

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)
	Brentwood Community Hospital	Tissue viability, epilepsy, Parkinson's disease, dementia, intensive crisis support, speech and language therapy.	CM15 8DP
	Grays Court Community Hospital	District nursing, community health and health care service, community treatment team, neuroscience specialist nursing, falls service.	RM10 9SR
	Harold Wood Polyclinic	Physiotherapy, long term conditions centre, community rehabilitation.	RM3 0AR; RM3 0DU
	Orsett Hospital	Minor injuries unit, Anthony Wisdom Centre for sexual health.	RM16 3EU
	Thurrock Community Hospital	Rapid responses assessment service.	RM16 2PX
	Billericay Health Centre	Nutrition and dietetics.	CM12 0BJ
	Harold Hill Health Centre	District nursing.	RM3 9SU
	Health and Social Care Seven Kings	District nursing, community health and social care services.	IG2 7SR
	Vicarage Field Health Centre	Physiotherapy.	IG11 7NR
	Oliver Road Polyclinic	Sexual and reproductive health.	E10 5LG
	Porters Avenue Health Centre	Intermediate care therapy, long term conditions service, respiratory team, MSK, orthopedics.	RM8 2EQ
	Phoenix House	Integrated community teams.	SS14 3EZ
	Woodbury Unit	Rapid response assessment service.	E11 1NR

# Summary of findings







This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust (NELFT). 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 NELFT and these are brought together to inform our overall judgement of NELFT.

# Summary of findings

## Ratings

Overall rating for the service	Good	
Are services safe?	Requires improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

# Summary of findings

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# Summary of findings

## Overall summary

### **Overall rating for this core service:** Good

North East London NHS Foundation Trust provides adult community health services across parts of London and Essex. This includes 45 distinct specialties or services including district nursing and integrated care teams. To come to our ratings we spoke with 20 patients, eight relatives and carers and 56 members of staff in a variety of roles. We observed 13 home visits and reviewed over 300 individual items of evidence.

We last inspected this service in April 2016 and rated it requires improvement. This reflected concerns about the documentation of medicines and risk assessments, a lack of consistency in staff appraisals and ineffective governance systems.

Overall we rated adult community health services as good because:

- There were a number of strategies and programmes in place to improve patient safety, which were led or supported by a dedicated harm free care team. This work had resulted in reduced falls and pressure ulcers and an improved early warning scores system.
- Staff recruitment remained a significant challenge for the trust. For additional shifts, 41% were filled by agency staff and 59% by bank staff. However, some teams had restructured to enable staff to better manage workloads, and strategies were in place to improve retention and make the recruitment process more efficient.
- There was significant evidence that care and treatment was based on best practice national and international guidance. Clinical teams used research, pilot projects and audits to benchmark their standards of care.
- There was consistent use of multidisciplinary working and coordinated care and treatment pathways for patients in all areas of the trust.
- Staff had access to specialist training and clinical competency development on a regular basis.

- During all of our observations and home visits we saw staff treated patients with care, compassion and kindness.
- There was a consistent focus on adapting services to meet the needs of local people. This included through service redesign and adaptation as well as ensuring care was delivered in line with equality and diversity priorities.
- The dementia crisis support team had developed and implemented an innovative model of care for patients that improved access to specialist services and reduced mortality and hospital admissions.
- Individual teams implemented projects to improve access, including restructuring and improving assessment methods.
- There was evidence of learning from complaints including the implementation of new policies and practices.
- Local clinical governance processes had been improved and a quality improvement and monitoring system had been established. As a result there were clearer links between locality teams and the trust board.
- The strategic patient experience partnership had a demonstrable role in quality improvement and took the lead in strategies and projects to improve patient experience.

However:

- Only one locality team met the trust's target of 85% for completion of appraisals.
- Completion of mandatory training was variable between teams and localities.
- There was a lack of evidence that action plans from audits were consistently followed up or implemented.
- Although clinical governance processes had improved, some staff did not feel part of the trust. Results from the 2016 staff survey indicated a number of areas for improvement.

# Summary of findings

## Background to the service

### Information about the service

North East London NHS Foundation Trust provides adult community healthcare services in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest and the Essex boroughs of Basildon, Brentwood and Thurrock. The trust employs around 7000 staff and between October 2016 and September 2017 adult community health services recorded 1,272,921 patient contacts including face-to-face and telephone contacts.

Adult community services are managed on a locality basis with specialist directorates. Each locality has district and community services and London boroughs have integrated care teams. The trust provides services in a number of clinical specialties such as diabetes, tissue viability and nutrition and dietetics. Integrated care teams worked with mental health and social care colleagues to deliver coordinated services. Two sexual health services were part of the trust at the time of our inspection and were in the process of retendering to other providers.

## Our inspection team

### Our inspection team was led by:

Inspection manager: Max Geraghty, CQC

The inspection team included two Care Quality Commission (CQC) inspectors and a number of specialists, including community nurses, community physiotherapist, a pharmacist, a safeguarding nurse for adults, and an Expert by Experience.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme, to follow up the progress of the service following our previous inspection in April 2016.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

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

We spoke with 20 patients, eight relatives and carers and 56 members of staff in a variety of roles. We observed 13 home visits and reviewed over 300 individual items of evidence.

## Good practice

- The harm free care team provided a multidisciplinary, sustained improvement to safety performance that demonstrated improved patient outcomes and

experience. This included through a highly active pressure ulcer investigation group and engagement

# Summary of findings

with staff and patients. This team had reduced pressure ulcers by 45% between November 2015 and September 2017 and had achieved a falls rate 81% lower than the national average.

- The strategic patient experience partnership worked to an established and governed policy and in 2016/17 achieved 2554 hours of patient involvement and engagement activities. This group attended new staff interviews and represented the needs of patients to drive quality improvement. Patients attended board meetings to present their experiences of care in the trust.
- The dementia crisis support team had implemented an innovative model of first responder care that reduced pressure on hospitals and improved patient outcomes.
- Staff reporting a pressure ulcer in their service were invited to present the care at a pressure ulcer

investigation panel as part of an engagement and learning process. The whole team responsible for the patient attended the panel, which was held as a roundtable event to enable each team to learn from each other. This approach had contributed to a 45% reduction in pressure ulcers between November 2015 and September 2017.

- The tissue viability team had completed a three-month study to improve pressure ulcer care. The pilot scheme had saved a total of 1156 district nursing hours and as a result the study leads were developing an innovative care framework.
- The safeguarding team had developed and implemented an innovative training scheme that utilised actors to help staff complete mental capacity assessments with patients who had complex needs.

## Areas for improvement

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

#### Action the service **MUST** take to improve

The trust must ensure staff are given regular supervision, including clinical supervision, and appraisal. Regulation 18 (2)(a)

#### Action the service **SHOULD** take to improve

The trust must ensure agency staff, including agency nurses, have documented evidence of their clinical competencies.

The trust should ensure audit action plans are followed up and improvements or changes to services documented and monitored.

The trust should ensure all staff, regardless of work location, have the opportunity to provide feedback and engage with senior teams.



# 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:

- A lack of oversight for agency nurses remained and we did not find that agency nurses were appropriately checked for their clinical competencies.
- There was inconsistent understanding of the role of the safeguarding team in some localities and teams.
- Mandatory training rates, including safeguarding, were variable across teams and localities.
- Although we saw good standards of medicine management during our inspection, audit data suggested there were still areas for improvement. For example none of the six community health teams audited were fully compliant with the trust's policy standards for missed doses.

However:

- The trust had implemented initiatives to reduce the staff vacancy rate and a number of teams were fully staffed with no agency staff use.

- The trust had taken steps to address severe staffing shortages that we highlighted at our previous inspection.
- We found continual improvements in the quality and consistency of risk assessments.
- The trust had standardised lone working policies and we found safe systems of work were in place for all staff, which had been tested and implemented with evidence they worked well.
- A harm free care team had made significant improvements in patient safety with sustained reductions in pressure ulcers and falls.
- There was an embedded culture of incident-reporting and staff said they were empowered to raise safety concerns. There was a consistent track-record of structured incident investigation and root cause analyses that led to improved practice.

### Mandatory training

- Mandatory training compliance varied by team. In Brentwood and Basildon, 90% of staff had up to date manual handling of people training. This was an average and 100% of the dementia crisis, epilepsy

## Are services safe?

nursing, tissue viability and Parkinson's disease teams were up to date. There were variances in compliance with fire safety training, from 75% of the Parkinson's disease team to 100% of the epilepsy nursing team

- Staff on Thorndon Ward in Brentwood had a 91% compliance rate with mandatory training.
- The minor injuries unit team at Orsett Hospital had 100% compliance with mandatory training and each member of staff was scheduled to attend Mental Capacity Act (2005) and Deprivation of Liberty Safeguards training that had been updated in July 2017.
- We saw mandatory training was a standing agenda item in team meetings. However there was limited evidence this was discussed in detail or what support was given to staff. For example in 17 examples of team meeting minutes we looked at there was a standard statement included that all staff should complete training. Some meeting minutes indicated individual staff members who were to complete training module.

### Safeguarding

- A dedicated safeguarding team operated a duty line between 9am to 5pm Monday to Friday. Outside of these hours staff were directed to the trust safeguarding intranet site and the local authority. A member of the safeguarding team visited clinical staff across all services on demand to provide support in completing patient protection plans. Although this team was available to all services in the trust, some staff were not aware of the team and said they referred to local safeguarding services provided by the local authority or other NHS providers instead. This meant although patients were cared for by appropriate professionals, the trust did not have a consistent system for managing and monitoring safeguarding referrals across all sites.
- Staff we spoke with in all services demonstrated appropriate knowledge of local safeguarding referral pathways and specialist teams. Where staff worked in centres that delivered care and treatment to patients under more than one clinical commissioning group, they demonstrated how they ensured they used the correct referral processes.
- Staff liaised with the trust's safeguarding team and local services to ensure care was coordinated and appropriate. Individual services had developed local processes to meet their patients' needs. For example the health advisor in the Anthony Wisdom Centre (AWC) completed an incident report for each young person

under the legal age of consent who presented with a sexually transmitted infection. In addition they made a referral to the local child safeguarding team who then worked with them to identify if there was a safeguarding risk.

- Electronic patient record systems (EPRS) included a discreet visual flagging system so staff could identify patients who were at risk. This included reception staff at the first point of contact. Some teams could also submit safeguarding information instantly through shared electronic systems. For example we saw when a child with known child protection concerns presented at the minor injuries unit at Orsett Hospital; reception staff were able to inform other professionals such as their school nurse and health visitor through the EPRS.
- Where sexual health clinics did not have both male and female doctors available on a shift, the nurse in charge ensured a trained chaperone was always available. For example if only male doctors were available on a shift, there was always a female chaperone available. Chaperones were routinely available in all other services and all patients with a learning disability had a chaperone for appointments.
- Safeguarding was part of the trust's mandatory training programme and the trust determined the required level of training for each team based on national standards. Each service or clinical lead also influenced this based on the needs of their team and patient population. For example in the Anthony Wisdom Centre staff working at bands 3 or 4 completed level 2 safeguarding and staff at bands 5 to 8 completed level 3 safeguarding.
- Amongst the Basildon and Brentwood community teams, 59% of staff had up to date safeguarding adults enhanced training. These were average figures and training rates for individual teams varied significantly. For example 33% of the tissue viability team had up to date safeguarding adults enhanced training and 100% of the dementia crisis team, Parkinson's disease and tissue viability teams had safeguarding adults recognition and referral training. Child safeguarding rates were also variable. For example 100% of staff had completed child safeguarding level 1 training and 88% of staff had child safeguarding level 2 training. This included 100% of staff in the dementia crisis and epilepsy nursing teams and the Parkinson's disease team. In the same locality 93% of staff had completed the government's national Prevent training, which

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relates to recognising signs and risks of radicalisation amongst patients. This included 100% of the dementia crisis team, epilepsy nursing team and tissue viability team.

- In addition to the trust's safeguarding processes, individual services developed templates and pathways that were specific to their patient groups. For example the family planning, sexual health and community gynaecology team at the Oliver Road Polyclinic had developed safeguarding pathways for female genital mutilation, domestic violence and child sexual exploitation.
- We saw from looking at the investigation of a safeguarding incident report that staff at all levels were proactive in raising concerns with relevant teams, including when multiple organisations provided care for a patient. For example, when a patient had been placed at risk due to a combination of inappropriate care from a home care agency and an ambulance service, a district nursing team liaised between agencies to ensure the patient received appropriate care. However, this was not always carried out consistently. For example the outcome of a serious incident (SI) highlighted that there was no coherent process or established guidance for coordinating safeguarding enquiries with social care teams. The investigation noted this sometimes resulted in chaotic situations for staff and had a subsequent impact on patient care. In response the trust board developed an adult social care pathway that would lead to a policy for multi-agency safeguarding referrals.
- The safeguarding team completed two audits in 2016/17. The first audit found 100% compliance with the trust's 'making safeguarding personal' policy. The second audit was to identify the quality of advice given by the specialist safeguarding adult practitioners. The audit found a need for improved signposting and advice with regards to section 42 enquiries. The results of both audits were shared with staff through safeguarding link practitioners.
- In July 2017 the safeguarding adults team lead completed a safeguarding service evaluation. The results indicated a significant improvement in utilisation of the team's intranet page, from 16% of staff in 2016 to 54%. The audit identified a need for improved engagement with trust staff in relation to communication and access to the service. We saw an action plan was in progress to achieve this and was due to be completed in December 2017.

## Cleanliness, infection control and hygiene

- Infection control link practitioners were in post in some areas. For example in the AWC link practitioners worked to evidence-based practice issued by the Department of Health in 2007 in relation to local policy for uniforms and work wear.
- We saw from observations in clinics and in people's homes that staff provided care and treatment with a consistent standard of infection control and prevention. For example clinical staff washed their hands and used antibacterial hand gel at appropriate times and also used personal protective equipment.
- The trust undertook an annual audit of infection control standards against the guidance of the Department of Health code of practice for the prevention and control of health care associated infections. The latest results were collected between April 2016 and March 2017 and indicated wide variances in compliance with trust policy, ranging between 57% and 100%. The audit identified two areas for improvement. This included improving compliance with infection control standards by agency nurses and hand hygiene standards by staff with minimal clinical contact.
- Some of the buildings used by the trust were in a poor state of repair and presented challenges to staff in maintaining appropriate standards of infection control. This included the prosthetics service in Harold Wood and services offered from Orsett Hospital. We spoke with the trust about this at the time of our inspection and were assured full infection control audits would be undertaken immediately for these sites.
- Infection prevention and control was part of the trust's mandatory training programme. In the Brentwood and Basildon team overall compliance was 93%. The tissue viability, epilepsy nursing and dementia crisis teams had 100% compliance with 75% up to date training in the Parkinson's disease team and 92% in the phlebotomy team.

## Environment and equipment

- A service lead led a dedicated community equipment team, which provided equipment support for clinical services in each area. The team included equipment coordinators, community response technicians and operatives as well as an administration team.

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- Healthcare assistants (HCAs) in the AWC took lead roles in preparing the clinic for patients each morning. HCAs followed a preclinical procedure checklist to ensure this was completed consistently and safely, including in the preparation of liquid nitrogen bottles.
- A biohazard spill kit was stored in the AWC and all of the items in the kit were within their expiry date.
- We checked a sample of equipment and environments across all of the areas we inspected and found variable standards. For example in Thorndon ward commodes, hoists, stands swivels and fridges were maintained and had documented checks. There was room for improvement in the documentation of safety checks on resuscitation equipment in the Seven Kings health and social care service. This was because weekly checks were only carried out on the defibrillator and battery and not other emergency equipment. In addition there was no oxygen available in this unit.
- The trust carried out an annual audit in line with the code of practice for the prevention and control of health care associated infections, the Medicines and Healthcare Products Regulatory Agency management of medical devices, the national specifications for cleanliness in the NHS and Department of Health Health Building Notes. The latest audit was completed in 2016/17 and did not include any learning points or lessons learned. Three areas for improvement were identified including improved reporting processes to the estates department, a replacement programme for fabric furniture and better monitoring of external cleaning contractors. However, we did not find that the outcomes had been acted upon. For example, external contractors did not complete cleaning checklists consistently completed in all areas. For example, there were no cleaning checklists available for the minor injuries unit at Orsett Hospital but a weekly checklist was available for the AWC in the same building. This meant staff in the minor injuries unit could not demonstrate equipment was appropriately cleaned and disinfected. This unit had fabric chairs in some patient treatment rooms, which presented an infection control and contamination risk.
- The minor injuries team at Orsett Hospital provided an on-call emergency service to all departments as part of the crash team. They were able to respond to patients with chest pains and had access to emergency equipment including a defibrillator and grab bag.
- Staff in the minor injuries team at Orsett Hospital used a deteriorating patient protocol to ensure those with serious conditions were monitored and prioritised for treatment. We saw this worked well in practice when a patient who was experiencing difficulty breathing presented in the unit.
- All clinical staff were required to complete basic life support training and non-clinical staff had the option to undertake this if they wanted to. Compliance rates with this training were variable. For example in Basildon and Brentwood 81% of staff had this training. This reflected a range from 100% of the epilepsy nursing team to 67% in the Parkinson's disease and tissue viability teams. Staff in some services had more extensive training. For example all clinical staff in the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic had completed immediate life support training.
- District nurses told us daily handovers were useful to share learning about specific case and ensure patients whose needs had changed were reviewed. We observed three handovers and saw they were well structured and included opportunities for learning and sharing.
- RRAS teams used a series of risk assessments to structure home care for patients considered to have safeguarding risks or complex behavioural needs. The team worked with colleagues in mental health services and social services to ensure risk assessments were appropriate and multidisciplinary. Risk assessments were part of a triage system to identify which patients had the highest level of need according to a red amber green warning system.
- Processes were in place to ensure the safety of trust staff and patients where services were offered in buildings operated by other providers. For example at Orsett Hospital, security staff completed hourly patrols and housekeeping staff were available at all times services were open. A site manager was available at all times the service was open.
- We saw from our observations of home visits that staff supported patients to manage risks relating to their treatment. For example on one home visit the patient

### Assessing and responding to patient risk

- Emergency equipment was located in most clinical areas. This included resuscitation trollies, defibrillators and oxygen. Some services such as the AWC had an emergency grab bag and stocked adrenaline.

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had a sharps bin in their home. The district nurse noticed there was a small child in the home and discussed the risk assessment with the patient and their relative to reduce the risk of sharps injury.

- The head of access and assessment at Brentwood Community Hospital had introduced clinical risk training in August 2017 and 17% of staff had completed this to date.
- We observed a pulmonary rehabilitation class and noted staff adhered to established safety protocols. This included an initial check of each patient's oxygen saturation level and continual monitoring of each individual during the gym session.
- The physical health in mental health team in the HFCT had developed and introduced a modified early warning scores (EWS) system. This resulted from a trust research programme to identify how staff cared for deteriorating patients and also brought community services in line with acute services to provide consistent assessment.
- A district nursing task and finish group was in place in London boroughs that aimed to complete a demand and capacity model to better enable teams to meet the needs of patients with increasingly complex needs. The groups identified assessing patients living in deprivation and nurse deployment strategies as key areas of focus.
- Between October 2016 and September 2017 there were 158 instances of a patient abusing a member of staff. The trust had implemented a new lone working policy that included a system staff could use to summon urgent help. All of the staff we spoke with said this worked well in practice.
- An occupational therapist based in the ICT team had developed a deteriorating patient protocol specifically for care home staff to use. This was in response to local incidents in which the team identified gaps in training for care workers responding to patients who became unwell. The new protocol included clear escalation guidance and reduced the risk of inappropriate referrals. Staff completed three awareness-raising sessions and planned to return in six months to complete an impact assessment.

### Staffing

- The average staff vacancy rate across all services was 13% in September 2017. Vacancies in individual services varied significantly, from 76% in the Redbridge stroke rehabilitation service to 22% above establishment in the Redbridge tissue viability service. Some teams were very

small with only two or three funded posts, which accounted for some of the wide variances in figures. As of September 2017, 30 individual services were staffed to their full establishment or had less than one whole time equivalent vacancy. Integrated care team services in Waltham Forest had an overall vacancy rate of 9%, which represented an improvement of 41% since our last inspection.

- In September 2017 the average staff turnover rate was 15%. From speaking with clinical leads and other senior locality staff we found individual teams had developed their own strategies to improve staff retention. This included offering leadership skills courses to support band six nurses with promotion pathways and providing rotational opportunities so staff could spend time developing skills in other services.
- The trust did not use a standardised staffing acuity or staff to patient ratio tool. As such staffing levels in each service were highly variable. For example:
  - A clinical lead, 3.5 emergency nurse practitioners, two healthcare assistants and two administrators staffed the minor injuries unit at Orsett Hospital. This team had two part time vacancies in the clinical team.
  - A team of 19 staff provided RRAS services in London and Thurrock, including two band 7 nurses, seven band 6 nurses, three band five nurses and seven healthcare assistants. This team provided care to a high volume of patients after referral. For three days in the month prior to our inspection the average number of daily referrals was 58 patients.
  - A band 7 nurse lead, two respiratory nurses, a pulmonary rehabilitation physiotherapist, an associate practitioner and a physiotherapy HCA provided the respiratory service and pulmonary rehabilitation clinic at the Porters Avenue Health Centre.
  - A team of 18 provided the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic. This included a consultant, two specialty doctors, six qualified nurses and five HCAs. Foundation level doctors also completed rotations in the clinic.
  - A consultant led the dementia crisis support team and was supported by a foundation level doctor, a senior house officer, nine nurses, an advanced practitioner and five support workers.



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- The inpatient rehabilitation ward at Brentwood Community Hospital had a 50% nursing vacancy rate, which the senior team attributed to its location and lack of London weighting pay. As a strategy to improve this, bank staff were offered block booking and training opportunities to ensure they were incentivised to provide a consistent service to the service and to patients.
- Staff in the nutrition and dietetics service in Billericay managed caseloads in line with the national safe staffing and safe workload guidance from the British Dietetic Association. The team achieved this by rotating home visits with Abbott nurse advisors for patients who received enteral feeds.
- Some areas of adult services had significant challenges with regards to staffing. For example three emergency nurse practitioners had retired within the previous year at the minor injuries unit in Orsett Hospital. To ensure continuity of service, the clinical lead had arranged for these staff to continue working on a part time basis.
- The integrated community team based at Phoenix House had implemented a staffing strategy that focused on recruiting newly qualified staff as part of the service redesign. The operational lead said this was part of a drive to support ambitious practice and individual working.
- Staff in each service told us one of their main challenges was managing capacity alongside staff vacancies. While the trust had a rolling programme of recruitment, individual service leads had implemented innovative service changes to reduce vacancies and improve waiting times. For example the senior team in the community health and social care services integrated care team had created a new rehabilitation support worker role, which helped to increase capacity. In addition this team provided additional competency-based training to integrated care assistants to address the shortfall in band 5 staff recruitment.
- At our last inspection we found processes to recruit new staff were lengthy and resulted in significant delays in services filling vacancies. As part of the trust's quality improvement programme, human resources introduced a key performance indicator of 60 days from accepting an application to recruitment. Senior staff in each service told us this was consistently achieved and had improved their ability to fill posts after the selection process.
- In 2016, the frailty community of practice completed a study of the visit times of district nurses as a benchmarking exercise alongside a dependency tool and time nurses spent on visits including for travel and recordkeeping. The trust was preparing to compare the results with other community trusts nationally and to test a dependency tool.
- The integrated care team had changed their caseload planning processes to implement structured work activity teams. Seven members of the team we spoke with said although the transition had been challenging, the new work structure meant caseloads were no longer overwhelming.
- Between October 2016 and September 2017 agency nurses delivered 2943 patient contact hours. This represented an overall average of 41% of shifts filled by agency nurses with wide variances between localities. For example agency nurses filled over 50% of shifts in Redbridge in every month during this period. Thurrock services had reduced the average number hours filled by agency staff to less than 20% in every month from March 2017 to September 2017. In the six months prior to our inspection there were 53 instances where 100% of a service was provided by agency staff. This included Havering community dietetics and dieticians in every month and Havering orthopaedic therapy and speech and language therapy in each month from May 2017 to September 2017. Some services achieved consistently low rates of agency staff usage, including the Waltham Forest respiratory team and AWC, both of which had a 0% agency staff rate for the six months prior to our inspection.
- At our last inspection we identified significant gaps in the monitoring and management of agency nurses. This was because the trust could not be assured agency nurses always had appropriate training and in some cases they did not have access to patient records or recording systems. At this inspection we found nurses completed self-declared competency checklists before they were able to complete shifts. The HFCT recognised the need for improved governance of agency nurses and had initiated a work stream to better monitor competencies. In addition a dedicated professional lead had been appointed to improve the system used for temporary staffing quality assurance. Some individual teams, including the Seven Kings health and social care team had developed agency nurses and were working to improve documentation of competencies.

# Are services safe?

- A member of staff in Brentwood Community Hospital said they had not been able to deliver care according to the service specification for over six months due to short staffing. Staff in other services noted the pressure they experienced due to staffing levels and this was reflected in the results of the staff survey.

## Quality of records

- Each team worked to improve the integration of patient records systems with other local services, including GPs. For example nutrition and dietetics staff in Billericay had adapted the EPRS to include care plans, skin integrity observations and bowel conditions. This meant the multidisciplinary team used a single record for multiple facets of care.
- Staff in sexual health and HIV services maintained paper records of HIV testing and treatment to ensure confidentiality with other clinical services. We looked at a sample of 10 sets of notes in the AWC and found in each case they were clearly written and included detailed relevant histories. Staff who completed the notes had included their grade and designation in each case as well as the batch numbers of medicines prescribed and detailed notes of any multidisciplinary team involvement. We also looked at the care plans of 12 people who received care from district nursing teams. In each case we found these to be up to date and include details the patient's care needs, medicines and key risks.
- At our last inspection we identified the quality of records in Waltham Forest district nursing as an area for improvement in relation to risk assessments. In response the trust introduced a quality of care audit to measure improvements. The audit identified documentation of consent and timely record entries as key priority areas for the team to continue improvement.
- We looked at the risk assessments for 12 people we visited with district nursing teams. We found in each case risks were assessed individually and contained a clear identification of strategies to reduce risks and protect patients and staff from harm. For example, staff had completed risk assessments for patients with pets at home to ensure staff would be safe when visiting the premises. District nurses we spoke with said new risk assessments for patients who were known to behave unpredictably or aggressively had helped them to provide care more safely.

## Medicines

- Nurses in several services were non-medical prescribers. This included in the rapid response and assessment service (RRAS) teams, in the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic and in the Anthony Wisdom Centre. Nurse prescribers used patient group directions (PGDs) to prescribe medicines for certain conditions. We looked at a sample of PGDs in each service with nurse prescribers and found in all cases they had been kept up to date and the current versions were within their review dates.
- Medicines in all of the services we looked at were stored appropriately and securely, with daily recorded temperature checks. This included for refrigerated medicines. This meant medicines were always stored within the safe temperature range identified by the manufacturer. Fridges in some services, such as the AWC, had electronic data packs installed that enabled staff to monitor temperatures over a weekly period.
- A pharmacy manager in the AWC completed a weekly stock control audit and maintained a log of medicines received and destroyed. We saw this unit had a seamless process for the management of HIV antiretroviral medicines. A consultant prescribed these and a nurse dispensed them. This was signed and logged in a book used to track batch numbers for product recall purposes. The pharmacy manager maintained quality oversight of this process.
- Staff in the AWC used FP10 prescription pads for issuing prescriptions. This is controlled stationery that requires auditable record keeping and access restriction. Staff adhered to this requirement and pads were kept in a locked cupboard with restricted access.
- A trust audit in 2017 identified that 90% of non-medical prescribers understood what to do if a prescription was lost or stolen. In addition 69% of this staff group had attended an annual training update on FP10 processes. Although we saw consistent examples of security during our inspection, a long term conditions team reported an incident in September 2017 whereby a prescription pad was stolen from a consultant's car. This meant there was room for improvement in how staff managed document security when working remotely.
- A senior medicines management technician completed an annual medicines management audit across the trust. The latest available results were from March 2017

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and indicated there was room for improvement in the security and storage of medicines. This included in the documentation of room and refrigeration temperatures. The audit highlighted improvements in the storage and management of oxygen, the use of PGDs, safe disposal of medicine and controlled stationery. The action plan identified plans to achieve the recommended improvements, including training for staff and the use of posters to remind staff of their responsibilities.

- The deputy chief pharmacist completed an annual antibiotics audit. The latest results from January 2017 indicated a year-on-year improvement in compliance with trust policies. For example, in the sample of 524 prescriptions in this audit, 100% of patients prescribed antimicrobials had allergy information documented and 100% of antimicrobial prescriptions were within the appropriate formulary. The audit found a 25% compliance improvement in documentation standards from 2012 to 2017. The key areas for improvement were staff awareness and knowledge of microbiology cultures, antimicrobial stewardship and the trust's medicines policy.
- The e-prescribing lead completed an omitted doses re-audit in February 2017. This audit benchmarked the trust against the National Patient Safety Agency 2010 rapid response report on reducing harm from omitted and delayed medicines in hospital. The audit showed a 0.2% improvement in missed doses from 2016 with 31% of all doses missed. This audit included inpatient wards as well as community health services. Antidepressants represented 24% of missed doses and community health-prescribed anti-arrhythmic medicines represented 10% of missed doses. None of the six community health teams audited were fully compliant with the trust's policy standards for missed doses.
- A medicine safety management group worked across teams to support the reduction of missed doses, adherence to local formularies and the investigation of incidents.
- We looked at a sample of 20 care records during our inspection. In each case we found medicine administration was clearly documented and we found no errors or omissions.

### Safety performance

- A dedicated harm free care team (HFCT), led by a director of nursing for patient safety, was responsible for implementing and monitoring safety processes across

the trust's adult community health services (ACHS). A number of specialties were represented in the team including frailty care, equipment and adult dietetics, tissue viability, long term conditions and patient experience. The range of senior staff in the team meant they could be responsive to unexpected increases in harm in specific localities by sending a team to that area to investigate.

- The HFCT had established a safety dashboard that was shared with key service leads and reflected performance in harm free care pathways such as medicines, physical health in mental health settings, bone fractures and venous thromboembolism.
- A falls strategy group worked within the HFCT, had a dedicated lead and worked across the trust to improve staff education and patient care. As of September 2017 the team had achieved a falls rate of 1.8 per 1000 bed days, which was significantly lower than the national average of 6.6. In September 2017 a total of 64 falls were reported, of which 75% resulted in no harm. Minor harm occurred in 11% of cases, moderate harm occurred in 14% of cases and severe harm occurred in one case, which represented less than 0.5% of the total.
- Between April 2017 and September 2017, adult services reported 703 pressure ulcers. Of this total, 76% were grade 2, 20% were grade 3 and 2% were grade 4. Less than 0.01% was reported as grade 1. The integrated community team (ICT) in Basildon and Wickford reported the highest overall number of pressure ulcers, at 13% of the total and 12% of grade 2 pressure ulcers.
- The HFCT had launched four quality improvement projects in the previous 12 months, each aimed at improving safety performance in specific patient groups. For example one project aimed to achieve 100% accurate grading of pressure ulcers at the point of referral when moving between the acute setting to the Barking and Dagenham district nursing team. Such projects enabled the team to target specific services, teams or patient populations in response to data on incidents and patient outcomes.
- The trust had established a mortality assurance framework (MAF) that aimed to ensure patients, staff and other organisations were involved in mortality investigations and learning. The framework was in development at the time of our inspection and was due to be fully completed in May 2018, which would include a six month mortality review period. We looked at the minutes and outcomes of three mortality review group



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meetings and found them to be consistently attended by an appropriate range of senior and clinical staff. The group benchmarked work to implement the MAF against the National Guidance Learning from Deaths and were in the process of developing an internal mortality dashboard.

- The HFCT had initiated a programme to reduce the incidence rate of catheter-acquired urinary tract infections (CAUTIs) following previous concerns that data was not reliable. The team had mandated incident-reporting of each CAUTI and reminded staff of this through weekly newsletters.

## Incident reporting, learning and improvement

- Between October 2016 and September 2017 staff in ACHS reported 6127 incidents. Pressure ulcers accounted for 47% of all incidents with other incidents shared between 71 other categories. Abuse (6%), moving and handling (4%), medicine errors (4%) and information technology (3%) were the four most common incident categories after pressure ulcers.
- Between September 2016 and August 2017 staff reported 115 SIs. Of these, 65% related to grade 3 or grade 4 pressure ulcers. Other SIs related to a fall, a data breach, an environmental issue and a deteriorating patient. A senior incident investigator was assigned to each SI and worked with a team, including staff involved, to identify areas for learning and improvement. We saw root cause analyses were thorough and promoted learning and development. For example following an incident involving the avoidable loss of patient data, policies were changed to improve information governance by ensuring personal information was stored electronically with restricted access.
- Where incident investigation teams found themes in SI reporting, they carried out a multi incident root cause analysis (RCA) investigation. We looked at 16 examples of these and found them to involve multidisciplinary teams and an investigation of each patient's journey through the trust. The investigation team prepared action plans in each case and the outcomes of these were monitored for completion. For example, one multi incident RCA investigation considered eight patients who had acquired pressure ulcers. The investigation compared the care and treatment each patient had received and identified where their condition could have been improved.
- The action plan required a review of the nurse preceptorship programme, and improved deteriorating patient protocols for the rapid response assessment service (RRAS) teams were implemented. This process had resulted from a pilot project to identify methods of carrying out effective investigations while reducing the need for clinical staff to spend time away from patients. The pilot project indicated a significant saving in clinical hours while maintaining a high standard of investigation.
- Staff in all areas were proactive in reporting incidents and identifying areas for learning, including from near misses. For example, a matron in Brentwood Community Hospital had self-referred a potential case of organisational neglect following a fall. Although the outcome was pending, the matron had reviewed systems and processes to reduce risks including improving risk assessments, adding sensors to patient beds and reviewing patients with complex needs.
- We saw staff were proactive in completing incident reports where the situation included other services. For example, staff in the London RRAS team had submitted an incident report when they found evidence that self-neglect had led to a pressure ulcer in a patient. This patient was also under the care of social services and the incident report reflected this. Although staff told us this was an effective system for reporting they did not usually receive feedback when an incident involved colleagues from another service. This meant opportunities for learning were limited to their own team. Teams that worked cross-borough and cross-service were the exception to this. For example the trust-wide pressure ulcer investigation group demonstrated an effective communication process for all teams.
- Staff in the minor injuries unit at Orsett Hospital reported one SI in the previous 12 months. We saw evidence the senior clinical team had investigated this and implemented improvements to the service as a result. For example, staff were trained to take a more detailed patient history and consider more holistic care following an undiagnosed pathological hip fracture.
- A dedicated pressure ulcer incident panel led investigations into pressure ulcers acquired in ACHS. This team had implemented a number of strategies and care improvements to reduce the incidence of pressure ulcers. In September 2017 the average number of pressure ulcers per week was 1.6, which was a reduction of 45% since November 2015 and represented 133 fewer

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patients harmed in that period. The group achieved this by organising a conference to discuss skin integrity and tissue viability with a range of staff, implementing a new pressure ulcer policy, refining the SSKIN five-step approach bundle and agreeing a standardised malnutrition universal scoring tool (MUST).

- A dedicated falls team in the HFCT supported staff that submitted an SI as a result of a fall. For example they helped to train and implement a falls champion, conduct table top training exercises and complete weekly audits.
- We looked at a sample of two incident reports for each service we inspected that had been submitted in the previous 12 months. In each instance we found staff had taken appropriate action and liaised with other services, including where a patient's safety was at risk. For example we saw staff arranged for a fire safety officer to visit a patient's home who was at risk due to clutter.
- In the 2016 staff survey 65% of respondents said that when errors, near misses or incidents were reported, the trust took action to ensure that they did not happen again. In addition 54% said they received feedback about changes made in response to reported errors, near misses and incidents.
- We found from looking at incident reports that staff consistently adhered to the principles of the duty of candour. For example when patient data stored in a diary was misplaced, the trust communicated with each person involved. They were given an explanation of the situation, offered support and told how the trust would reduce the risk of such an incident recurring.
- Each multi incident root cause analysis and serious incident investigation included sharing findings with patients and relatives as part of an action plan. This demonstrated the duty of candour was embedded in the trust's incident investigation process.

# 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 good because:

- Staff in each service could demonstrate how they delivered care that met national and international best practice guidance from relevant organisations, including the National Institute for Health and Care Excellence, British Dietetics Association, British Thoracic Society and the British Association for Sexual Health and HIV.
- The trust maintained a comprehensive audit programme that aimed to standardise some standards, such as record keeping and infection control, and allow individual services to benchmark the quality of care they provided.
- Individual services worked with the clinical audit and effectiveness department to establish workflows and processes that were evidence-based and appropriate to patient needs.
- Eating disorder, sexual health and dementia and memory services demonstrated consistently good patient outcomes.
- Staff had access to specialist training and there was a clear drive to develop healthcare assistants by providing clinical skills training.
- The trust had taken steps to improve information sharing between services, including between disciplines in integrated care teams. In addition teams were proactive in working with other healthcare providers to improve transition and transfer pathways.
- There was consistent use of multidisciplinary working and coordinated care and treatment pathways for patients in all areas of the trust. Clinical teams also provided training to staff in other services to help them provide appropriate care.
- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards had significantly improved.

However:

- It was not always evident that audit action plans were shared with all appropriate staff.
- Some services could not demonstrate patient outcomes because they did not routinely collect data.

- Only one locality met the trust's target of 85% for up to date appraisals and overall 81% of staff had received an appraisal in the previous year.

## Evidence based care and treatment

- In addition to the records and infection control audits that staff in each service carried out, a further 43 audits were carried out in 2016/17. In 2017/18 77 audits were planned, of which 43 had been completed at the time of our inspection. Of the total, 56% were carried out to measure clinical practice or services against National Institute for Health and Care Excellence (NICE) clinical guidance and advice.
- We looked at 22 service-specific audits to understand how service leads provided evidenced-based care. In each case we saw the audit leads created an action plan that was timed and assigned to accountable staff to ensure improvements were made. For example in the National Diabetic Foot Care Audit the team identified that only 32% of patients received blood glucose monitoring in line with NICE guidance. In response the audit team completed an action plan to establish a diabetes specialist foot care team, improve patient education and establish rapid referral pathways.
- Nutrition and dietetics services provided services based on the national best practice guidance of the British Dietetics Association. This included providing structured diet advice such as high protein diets for wound healing and soft diets that still met patient likes and dislikes.
- The rapid response assessment service (RRAS) teams had developed a triage and assessment system for patients with urgent and complex needs. Care was provided using evidence-based tools and pathways, such as the five-step SSKIN bundle, the malnutrition universal scoring tool (MUST) and a catheter care protocol.
- The respiratory and pulmonary rehabilitation team provided care in line with national best practice standards including from the British Thoracic Society, NICE guidance and the Global Initiative for Chronic Obstructive Lung Disease (GOLD). This team based their care on research, which was monitored by a dedicated



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evidence based group. A community orthopaedic physiotherapist was in the process of researching the delivery and outcomes of exercise classes to establish a benchmark of best practice.

- Individual services worked with the clinical audit and effectiveness department to establish workflows and processes that were evidence-based and appropriate to patient needs. For example staff in the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic used a four-week standardised process for handling positive test results for chlamydia and gonorrhoea.
- Staff in sexual health and family planning services had online access to the latest guidelines from the British Association for Sexual Health and HIV (BASHH) and the British HIV Association to ensure care and treatment reflected the latest national standards of practice.
- In 2016/17 the pressure ulcer investigation group audited 200 patient notes in London and Essex for completion of SSKIN bundles. The audit resulted in the implementation of a new bundle and the group was working with the IT department to carry out a re-audit in late 2017. In addition the group had worked with an acute trust to audit 100 admitted patients to identify where community care could have avoided pressure ulcers. There was demonstrable improvement in compliance with SSKIN standards; however, some teams required further improvement. For example, the dementia crisis support team achieved 70% compliance in a September 2017 audit.
- The harm free care team audited a sample of risk assessments across the organisation against the NICE guidance relevant to each service. As a result they implemented new standards of risk assessments that met all NICE guidance.
- The tissue viability team demonstrated a sustained programme of audits and research to generate new knowledge of best practice care and therapy. This included testing and review of a low frequency ultrasound therapy system, which the team published as a national sharing paper. The team was also proactive in using the research findings of other teams to present to trust staff to contribute to evidence-based care.
- Where teams were formed of multiple specialists and health professionals, appropriate NICE guidance was

embedded in practice in relation to each treatment pathway. For example the integrated care team (ICT) provided care in line with NICE clinical guidance relating to sepsis, end of life care, obesity and falls.

- The Anthony Wisdom Centre (AWC) team maintained a programme of three annual audits, which changed each year depending on patient needs. For example the 2017 audit would be based on the service experience of HIV positive patients. Previous audits indicated staff used them to improve services such as a 2016 gonorrhoea audit that resulted in international recognition for evidence-based treatment.
- Although each audit we looked at resulted in an action plan for the relevant services and teams, knowledge of this amongst staff we spoke with was sometimes limited. For example, none of the staff we spoke with in Grays Court Community Hospital knew what was on their service action plans and local senior staff were unable to locate these.
- The community treatment team used the Manchester Triage Tool for all first telephone assessments, which enabled them to identify the level of clinical risk for each patient.
- Diabetes services used the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) tool to support patients to maintain their health in line with national best practice guidance.

### Nutrition and hydration

- We spoke with seven patients who received care from nutrition and dietetic services, all of whom spoke positively about improvements in their condition. One patient said, "I was scared to join this [service] but they've helped me improve my lifestyle and put together a diet for me and I'm doing much better now."
- In 2017 the nutrition and dietetic team, with support from Macmillan nurses, carried out a re-audit of compliance with the head and neck cancer nutrition guidelines. This measured the service against London Cancer and Clinical Oncological Society of Australia best practice guidance. The audit identified overall compliant standards of practice and identified dissemination of learning, triage and referral times as key areas of improvement.
- The harm free care team had developed a catheter passport for patients who moved between community and acute services. The team had delivered learning

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sessions to patients, carers and acute staff about the use of this and encouraged patients to meet their hydration targets to reduce the risk of catheter-related problems.

### Patient outcomes

- The RRAS teams provided a patient visit and assessment within two hours of referral for patients considered to be at high risk according to their initial risk assessment. This reduced the risk of a hospital admission and also reduced psychological distress.
- The pulmonary rehabilitation team offered continual monitoring to patients during a six week programme that included using the national quality of life score as well as anxiety and depression scores. This meant the team could identify where patients would benefit from additional help and support from mental health or counselling services.
- We saw from our observations of home visits that staff worked with patients to improve their outcomes when current treatment did not work as expected. For example a nurse from the London RRAS team worked with a patient to identify factors that worsened the symptoms of chronic obstructive pulmonary disease (COPD) and helped them with strategies to improve breathing. A patient we spoke with in the diabetes service said the team had invited them to an educational session to learn more about their condition and how to control it.
- The family planning, sexual health and community gynaecology team at the Oliver Road Polyclinic had improved the process for fitting implants as a result of audits and patient feedback. The new process involved a healthcare assistant (HCA) led telephone triage appointment followed by a clinic appointment to fit the implant. This meant patients were seen more quickly.
- The senior team at the Oliver Road Polyclinic family planning, sexual health and community gynaecology service measured a range of patient outcomes. In 2017, the service achieved an 85% uptake rate of HIV screening and an 85% uptake of chlamydia screening in the under 24s. Although there are no national benchmarks for the uptake of testing of either condition, services provided by the trust worked in line with Public Health England and NICE guidance to increase opportunistic testing. In addition the service achieved an 85% turnaround rate of 10 days or less for test results.

- The Waltham Forest eating disorders service met the national referral to treatment time target of 100% for urgent cases.
- In the 18 months prior to our inspection, the Waltham Forest dementia and memory services teams' consistently diagnosed dementia at rates above 70%, which was better than the national target of 66%.
- Staff in the Brentwood tissue viability team said they could not determine the impact or effectiveness of the service because there was no monitoring in place for patient outcomes. This was not consistent with the work being undertaken elsewhere in the trust by tissue viability teams. After our inspection the trust told us tissue viability teams worked to a standard specification with agreed outcome measures that were presented as part of clinical and quality governance. The team we spoke with were not aware of this. This meant there was not an effective mechanism in place for teams to share learning and improve patient outcomes trust-wide.

### Competent staff

- As of August 2017 an average of 81% of staff in adult community services and 75% of staff in community rehabilitation services had completed an appraisal in the previous 12 months. The figure for adult community services was an average and reflected a range from 74% in Havering to 88% in Redbridge. Local service leads monitored appraisal rates and we saw these were discussed at locality performance meetings and other governance and quality meetings. However, only the Redbridge locality met the trust's target of 85% completion.
- Where staff worked within established teams they reported frequent and consistent supervision from the local senior team. However, where staff worked alone or in very small teams they reported fewer opportunities for supervision. For example a nurse working in the Brentwood epilepsy service was isolated compared with the other teams working there and did not have access to regular supervision. They said, "I have not had clinical supervision in a long time."
- Only one locality met the trust's target of 85% for up to date appraisals and overall 81% of staff had received an appraisal in the previous year.
- We reviewed 30 anonymised appraisals from 16 teams or localities. We found staff were supported to identify and achieve professional goals, access clinical training and work towards career progression. Appraisals also



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indicated staff received personal support during service restructures or periods of high levels of stress. There was a consistent focus on the Mental Capacity Act (MCA) in the sample we looked at.

- Nurses in the RRAS teams told us annual appraisals were a useful opportunity to plan their development and identify areas of good practice and for improvement.
- We spoke with a student nurse practitioner who said their induction and shadowing period had been detailed and the care team had been supportive.
- The nutrition and dietetics service at Billericay Health Centre had increased focus on training in the effective use of MUST. This formed part of a renewed policy for MUST documentation and meant patients were monitored more closely over a longer period. For example, staff calculated percentage weight changes over a three to six month period instead of reacting to monthly changes. This meant weight changes could be monitored for significant changes and staff could then implement food and fluid charts if it would help to track and improve the patient's intake.
- Nurses in each service took on lead roles in specific areas of care. As part of this additional work they attended specialist training, met with service leads and provided updates and refresher training to other staff in their service. For example, emergency nurse practitioners (ENPs) and HCAs in the minor injuries unit at Orsett Hospital had taken on lead roles in safeguarding, infection control and domestic violence.
- Nurses in the RRAS teams completed training to enable them to practise autonomously. This included providing care and treatment for patients with pressure ulcers and COPD and carrying out diagnostic assessments.
- The trust had improved the training and development opportunities offered to HCAs, which included access to an advanced practitioner course and the national care certificate. For example 79% of HCAs at Brentwood Community Hospital had achieved the care certificate. Individual services provided specialist training to their HCA teams to ensure the continual development of clinical skills. For example, HCAs in the London RRAS team were trained in catheter care, wound care and insulin management. HCAs in the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic had completed sexually transmitted infection consultation training and phlebotomy training.
- The ICT had developed integrated care assistants (ICAs) with nursing and therapy training opportunities. This formed part of a drive to implement a competency framework and to retain existing ICAs.
- Clinical leads in each service area arranged specialist training for staff based on the needs of patients. For example, staff in the Orsett Hospital minor injuries unit attended annual training for treating burns. The senior team in this unit had established relationships with local ophthalmology and fracture services that enabled staff to attend training.
- District nurses said they provided feedback to colleagues in team meetings after they attended training or briefing days. They used this as a strategy to ensure others they worked with had access to the latest practice and policy advice,
- One district nurse told us the palliative care training was “brilliant” and had greatly contributed to their ability to provide care.
- Staff in the AWC and the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic had access to ongoing training, including from the Faculty of Sexual and Reproductive Health. Recent training included an update to counselling for all clinical staff and competency training for nurses in sexual history taking and microscopy. HCAs in the AWC completed microscopy training and an annual BASHH course. The consultant based at Oliver Road provided remote video supervision for foundation level doctors who worked across other services. This enabled them to develop skills in the context of the needs of the service. Nurses had the opportunity to apply to annual Sexually Transmitted Infection Foundation (STIF) training and the mentorship programme.
- The falls strategy group held falls workshops every three months to identify areas of support needs amongst clinical teams, including those involved with the transition of patients from acute to community services. This process had led to the provision of slippers and slipper socks for patients to purchase before they were discharged from an inpatient ward.
- There was evidence from team meeting minutes that individual services were proactive in ensuring staff had access to professional development and specialist training. For example in one case we saw staff in a team meeting had noted two dieticians had qualified to



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prescribe and administer the 'FODMAP' diet, which refers to a specific type of carbohydrates and how they are digested. This meant more specialised care could be provided.

- Protected teaching and learning time varied between services. For example the AWC team had protected teaching time one afternoon per week. This combined a departmental meeting with case study reviews and a teaching session. However, staff in Brentwood Community Hospital told us they had not had recent organised teaching and learning time due to pressures to meet care targets. After our inspection the trust told us all teams had protected time for learning. We could not establish why this team had not accessed this.

### Multi-disciplinary working and coordinated care pathways

- There was consistent use of multidisciplinary (MDT) working and coordinated care and treatment pathways for patients in all areas of the trust. For example, staff in the AWC had established pathways with a local sexual assault centre and a centre specialised in providing support to victims of rape and incest.
- The crisis support team (CST) at Brentwood Community Hospital worked within an MDT community care approach that included dementia and mental health specialists. We spoke with a trainee doctor in this team who said the MDT care model meant patients had seamless care compared with acute services and the team were able to work much more closely to coordinate care.
- Staff in the Brentwood Community Hospital rehabilitation inpatient ward said they were experiencing a significant increase in patients with high levels of acuity and complex needs. This included patients living with dementia, acutely unwell patients and those with end of life care needs. Staff told us although the MDT team worked well they were not always able to manage the complexity of patients. After our inspection the trust told us the increase in acuity was due to the implementation of a new model of intermediate care in April 2017. All staff had undertaken training in caring for deteriorating patients and end of life care. In addition a consultant geriatrician and an older age psychiatrist were available for support.
- The nutrition and dietetics service in Billericay shared diet guidance with the trust's pressure ulcer working group so the wider MDT had access to appropriate referral criteria. This strategy also aimed to reduce failed referrals.
- Speech and language therapists and the nutrition and dietetics service worked together to provide coordinated care, and consultants were available post discharge from hospital.
- Patients seen by the minor injuries team at Orsett Hospital had access to an on-site x-ray service and consultant radiologist. These services were provided through a service level agreement with the trust that operated the hospital. Patients received x-ray results within two days through a return visit to the minor injuries unit. The team were able to refer directly to the radiologist in the event a patient needed specialist care.
- RRAS teams worked collaboratively with colleagues in mental health services, community support, GPs, social services and voluntary agencies to provide coordinated MDT care. The team also work with specialist teams in COPD, diabetes and learning disabilities to ensure patients received the most appropriate individualised care. There was a single point of access for referrals and the team used this to refer patients to the end of life care and palliative care teams.
- The health advisor in the AWC had delivered training to local GPs and practice nurses in the use of patient group directions for the treatment of chlamydia in young people. This meant local practices could treat young people and provide further signposting to the specialist centre if needed. In addition the health advisor had visited local schools and provided training and guidance to staff on the handling of students who brought gas canisters to school for the purpose of misuse. An established relationship between the centre's team and local acute hospitals meant a consultant or health advisor would visit patients who were diagnosed with HIV while admitted to a ward. This meant they received individualised support and treatment in their ward without waiting to need to attend a sexual health service on discharge.
- The dementia crisis team based at Brentwood Community Hospital had established working relationships with non-profit specialist organisations, including the Alzheimer's Society, to provide patients with a range of support options.

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- The respiratory nursing team at Porters Avenue Health Centre had offered teaching sessions to local GPs to improve services for patients with pulmonary conditions. This included guidance on oxygen therapy, rehabilitation, asthma and inhalers.
- The service lead in the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic attended monthly multi-agency sexual exploitation meetings with colleagues from acute NHS services, the police, community sexual health and social workers. Staff from this service also attended local looked after children meetings as part of their remit of safeguarding.
- The integrated case management team and health and social care services team in Redbridge worked from four local clusters to provide coordinated care. This structure enabled patients to receive treatment from district nurses, community matrons, occupational therapy practitioners, as well as social care teams.
- The Waltham Forest community team delivered a training programme to staff in 12 care homes in 2016/17 to help them identify the early warning signs of deterioration. The team provided care home staff with decision trees based on the 'significant 7' strategy that would enable them to identify signs such as confusion, mood changes and pain. Following the training 90% of care workers in the homes used the decision tree and 55% used the training tools on a daily basis.
- The harm free care team had established working relationships with cardiac and diabetes clinical nurse specialists to include skin integrity checks on patients who were seen in a crisis.

### Health promotion

- Staff in the nutrition and dietetics service had developed an assessment page on the local electronic patients record system (EPRS) that could be shared with GPs who also used the system. This enabled the team to calculate and record nutritional, energy and protein requirements and monitor intake. This enabled patient histories to be shared immediately by the MDT. The nutrition and dietetics team had developed this as a specialised addition to the existing system and it included sections for the recording of gastrointestinal conditions, nutrition support, enteral feeding and

therapeutic diets. Staff could track access to the notes in the system, which enabled them to see which professionals had viewed and acted on them and delivered health promotion interventions as a result.

- Staff in the AWC had established referral pathways with local services to provide patients with a more seamless service. This included with local acute trusts, community treatment teams, home treatment teams and refugee services.
- The pressure ulcer investigation group had implemented a health promotion element to discharge records for patients at risk of pressure ulcers. This involved giving patients a contact card so they could directly speak with a clinical member of staff they noticed a deterioration in skin integrity.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff on Thorndon Ward said they had access to MCA policies but we were unable to access them at the time of our inspection. Staff demonstrated knowledge and awareness of the MCA and their responsibilities under this although there was room for improvement in training to act on suspicions of abuse or neglect.
- Senior nurses in each service were trained to carry out mental capacity assessments in the event a patient did not understand the consent process or found it difficult to give consent.
- Staff who cared for patients in inpatient areas as part of the MDT completed risk assessments where an individual had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. This assessed their level of mental capacity and identified the extent to which they could make their own decisions.
- RRAS teams had developed assessments for patients with fluctuating capacity and for those with a DoLS authorisation in place.
- During our observations of the minor injuries unit and AWC at Orsett Hospital we noted reception staff proactively asked patients for their consent to share details of their visit with their GP.
- During our observations of home visits we saw district nurses and dieticians always asked for consent before providing care or treatment. For example, we saw nurses told patients what they planned to do and asked them if this was okay before proceeding.
- Amongst the Brentwood and Basildon community teams, an average of 90% had up to date MCA and DoLS



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training. This included 100% of the dementia crisis, tissue viability and epilepsy nursing teams. Within the same service, 82% of the phlebotomy team and 67% of the Parkinson's disease team had up to date training.

- The safeguarding team had implemented an innovative approach to improving staff knowledge and application of the MCA. This involved utilising professional actors as patients with complex needs to enable staff to carry out capacity assessments in a controlled environment. The team had carried this out as a pilot project and noted significant improvements. As a result the training was being rolled out across the trust.

- A clinical lead for MCA, Prevent and DoLS was in post and worked across teams to improve use of the policies and training.
- The trust had implemented a self-neglect policy in 2016 in response to an incident investigation that found low levels of referrals to independent mental capacity advocates (IMCAs) in Waltham Forest. An audit of the service was also implemented to provide a benchmark for IMCA referrals.

# 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:

- During all of our observations and home visits we saw staff treated patients with care, compassion and kindness.
- Staff knew how to deliver individualised care and we received consistent feedback about this from patients, relatives and carers.
- The trust received consistently good feedback and scores in the monthly patient survey.
- All of the patients and relatives we spoke with said they felt appropriately involved in their care. Patients who had received care from the trust for long periods of time were very enthusiastic and passionate about the staff who cared for them.
- Staff readily provided emotional support to patients and used emotional support triage tools to ensure this was appropriate.

## Compassionate care

- As part of our inspection we spent time with staff who visited patients in their own homes. In all cases we found staff were respectful and compassionate and worked with patients to meet their needs. For example, we saw a district nurse help to comfort a patient who was upset on arrival after a hospital appointment was postponed. The nurse helped them to understand the situation using straightforward language and explored other options to make them more comfortable. In the falls clinic we observed a healthcare assistant (HCA) help a patient who used a wheelchair to stand and be measured. We saw the HCA provided gentle encouragement and reassurance and made sure the patient was not at risk of falling or being injured.
- We spoke with 11 patients and five relatives about the care they received from district nurses. In all cases we received positive feedback. One patient said, "I couldn't ask for better treatment. They do their job with a smile and are always happy and respectful." Another patient said, "They are amazing!" One patient said, "When I was in hospital they missed a pressure ulcer. The [district] nurse found this straightaway when I got home; it saved me a lot of extra treatment."

- Reception staff in the Anthony Wisdom Centre (AWC) and the minor injuries unit (MIU) at Orsett Hospital demonstrated a consistently friendly, welcoming and compassionate approach to patients. For example when a child was brought to the MIU the receptionist spoke directly to them, made them feel welcome and demonstrably calmed their parents. A receptionist in the AWC helped a patient walk from their car into the clinic when they phoned to say they were too scared of receiving a test result to walk in themselves.
- Two patients who used the rehabilitation service in Brentwood said they felt well looked after and treated with respect and understanding. A patient we spoke with who received care from the rapid response assessment service said, "I've got high praise for the team. I couldn't cope with going to the hospital or the GP every time I need help."
- The trust launched a social media account as part of the NHS England Experience of Care week in March 2017 to enable staff to respond to queries or concerns immediately.
- The trust carried out a monthly 'Your views count' survey. The latest available data related to August 2017, in which 872 people completed a survey. During this month 95% of patients said they would recommend the service, which was a consistent result for three consecutive months. The sexual health team at Orsett Hospital carried out a similar service. In the 12 months prior to our inspection 100% of patients said they would recommend the service and 100% said the service met their expectations.
- We observed numerous examples of compassionate care. For example an occupational therapist in the dementia care support team acted as an advocate for a vulnerable patient who demonstrated signs of severe neglect. The member of staff liaised directly with an acute hospital and mental health colleagues to secure an urgent admission.

## Emotional support

- During all of our observations we saw staff knew how to maintain patient dignity and respect. For example,

## Are services caring?

during observations of district nurses we noted they accompanied patients to the bathroom when providing personal care and asked if they would like the door closed.

- Staff implemented practical strategies to help patients improve their feelings about treatment. For example, we saw a district nurse helped a patient to plan how they could drink more water to reduce the risk of frequent catheter changes, which had made them upset. During another observation a patient was anxious and upset about having a stoma bag fitted. We saw the nurse took time to reassure them, show the patient how it worked and use reassurance and good humour to make the patient feel better. For example, the nurse said, “You look great and the bag is working beautifully. I promise there’s nothing to worry about.” This had a demonstrably reassuring effect on the patient.
- The rapid response assessment service team worked to provide emotional and personal support for patients with complex needs. For example the team had arranged for personal care and for a patient to be supported to better look after their pets. This team’s triage system included an assessment of emotional distress in patients and family members, which contributed to the risk rating for each patient.

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

- Two patients we spoke with in Brentwood Community Hospital said they felt doctors, nurses and physiotherapists kept them informed of their progress and made sure they were involved in discussions about their care. A relative also said they felt involved and that staff included them appropriately.
- Reception staff in the MIU at Orsett Hospital demonstrated how they ensured the waiting environment was suitable for all patients. For example, they changed the channel on the TV screen when a child arrived and the programme may have been unsuitable for them.
- We spoke with 22 patients and relatives about being included in their care. One relative of a patient who received home visits from the district nurse team said, “[Patient] really understands their situation and

treatment plan. I hear how nurses talk to [them] and it’s very easy to understand.” Another patient said, “They’ve [district nurses] involved me every step of the way and always given me a choice about what happens next.” A patient in the falls clinic told us, “The doctor changed my medicine a little while ago and he explained why this was a good idea and what he was changing it too.” A relative in the same clinic said, “We’ve always been happy with the treatment here and I’d feel comfortable asking the doctor if I wanted to know anything else.”

- We saw the HCA working at the falls clinic asked a patient if they minded seeing a different doctor than they were expecting due to a staffing change. This helped to keep the patient informed of the details of their appointment and what to expect.
- During our observations of home visits staff routinely involved patients in making decisions. For example we saw a dietician worked with a patient to make a meal plan for the rest of the week when they said they did not enjoy making their own meals. The member of staff helped the patient to identify what they could eat as a snack as well as a treat and also arrange for a speech and language therapy referral to address a swallowing issue. During our observations we also noted staff supported patients with non-clinical decisions. For example, we saw a dietician asked a patient which of their bins they could use to dispose of consumables relating to the visit. This demonstrated respect for the patient and their home.
- We saw that staff discussed the details of treatment and prevention with patients when asked. For example, one patient wanted to know how a leg ulcer had formed. The district nurse took the time to explain how leg ulcers occurred as well as what the patient could do to prevent more in the future. The nurse demonstrated patience and understanding and also explained what they could do in the future if the patient was at risk, such as providing an air mattress.
- One patient in the diabetes service told us, “I feel really involved in my care.” A patient who received care from the respiratory team said, “I feel more in control now; the team have explained everything to me and I know how to manage it.”

# 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 good because:

- There was substantial evidence individual services had adapted to meet the needs of the local population. This included where there were gaps in the services offered by local GPs.
- A dedicated equality and diversity team and the strategic patient experience partnership had embedded the principles of equality and diversity into service delivery. This included through adapting services to meet the needs of individuals.
- The dementia crisis support team had developed and implemented an innovative first responder model of dementia care that redesigned the service meet the needs of patients living with dementia in the community.
- The trust had a substantial track record of adapting services to meet the needs of people who were vulnerable. This included patients with a learning disability or in a social situation that made them vulnerable.
- The harm free care team established a series of 'communities of practice' to ensure the most vulnerable patients received appropriate care.
- The London rapid response assessment service consistently saw 96% of urgent referrals within two hours.
- Individual teams implemented projects to improve access, including restructuring and improving assessment methods.
- There was evidence of learning from complaints including the implementation of new policies and practices.

However:

- District nurse referral times for urgent cases increased significantly in Basildon and Brentwood and Thurrock in 2016/17. The trust was aware of this and had implemented strategies to address it.
- The response time for urgent referrals to the Essex rapid response assessment service had increased significantly in 2016/17.

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

- The minor injuries unit at Orsett Hospital included treatment rooms adapted to the needs of patients. This included a plaster room, emergency room, paediatrics room, eye emergency room and a bed for bariatric patients. The team at this service were trained to provide emergency contraception including assessment and counselling. The Anthony Wisdom Centre was located in the same hospital and included a dedicated room for patients who were under the escort of the police or prison officer as well as a room for escorted young people.
- We saw from our observations in the minor injuries unit at Orsett Hospital a significant number of patients attended because they could not access wound dressing or staple removal services through their GP. Although emergency nurse practitioners (ENPs) were able to provide treatment, this was not within the scope of the service and added pressure to staff and waiting times. In addition, only two GPs in the area offered long-acting reversible contraception (LARC), which meant patients relied on the Anthony Wisdom Centre (AWC) for these services. As a result there was a waiting time of two months for implants and four months for coil fitting.
- Staff in the AWC maintained a stock of a wide range of different condoms, which patients could access on a walk-in basis. All staff in this unit were trained to provide health promotion in relation to condom use and patients had access to a dedicated health advisor.
- Sexual health, HIV, genitourinary medicine (GUM) and family planning services were tailored to the needs of local populations. For example, staff from the AWC at Orsett Hospital provided level 1 HIV and general syphilis care through satellite clinics as well as baseline condition counselling at all sites they worked from. In addition staff were trained to provide care and treatment to patients at different levels of risk for sexual infection such as men who have sex with men and sex workers. The team had also adapted their training and service provision to meet the needs of local people who were elderly and living with HIV. This population group represented the first community to live to old age with the virus and presented specific challenges for the



## Are services responsive to people's needs?

clinical team. The team at the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic provided level 1 asymptomatic sexual health and level 3 LARC as well as community outreach services.

- Staff in the AWC were trained to provide both pre- and post-exposure prophylaxis, which are medicines used to counteract HIV in certain circumstances. This meant patients in the local population who were at risk of HIV infection had options to reduce this risk and prevent infection and transmission.
- As part of a service redesign, the integrated community team (ICT) based at Phoenix House had spent time with hospital-based colleagues to identify how to better meet the needs of the local population. This related to patients who transitioned between acute and community services.
- Rapid response assessment service (RRAS) teams had redeveloped the service to better serve the local population through the introduction of a two hour response time for patients at high risk and a 14-day referral time to the integrated care team.
- RRAS teams had recognised that many of their patients could not read prescriptions or medical information due to language difficulties. As a result the team had worked with patients to help them interpret prescriptions and ensured interpreters were available.
- RRAS teams had a demonstrable focus on ensuring equality and diversity were embedded in their service. For example, members of the team ensured they had a good understanding of different cultures and faith in order to provide sensitive care. The team had also developed to be representative of the population they served and included staff from diverse backgrounds.
- Staff training and referral pathways were in place for patients who disclosed domestic violence. In some services, such as in the AWC, patients were asked to disclose issues in a triage proforma at the first point of contact. Information on agencies that provided specialist help to the victims of domestic violence was available in discreet locations, such as on posters in toilets.
- A consultant-led respiratory clinic was available in the Porters Avenue Health Centre, which provided more options for patients who attended the respiratory services.

- Patients who received care from the pulmonary rehabilitation team had access to a musculoskeletal gym two days each week at Porters Avenue Health Centre.
- Staff in each service provided a range of printed materials for patients that signposted them to other specialist and non-NHS services. Services also provided their own printed information for patients on specific conditions and treatment. For example, staff provided specific information on sexually transmitted infections in the sexual health and family planning clinics and dieticians provided specific diet information in the nutrition and dietetics service.
- ICTs provided printed information leaflets for patients in nine of the most commonly spoken languages locally. Staff within this team who supported patients with a learning disability had developed a large-print easy read leaflet that explained care and treatment.
- A dedicated pharmacist was based in the AWC and provided one-to-one sessions for patients who were starting HIV antiretroviral therapy. They also provided support to patients who experienced side effects as a result of their medicine.

### Meeting the needs of people in vulnerable circumstances

- The nutrition and dietetics team had developed a patient passport for patients who received home enteral feeding. This enabled them to take their care and treatment details with them if they were admitted to hospital so that the hospital nutrition nurse specialist could assess their needs based on current treatment. This also ensured hospital staff had the contact details of the patient's multidisciplinary team including their Abbott nurse, who provided specialised equipment support.
- RRAS teams worked with other specialists to provide care for patients with a learning disability, autism or dementia. This included arranging double or triple-handed visits with the disability support team.
- RRAS teams had implemented strategies to support patients in local traveller communities, who presented with complex needs. This included providing double-handed visits and supporting patients with needs relating their community.



## Are services responsive to people's needs?

- The AWC had two waiting areas, which staff could use to separate male and female patients if this was appropriate. Staff told us this was most often used if they knew a patient was vulnerable.
  - The dementia crisis support team at Brentwood Community Hospital had developed and implemented an innovative first responder model of dementia care that redesigned the service to meet the needs of patients living with dementia in the community. This had led to reduced patient mortality and reduced hospital admissions. The team functioned on a crisis model that meant all referrals were triaged and assessed within 24 hours. The team accepted referrals from acute services, GPs and paramedics as well as non-health providers such as the police and voluntary agencies and had been recognised nationally for their work in improving access and patient outcomes.
  - A healthcare assistant working with the harm free care group and pressure ulcer investigation group had delivered monthly training to care home staff to help reduce pressure ulcers. This training was targeted at staff who provided care for vulnerable people, including those living with dementia and cared for under a Deprivation of Liberty Safeguards (DoLS) authorisation. After 12 months of this education programme the care homes reported no new pressure ulcers.
  - The harm free care team established a series of 'communities of practice' to ensure the most vulnerable patients received appropriate care. This included facilitating work between psychologists, allied health professionals, district nurses and operational staff to provide coordinated care for patients with needs relating to frailty, mental health, learning disabilities and long term conditions. As part of this project the team was establishing the research-based 'Purpose-T' tool as an initial assessment method.
- Access to the right care at the right time**
- The minor injuries unit (MIU) at Orsett Hospital was open from 10am to 7.30pm seven days a week. Although clinical services were not available until 10am, patients often arrived before this when the building opened. To ensure patients were seen in the order they arrived, the team had implemented a self sign-in system. A notice advised patients to sign in on a waiting list and that they would be seen in order of arrival once the service opened. We observed this process during our inspection and found reception staff called each patient in the order they were signed in and added their details to the system, which was used to monitor waiting times.
  - The on-site x-ray service offered by the hospital trust was available until 5pm each day. Out of these hours staff referred patients to the nearest emergency department or instructed them to come back the next day depending on their level of need. Reception staff triaged patients who were returning for the results of x-rays so they were seen by the appropriate member of staff and without needing to wait.
  - Patients were referred to the MIU at Orsett Hospital by the NHS 111 service. The reception team received an alert when this happened and an emergency nurse practitioner (ENP) reviewed the referral before the patient arrived. Where referrals were inappropriate an ENP contacted the referring 111 nurse to discuss this.
  - Patients who received care at home from district nurses told us the service was easy to access. For example patients said whenever they called a nurse would come quickly and there was never a delay in reaching someone by phone. One relative of a patient said, "The out of hours [district nursing] service is brilliant. They answer straightaway and the longest we've waited for a nurse to call us back or confirm a visit is 10 minutes."
  - Seven nurse-led respiratory clinics and two pulmonary rehabilitation clinics were available each week in the Porters Avenue Health Centre. This team had also restructured the oxygen clinic to offer priority appointments to see people more quickly and appropriately. As part of a drive to improve patient access overall, patients were able to self-refer back to the service after initial treatment.
  - The diabetes service scheduled patients with long-term care needs up to one year in advance. Patients also received a text message reminder of the appointment two days beforehand with instructions if they needed to reschedule.
  - The operational lead for community health and social care services had implemented a new competency framework for community respiratory services to reduce waiting times.
  - Patients living with HIV who attended the AWC had access to a two hour prescription collection service through an arrangement with a local pharmacy.
  - The trust monitored referral times for district nursing for Essex, Basildon, Brentwood, Thurrock and the London



# Are services responsive to people's needs?

boroughs of Barking and Dagenham, Havering and Redbridge. Between September 2016 and August 2017 patients were seen by a district nurse or the ICT between 37 minutes and four hours after an urgent referral. Referral times for most areas remained static for this period with the exception of Basildon and Brentwood (B&B) and Thurrock. In B&B the average referral time in September 2016 was 47 minutes and in August 2017 it was four hours and nine minutes. Similarly, the referral time for Thurrock increased from an average of 42 minutes to two hours and 18 minutes in the same period. For routine referrals, patients across all areas waited an average of 4.7 days.

- The trust had a long standing service level agreement with another NHS trust that enabled them to provide a community frailty and falls clinic. This was consultant-led by a jointly appointed geriatrician and a trust-employed HCA. This meant patients had greater access to frailty services in the community.
- Between September 2016 and August 2017 the average referral time for urgent cases in the Essex RRAS team was 1.5 hours. This represented an increase from 0.6 hours in September 2016 to 2.3 hours in August 2017. The RRAS team saw routine referrals within an average of 1.5 days. In London, 96% of urgent referrals were seen within two hours.
- The MIU and AWC at Orsett Hospital operated on a walk-in basis. We asked the clinical lead for each service about capacity limits and procedures if demand was significantly higher than staff could reasonably manage. In both cases we were advised the clinical lead would liaise with their operational manager and make a decision to close the services to minor cases. For example, staff in both units would triage and signpost patients to alternative services if more appropriate. If a patient with an urgent treatment need for an injury or symptomatic sexually transmitted infection presented then services would accept them regardless of capacity.
- Staff from the AWC operated a number of satellite clinics in addition to the walk-in service and appointment-based clinics at Orsett Hospital. This included drop-in advice and testing sessions for students at local colleges and evening and weekend clinics in community health centres. Patients newly diagnosed with HIV were seen immediately by a health advisor.
- The operational lead for the community integrated team at Phoenix House had spent one month in an acute

hospital to work with colleagues and identify how transfer and discharge pathways could be improved. This experience contributed to the service's redesign and meant community-based staff had a better understanding of the challenges facing hospital-based colleagues. As a result the operational lead implemented a discharge improvement project to improve the experience of patients moving between acute and community services.

- RRAS teams provided cover between 7am and 10pm seven day cover and patients were referred from a variety of sources such as care home staff and GPs. This team provided care for patients transitioning to the integrated discharge team and had a 14-day target to transition patients to the integrated community team.

## Learning from complaints and concerns

- The trust teams based at Grays Court Community Hospital had displayed a 'you said we did' board to indicate how they improved the service based on patient feedback. For example patients had said they found the trust's services confusing and communicating between them difficult. As a result the trust had introduced direct referrals between services to reduce the need for patients to set up appointments themselves.
- In quarter one of the trust's 2017/18 'How we are doing' survey, the team at Grays Court Community Hospital reported 15 compliments and no complaints.
- None of the patients we spoke with said they knew how to make a complaint or what the trust's policy was. However, every person said they would feel confident in speaking to staff if they had any concerns.
- Not all clinics had information readily on display about how to make a complaint. For example this information was available in the reception area of Porters Avenue Health Centre but not in the clinical areas at Orsett Hospital.
- The family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic had received one complaint in 12 months prior to our inspection. This related to the language used by a member of staff. In response the service provided communication training to the team.
- The dementia crisis support team had received no formal complaints in the previous four years.

# 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 good because:

- There was evidence of sustained improvement in clinical governance processes in most services. Adult community services was clearly represented at trust board level and senior teams for services and localities were well organised.
- All of the staff we spoke with described their local managers and senior team as supportive and encouraging.
- There was substantial evidence of staff engagement across most services including during service restructure.
- The strategic patient experience partnership was well organised and represented by a wide range of patients. The partnership had a demonstrable impact on service development and quality improvement and had ambitious plans to develop the service.
- Some teams demonstrated a drive for innovative practice through research projects and pilot schemes that led to new ways of working.
- Staff in each team had developed their own service values and goals, which prioritised patient experience and safety.
- There was a notable drive from senior divisional teams to engage staff at an early stage of joining the trust.
- Innovation was encouraged and celebrated and we saw numerous examples of national and international recognition for leading-edge work by service teams.

However:

- Although we saw evidence the trust had improved communication about its vision, goals and values, knowledge of these varied widely.
- There was a lack of support for staff in one service that was being retendered. This led to low levels of morale and high sickness rates.
- Staff in two services said they did not feel valued by or connected with their senior service teams. In addition, staff did not always feel engaged or listened to.
- Adult services did not have an established, embedded system or culture of sharing learning and initiatives.

- The trust participated in the 2016 national staff survey. Results across the 1996 respondents were variable with common themes of work pressure, excessive caseloads and patient safety as areas for improvement. All of the themes highlighted were in line with national performance in the same survey.

## Leadership

- An operational lead and associate director was responsible for each service, including each community health and social care service. These services were organised into locality teams and included district nurses, community matrons and therapies staff. Individual services had additional senior staff such as an integrated care director for community health and social care services. In addition each service had a combination of band 7 team leads, service leads and clinical leads.
- We found evidence of structured and effective change leadership in the London rapid response assessment service (RRAS) team during a period of transition. This included consultation exercises with staff by the operational lead, regular appraisals and feedback on the changes to shift patterns. Staff in this service were very positive about the support they said they received from the senior team, including when they had to balance work with unexpected personal events. One member of the team described the operational lead as “compassionate and understanding” and there was a demonstrable and coherent leadership structure that contributed to an efficient team that valued patient outcomes and staff wellbeing.
- The Anthony Wisdom Centre (AWC) and the family planning, sexual health and community gynaecology service at the Oliver Road Polyclinic were in the process of being retendered at the time of our inspection. The trust had not bid for the services, which meant other organisations would bid to take it over. Staff in the AWC spoke negatively about this process and about how they felt treated by the trust. One member of staff said, “The director and assistant director came and told us the trust was getting rid of the service just before a team



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meeting. They left after 10 minutes and we weren't allowed to ask any questions." Staff in both services spoke positively of local leadership and told us they felt supported by the clinical leads.

- Senior staff in community health and social care services (CHSCS) attended a monthly senior leader's forum in addition to locality leads meetings, CHSCS leaders meetings and individual team meetings. As part of our inspection we looked at a sample of minutes from 155 team meetings that took place across the trust from December 2016 to September 2017. We saw the meetings were consistently well-attended and staff used them to discuss incidents, complaints and changes to the risk register of the service. Actions documented in relation to the meetings were variable but there was evidence positive change took place as a result.

## Vision and strategy

- Staff in each service had established their own team purpose and key quality outcomes and identified the aims of the service. Staff completed a large-format poster with this information and in some areas this was on display for the public and in others they were available in staff areas. For example, the minor injuries team at Orsett Hospital had identified their purpose as, "Provide excellent care and provide a service close to home for minor injuries." One of the aims of the service was to provide 100% of treatment within four hours of arrival, which also formed a key quality indicator.
- Although understanding of trust-wide values and vision was variable in our conversations with staff, a sample of 30 appraisals we looked at indicated this topic was included in professional development plans. In 10 cases staff had noted they felt much more involved with the trust and understood the trust's plans and future direction. Where staff felt they did not have a good understanding of the trust's vision and values we saw evidence their appraiser set goals to achieve this understanding.
- There was a notable increase in the number of staff who were aware of the trust's vision and values since our last inspection. However this was still limited in some areas and varied by team and location. For example, six out of eight members of the crisis support team in Brentwood knew what the trust's vision was. However, a member of staff at Orsett Hospital said, "We feel like a standalone service, like we're kept very separate from the main work of the trust, which is mental health."

- RRAS teams had redeveloped their service vision during a restructure of the service. The team had a demonstrable focus on patient outcomes, which they prioritised as their key aim.

## Culture

- The crisis support and RRAS teams demonstrated enthusiasm and passion for their service and told us they felt well supported by their senior teams.
- Most of the clinical leads we spoke with described a positive relationship with operational managers. For example, the clinical lead for the minor injuries unit at Orsett Hospital said their operational manager called them daily and met with them once per week to discuss all aspects of the unit's operation.
- Adult services did not have an established, embedded system or culture of sharing learning and initiatives. For example the trust operated two minor injuries units, one in Barking and one in Essex. Staff told us there were no opportunities to learn from the practice of each service and they did not communicate with colleagues at different sites. This meant although learning and sharing of practice took place at a local level, there was limited scope for this outside of the individual service. This was reflected in our conversations with staff in other services. For example, senior staff in CHSCS said they were aware of initiatives in other boroughs through the intranet and communication directly from the trust but each borough team worked differently and to a different agenda.
- In every service we visited as part of our inspection we asked staff what they were proudest of in their work. In every conversation staff told us team work and working relationships with colleagues that contributed to patient care were the most positive aspects of their work. For example one person at Orsett Hospital said, "This is a positive and really happy team. I'm proud of our service and all the compliments we receive."
- District nurses we spoke with from Grays Court Community Hospital said they felt well supported by their managers. They also told us managers would accompany them to home visits if they needed extra support or if a patient had complex needs.
- The harm free care team identified a 'champion of the month' who was recognised for their focus on



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improvement. We spoke with the senior members of this team who told us the recognition award was part of their drive to reward improvement rather than highlight mistakes.

- Staff in the Brentwood tissue viability team described a culture of disempowerment. For example one member of staff said, “There is a culture of ignoring e-mails, not answering messages and constant chasing for an answer. Unless the CCG asks for something nothing gets done.” A member of staff in the Seven Kings health and social care service said, “I’m frustrated by the constant change of leadership and their constant changes. It means we have poor continuity of care that leads to confusion amongst staff. It’s difficult to keep everyone updated.”

### Governance

- Senior teams used the Directorate Performance Quality and Safety Group (DPQSG) as a key tool for clinical governance and risk management. We looked at a sample of 95 DPQSG minutes across seven directorates and found there was documented evidence of service development and improvements as a result of the trust’s focus on quality.
- The range and complexity of services, including the geographic area they covered, meant there were differences in how different teams felt about the cohesion of their service with the trust and other local services. For example, staff in one area told us they found it challenging to engage with district nurses from another trust, which meant coordinated care could be difficult. Local teams described varying relationships with operations managers in supporting them to overcome local difficulties. For example, nutrition and dietetics staff said a local operations manager was supporting them to build better working relationships with district nurses provided by a different trust in the area.
- The integrated care team (ICT) based at Phoenix House was undergoing a period of transition and service redesign. To support staff during this period, a buddy system was in place and staff we spoke with said they felt well informed.
- There was limited evidence of effective clinical governance from the trust in relation to the change in tender of the AWC. For example since the trust announced the decision the service would no longer be part of their portfolio, staff sickness had increased significantly. One member of staff said, “I feel very let down by the trust. Sending the director in to speak to us was a tick-box exercise; they made it clear they had no interest in what happens to us. It’s like we’re invisible, they haven’t even taken notice when our sickness rate hit 25%.” We spoke with the trust about this after our inspection, who provided evidence they had told staff a transfer of undertakings protection of employment (TUPE) consultation would take place in January 2018, which could protect some roles. We reviewed the consultation that had taken place with the transfer of provider for the sexual and reproductive health team based in Waltham Forest. We saw this was a structured process in which the trust supported staff and communicated openly with them. Although this suggested the same process would take place at the AWC, there was a clear and demonstrable negative impact on staff in the interim.
- ICTs were organised into localities aligned with GP networks and we co-located with social services teams.
- The strategic patient experience partnership maintained a direct link between patients and the trust board. This included a ‘patient journey’ section at the beginning of each board meeting when a patient or carer would describe their experiences in the trust.
- Each locality had an integrated patient experience partnership group with a dedicated chair and vice chair. Local teams maintained regular contact through meetings with senior teams and the chair of the strategic patient experience partnership represented patient experience at board level.
- The strategic patient experience partnership had developed relationships with local Healthwatch teams, clinical commissioning groups and various patient-led volunteer groups. This was part of a strategy to improve learning across local services and build information-sharing relationships.
- As part of the trust’s quality improvement programme, three peer tutors in the expert patient programme were undertaking quality improvement facilitator’s programme. On completion one of the tutors would join the quality improvement steering group to help embed changes across trust services and standardise quality.
- As part of the trust’s overall quality improvement strategy, each service contacted five of their patients each month to ask five questions about their experience. This strategy had resulted in 12000 patient contacts in the previous 12 months that service leads

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used to influence their care. Although uptake of this programme was generally consistent, we saw there were gaps from looking at monthly team meeting records. For example, services in Waltham Forest had not always achieved the five contacts per month in the six months leading to our inspection. In addition there was inconsistent follow up with patient comments. For example, we reviewed the 15 patient comments generated from calls to patients from the sexual health service at Orsett Hospital between July 2017 and September 2017. Although all 15 patients said they were generally happy with the service, three patients provided feedback about concerns. For example, one patient said they experienced “severe delays” in the service although they noted reception staff kept them informed. Another patient noted they wanted to be more involved in their treatment regime but was worried about “upsetting the consultant.” We did not find that this was followed up by senior staff. Overall it was unclear how services used this information to improve.

### Management of risk, issues and performance

- The harm free care group met quarterly with the quality and safety committee to discuss exceptions to safety performance. This was shared with clinical commissioning groups as part of the group’s strategy of transparency and open communication. Outcomes from the meetings were added to service risk registers so that improvements could be monitored.
- The harm free care team met weekly with the chief nurse group to identify work streams for improving safety and quality.
- The county that neighboured the AWC had no operational sexual health service, which meant the centre received referrals and patients from out of area. Although no patient was turned away this caused a governance challenge for the senior team who told us it was difficult to get payment for such patients.
- Each service area had a business continuity plan for major incidents as well as for short staffing and other events that could impact the service. At Orsett Hospital, staff in the minor injuries unit referred patients to x-ray services at a nearby acute hospital in the event of a diagnostic systems failure.
- The clinical lead in the AWC had planned to implement the business continuity plan following a staff sickness

absence rate of 28%. There had been no demonstrable impact on patient safety and the local senior team told us preparations had worked well, without ultimately being implemented.

- Where staff provided services from a clinic they adhered to local fire safety and evacuation procedures. Some sites such as the Porters Avenue Health Centre, had evacuation chairs to help patients with reduced mobility. Staff told us they had received training in the use of this equipment.
- District nurses said they were frustrated by the unreliability of the laptop computers they used on home visits. We saw during our observations that the software sometimes failed to load or was too slow to be used in a patient’s home. One nurse said, “I want to be able to show [my patients] what I’m writing so they understand their care plan but this isn’t always possible because the laptops don’t work.”
- The falls strategy group had conducted a review of all of the types of movement sensors and detectors used by community teams. This was part of a strategy to reduce the incidence rate of falls. As a result of the review the team had standardised the trust approach to recommending movement sensors and they shared this with discharge teams.
- Staff who delivered care under agile working processes were issued with a mobile phone to maintain contact with colleagues and their base. However, we received consistently poor feedback from staff regarding the reliability of this equipment.

### Information management

- There was room for improvement in the structure and integrity of local clinical governance processes in some areas. For example, locality leads based in Grays Court Community Hospital said they did not attend clinical governance meetings and said there was no recent changes in practice or policy from incident learning or audits. We were also unable to confirm that senior local staff understood the trust’s structure or quality dashboards.
- No-one in the Grays Court Community Hospital district nursing team could locate the risk register or identify the key risks to the service. This was not a common feature of our discussions with staff and we found those working in other services knew how to access quality and governance information. In addition the Grays Court team were aware of specific risk assessments.

## Are services well-led?

- The EPRS used by the nutrition and dietetics service in Billericay enabled discharge summaries to be shared with GPs and included details of which goals patients had achieved by the time of discharge. This reduced the need for multiple discharge summaries and meant patients had a single easy-to-read summary.
- The respiratory and pulmonary rehabilitation team at Porters Avenue Health Centre completed a structured discharge summary for each patient, which was sent to GPs and stored in the event the patient made a future self-referral.
- Sexual health and family planning services used an independent electronic patient records system. This was accessible by staff who led satellite and remote services, which meant staff could share and access records efficiently. This system was not connected with other EPRS in the trust to maintain confidentiality.
- The pressure ulcer investigation group worked with patients, relatives and carers to improve understanding of the risks and symptoms. For example the team provided educational information on their public social media page and created a new pathway that could be accessed electronically by the public. In addition the group invited patients who had previously experienced a pressure ulcer to join multi-agency meetings to talk about their experience. This was used a strategy to help staff understand their experience of care leading up to a pressure ulcer.
- There was a notable drive from senior divisional teams to engage staff at an early stage of joining the trust. For example, healthcare assistants who had joined the trust in the two months prior to our inspection were scheduled to attend a meet and greet session with the directors. In addition the senior team in Thurrock had arranged an afternoon tea for staff to get to know the senior local team. However there was limited evidence this applied to existing staff or teams. For example staff in the respiratory service at Porters Avenue said the trust communicated with them on a reactionary basis and said there was little opportunity for engagement or reflection.

### Engagement

- A chairperson and associate director of nursing led a strategic patient experience partnership. This group worked to an established and governed policy and in 2016/17 achieved 2554 hours of patient involvement and engagement activities.
- A team of 112 patient representatives provided structured guidance and feedback to clinical teams across the service. This represented a significant involvement of service users and meant they were engaged with policy changes, recruitment and service improvement. For example, the nutrition and dietetics service in Billericay ensured a patient representative formed part of the interview panel for new staff and had sent proposed policy changes to patient representatives for their feedback on readability. Most recently this involved the enteral feeding policy.
- As a result of patient feedback, the clinical lead of the minor injuries unit at Orsett Hospital had implemented a waiting system for patients who arrived before the service opened. This process was clearly displayed in the unit and meant patients were seen fairly once the service opened.
- A dedicated equality and diversity team were responsible for the delivery of the NHS England Equality Delivery System 2. This team worked with the strategic patient experience partnership to ensure patient diversity was represented in the trust's engagement activities.
- The community support team (CST) said they felt listened to by the senior team and said they could give constructive feedback at any time and felt this would be acted on. Staff in the long term conditions centre and Harold Hill health centre said they rarely saw the senior leadership team. One member of staff said, "I don't think we're valued by the senior team. We have no contact with them; never see them. But our local managers are great."
- Clinical leads had monthly meetings with their operational manager as part of a process of clinical governance and engagement that enabled both to provide feedback. In addition some clinical leads noted the assistant director of their service provided opportunities for regular feedback.
- District nurses highlighted that patient needs were becoming increasingly complex. As a result senior teams in some areas had arranged briefings from other teams in staff meetings. For example, the health and wellbeing coordinator had presented at a district nurse meeting at Grays Court Community Hospital and nurses told us they had the opportunity to talk and reflect on their patients and recent cases.

## Are services well-led?

- Staff who used laptop computers to access electronic patient records in people's homes said they did not feel senior teams listened to them in relation to IT problems. For example, during our observations of home visits we saw laptops often failed, which meant nurses could not enter patient notes. Nurses said they escalated these issues to their senior team but did not feel that there was work ongoing to resolve it.
- RRAS teams had restructured their shift system as part of a project with the senior divisional team to increase capacity and responsiveness. This had resulted in a seven day service between 7am and 10pm and an increase in referrals from an average of 12 per day to 58 per day. Members of the team we spoke with said the operational lead had been supportive during the service change and they had felt listened to.
- Staff in the AWC said the trust did not engage with them. For example, one member of staff said, "The assistant director and head of service seem to have a huge area to cover and they don't seem to have time to engage with us. The last assistant director used to spend one day a week here, the new [assistant director] is rarely seen and I think we'd be lucky if they know the name of anyone who works here." In relation to the change of provider for the service, one member of staff said, "There has been no involvement from human resources and no visibility from the senior [team]. This despite such high sickness and anxiety."
- Staff in the ICT that formed part of community health and social care services had been consulted on the implementation of a service redesign project and a new competency framework. Although staff told us the consultation process was positive, they were concerned at the frequency of restructures from the trust. For example, some staff had experienced four restructures during employment with the trust. From our discussions it was clear staff did not always understand the purpose or value of restructuring despite an improved drive for engagement from the trust.
- A communication lead in the harm free care team led engagement with staff across the trust to embed quality improvement in safe care. For example, the lead provided a link between patient groups and staff teams and organised awareness events, such as a falls week, to raise awareness amongst staff.
- The trust participated in the 2016 national staff survey. Results across the 1996 respondents were variable with common themes of work pressure, excessive caseloads and patient safety as areas for improvement. For example, 92% of respondents said they felt under pressure to go to work even when they were unwell. In addition 25% of respondents felt there were enough staff to meet patient needs and 26% said there were enough staff in the organisation to do their job properly. The trust had initiated action plans to address key concerns, including a task and finish group for capacity and demand and an initiative led by the senior trust team to be more supportive of staff who were unwell. Other results from the survey included 73% of staff said they were often or always enthusiastic about their work and 75% felt they were able to make suggestions to improve work. However, 52% said they had adequate materials and supplies and 69% said they were satisfied with immediate manager support. Although 80% said they were satisfied with the quality of care, 42% said they had been unwell as a result of work related stress.
- Staff in smaller teams did not always have the opportunity to have their views heard. For example a member of staff in the epilepsy service said they had submitted feedback and suggestions about service improvement but did not always feel listened to.
- The strategic patient experience partnership collected data on its members to gauge the diversity of the group in relation to the trust's patient population. In 2016/17 31% of the group were from black and minority ethnic backgrounds and 10% identified as lesbian, gay, bisexual or transgender. The chair of the group identified engagement with young people as a key priority for 2017/18 and there were 16 members under the age of 18 in place to help deliver this. The young person's representatives planned to develop a virtual involvement forum so young patients and carers could connect digitally in a safe and structured environment. In addition, the experiences and needs of patients with a disability were represented by group members. This included 60% of members who had experience of a mental health problem, 30% of members who said they had a physical or sensory disability and 10% who said they had a learning disability.

### Learning, continuous improvement and innovation

- Some teams promoted innovation and service development through research. For example the CST had been awarded a Health Service Journal 2016 award for providing an exemplar service.



## Are services well-led?

- Staff in the long term conditions centre said there was no succession planning for the service. The team told us this was problematic because all of the team were due to retire in the near future.
- Senior staff in the minor injuries unit at Orsett Hospital noted that patient need was far higher than the capacity of the service, which presented sustainability challenges. For example we saw during our inspection patients routinely filled the waiting room and had to queue in corridors, blocking access to other services.
- Staff in the AWC worked to a model of care that enabled them to be dynamic in adapting service provision and staff training to the changing needs of the local population. For example staff had noted a recent new risk amongst local female patients who reported high-risk drug use. The team established this was a particular issue for Tilbury and planned a pilot intervention scheme with a local health improvement team. In addition the team prioritised college-based health promotion following an identification that college-age students were presenting in the service with elevated risks of HIV exposure.
- Staff reporting a pressure ulcer in their service were invited to present the care at a pressure ulcer investigation panel as part of an engagement and learning process. The whole team responsible for the patient attended the panel, which was held as a roundtable event to enable each team to learn from each other. This approach had contributed to a 45% reduction in pressure ulcers between November 2015 and September 2017.
- The allied health professional team was research active and had five projects in progress. Each research project was relevant to the team's clinical practice and could lead to improved care standards. This included research into providing care for patients living with dementia and improving outcomes for patients with neurological conditions.
- The tissue viability service lead had established a research programme to identify the best equipment to use for training competencies to improve patient outcomes. The study was suspended at the time of our inspection due to a shortage of support staff in one locality and participants in another locality. However, the research design demonstrated a drive towards improving services through the development of a local evidence base. In addition the tissue viability team had completed a research and audit study that involved a private training company in the work of the team as a strategy to improve tissue viability nurse competencies and patient care. One of the key aims was to reduce the time district nurses spent with patients who needed wound care, particularly for leg ulcers. The study took place over a three month period and saved a total of 1156 district nursing hours. The study leads were developing an innovative care framework as a result at the time of our inspection.
- Staff and patient members of the strategic patient experience partnership attended the 2017 World Congress of Psychiatry in recognition of their innovative work in involving patients in competency training and educational facilitators in mental health care scenarios.

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

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

#### Regulation 18 (2)(a)

Staff were not consistently or regularly given clinical supervision or appraisals.

**This was a breach of regulation 18(2)(a)**