East London NHS Foundation Trust

RWK

Community health services for adults

Quality Report

East London NHS Foundation Trust
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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)
RWKGY	Trust Headquarters	Primary Care at Home South Team Hub One	LU6 3JA
RWKGY	Trust Headquarters	Primary Care at Home South Team Hub Two	LU7 1AR
RWKGY	Trust Headquarters	Primary Care at Home Mid Hub	SG17 5FS
RWKGY	Trust Headquarters	Primary Care at Home North Hub	MK41 6AT
RWKGY	Trust Headquarters	Complex Care Team	MK42 7PN
RWKGY	Trust Headquarters	Warfarin Team	MK42 7PN
RWKGY	Trust Headquarters	Specialist Care Team	MK42 7PN
RWKGY	Trust Headquarters	Speech and Language Therapy Team	MK42 9DJ

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

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

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

Summary of findings

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Overall summary

This was a focused inspection of services delivered only in this geographical area. We did not rate this service:

We found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good quality care and treatment, ensured patients had sufficient fluids and nutrition, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to information they might want or need. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff said they felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However, we found the following areas that needed to improve:

- The community speech and language therapy service was not triaging patients at the point of referral to identify patients presenting a high risk. This service was not seeing high priority patients within the required two-week timescale, with 80% of high priority patients having to wait considerably longer.

Summary of findings

Background to the service

East London NHS Foundation Trust provides community health services throughout the county of Bedfordshire. These services include community nursing teams that deliver primary care services in patients' homes. The trust also provides specialist services that include a nutrition and dietetics service, community rehabilitation and enablement, continence care, podiatry, specialist heart failure clinics, a palliative care service, specialist nursing for patients with neurological conditions, wound care, nursing for patients with tuberculosis, speech and language therapy, a wheelchair service and a warfarin service.

Services are provided in patients' homes or at clinics based at community health centres.

These services have been provided by East London NHS Trust since April 2018. Before this date the services were provided by South Essex Partnership University NHS Foundation Trust. The CQC inspected these services as part of an inspection of South Essex Partnership University NHS Foundation Trust in 2015. The CQC rated these services as being good in all the domains of safe, effective, caring, responsive and well-led.

How we carried out this inspection

During the inspection, the inspection team visited the community nursing teams in North, South and Mid-Bedfordshire. We attended a leg ulcer clinic, heart failure clinic, warfarin clinic and the speech and language therapy service. We also attended appointments with nurses in patients' homes. We carried out the following activities:

- looked at the quality of the environment in the offices and clinical settings
- observed how staff were caring for patients
- spoke with 39 patients
- interviewed 56 members of staff including service managers, registered nurses, occupational therapists, community matrons, the head of the single point of access and an assistant director
- looked at 20 care records
- attended two multidisciplinary team meetings, a staff meeting and a meeting for senior nurses
- looked at a small sample of medication charts and records of physical observations
- looked at other documents relating to the running of services including policies, supervision records, appraisal records, incident records, minutes of team meetings and safeguarding records.

This was a focussed inspection of community health services within this geographical area. The trust also provides community health services within several London boroughs, which we did not visit during this inspection. We therefore did not rate this service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

The trust must ensure that referrals to the speech and language service are assessed promptly to identify any high-risk patients and ensure they receive an appropriate assessment in a timely manor. The service must also ensure that patients are seen within an appropriate time. Appropriate information must be available to managers to ensure they can monitor this service. **Regulation 12 Safe care and treatment (1)(2)(a)(b)**

Action the trust SHOULD take to improve

Summary of findings

The service should ensure there are effective processes to identify and remove out-of-date clinical items in a timely way.

The service should ensure supervision takes place regularly for all staff.

East London NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We did not rate this service.

We found the following areas that needed to improve:

- Staff at the speech and language therapy service did not triage referrals when they received them. Over 60% of referrals had not been triaged within two weeks of their receipt. This meant the service was not aware of the level risk presented to patients whose referral had not been triaged and that patients requiring urgent treatment may experience delays. This meant that some patients might be at high risk of significant harm due to chocking.
- We found that one service held a large number of out-of-date items in their stock room that should have been removed. There was no system to remove out-of-date items.
- The Primary Home Care service in North Bedfordshire had a staff vacancy rate above 20%.
- Some staff had difficulties in accessing patients' records through their equipment for mobile working due to a lack of signal coverage in rural areas.

However, we found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Most services had enough staff with the right qualifications, skills, training and experience to keep

patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and stored securely.
- The service used systems and processes to safely administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

Detailed findings:

Safety performance

Mandatory training

The service provided mandatory training in key skills to all staff. Managers ensured that staff completed this training.

The overall compliance rate across all mandatory training courses was 89%. This was in line with the trust's target. Staff who had not yet completed mandatory training sessions were booked onto future courses. Service managers received weekly updates on training compliance from the trust's quality team which they forwarded to team leaders for action when necessary.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply their learning.

All staff with direct patient contact, including district and specialist nurses, had completed Level 3 safeguarding training. Between July and September 2019, the service in south Bedfordshire had reported 39 safeguarding concerns. This included 15 concerns relating to neglect, 11 relating to self-neglect and eight covering multiple categories of abuse, usually including emotional abuse.

At the last inspection, we told the trust that they should ensure that staff had greater clarity of the thresholds for making safeguarding alerts. At this inspection, we found that staff had a good understanding of safeguarding and when to make referrals to the local authority. Staff were able to give examples of when they had raised safeguarding alerts. The community safeguarding lead kept a detailed report on the progress of safeguarding referrals. This included details of the referral, the type of abuse, the date staff informed the local authority, the response from the local authority and details of any outstanding actions.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Staff members visiting patients carried a range of equipment with them, including a stethoscope, blood pressure machine, thermometer, torch, glucometer and adrenaline kit. We saw that staff used antibacterial wipes to clean equipment following patient visits. We saw that staff washed their hands before and after any patient contact and used personal protective equipment to protect themselves and patients against any infections. The portable equipment carried by staff had all been tested and carried 'clean' stickers which were in date.

Services conducted infection control audits covering hand hygiene, the care environment, clinical practices, waste disposal and handling sharps. The trust infection control lead had held a conference at which staff presented examples of good infection control practice for their services. A microbiologist had attended via videoconferencing to talk about antimicrobial resistance, which is when a bacteria or virus is resistant to common treatment such as antibiotics, and can stay around for longer and end up being passed to others.

Equipment and environment

Are services safe?

The service had suitable premises and equipment and looked after them well.

Staff mostly visited patients in their homes and carried the necessary equipment with them. Staff also carried antibacterial wipes and hand gels to clean equipment. Patients who required injections kept sharps bins in their homes. Nurses replaced these bins when they were full. Full sharps bins were sealed and returned to the offices for safe disposal. Nurse led clinics, such as the leg ulcer clinic, warfarin clinic, heart failure clinic and tuberculosis clinics took place at community health centres. Staff ensured that the premises were clean, well equipped and well-maintained.

Staff completed regular assessments of the care environment. The waste segregation audit, which monitored how waste was managed, was completed in July 2019. During the inspection, we saw that staff carrying out home visits or clinics in the community handled waste appropriately. This included clinical waste, general waste and sharps. Where staff used sharps bins, we saw they had labels with the date of assembly and relevant staff signatures and were not overflowing.

Each service completed a fire safety checklist each month at the office bases where staff worked. Fire risk assessment was completed in February 2019. Actions from these audits had been completed. The trust's annual security risk assessment was completed in December 2019.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

During the inspection, we completed a comprehensive review of 20 patients' care records. All these records demonstrated good practice in assessing and managing risks.

Assessment of patient risk

Staff were competent and confident to assess and respond to risks to patients. Staff completed appropriate assessments to find out whether people needed urgent medical attention, or referral for additional support or treatment. Community nurses completed a number of assessments with each patient. This included checking the patient's pulse, blood pressure, respiration and oxygen saturation. Nurses also completed specific assessments in relation to pressure sores, nutrition and hydration and tissue viability.

Staff were clear about the process to follow should a patient become unwell in the home, during a clinic appointment or in a community setting. If a patient was receiving palliative care, a plan was agreed with the patient and their carers on what to do when the patient became unwell. For other patients, staff would either inform the patient's general practitioner, increase the frequency of visits or arrange for the patient to be taken to hospital depending on the severity of the patient's condition.

Staff used recognised risk assessment tools. For example, the service used the National Early Warning Scores (NEWS) to record patients' pulse and blood pressure. Staff used Waterlow scores and S SKIN bundles to measure and record details of ulcers and pressure sores. The service also used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of malnutrition.

Management of risk

Staff responded promptly to sudden deterioration in a patient's health. For example, we saw evidence of staff preparing food for an elderly patient whose blood glucose levels had dropped. They monitored the patient's wellbeing until they were settled again. They reviewed the risk of this happening again and made relevant referrals to other organisations to ensure the patient had increased support during the day.

Staff mostly managed patients on the waiting list well. Most of the services, except the speech and language therapy service and tissue viability service, did not have active waiting lists at the time of the inspection. The tissue viability service had a waiting list of 22 patients. Staff were able to prioritise referrals depending on the severity of their wounds. Patients on this waiting list were usually seen within two weeks, well within the target time of six to eight weeks. At the speech and language therapy service, staff sent a letter informing patients of the waiting times. The letter encouraged patients to contact the service again if their condition deteriorated.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. All staff working in the community were provided with an overview of the lone working

protocols for each team during their induction. The services displayed a flow chart in their offices to show staff what actions to take in the event of a lone-working concern. Staff informed the duty nurse of their daily appointments. When staff were not returning to the office after their final appointment, they were required to contact the duty nurse to confirm they had arrived home safely.

Staffing levels and caseload

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The caseloads for the community nursing services varied between 393 and 750 depending on the size of the population each service covered. The warfarin team had 550 patients on its caseload. The complex care team did not carry a caseload, as they offered immediate interventions upon referral and usually discharged patients following this visit. This team had recently implemented two follow-up visits for patients in residential care to ensure that the care home staff felt confident with instructions given at the first visit.

The tissue viability nursing team had a caseload of 163 patients across the North, Mid and South of Bedfordshire. The team had 22 patients on the waiting list. The heart failure team had 218 patients on its caseload across the North, Mid and South of Bedfordshire, and Ivel Valley.

Staff had regular discussions with their team leaders to manage caseloads and patient waiting lists. These meetings took place every four to six weeks.

Most services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The overall vacancy rate for the service was 9%. There were 15 vacancies for registered nurses out of an establishment of 174. The vacancy rate for occupational therapists was slightly higher, with 3.6 whole time equivalent (WTE) vacancies out of an establishment of 20.3. However, the Primary Home Care Hub (North) had 11.5 WTE vacancies out of an establishment of 53 staff, representing 22% of the workforce. This service were recruiting staff to address this. Four of these posts had been filled and the new members of staff would be starting in January 2020.

The service engaged in ongoing recruitment strategies to fill the vacant posts. This included setting up stalls at recruitment fairs, social media advertising, visiting local universities, a starter bonus for new staff and managing a student development programme.

The sickness level across the service was 4.5%. This was higher than the average sickness level for the trust which was 3.5%.

The staff turnover rate was 18.7%.

The service used bank staff to cover staff absences and vacancies. Bank staffing usually comprised of permanent staff providing additional hours. This meant that bank staff received supervision. All bank staff were required to complete the mandatory training courses. Only one person working within the service was employed by an agency.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care

We examined 20 patient records across the district nursing, complex care, warfarin and tuberculosis teams. We found that the records were accurate and provided a good overview of the patients' care.

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Throughout the inspection we found that records were clear, easy to understand and up-to-date. Key risk indicators were shown on the front page of the record. Key risk assessments were all up-to-date and easy to access.

All information needed to deliver patient care was usually available to all relevant staff when they needed it and in an accessible form. That included when patients moved between teams. Staff across all services used the trust's electronic patient record. As well as recording details of care and treatment, the system enabled staff to send 'tasks' to other teams in order to organise work effectively. For example, when a call handler at the single point of access received a call, they recorded the details and assigned the referral or patient enquiry to the relevant team. The system alerted managers or staff on the duty desk to the information, enabling them to respond promptly. However, some staff did have difficulties in accessing records through their equipment for mobile working due to a lack of signal

coverage in rural areas. This meant staff often had to return to their office to write up their notes, leading to staff working long hours. The trust was aware of these problems and was in the process of changing their internet provider to ensure more comprehensive coverage.

Medicines

The service used systems and processes to safely administer medicines.

When medicines were administered on site or in patients' own homes, staff followed good practice in medicines management and it was done in line with national guidance. All medicines were prescribed by each patient's general practitioner (GP). Patients' friends or family members collected the medicines from the pharmacy or they would be delivered by the pharmacy service. Nurses recorded the medicines they administered on medicines administration records, insulin charts, syringe driver charts and intravenous medicine charts. When a patient kept controlled drugs in their home, nurses completed a 'controlled drugs balance sheet' to check that all these drugs were accounted for. All these records were kept in the patient's home and returned to the service when the period of care had finished. Nurses checked that patients were storing medicines correctly. For example, they checked that patients were keeping medicines in the fridge when this was required. Patients' families returned medicines to the pharmacy when they were no longer needed. The pharmacy team had carried out an audit of all the medicine errors reported by the complex care, warfarin team and district nurses' teams in Bedfordshire.

Staff regularly reviewed the effects of medication on patients' physical health. Nurses discussed patients' medicines with them during each visit to monitor any changes in the patient's condition that was a result of the medication. Nurses also used this to monitor patients' compliance with medication.

Staff received training in medicines management and administration. The service regularly assessed the competency of staff who had completed this training. Training in the management of medicines was compulsory for all registered nurses. Managers also completed regular competency checks of staff in relation to the use of syringe drivers, management of diabetes and the management of patients on anticoagulant medicines. Some staff in the specialist nurses' teams prescribed medicines and did so safely. They had had specific training in non-medical prescribing and were regularly assessed for a revalidation of their skills. Staff were assessed on their prescribing competencies four times a year, and new prescribers had to attend six competency sessions.

At Leighton Buzzard Health Centre we found the service held a large number of items in stock, much of which had passed its expiry date. For example, two boxes of epaderm ointments had expired in May 2019, eight adhesive removal foam applicators had expired in November 2019 and a full box of flu swabs had expired in November 2019. A box of 50ml syringes, had expired in September 2019. We raised this matter during the inspection. Staff removed these items and disposed of them immediately.

Safety performance

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The trust reported a total of 1,129 incidents at these services between July and September 2019. A total of 920 of the incidents, accounting for 81%, related to care and treatment. This included 313 pressure ulcers acquired before admission to the service and 265 pressure ulcers that had developed or worsened whilst the patient was receiving care from the service. Thirty-two incidents related to slips, trips or falls. As part of the trust mortality review, staff reported all deaths of patients. During this period, 80 of the 85 deaths were classified as expected deaths. Four deaths required further investigation as they were unexpected or the cause was unknown. Overall, 52% of incidents were classified as low-harm, 23% were moderate harm, 7% related to patient deaths and 0.1% were classified as severe.

Incidents and safety performance was monitored through monthly management meetings within each locality. Data on incidents was presented in a report to the directors' quarterly meeting. This also included details of investigations into unexpected deaths and other serious incidents.

Never events

Are services safe?

There had been no never events in the 12 months before the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Incident reporting, learning and improvement

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

All staff knew what incidents to report and how to report them. All staff received training in recording incidents on the electronic incident reporting system. Senior nurses supported healthcare assistants to complete reports if they did not feel confident in doing so.

Staff reported all incidents that should be reported. For example, staff recorded incidents relating to pressure ulcers, safeguarding concerns, alerts about poor discharges from hospital and patient deaths.

Staff understood the duty of candour. They were open and transparent and gave a full explanation to patients and families if and when something went wrong. The service sent a duty of candour letter to any patient involved in an incident classified as causing moderate or severe harm. For example, the service routinely sent out a duty of candour letter whenever a patient acquired a pressure ulcer of category three or above. The duty of candour letter included an apology and details of how the incident had happened.

Staff received feedback from investigations into incidents both internal and external to the service and staff met to discuss that feedback. All incidents were reviewed by the team leader who carried out an initial investigation. For example, we reviewed an incident record relating to a patient with multiple category three pressure ulcers that had worsened. The team leader checked that appropriate assessments had been completed, that the correct equipment had been provided and that referrals had been made in a timely manner to the tissue viability service. Staff discussed reported incidents at regular locality and multidisciplinary team meetings. For example, the service held a 'Skin Matters' meeting. District nurses team leads, locality managers, tissue viability nurses, podiatry nurses, dietitians, continence nurses and the safety lead for the Clinical Commissioning Group all attended this meeting to review incidents involving pressure ulcers rated as category three or higher. At these meetings, staff discussed each incident and identified any lessons that could be learned. The meeting in November 2019 found that, in one case, staff concluded that a referral to podiatry could have been made sooner. In another case, the staff agreed to advise carers to contact them as soon as they noticed any skin changes, as this may have prevented deterioration. Staff across the county also completed a 'poor discharge from hospital' alert when patients were discharged without sufficient co-ordination of their care being in place. For example, the service would complete an alert if they had not been informed that a patient was being discharged. These alerts were referred to the safeguarding team and reviewed with the discharge liaison manager at the hospital.

There was evidence of change having been made as a result of feedback. For example, one service identified a series of incidents that involved staff missing diabetic patients off their schedule. The service changed its system to ensure that the duty sister was responsible for overseeing all visits to diabetic patients and ensuring they took place. The service also provided learning sessions for nurses with the specialist diabetic nurse from the local hospital.

Staff were debriefed and received support after a serious incident. Managers recognised emotional demands of palliative care. Managers and colleagues provided support to staff when patients died. Staff also received support in managing emotions from McMillan nurses. The services could refer staff to a psychologist if there were specific reasons to do so.

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 did not rate this service.

We found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff kept up-to-date, accurate and comprehensive records on patients' care and treatment. All staff had access to an electronic records system that they could update.

Detailed findings:

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

During the inspection, we reviewed 20 care records. All these records demonstrated good practice in relation to compliance with national guidance and the use of rating scales to monitor the severity of patients' conditions.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, National Institute for Health and Care Excellence (NICE) guidance. For example, at the heart failure clinic, a nurse regularly met with each patient to monitor their condition. As a non-clinical prescriber, the nurse could adjust the patient's dose of medicines recommended by NICE such as diuretics and beta-blockers. A key part of the nurses' role was to help patients understand heart failure and how to manage their condition. Staff followed the NICE guidance on the prevention and management of pressure ulcers. For example, they used photographs for ulcer measurement, provided pressure redistributing devices and applied appropriate dressings. At a meeting of the Parkinson's team in November 2019, staff discussed elements of care recommended by NICE including presentations on the use of apomorphine and offering vitamin D supplements to patients. In all the services, managers checked to make sure staff followed guidance. The trust leads met to discuss any updates to the national guidance and they implemented this in their services.

Patients had clear, personalised outcome goals and associated care plans. Each of the records we reviewed had specific care plans for each element of care and treatment. For example, one record had a care plan for catheter care. Another record included care plans for wound care, hydration and mental capacity.

Nutrition and hydration

Staff ensured patients received enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff used the GULP Dehydration Risk Screening Tool to assess patients' risk and severity of dehydration. Similarly,

the tissue viability team used the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition or obesity. Staff made adjustments for patients' religious, cultural and other preferences. For example, staff in the heart failure team gave advice on diet and supported patients who had a more restricted diet due to cultural, religious or lifestyle preferences.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and arranged additional pain relief to ease pain.

We observed that staff routinely asked patients about pain, and whether they needed pain relief, whenever this was relevant to the patient they were seeing.

Staff used appropriate pain management tools according to the patient's needs. On some records, staff had recorded a severity of pain rating score on the wound care assessment tool or the care plan for palliative care. We reviewed the records of one patient who was unable to communicate through speech. Nurses worked closely with staff at the patient's care home to monitor any signs of distress and administer pain relief in accordance with their care plan.

Patient outcomes

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. Patients had personalised outcome goals and associated care plans depending on the type of intervention offered. For example, staff reviewed MUST scores to measure the severity and outcomes of treatment relating to malnutrition. The service had introduced a more general outcome scale relating to patients' lifestyle, but staff found that this was not relevant to many patients. The trust was looking at other outcome measurement tools that may be more useful.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. Senior nurses audited a sample of patient records every six to eight weeks to ensure that all documentation was correct. Through these audits, senior nurses checked that their colleagues responded appropriately when there were signs of patients' conditions deteriorating. Senior nurses also reviewed a sample of records each week to check that assessments and care plans had been completed appropriately. Each service also completed standard audits of hand hygiene, infection control and equipment calibration.

Staff were aware of the opportunities available to them to participate in quality improvement initiatives. Therapy staff in mid-Bedfordshire had embarked on a quality improvement project to improve the information they provided to patients about the service.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Registered nurses were required to complete written tests of their competency in key areas of their work such as wound care, using syringe drivers, catheter care and safeguarding. Nurses were required to complete these tests within their first nine months. Senior nurses were also required to complete competency tests relating to management and leadership.

Managers provided new staff with appropriate induction. All new staff received a four-week induction programme. During this programme they worked alongside an experienced colleague. New staff attended a corporate induction programme to learn about the organisation. Newly qualified staff participated in a six-month preceptorship programme.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The trust supervision policy stated that supervision should be provided once every six weeks. Across the teams we inspected, staff received supervision in accordance with this requirement. Staff supervision comprised of conversations around training and development, service development, information technology, personal well-being and lone working. Supervision sessions also involved discussions about care and treatment for specific patients. Staff said they found supervision sessions helpful and that they were well-supported by their managers.

Are services effective?

Over 90% of staff had received an appraisal in the previous 12 months. Managers completed annual appraisals for each member of staff on a standard form. This included details of how the member of staff had completed the previous year's objectives, a review of how they had demonstrated the trust's values and a performance rating. During these sessions staff also discussed their personal development, career aspirations and agreed objectives for the following year.

Managers ensured that staff had access to regular team meetings. Managers held meetings for all their staff every month. Team meetings typically involved discussions about staffing, team development, incidents, complaints, practical matters such as ordering stock and feedback from training courses.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. The managers and team leaders supported staff development. Staff had access to training programmes suitable for their roles. Staff also had the opportunity to shadow and train with staff in other areas to gain knowledge and experience. For example, district nursing staff could shadow palliative nurses at the local hospice to learn about providing end of life care. Staff could also book time with other professionals including the tissue viability nurses, leg ulcer clinic, matron, continence nurse and the infection control team. Staff also had access to 'lunch and learn' sessions to provide them with development and skills enhancement. Learning sessions had been held on pressure ulcer assessment, moisture damage (MASD), holistic assessments and pressure relieving advice for patients and carers.

Managers ensured that staff had access to specialist training to fulfil their roles. Staff felt that managers supported any additional training or development needs they had, and accommodated specialist training. For example, the South Bedfordshire team had provided a development programme for all staff, with training sessions on sepsis, resilience development, having difficult conversations with patients and mesothelioma. Staff could complete online training modules such as a module on the safe administration of insulin in the community. Each year, the trust funded a place for a nurse to complete an MSc in Community District Nursing provided by the local university.

Managers dealt with poor staff performance promptly and effectively. Managers monitored staff performance through supervision and competency checks. If the service had concerns about an employee's performance, a manager would work with the employee to develop an action plan for improvement. The plans usually set objectives for improvement within two or three months. If there was no improvement, the manager would refer the matter to the human resources department and formal capability procedures would be followed.

Multi-disciplinary working and coordinated care pathways

Staff of different professions worked together as a team to benefit patients. Doctors, nurses and allied health professionals supported each other to provide holistic care, using innovative and efficient methods.

The team included, or had access to, the full range of specialists required to meet the needs of patients. Teams included nurses, physiotherapists, occupational therapists, pharmacy technicians, McMillan nurses, tissue viability nurses, healthcare assistants, and assistant nursing practitioners. Services could refer patients to dieticians and speech and language therapists when necessary.

Staff shared information about patients at effective handover meetings within the team. Staff used a secure messaging application to share urgent updates about patients. This application was also used to communicate any urgent or cancelled appointments.

Staff of different professions worked together as a team to benefit patients. The nurses we spoke with liaised well with other healthcare professionals, including occupational therapists, consultants, GPs and other specialists to provide holistic care for patients. Staff had regular multidisciplinary meetings with district nurses and the GPs. Staff held monthly multidisciplinary meetings to discuss high risk, complex cases. These meetings were attended by the community matrons, tissue viability nurses, social services and therapy staff involved in the patients' care. In addition, staff engaged in weekly cluster meetings which were GP led. There were further meetings with GPs to discuss advance care plans for patients receiving palliative care.

Health promotion

Are services effective?

Staff gave patients practical support and advice to lead healthier lives.

Staff supported patients to live healthier lives, for example, through participation in smoking cessation schemes, acting on healthy eating advice, managing cardiovascular risks, screening for cancer or dealing with issues relating to substance misuse. During each initial assessment, nurses asked patients about smoking, mental health, friends and family networks, and physical activity. If staff felt patients would benefit from assistance with any of these matters, they made referrals to social services or other organisations.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff used a specific template to record patients' capacity assessments. In the records we looked at, these were filled out with sufficient detail, covering each component of mental capacity. However, a recent audit of care records in North Bedfordshire found that five out of fourteen records did not include a record of the patient's consent to treatment. In response to this, the service was introducing training sessions on mental capacity assessments and consent to treatment.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to this policy and associated guidance through the trust's intranet.

Staff knew where to get advice from within the trust regarding the Mental Capacity Act. Staff sought advice from colleagues in mental health teams and the safeguarding lead for community health services.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Usually, this involved working closely with the patient's family to make decisions. If the patient did not have a family member who could assist with these decisions, staff discussed the decision with the patient's GP, other health professionals and the safeguarding lead.

Are services caring?

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

Summary

We did not rate this service:

We found the following areas of good practice:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Feedback from patients about their care was very positive, with many describing services as excellent.

Detailed findings:

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them with kindness, and with utmost respect for them as an individual.

Patients gave very positive feedback about the services they received. They said staff were friendly, knowledgeable, supported them to get help for a range of health needs and ran clinics on time. Many patients described the service as excellent.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, and advice at the time they needed it. During the inspection, we attended a number of clinics and visits to patients in their homes. Throughout these sessions, staff engaged with patients in a caring, respectful and responsive manner. When staff carried out a procedure, they took time to explain to the patient exactly what they were doing during each step of the process.

Staff supported patients to understand and manage their care, treatment or condition. Nurses explained that helping patients to understand their condition and monitor their symptoms was a fundamental part of their work. During each appointment, nurses talked to patients about their condition, their medication and how changes in the patient's lifestyle could lead to improvements.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff referred patients for tests at the hospital when these were needed and frequently encouraged patients to see their GP about any additional health concerns.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

During our inspection, we saw examples of patient involvement. For example, during an appointment we saw that staff discussed medication with the patient and their partner. This included the reasons why the medicine was prescribed and possible side-effects of the medicine. Following each appointment, staff sent a letter to the patient's GP. Staff routinely read these letters to patients. Carers observations about the patients' presentation were recorded in patients' notes. Nurses gave advice to carers on how to optimise care.

Staff involved patients in care planning and risk assessment where possible and where patients had the capacity to contribute. Records showed that care plans had been discussed with patients. Staff provided copies of care plans when patients requested them.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. We saw that staff adapted themselves to suit the communication needs of the patient and involved family members in the care they provided. Patients had a red folder in their homes which staff used to communicate important aspects of care to other healthcare professionals. This was particularly important for patients who were less able to communicate to others about their care.

Are services caring?

Staff involved patients when appropriate in decisions about the service. A patient was included in recruitment panels for all registered nurses.

Staff enabled patients to give feedback on the service they received. The service in South Bedfordshire had received 105 responses to the friends and family test between July and September 2019. Fifty-four responses related to completed episodes of care. Of these, 35 said they were extremely likely to recommend the service, five said they were likely to recommend the service and 14 declined to answer. Staff in north Bedfordshire had an application installed on their telephones through which patients could give feedback about the service. Between July and September 2019, staff had collected 199 responses. These responses were positive about the care that was provided.

Staff enabled patients to make advance decisions when appropriate. For example, staff within palliative care teams worked closely patients and carers to agree when treatment would be withdrawn.

Emotional support

Staff nurtured patients by respecting and understanding the physical, mental and emotional challenges they faced.

Staff took a holistic approach when treating patients and placed as much focus and support on patients emotional and social wellbeing as their physical care. Nurses took a person-centred approach to each appointment, rather than simply focusing on the task or procedure they had to complete. None of the appointments appeared rushed. Nurses always asked patients how they were feeling. They usually asked other questions about the patient's family and what the patient had been doing. This meant that staff had a good understanding of patients' lives, their interests and their relationships. Staff referred patients to a psychologist for emotional support with specific matters. For example, staff referred a patient who needed emotional support regarding their terminal illness.

Are services responsive to people's needs?

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

Summary

We did not rate this service.

We found the following areas that could be improved:

The community speech and language therapy service was not triaging patients at the point of referral to identify patients presenting a high risk. This service was not seeing high priority patients within the required two-week timescale, with 80% of high priority patients having to wait considerably longer. Sixty-two patients on the waiting list had waited longer that 18 weeks.

However, we found the following areas of good practice:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Detailed findings

Planning and delivery of services that meet peoples' needs

The trust planned and provided services in a way that met the needs of local people.

Leaders, managers and staff understood people's individual needs and preferences and provided services to accommodate this. For example, the services visited patients at home if the patient found it difficult to get to clinics. Staff offered flexible appointment times, including early and late appointments for patients who were at work during the day.

The trust knew their local population and provided services that met local needs. Services tended to operate in areas that were quite rural, with a high proportion of elderly residents. Most services were provided in patients' homes. The service was also looking to establish dementia clinics in GP practices. The service in mid-Bedfordshire was appointing additional senior nurses to work with an increasing number of patients who presented with long-term health conditions such as chronic obstructive pulmonary disease.

Patients had flexibility and choice when choosing clinics to suit their needs. For example, following requests from patients for more flexible appointment times, staff had developed a catheter clinic and drop-in warfarin service. These services were based in community settings that were easy to access.

Equality and diversity

The service made adjustments for disabled patients. For example, all premises had step-free access. Staff recorded any difficulties patients had with communication on the patient's record. For example, staff had noted that a patient found it difficult to speak on the telephone. The notes stated that all discussions should take place at home visits.

Staff supported and adhered to equality and diversity standards in the services they provided. This included serving those with protected characteristics or in otherwise vulnerable circumstances. For example, the services worked with transgender patients. In order to support this, the services provided training for staff with a health organisation that specialised in transgender care. Some staff wore rainbow coloured lanyards in support of the lesbian, gay, bisexual, transgender (LGBT+) community and welcoming patients who identified as such.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and so on. Each service provided an information pack for patients. This included information about local voluntary organisations for older people and people with specific health conditions.

Meeting the needs of people in vulnerable circumstances

Are services responsive to people's needs?

Support was provided for vulnerable patient groups including people living with dementia, people with learning difficulties and those with mental health needs. For example, a patient living with learning difficulties was supported using applications on their mobile telephone and technological devices to aid their understanding of the care and treatment provided. Staff had also worked with a patient who had a learning disability and diabetes. Staff developed information specifically for this patient and provided additional support to ensure the patient felt safe. All staff had been trained in supporting patients with dementia.

Staff could access advice and support from other services within the trust, such as the learning disability and community mental health teams. For example, staff worked closely with trust mental health leads to develop a Dementia Pathway in order to meet the needs of this patient group more effectively.

Access to the right care at the right time

People could access most services when they needed it. In all teams apart from the speech and language therapy team, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The service had clear criteria for which patients would be offered a service. The criteria did not exclude patients who needed treatment and would benefit from it. The service accepted patients over 18 years of age, registered with a GP in the designated area, be predominantly housebound, or have a complex nursing need where their care is best provided in the home-based setting. Patients could self-refer, or be referred through their GP or other healthcare professionals. The specialist nurses' clinics only accepted referrals from GPs or other healthcare professionals.

The provider had set a target for time from referral to triage/assessment and from assessment to treatment. Community nursing services classified referrals as being urgent, for the same day, for the next day or for a specific time. For example, catheter care for patients unable to manage independently required a same day visit. Requests for routine dressings were classified as needing a visit on the following day. The service responded to the need for urgent care within two hours. However, referrals to the speech and language service should have received a full clinical triage at the point of referral to identify any patients in urgent need. Data from the trust showed that in October 2019, staff failed to triage over 60% of referrals within two weeks of receiving them. The operational policy for this service also stated that, in accordance with national guidance, urgent referrals, such as patients who found it difficult to swallow should be seen within two weeks. Between 14 and 21 October 2019, none of the patients assessed as being a high priority were seen within this time. Eighty percent of high priority patients were not seen for over six weeks and 30% had to wait more than 11 weeks. In October 2019, there were 62 patients on the waiting list who had been waiting for more than 18 weeks. Of these, 48 were higher risk patients due to difficulties relating to swallowing. Across all the services, managers did not have systems in place to audit their compliance with the target time for referrals. Compliance with these target times would only be identified during peer review of the records.

In all other teams, staff were able to see urgent referrals quickly and non-urgent referrals within an acceptable time. Each service allocated staff to an unplanned care team. The team received and assessed requests for urgent care. They then contacted any colleagues working near the patient and asked them to visit. If there were no nurses working near the patient, staff in the unplanned care team would visit.

Staff responded promptly and adequately when patients telephoned the services. All calls and referrals were received by the single point of access team. This team operated 24 hours a day, seven days each week. The single point of access team sent referrals and details of calls to the relevant care teams as a 'task' on their electronic case management system. Managers could see outstanding tasks on their system and allocate these to staff. When calls were urgent, the single point of access team also telephoned the nursing team to confirm they had received the message.

Staff tried to make follow-up contact with people who did not attend appointments. Staff followed the trust procedure for patients who did not attend or did not open the door to staff for home visits. For patients who did not open the door for home visits, this included checking all avenues of entry to the property, contacting the patient and next of kin, checking local hospitals for admission and finally, informing the police.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to

access treatment as soon as possible. Whenever possible, staff identified colleagues working nearby to fulfil appointments if the allocated member of staff was unable to attend. Appointments usually ran on time and people were kept informed when they did not.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The service had received six formal complaints since December 2018. Four of these complaints had been upheld. No complaints had been referred to the Parliamentary and Health Service Ombudsman. Patients had raised 89 matters of concern with the Patient Advice and Liaison Service (PALS). These matters had been resolved locally.

Staff provided patients with information about how to make a complaint when the patient was first seen by the service.

Staff knew how to handle complaints and how to support patients in getting their concerns heard. Complaints were discussed at locality meetings and any lessons learnt were circulated to all Bedfordshire community health services. For example, a carer had complained that they did not feel involved in the district nursing care provided to their family member. In response to the complaint, staff involved the carer in training and advice about the condition and treatment options. The carer liaised with staff about the care of the patient, and regularly sent in pictures of the wound that showed improvement in the condition.

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

<Enter findings here>

Detailed findings:

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders had the skills, knowledge and experience to perform their roles. The service had divided the county into three operational teams; North Bedfordshire, South Bedfordshire and Mid-Bedfordshire. Each team was led by a senior manager. Senior nurses and occupational therapists led the district nursing and therapies work within each team. District nurses divided their areas up into smaller teams, each led by a charge nurse. All the staff leading these teams had appropriate qualifications and had worked in junior roles for a number of years before moving into leadership positions. This ensured they had the skills and experience to carry out their role.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. All the operational leaders worked alongside the district nurses and therapists each day. They routinely discussed new referrals and operational difficulties. Leaders regularly reviewed performance data and reports of incidents.

Leaders were visible in the service and approachable for patients and staff. The associate directors regularly visited the services and were familiar with the staff. Executive directors had also visited. Team managers met with executive directors at operational meetings. For example, the district nursing team leaders met with the director of nursing at the Nursing Steering Group, held by the trust every three months.

Leadership development opportunities were available, including opportunities for staff below team manager level. For example, the service in mid-Bedfordshire had developed succession plans for all the senior roles to ensure that changes in managers and team leaders went smoothly. These plans involved charge nurses deputising for team managers in their absence. It also involved nurses being involved in discussion about finance, quality assurance, budgets, human resources and information technology.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff, patients, and key groups representing the local community.

Staff knew and understood the providers vision and values and how they were applied in the work of their team. The trust's core values were to care, to respect and to be inclusive. Staff were asked to review their work in relation to the trust's values at their annual appraisal. Staff gave examples of how they applied the trust's values. For example, staff told us about the importance of providing person-centred care during every home visit, rather than simply focussing on the tasks they needed to complete.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. All staff received emails with news and information from the trust at least once a week. The Chief Executive kept staff informed of the work they were doing through regular messages on the staff intranet.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, managers had discussed with staff the integration of the service in mid-Bedfordshire with social workers employed by the local authority reablement team. This service had also planned a meeting a week after the inspection to talk to staff about a new 'Home First' initiative to enable patients to be discharged from hospital more quickly. Managers said that staff were usually positive about strategic change when there were clear benefits for patients.

Culture

Are services well-led?

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff felt positive and proud about working for the provider and their team. Some community health teams, such as complex care, were new to the trust. The specialist nursing manager had worked to create a welcoming and supportive culture. This included arranging an away day and having more regular supervisions with staff to ensure they felt valued and supported.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. Each service displayed information about the role of the Speak Up Guardian in their offices. This included information about the whistleblowing process and the contact details for the Speak-Up Guardian.

Managers dealt with poor staff performance when needed. Managers were able to give examples of where they had dealt with poor staff performance in the past. At the time of the inspection, none of the staff were subject to performance management.

Staff appraisals included conversations about career development and how it could be supported. Staff training and development needs were also discussed in supervision. Staff also had ownership of their competency pack in which they were able to enlist onto training courses for skills they felt were lacking or could be further developed. Managers supported this process.

The service's staff sickness and absence rates were higher than the average for the trust. The sickness level across the service was 4.5%. This was higher than the average sickness level for the trust which was 3.5%.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The trust provided an employee assistance programme. Through this service, staff could access counselling, support with stress at work and assistance with legal matters. Information about this service, including the contact details, were displayed in the staff offices.

The provider recognised staff success within the service. At monthly locality meetings, managers announced the winner of the 'Employee of the Month' award. This was awarded to staff who had worked particularly hard or achieved a particularly positive outcome for a patient. Staff were genuinely pleased to receive this recognition. In some teams, staff communicated through secure social media applications. Managers used this to send thank you messages to staff for particularly good pieces of work. The trust held an annual award ceremony for all its staff. Awards were presented in categories such as team of the year, employee of the year and working in partnership.

Governance, risk management and quality measurement

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care, by creating an environment in which excellence in clinical care would flourish.

The provision of a single point of access meant the service could respond quickly to referrals and requests for assistance. The information technology infrastructure meant that messages and tasks could be sent quickly from the single point of access team to the operational teams. District nursing teams responded to patients promptly, in accordance with required timescales. Apart from the speech language and therapy service and the wheelchair service, all therapy teams saw over 80% of patients within 11 weeks. Nursing staff were able to use time efficiently to focus on patient care. The staff competency framework and supervision arrangements provided assurance that staff were suitably skilled and knowledgeable to provide a good quality of care and treatment. Assessments were thorough and the arrangements for recording information worked well. There was a positive culture of ensuring that all incidents were reported. Managers reviewed all incidents and we saw many examples of staff discussing how they could learn from incidents to improve their service. Premises used for clinics were safe and clean. Overall, the responsiveness and effectiveness of the service, along with the caring attitudes of staff, were reflected in consistently positive feedback from patients.

There was a clear framework of what must be discussed at a team or directorate level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The directorate management team meeting, attended by directors and assistant directors, was held once a month to discuss performance, finance, budgets, recruitment and strategy. Senior managers held a quality assurance group and governance meeting each month. During these meetings, senior staff reviewed incidents, safeguarding referrals and

performance data. Specific meetings were held to discuss staffing and information technology. Each locality held monthly team meetings for all its staff. Information from the senior level meetings were disseminated at this meeting. Other meetings were held for specific professional disciplines. For example, senior nurses met together once a month.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. The service ensured that staff were aware of recommendations from these reviews through regular meetings such as locality meetings, quality assurance meetings and 'Learning, Evidence and Quality' meetings. The trust circulated written information about lessons learned, such as the lessons learned bulletin produced by the Skin Matters Group.

Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Services carried out routine audits of patient records, assessments of patients and infection control audits. Services also completed reviews of specific aspects of care and treatment. For example, the service completed and in-depth review of incidents relating to the administration of insulin between January 2019 and June 2019. This review found that these incidents were often related to problems with scheduling, poor communication and pressure on staff. The report of this review included recommendations for action to address these concerns.

Staff understood arrangements for working with other teams, both within the trust and external, to meet the needs of the patients. All the services worked closely with GPs and the local hospitals. The service in mid-Bedfordshire was leading an initiative to provide more integrated health and social care services. This will involve social workers within the local authority reablement team being based in the community health team's offices from January 2020. This initiative was being developed through the local integrated care system to achieve the strategic objectives of the NHS Long-Term Plan.

Management of risk, issues and performance

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.

Staff maintained and had access to the risk register for each service. Staff concerns broadly matched those on the risk register. For example, the register included details of risks relating to difficulties with equipment used for mobile working and difficulties with recruitment. The risk registers provided details of the measures the trust was taking to address these risks.

The service had plans for emergencies. Each service had a resilience and business continuity plan that included plans for adverse incidents such as severe adverse weather, power failures or exceptionally high levels of staff sickness. These plans included details of the roles and responsibilities of key staff in addressing the difficulties.

Public engagement

Patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, the trust published information about its services on its website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. For example, staff carried mobile phones that had a patient feedback application. This meant patients could quickly provide feedback at the end of each visit. Patients and carers could complete 'Friends and Family' questionnaires, stating whether they would recommend the service to people they knew. Feedback was discussed by staff and managers at quality assurance meetings.

Patients and carers were involved in decision-making about changes to the service. Patients were enlisted for recruitment panels. Patients were also involved in the 'working together' group, led by the patient participation lead. Within this group patients could collaborate with the trust on various quality improvement and involvement projects. This group met once a month. The patient participation lead also made opportunities available for patients to attend conferences.

Directorate leaders engaged with external stakeholders. Directors regularly met with commissioners to review the performance of each service.

Staff engagement

Staff were actively engaged in the running of the services. The views of staff were reflected in the planning and delivery of services and in shaping culture. Staff said that they felt the recent restructuring of services had given them opportunities to voice their opinions and to give feedback

on the changes proposed. However, some staff said that the trust had not sufficiently addressed the emotional toll and anxiety that staff experienced because of the changes, as some staff were not sure about their jobs being secure. Staff felt that the trust could have provided more insight and reassurance to prevent unnecessary anxieties.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, some specialist nursing team members presented at a conference on Parkinson's Disease in Vienna. Staff had also attended a heart failure conference.

Staff used quality improvement methods and knew how to apply them. Staff in the tissue viability nursing team were involved in a quality improvement project to see patients more quickly before complications developed. This had been successful. The regional management were working to roll this out to other nurse-led clinics. The patient participation lead for community health services was involved in setting up quality improvement projects around monitoring patients' experience, staff wellbeing, increasing the use of video conferencing for assessments and improving patients' self-management.

The teams participated in accreditation schemes relevant to the service and learned from it. Five nurses working with this service had received the Queen's Nurse award for community nursing. Two nurses had received this award in the last two years.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that referrals to the speech and language service were assessed promptly to identify any high-risk patients and that they received an appropriate assessment in a timely manor. Staff were not always able to see patients within an appropriate time. Managers did not always have access to the appropriate information to ensure they could monitor this service. This was a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1)(2)(a)(b).