nursing leads were very understanding of the challenges the team faced in terms of resources and capacity, and they often worked extra hours to support their team as much as possible.
- The trust offered staff the opportunity to move to other areas of the trust if they did not want to move into the new integrated care services. Staff in Redbridge stated that if the new integrated care bases were more difficult

for staff to travel to from home, or if the move was unsuitable in other ways, the Trust offered to facilitate a transfer to a preferred service, rather than force staff to move.

- Senior staff were proud of their teams and the support provided by staff to each other across services and locations. Assistant Directors stated the nursing and therapy teams they had worked well together and were passionate about the care they delivered, despite working with some difficult challenges in terms of vacancies and capacity. Managers also stated they had some very experienced and knowledgeable team members available to support new staff.
- The trust clearly displayed posters of its values in public areas at health centres for patients to review.
- Many of the staff we spoke with told us they felt more connected to their locality than to the wider trust. The trust was seen as a large organisation and they felt this impacted on joined up communication for staff working in seven localities, with subsequent disparity of service provision and ways of working. Some staff said they felt more connected to their team and locality than with the trust as a whole. Some staff told us they did not have much understanding of what was happening at trust level.
- Some staff in Redbridge felt pressure from local managers to continue with work in the new integrated care bases, despite concerns that the correct processes were not in place to run the service effectively. Staff stated there was pressure to get on with the work despite the environment on arrival not being fit for purpose and many vacancies in the staff team. Staff felt that this might compromise the quality of service they could deliver. Staff also told us they had concerns about the process for communicating messages to team members who were not in office after several messages had gone missing.

Public and staff engagement

- The trust consulted with staff across Essex to ask them how to improve recruitment and retention of staff in their area. Some of the staff had put forward ideas, such as holding jobs fairs to recruit local healthcare professionals, which had been actioned by the Trust and ran on a monthly basis. Essex staff were also consulted by management on the merging of the three Integrated Care Teams in the area into two larger teams. Staff stated they were informed where they could access more information on the proposed change ahead of the consultation, which the trust ran over the summer and autumn of 2015. Operational leads and managers within the teams sent out weekly update to their staff on the progress of the move, and open meetings were held locally for discussion.
- The Trust had a "You Said, We Did" initiative, which encouraged staff to contribute ideas to the Trust for development. Ideas contributed by staff were responded to by the Trust in newsletters and through the web site. Many staff we met with were aware of the "You Said, We Did" and some had contributed ideas to be actioned.
- The trust held a consultation with managers and directors for the move to integrated care in Redbridge Health and Social Care Services, however frontline staff felt uninvolved and uninformed. Senior staff stated there had been a consultation from summer 2015 regarding the move to Health and Social Care Services. In October 2015 he consultation had more engagement with Band 7 and 8 staff, including several workshops (initially only for band 8a before opening up to band 7s closer to the move), with managers expected to disseminate information to staff within their teams. Inspectors spoke to a number of district nursing staff who had recently moved to the new bases for Redbridge Health and Social Care Services, who felt frontline staff were not part of the consultation process and the staff were concerned an unprepared move could impact on quality of care. Staff were given one week of notice ahead of the move, and felt when they arrived the environment was not fit for purpose. Many staff we spoke with including managerial staff stated that the move could have been communicated better, and they were unsure if there would be changes to staff jobs in the new integrated care model or if jobs were at risk.
- All community health services staff completed a monthly patient satisfaction survey with five recently discharged patients. Staff members asked patients five questions and results were collated to inform future team meetings and practice. Results and key messages were displayed on staff boards across the teams. Some staff stated the use of the telephone questionnaires for patients needed to be reviewed as it seemed like "cold calling", and this could produce anxiety for vulnerable people in care.

Innovation, improvement and sustainability

Requires improvement

Are services well-led?

- The Diabetes team in Essex developed a number of initiatives to meet the needs of the local population more effectively. The team provided Skype appointments and telephone assessments depending on patient needs, and texted blood results to patients to spare them an appointment. The team is also looking at apps to facilitate providing information, monitoring and instruction to patients on managing their illness. The team had two articles published in diabetes journals in the past three years.
- The Tissue Viability service in Essex developed a "passport" which is a template used to draw together pressure ulcer assessment and care information for patients. This supports easier access to information for other professionals involved in the patients care and follows the progress of a pressure ulcer as it heals or deteriorates.
- The service was involved in the development of a new treatment for dementia in collaboration with University College London researchers. Cognitive stimulation therapy provided patients with mild to moderate dementia stimulation in a social group setting, which improves thinking, concentration and memory. The treatment is the only non-medical therapy endorsed by UK government guidelines for the cognitive symptoms of dementia.
- The community treatment team worked closely with local acute hospitals to reduce emergency admissions to hospitals for patients, who were treated in their own homes. The service has been highly commended and has won a national patient safety award in partnership with London Ambulance Service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff did not follow policies and procedures in relation to the safe administration and recording of medicines. Staff in Redbridge did not consistently use medication charts to record administration and prescription in patient notes. **This was a breach of regulation 12(2)(g)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • There was not an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. There were insufficient governance structures in place to monitor the quality of patient records and a lack of measuring and comparing quality and performance across services. • The services did not consistently maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The staff did not consistently complete risk assessment documentation in patient notes. **This was a breach of regulation 17(2)(a)(c)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

- Community health services for adults were not meeting targets for supervision and appraisals set by the trust, and there was a lot of variation in compliance across different localities.

This was a breach of Regulation 18(2)(a)