Beckenham Beacon

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Overall, we rated community services at Beckenham Beacon as good because:

- Staff knew how to report incidents and the senior team disseminated learning from incident investigations to their teams. There were effective arrangements for safeguarding vulnerable people and staff demonstrated how they fulfilled their responsibilities regarding this.
- There were effective systems in place to protect patients from harm. The incidence of pressure ulcers was low.
- Clinical effectiveness service goals were used in each service to support quality improvement. All services met or exceeded their goals in at least two months of the most recent programme.
- Patient records were comprehensive with appropriate risk assessments completed. Each service had adapted the electronic patient records template to ensure patient notes were individualised and could meet their needs. An annual quality audit was used to identify areas of improvement in documentation.

Summary of findings

- Staff routinely assessed and monitored risks to patients. Services consistently exceeded their monthly safety targets in relation to patient risk assessments and documentation.
- Audits were embedded in the service and staff used the results to establish practice in line with national guidance from accredited organisations. The services monitored patient outcomes to improve care.
- Effective medicines management processes were in place and monitoring of safety systems included learning from errors and regular training for independent prescribers.
- Infection prevention and control standards and practice were benchmarked against national best practice guidance. An infection control lead was in post and each service had hand hygiene champions to support compliance with cleanliness and hygiene standards.
- Patients were cared for by appropriately qualified staff. Staff received an induction to the unit and achieved specific competencies before being able to care for patients on their own. Service teams were positive about the quality of training offered to them and staff had undertaken specialist training to ensure they continued to meet demand on the service.
- There was effective internal and external multidisciplinary team working and staff worked with staff in other agencies to ensure patients received co-ordinated, specialist care. This included working with psychologists, sexual health services, care homes and social workers. The quality and therapies teams worked together to establish and improve clinical effectiveness. The health visiting team was involved in the development of a new perinatal mental health service at a local trust.
- Staff provided a caring, kind, and compassionate service and we received positive comments from patients. We observed the way patients were treated in their homes, in clinic settings and at a school. Patients reported they were involved in their care.
- Staff continually sought to exceed the expectations of patients and their relatives by providing individualised care that improved their social wellbeing as well as meeting their physical needs. For example, the integrated care team provided patients with 'social prescriptions' that provided access to day centres to help them make new friends. Staff in the HIV service facilitated patients' access to a peer support group.
- Services were planned and delivered in line with local needs. Community clinics for children and families were available in different locations across the borough making it easy for children and their families to access the nearest location to them. There were systems and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed promptly.
- Waiting times for podiatry and speech and language therapy appointments reduced significantly in the 12 months prior to our inspection as a result of improved communication and access. In addition, the HIV and diabetes teams both consistently met their target for referral to assessment times and the integrated care nursing team offered weekend drop-in clinics.
- The health visiting team carried out five mandated checks in line with the healthy child programme. Performance against these checks was better than the London average but sometimes lower than the provider's own target.
- We saw positive local leadership within the service and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development. There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There was a robust governance system in place, which included a range of committees attended by service leads and members of the executive team. Staff had regular team meetings and received regular communication from the executive team. The management team had oversight of the risks within the services and mitigation plans were in place.
- A patient experience group led patient engagement and there was evidence this group was able to influence executive decisions to adapt and improve

Summary of findings

services. Each clinical service had developed patient engagement strategies based on their knowledge of their own patients. This included surveys, peer support groups and social clubs.

- Staff valued opportunities to take part in pilot schemes and competitive applications for programme funding that enabled them to expand local services. There was a commitment to drive innovative practice within the teams.

However,

- Although there had been an improvement in staffing levels within the health visiting team, the caseload still exceeded recommended levels.
- Although the quality of patient records was consistent within the integrated care community nursing team, there were some consultations with no electronic documented notes. However, there were paper records left in the patients' homes, and the provider took action to address the backlog of uncompleted electronic records.
- Staff turnover within the adult community services was significantly higher than the organisational average and there was a vacancy rate of 17%.

Summary of findings

Contents

Good

Beckenham Beacon

Services we looked at

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

Summary of this inspection

Our inspection team

Team Leader: Temi Oke, Care Quality Commission

The team included CQC inspectors and specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

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?

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew. We carried out an announced visit on 13 and 14 December 2017. During the visit, we spoke with staff and people who use services. We observed how people were being cared for and reviewed care records of people who use services. We carried out an unannounced visit on 5 January 2017.

As part of our inspection, we spoke with 47 members of staff and 32 patients, parents and relatives. We accompanied staff on home visits, visit to a care home, a school visit and a new birth visit. We observed care being delivered and reviewed 43 sets of records.

Information about Beckenham Beacon

We inspected two core services at Beckenham Beacon: community health services for adults, and community health services for children, young people and families. Bromley Healthcare Community Interest Company (Bromley Healthcare) provides these service. Bromley Healthcare is a social enterprise company providing community healthcare services to residents of Bromley, and specialist services to Bexley, Croydon and Lewisham.

Services provided for adults include integrated care community nursing, HIV specialist nursing, adult speech and language therapy, diabetes and podiatry.

Community nursing teams covering Beckenham and Penge work seven days a week from 8.15am to 10.30pm. All other teams are available from 9am to 5pm Monday to Friday and cover Bromley.

Between April 2016 and November 2016, the Beckenham integrated community nursing team had 42,430 patient contacts, the podiatry service had 16,026 contacts and the adult speech and language therapy team had 2902 contacts. During the same period, the HIV service had 13,945 patient contacts.

Services provided for children and families include the health visiting service, and the speech and language therapy (SALT) service.

Summary of this inspection

The health visiting teams had 61,800 contacts a year. There were four teams of health visitors covering geographical patches across Bromley. These included Beckenham and Penge, Orpington, Prince's plain, Mottingham and Bromley North. Parents could access baby clinics at nine locations across the borough.

The speech and language therapy (SALT) team had 19,388 patient contacts between April 2016 and November 2016. The SALT team offer an assessment, diagnostic and intervention service for pre-school and school age children attending mainstream schools aged zero to 11 years who meet the eligibility criteria. This is to meet speech, language and communication needs and eating and drinking (swallowing) difficulties related to a complex or chronic health and developmental difficulty. They work in five community clinics, four special schools and 18 specialist provisions, six children's centres and most mainstream primary schools in Bromley.

What people who use the service say

We received positive comments from patients and those close to them about the caring staff. Patients noted that care was individualised and that staff were interested in them as a person.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- There were effective systems in place to protect patients from harm. The adult community teams recorded 99% harm-free care within adult community teams.
- Staff knew how to report incidents and there was shared learning from investigations of incidents.
- There were effective arrangements for safeguarding vulnerable people and staff demonstrated how they fulfilled their responsibilities regarding this.
- Patient records were comprehensive with appropriate risk assessments completed. An annual quality audit was used to identify areas of improvement in documentation. Services consistently exceeded their monthly safety targets in relation to patient risk assessments and documentation.
- Equipment was clean and staff complied with infection prevention and control guidelines.

However,

- The health visiting service balanced scorecard showed that the service achieved only an average of 42% for equipment calibration between May and October 2016 against a target of 100%.
- Although there had been an improvement in staffing levels within the health visiting team, the caseload still exceeded recommended levels in line with national guidance.

Are services effective?

Good

- Staff delivered universal and specialist services in line with national guidance and good practice.
- Audits were embedded into the service and staff used the results to establish practice in line with national guidance from accredited organisations. The services monitored patient outcomes to improve care.
- Clinical effectiveness service quality improvement goals were used in each service to support quality improvement and all services met or exceeded their goals in at least two months of the most recent programme.
- Patients were cared for by appropriately qualified staff who received an induction to the unit and undertook specialist training to ensure they met the needs of patients.
- There was effective internal and external multidisciplinary team working and staff worked with staff in other agencies to ensure

Summary of this inspection

patients received coordinated, specialist care. This included multidisciplinary working with psychologists, sexual health services, care homes and social workers. The quality and therapies teams worked together to implement the Therapies Outcome Measures to establish and improve clinical effectiveness in specific needs such as psychosocial impact. The health visiting team was involved in the development of a new perinatal mental health service at a local trust.

- There were adequate supervision support structures in place for staff that enabled them to maintain their clinical competencies.
- The health visiting team carried out five mandated checks in line with the healthy child programme. Performance against these checks were better than the London average but sometimes lower than the provider's own target.

However,

- We noted that speech and language therapy staff did not always tick the consent box on the electronic record system to indicate that consent was obtained for the care provided.
- Three of the five service teams in adult community health met the provider's minimum target of 85% for up to date appraisals. Overall 92% of staff had an appraisal in the 12 months prior to our inspection.

Are services caring?

Outstanding ☆

- Staff provided a caring, kind, and compassionate service and we received positive comments from patients. We observed the way patients were treated in their homes, in clinic settings and at a school. Patients reported they were involved in their care.
- Staff continually sought to exceed the expectations of patients and their relatives by providing individualised care that improved their social wellbeing as well as meeting their physical needs. For example, the integrated care team provided patients with 'social prescriptions' that provided access to day centres to help them make new friends. Staff in the HIV service facilitated patient's access to a peer support group and had accompanied one patient to a community support group to help build their confidence.
- All services had a track record of high levels of performance in the NHS Friends and Family Test. This included 100% recommendation scores for the HIV service in every month it participated and 100% recommendation scores between April 2016 and December 2016 for the adult speech and language

Summary of this inspection

therapy and integrated care teams. The diabetes service scored 99% in the latest available result. The children speech and language therapy service scored 100% and the health visiting service scored 92%.

- All the patients and relatives we spoke with gave positive feedback about the service. The HIV service held an extensive collection of thank you cards and letters from patients and relatives. Patients noted the personalised and timely care of staff that extended beyond immediate clinical treatment to help them establish fulfilling lives. Parents who attended the baby clinics described health visiting service as "perfect" with no area requiring improvement. Children speech and language therapists received many compliments from parents, which indicated sessions, were positive and invaluable.
- There was a consistent focus on providing care that was holistic and went above and beyond expectations and immediate clinical need. For example, speech and language therapists worked with care home staff to make sure people had access to food that was important to them and that also met their dietary needs. Staff in the HIV service worked with newly diagnosed patients to help them understand the diagnosis, which included helping them with relationships and disclosure within their families and to their friends and partners.
- During home visits, community nursing staff took the time to provide practical guidance and education to people that would help the delivery of care. This included supporting relatives in the management of care plans and helping them to understand how to provide a healthy diet. Staff we observed were highly aware of social needs in peoples' homes and responded discreetly to the needs of carers, including involving them in care planning.
- Nurses in the HIV service held counselling qualifications and could refer patients to multidisciplinary support services, including for needs relating to alcohol and drugs. In addition, the team had set up a peer support service for patients newly-diagnosed with HIV to give access to others who were experienced in using health and social care services.

Are services responsive?

Good

- Services were planned and delivered in line with local needs. This included the provision of international travel advice for patients living with HIV and collaborative community-delivered education sessions for patients living with diabetes.

Summary of this inspection

Musculoskeletal orthotics, neurological rehabilitation including stroke rehabilitation for patients and relatives and speech and language therapy for patients living with Parkinson's disease were also provided.

- Community clinics for children and families were available in different locations across the borough making it easy for children and their families to access the nearest location to them.
- The integrated care district nurse team provided a four-hour rapid response service for urgent need including syringe drivers and blocked catheters.
- Staff in the diabetes service could facilitate rapid access to a diabetes psychologist at a nearby hospital for patients with complex needs. The HIV service had increased its ability to provide specialist care for HIV positive patients who had complex needs relating to drug use.
- Waiting times for podiatry and speech and language therapy appointments reduced significantly in the 12 months prior to our inspection as a result of improved communication and access. In addition, the HIV and diabetes teams both consistently met their target for referral to assessment times and the integrated care nursing team offered weekend drop-in clinics.
- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day to day tasks.
- There were systems and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed in a timely manner.
- Service users were able to self-refer for some services, such as speech and language therapy. Did not attend (DNA) rates were low and staff telephoned families to remind them about their appointment.
- Parents who used the health visiting service had access to a breast-feeding support group via a charity sponsored by the provider. The service also ran baby massage and new parent groups.
- There was evidence of action in response to complaints, such as the introduction of a new medication administration chart and improved bladder scanning training for nurses.

Are services well-led?

Good

- We saw positive local leadership structures within the service and staff reflected this in their conversations with us. Staff were

supported in their role and had opportunities for training and development. There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.

- There was a robust governance system in place, which included a range of committees attended by service leads and members of the executive team. Staff had regular team meetings and received regular communication from the executive team. The management team had oversight of the risks within the services and mitigating plans were in place.
- A patient experience group led patient engagement and there was evidence this group was able to influence executive decisions to adapt and improve services. Each clinical service had developed patient engagement strategies based on their knowledge of their own patients. This included surveys, peer support groups and social clubs.
- Staff valued opportunities to take part in pilot schemes and competitive applications for programme funding that enabled them to expand local services. There was an overall commitment to driving innovative practice within the teams. The adult speech and language therapy team had achieved a Health Innovation Network Award for their 'Making mealtimes matter' education programme with the adult dietetic service.

However,

- Results from a March 2016 survey amongst staff in the integrated care team indicated a need for improved communication between the senior management team and staff, including when important decisions were made. In addition, this service scored worse than the rest of the organisation in all 11 questions related to relationships with managers although results indicated general satisfaction. Results from this survey also indicated staff felt under pressure to come to work when they were unwell and that the pressure of work had contributed to spells of ill health. This was reflected by the response that 15% of respondents felt the provider did not take positive action on staff health and well-being.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Community health services for adults

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Information about the service

Information about the service

Community health services for adults at Beckenham Beacon are provided by the Bromley Healthcare Community Interest Company Limited (Bromley Healthcare). Five services make up this provision: integrated care community nursing teams, HIV specialist nursing, adult speech and language therapy, diabetes, and podiatry. Community teams covering Beckenham and Penge work seven days a week from 8.15am to 10.30pm. All other teams are available from 9am to 5pm Monday to Friday and cover Bromley.

At the time of our inspection the integrated care community nursing team had between 650 and 700 patient contacts per week and the diabetes service had 14,000 registered patients. Between April 2016 and November 2016, the Beckenham integrated community nursing team had 42,430 patient contacts and the Bromley podiatry service had 16,026 contacts. In the same period the adult speech and language therapy team had 2902 patient contacts. The HIV service had a case load of 296 patients.

In addition to our announced inspection, we conducted an unannounced inspection on 5 January 2017.

As part of our inspection we spoke with 23 members of staff, 14 patients and six relatives. We accompanied staff on home visits and visits to a care home. We observed care being delivered, reviewed 25 patient records and multidisciplinary notes and looked at over 50 other items of evidence to come to our rating.

Summary of findings

Overall rating for this core service

Overall we rated community health services for adults at Beckenham Beacon as good because:

- Staff in all services demonstrated consistent coordination with other service providers to ensure patients received coordinated, specialist care. This included multidisciplinary working with psychologists, sexual health services and care homes.
- Incident reporting and management systems were readily accessible to staff. Incidents were investigated appropriately and learning from these was shared with staff.
- Patients were protected from harm by a range of risk management and assessment policies based on national and international best practice guidance. Services consistently exceeded their monthly safety targets in relation to patient risk assessments and documentation. When an increase in pressure ulcers in the community was identified, the service responded quickly with the provision of additional expertise in a targeted programme to reduce the incidence.
- Effective medicines management processes were in place. This included learning from errors and regular training for independent prescribers.
- Infection prevention and control standards and practice were benchmarked and audited against the national best practice guidance of the Infection

Good

Community health services for adults

Prevention Society. An infection control lead was in post and each service had hand hygiene champions to support compliance with cleanliness and hygiene standards.

- Comprehensive safeguarding policies and staff training enabled teams to act quickly and appropriately in cases of suspected abuse or neglect. This also meant vulnerable patients were cared for by a team with the knowledge and experience to reduce the risk of avoidable harm.
- Audits were embedded into the service and staff used the results to establish practice in line with national guidance from accredited organisations and to improve patient experience. This included a programme of 14 audits in 2016/17 and previous audits with demonstrable outcomes, including in the use of effective mental capacity assessments.
- Each team demonstrated a commitment to continual improvement and sought out new ways to establish their effectiveness and how this could be improved. This included through multidisciplinary team working. For example, the quality and therapies teams worked together to implement the Therapies Outcome Measures to establish and improve clinical effectiveness in specific needs such as psychosocial impact.
- Clinical effectiveness service quality improvement goals were used in each service to support quality improvement and all services met or exceeded their goals in at least two months of the most recent programme.
- Diabetes and HIV teams contributed to improved patient outcomes through health promotion and structured education programmes for the local community, GPs and other health professionals.
- Service teams were positive about the quality of training offered to them and staff had undertaken specialist training to ensure they continued to meet demand on the service, such as in advanced chronic oedema and diabetic foot care.
- Each service had adapted the electronic patient records template to ensure patient notes were individualised and could meet their needs. An annual quality audit was used to identify areas of improvement in documentation.
- Staff continually sought to exceed the expectations of patients and their relatives by providing individualised care that improved their social wellbeing as well as meeting their physical needs. For example, the integrated care team provided patients with 'social prescriptions' that provided access to day centres to help them make new friends. Staff in the HIV service facilitated patients' access to a peer support group and had accompanied one patient to a community support group to help build their confidence.
- Waiting times for podiatry and speech and language therapy appointments reduced significantly in the 12 months prior to our inspection as a result of improved communication and access. In addition, the HIV and diabetes teams both consistently met their target for referral to assessment times and the integrated care nursing team offered weekend drop-in clinics.
- Governance and risk management structures ensured risks to the service were monitored with regular strategy meetings to establish risk reduction policies and practices. There was evidence the senior team used this process effectively and action taken to address risks had resulted in safer services and better experiences for patients and staff.
- The senior team effectively managed risks to the service through the use of a strategic risk register. Risks were proactively identified and were reviewed regularly. Each risk had a named owner and there was evidence action was taken to mitigate each risk. For example, capacity had been increased in podiatry and senior staff were given more clinical training to improve safety for patients with complex needs.
- The service encouraged and rewarded progression by staff by facilitating them to develop leadership and innovation skills.
- The patient experience group led patient engagement and there was evidence this group was able to influence executive decisions to adapt and improve services. Each clinical service had developed patient engagement strategies based on their knowledge of their own patients. This included surveys, peer support groups and social clubs.

Good

Community health services for adults

- Staff valued opportunities to take part in pilot schemes and competitive applications for programme funding that enabled them to expand local services. Staff in the HIV service were active in research and there was an overall commitment to driving innovative practice and change in every service.

However, we also found:

- The staff vacancy rate was 17% of the total workforce and there was evidence from staff survey results that this had an impact on morale and staff wellness. However, a workforce development group was in place and on-going recruitment drives were in place to improve staffing levels.
- None of the core service teams met the provider's minimum target of 85% of staff to have an up to date appraisal in the previous 12 months. Overall 66% of staff had an up to date appraisal.
- An audit of the completion of MCA documentation in patient records in October 2016 showed low levels of compliance, with 9% of the 554 records audited including a completed MCA template. However, there was evidence of immediate and sustained improvement and in all of the patient records we looked at, a mental capacity assessment was in place.
- Results from a March 2016 survey amongst staff in the integrated care team indicated a need for improved communication between the senior management team and staff, including when important decisions were made. In addition, this service scored worse than the rest of the organisation in all 11 questions related to relationships with managers although results indicated general satisfaction. Results from this survey also indicated staff felt under pressure to come to work when they were unwell and that the pressure of work had contributed to spells of ill health. This was reflected by the response that 15% of respondents felt the provider did not take positive action on staff health and well-being.

Are community health services for adults safe?

Good

We rated safe as 'good' because:

- Staff adhered to safety systems to avoid preventable harm and there was a track record of harm-free care.
- A quality and safer care team supported the investigation of incidents, and lessons learnt were shared across multidisciplinary teams. Where an incident partly involved staff from another organisation, the provider took appropriate steps to involve them in the investigation and outcomes process.
- Safeguarding processes were embedded in every service and staff demonstrated their adherence to these in their assessment and care of patients. A safeguarding lead and vulnerable adults panel provided clinical and governance oversight of safeguarding cases and provided support to staff in the delivery of care to vulnerable patients. Staff involved with safeguarding processes adhered to the Prevent Strategy 2011.
- A medicines management group monitored medicines safety and conducted audits to ensure practice was in line with safety policies. Medicines were stored and administered according to national guidance.
- Staff in each service maintained standards of cleanliness and infection control and demonstrated appropriate levels of hand hygiene during our observations. An infection control nurse conducted monthly audits in each service area and implemented action plans where there were areas for improvement. Service managers worked closely with the infection control nurse and actions plans were followed up.
- Risks to patients were well managed using established assessment tools and staff were responsive to change when the needs of patients increased or they noticed trends in the local population. For example, in response to an increase in the number of pressure ulcers in housebound patients, a lead nurse in the quality team was identified and an action plan implemented to address the problem. This included the introduction of the modified early warning system to help nurses identify when patients were deteriorating.

- The provider had a minimum target of 85% for the completion of mandatory training in each service and four of the five adult teams met or exceeded the minimum target.
- An audit of the use of the duty of candour led to improvements in how staff were supported to adhere to this within the standard 10-day time frame.

However, we also found areas for improvement:

- There were integrated care team consultations without documented notes on the electronic record system. However, paper records were taken and were available in each patient's home. Staff had adapted the use of an electronic template to the individual needs of each service and the quality of patient records was consistent.
- Staff turnover in the integrated care team was significantly higher than the organisational average and there was a vacancy rate of 17%. In addition, significant numbers of shifts went unfilled, including 80 in a four week period in October 2016 and November 2016. Evidence from waiting lists and minuted meetings indicated there was minimal impact on the safety of services but there was a cumulative effect of stress and pressure on staff as a result.

Detailed findings

Safety performance

- Between August 2015 and July 2016, 13 serious incidents were reported in community health adult services, of which 11 were reported by community teams and two were reported in podiatry. Grade three pressure ulcers were the most common incident, including two avoidable instances, five unavoidable instances and two instances of inconclusive origin. Both incidents in podiatry related to the deterioration of vascular diabetic foot, one instance resulting in an amputation and another in an admission to hospital. As a result, the senior team improved staffing cover in the podiatry team and implemented daily auditing of diabetic foot checks.
- Between December 2015 and November 2016, staff in the Beckenham Beacon Hub reported 361 incidents. Of the incidents 12% resulted in no harm, 62% results in low harm, 26% resulted in moderate harm and less than 0.05% resulted in severe harm. Individual services monitored local incidents specific to them. In the same period, HIV services reported four incidents, the speech and language therapy team (SaLT) reported 24 incidents, podiatry reported 55 incidents and the diabetes team reported 15 incidents.
- In the 12 months prior to our inspection, staff in the diabetes service reported 15 incidents. Of the incidents, 60% resulted in no harm, 27% resulted in minimal harm and 13% resulted in moderate harm. Results from a March 2016 staff survey indicated 100% of staff felt the provider encouraged them to submit incident reports and they felt confident in challenging unsafe practice. However, only 60% of respondents said they received feedback on the changes implemented as a result of incident reports.
- Between November 2015 and December 2016, 12 falls were reported by the integrated community team, one of which resulted in moderate harm and 11 resulted in low or no harm.

Incident reporting, learning and improvement

- Incidents were managed according to the NHS Improvement Serious Incident Framework (2016). This meant incidents were investigated using a partnership approach with everyone involved in order to identify what went wrong, how it went wrong and what could be done to make sure it did not happen again.
- Incidents and investigation outcomes were shared appropriately with other providers. For example, if an incident involved a weekend nurse clinic patient, this was shared with the referring GP if it related to their care or treatment. This meant patients received continuity in their care planning.
- Service managers and clinical leads monitored incidents for trends, which they used to ensure care and treatment was delivered safely. The most common incidents in the integrated care team related to pressure ulcers. Staff recognised this often occurred because many of their patients were bedbound and entered their care with existing pressure ulcers. However, staff always took action to prevent pressure areas deteriorating as well as the risk of new pressure sores. For example, each patient had a pressure ulcer risk assessment and nurses documented pressure areas using a body map and photograph. All nurses and healthcare assistants (HCAs) also had remote access to an equipment formulary that

enabled them to order pressure-relieving equipment for patients. In addition district nurses worked with tissue viability nurses to provide targeted care and treatment for patients with pressure ulcer risks.

- A dedicated safer care team supported service leads with incident handling and the management of recurring issues. For example, a pressure ulcer lead reviewed every incident of this to ensure the grading was accurate and then met with clinical staff to identify if the pressure ulcer had been avoidable or unavoidable. This individual attended team meetings and provided feedback to the incident caseholder on their findings. This helped to ensure all aspects of an incident were investigated and learning was identified.
- The pressure ulcer lead was coordinating a 30-point action plan to reduce pressure ulcers in 2016/17 as a result of learning from previous incidents. The action plan was due to be completed in March 2017 and was on target in December 2016, including the addition of pressure ulcers to the safety dashboard, audits on the use of the malnutrition universal scoring tool and the introduction of a new risk assessment template to the electronic patient records system.
- The safer care team gave reflection forms to staff involved in incidents so they could consider their actions before and after this event. This helped individuals to consider best practice and helped to identify anything they could do differently. The safer care team also tracked incident reports in the electronic system and ensured action plans were implemented and followed up.
- Staff discussed incidents as part of monthly team and governance meetings. This was an opportunity for staff to discuss each incident with each other and with managers and to consider solutions together whilst each incident was formally investigated. For example, during a diabetes team meeting staff discussed five incidents from the previous month and identified immediate action taken, including a computer failure and a communication problem with a GP.
- Staff liaised appropriately with other service providers when an incident involved wider teams. For example, the HIV service logged an incident that involved an unsafe medicine prescription from accident and emergency for a patient with complex needs. The service lead nurses discussed this at management and governance meetings and this led to the HIV team establishing more involvement in multidisciplinary care planning.

Duty of Candour

- The provider conducted an audit in September 2016 to assess compliance with the duty of candour regulations. The duty of candour is a legal duty to inform and apologise to patients if mistakes in their care resulted in avoidable harm. The audit considered 38 incidents subject to the duty of candour, including 28 avoidable pressure ulcers, between April 2015 and August 2016. Of the 38 incidents that passed the 10 day period allowed for duty of candour notification, staff met the requirements in 50% of cases. An action plan was implemented as a result of the audit, which included simplification of the notification process to ensure the patient safety team and risk team led duty of candour communications with patients. This was due for completion in October 2016 but had not been confirmed as at December 2016.
- The pressure ulcer lead in the safer care team visited patients personally in instances where a pressure ulcer was deemed to have been avoidable. In such instances the member of staff provided an explanation and apology to the patient and made sure they understood the plan to treat them.

Safeguarding

- An adult safeguarding strategy and training committee maintained oversight of processes and staff training in safeguarding and the protection of vulnerable adults. Each service lead contributed to this committee and ensured their teams met the competency framework including completion of mental capacity and training to identify radicalisation (PREVENT).
- Individual services delivered care and treatment in line with the provider's safeguarding adults policy and adult protection procedures. This incorporated national best practice guidance into care planning and delivery and ensured staff acted in line with policies including the Prevent Strategy 2011 and identified 16 distinct types of abuse along with appropriate action that should be taken.
- The safeguarding lead chaired a multidisciplinary vulnerability panel that was used to review patients with complex needs and those who were at risk in the

community. The panel ensured patients who received care at home were protected from avoidable harm. For example, when staff were concerned about a potential fire risk at someone's home, they liaised with the fire service to visit the home and give advice on safety. When one team identified a potential risk to a patient from a carer in crisis, they escalated the situation to local safeguarding teams and ensured a community matron visited the patient the next day to follow up. This ensured both the patient and their carer were protected from harm and supported when they needed it.

- Staff used established protocols in the event they suspected abuse. This included coordination between district nurses, the relevant service lead and the safeguarding lead to complete a risk assessment. If the patient did not have capacity to consent to this process, staff used an appropriate best interest process.
- Details of safeguarding protocols and safeguarding lead staff were clearly displayed in staff offices and clinical areas and staff had access to this electronically.
- Community teams participated in a Mental Capacity Act (2005) audit as part of the provider's safeguarding audit programme.
- Each team had a minimum target for up to date mandatory safeguarding training of 85%, which included adult safeguarding level two and child protection level two. At the time of our inspection 89% of SaLT staff were up to date with this training and 87% of the the integrated community team were up to date. Both members of staff in the HIV team had up to date training.

Medicines

- A pharmacy lead chaired a medicines management group that met weekly to review and monitor prescribing processes. This group had conducted a medication reconciliation audit in September 2016 and found 56% of patients said they did not know what their medicines were for. In response staff improved how they explained prescriptions and medicines to each patient.
- Two community matrons and the lead HIV clinical nurse specialist was an independent prescriber and maintained continuing professional development to do so safely. This member of staff also adhered to the provider's non-medical prescribing policy and received specialist supervision from an HIV consultant.
- Staff discussed incidents relating to medicines as part of monthly team meetings. For example, during a diabetes team meeting staff discussed an incident in which an insulin pen had failed during a home visit and the patient was given an incorrect dose. Staff identified there was no harm or risk to the patient in this instance and re-wrote the care plan to include a risk assessment for this issue. Another incident involved an incorrect prescription issued by a GP. As a result, staff used a medication passport more widely to ensure risks were reduced when patients received prescriptions from different providers.

Environment and equipment

- All staff who conducted home visits had their own hand hygiene kit and mobile safety kit that included a sharps bin, swabs and disposable apron.
- Equipment was audited on an annual basis and included a check that servicing requirements were up to date. As at August 2016, 86% of equipment had an up to date audit.

Quality of records

- The overall standard of patient records in all services we visited was of a level that meant patients were protected from avoidable harm. Care and treatment plans were person-centred and individual needs were clearly documented. For example, staff documented the outcomes of home visits in detail and provided the information to other services involved in providing care, including GPs. Staff always documented the details of investigations and examinations and involvement with relatives. This helped services to coordinate care and manage patient risk.
- Staff in all services used a standard electronic system to record patient contact, test results and follow-ups. A check and record of mental capacity, consent, multidisciplinary contact and confidentiality was common to every service. Staff in each specialty had developed the electronic system to record the individual needs of their patients. For example, nurses in HIV services had added a section to the patient care template that allowed them to record details of patient adherence to highly active anti-retroviral treatment (HAART).
- We looked at 25 patient records across all adult services we visited. Staff consistently recorded mandatory information, including consent and mental

capacity, and detailed patient needs in the narrative record. This meant patient care and treatment could be monitored and tracked by all appropriate staff and ensured continuity of care for each patient.

- District nurses recorded detailed notes in the care plans in patients' homes so that other health and care staff could access them. We saw evidence of regular assessments and photographs used to document wounds and pressure areas.
- Although the standards of record keeping were good, district nurses did not always have time to document consultations on the electronic records system immediately after visits. Some nurses told us they often had to complete notes out of hours from home. This sometimes resulted in delayed recording of notes. For example, during a multidisciplinary meeting we attended the team identified 350 missing consultations from patient notes that needed to be completed within the next eight days. These were all completed. After our inspection we spoke with the provider about this. They explained that the missed documentation of consultations had occurred during a period of transition from paper notes to an electronic system. Whilst training to use the new systems, nurses had to maintain their existing caseload, which had resulted in delays to documentation. The missing consultations applied only to central records and each patient had a copy of their notes in their home. The number of missed consultations in records decreased from 20 in January 2017 to three in March 2017. The provider completed the transition to electronic records in March 2017 and a system of performance management and support was in place for staff who did not document consultations.
- The provider audited the quality of patient records on an annual basis that included a check of the completion of 10 key items of information for each patient with a minimum target result of 90%. Scores for adult services were 79% in community teams, 88% in HIV services, 91% in the diabetes service and 94% in the SaLT team.

Cleanliness, infection control and hygiene

- Cleanliness in clinical areas and waiting areas was managed by a cleaning team contracted by the building operator. All of the areas we visited were visibly clean and tidy with antibacterial hand gel available in clinical areas and bathrooms stocked with soap and paper towels. Daily decontamination records were available in clinical areas and staff used these to ensure equipment was prepared for daily use.
- Some staff had been trained as hand hygiene champions and conducted spot checks in various areas of practice. In addition, an infection control nurse conducted unannounced inspections during care to monitor staff adherence to hand hygiene processes. This individual conducted monthly hand hygiene audits on 10 occasions in each service area. They gave immediate feedback to the member of staff and re-audited them if they had not fully adhered to hand hygiene standards.
- In November 2016, the SaLT team hand hygiene audit indicated 93% compliance with the provider's policy.
- During all of our observations staff demonstrated appropriate hand hygiene, including the use of personal protective equipment, hand washing and the aseptic non-touch technique.
- The management of hazardous waste, sharps and infectious waste, including storage and removal, met national best practice guidance. This included the use of hazardous chemical signs and appropriate protective equipment in the laboratory used to make orthotics.
- In November 2016 an infection control nurse conducted an infection control audit in the diabetes service following the Infection Prevention Society Care Setting Rapid Improvement Tool. The service performed well in some areas, including the safe disposal of sharps and the use of gloves. The auditing nurse produced a 15-point action plan to enable the service to demonstrate full adherence to provider policy. This included displaying sharps injury protocol posters; providing individual hand hygiene kits for each member of staff conducting home visits, and ensuring infection control was a standing agenda item in team meetings. In December 2016 the team had implemented all three recommendations as well as the remainder of the action plan. A similar audit in podiatry resulted in an action plan to provide holders for gloves, aprons and couch rolls and to replace worn out dressings trolleys.

Mandatory training

- All staff undertook a mandatory training programme on joining the service, which included basic life support,

infection control, safeguarding and moving and handling. Service managers supported staff to stay up to date with refresher training and they were given protected time to complete this.
- The provider had a minimum target of 85% for up to date mandatory training in each service team. As at December 2016, both the HIV service team demonstrated 100% compliance, the SaLT team had 96% compliance and the podiatry team had 91% compliance. Training in the integrated community team indicated 81% overall compliance and in the diabetes team this was 85%.

Assessing and responding to patient risk

- Staff working in HIV services encouraged patients to discuss self-identified symptoms to manage on-going risks, such as swollen lymph nodes or early signs of advanced HIV.
- Staff used national and international risk assessment tools to monitor patients with elevated risks. For example, staff in HIV services used the World Health Organisation fracture risk assessment tool (FRAX) for patients over the age of 50 who were at increased risk of a loss of bone density. This team also used a cardiovascular disease risk calculator that matched the tool used by local GPs, to ensure patients were assessed consistently. The HIV care template established patient acuity against three levels that indicated how frequently they should be reviewed and how stable their health was.
- Staff used the international patient health questionnaire (PHQ-9) to screen patients for depression and anxiety. They could provide rapid referrals to mental health services for patients whose scores indicated a need for psychological support or intervention.
- Staff used the best practice guidance of the European Pressure Ulcer Advisory Panel 2014 to ensure pressure ulcers were identified, graded, recorded and treated appropriately.
- Two district nurses led a weekend dressing clinic for patients who were being seen by practice nurses in the week and required weekend dressing changes. They were given an appointment to attend a dressing clinic run by the district nurses and held at Beckenham Beacon.
- A medical response team offered a service 24-hours, seven days a week to patients who deteriorated but might not need to attend a hospital emergency department. This service was staffed by advanced nurse practitioners, GPs and therapists and meant patients could be seen in their own home within four hours of referral from their own GP or the NHS 111 service.
- A director on call was also available 24 hours a day- to respond to any services clinical or non-clinical concerns.
- District nurses in the integrated care team were able to respond quickly to calls from patients with urgent needs. For example, if a patient with a blocked catheter or who was receiving palliative care had urgent needs, the service manager would contact the nearest district nurse by text message to divert them to the patient.
- The diabetes service coordinated care for high risk patients with specialists based on their needs, such a vascular consultant and a diabetic foot consultant. Staff used appropriate risk assessments for treating patients with complex co-morbidities, including immune depressant conditions.
- HIV specialist nurses had rapid access to an HIV consultant and matron in a nearby acute hospital unit through the hospital's bleep system. This meant nurses could urgently escalate a patient's care using an emergency pathway if they deteriorated whilst on site at Beckenham Beacon. This also enabled nurses to speak with the duty HIV matron ahead of an emergency transfer.
- The NHS Safety Thermometer was used to record patient harm in clinical areas to monitor safety performance. Between November 2015 and November 2016, 13 new cases of harm were recorded. This meant 99% of the care provided to this sample of patients was free from service-acquired pressure ulcers, preventable falls, preventable catheter-related infections and venous thromboembolism.

Staffing levels and caseload

- Adult services had a team of 92 substantive staff, with an average vacancy rate of 17%. This was higher than the organisational vacancy rate of 12% and reflected an average turnover of 28%, which was significantly higher than the organisational average of 18%. An establishment of 36 qualified nurses and six nursing assistants was needed to fully staff all adult community services. Between May 2016 and July 2016, there were

nine full time vacancies for qualified nurses and nursing assistants and 515 shifts filled by bank or agency staff as a result of sickness, absence or vacancies. Of this, 12 shifts could not be covered by temporary staff.

- Staffing was listed as a risk to the service on the strategic risk register due to the vacancy rate. In response, the establishment of bank staff was increased and the induction programme to improve consistency. Increased recruitment advertising for community nursing teams had reduced vacancy rates.
- We looked at a sample of staff rotas between 10 October 2016 and 6 November 2016 for all community adult services. In this period 80 shifts were unfilled. This included bank staff, community matrons and non-clinical staff.
- Service leads established the required skill mix for their service based on national clinical guidance and patient acuity. This was implemented according the banding (grade) of staff and represented increasing levels of responsibility as banding and experience increased. This system meant the senior team could match staff experience and clinical skill with the needs of specific patients.
- A senior nurse service lead and band six nurse led the HIV service.
- A clinical lead and two clinical nurse specialists led the diabetes service with support from two senior agency nurses.
- Adult speech and language therapy services was staffed by 7.75 whole time equivalent therapists.
- A podiatrist service lead and two band seven advanced podiatrists led the podiatry team. The band seven team provided support in minor surgery, musculo-skeletal procedures and diabetes wound care. In addition 7.5 podiatrists and two podiatry assistants worked in the department.
- The podiatry team worked with the diabetes team and diabetologist who specialised in the diabetic foot. This enabled patients with foot concerns as a result of poorly controlled diabetes to access specialist care.
- The integrated care nursing team were piloting a new shift structure that resulted from a review of the team's skill mix and the acuity of patients under their care within a safer staffing framework. This included the introduction of a twilight shift from 6.30pm to 10.30pm that enabled nurses to see more patients out of hours. A long day shift from 8am to 7pm had also been introduced to improve continuity of care. Five new healthcare assistants had been recruited to support the service and a recruitment programme was active to expand the team.
- Weekend dressing clinics were led by two nurses from the community adult team. As all nurses rotated through this service, training, experience and skill mix matched that of weekday services.
- All services were led by nurses and therapists and specialist clinics were available according to each consultant's work plan. For example, diabetes and HIV services had daily access to specialist consultants. Podiatry, SaLT and the community team did not routinely have scheduled medical staff input and had referral pathways in place through local NHS agreements. Patients could make appointments in advance depending on the availability of the consultant. Clinical nurse specialists in diabetes were available weekly and patients using the nurse-led HIV service had access to a consultant at all times the service was open.
- District nurses provided a daily 'meet and greet' for agency nurses to review the patient list and identify any additional resources or support they needed.

Managing anticipated risks

- All staff had basic life support and cardiopulmonary resuscitation training and protocols were in place to manage emergencies such as a cardiac arrest. An urgent care centre was available on site and was open at all times Bromley Healthcare services operated. Staff could obtain urgent help from staff in this unit and equipment was available throughout the building for emergencies. This included a defibrillator in the outpatients unit and first aid kits in every departmental reception office. Where services were based in another provider's department, they had access to the emergency equipment there. Each district nurse carried an emergency kit that included adrenaline and a 'shock pack' for anaphylaxis.
- All staff were trained in fire safety and evacuation procedures specific to this building and their area of work. At all times staff were on site with patients, security staff were available and conducted hourly 'sweeps' of the building. This provided reassurance to staff when working out of hours. Staff we spoke with said aggression or inappropriate behaviour from patients was very rare but when they had needed support from security staff this was provided quickly.

Good

Community health services for adults

- District nurses made sure patients who received care at home understood the warning signs and risks of their conditions. For example, when changing a wound dressing, the nurse discussed with the patient how to recognise early signs of an infection and what action they should take.
- The integrated care team recognised the risk of pressure ulcers in patients who received care at home. As part of the pressure ulcer lead's action plan to reduce pressure ulcers, the modified early warning scores system had been introduced. This meant staff could identify patients who might be deteriorating at an early stage and ensure appropriate interventions were put in place.
- Staff used a service specific workplace risk assessment to manage risks in their areas of work. Risk assessments included guidance for staff on how they could manage risks associated with areas such as moving and handling and the control of substances hazardous to health.

Major incident awareness and training

- All teams had an established continuity plan for use in the event of mass staff sickness or a significant outbreak. This included the use of a protocol to prioritise treatment for patients with the greatest risks, avoidance of referrals to hospital emergency departments and the use of partner agency resources. Clinical leads had a record of managers and directors with a clinical background, who would be deployed in the event home visits or appointments to sick patients were disrupted. This system had been used during a period of significant staff absence in the SaLT team and clinical managers had maintained the service to ensure patients with the greatest risk were cared for.

Are community health services for adults effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Each service participated in an audit programme to assess and benchmark the standard of the care they provided against national best practice guidance. This included standards published by professional bodies, the National Institute of Health and Care Excellence and the National Patient Safety Agency. Audits demonstrably led to improved practice and outcomes for patients, including a 90% improvement in the completion of diabetic foot risk assessments between February 2016 and November 2016.
- Risk management tools were in place to help staff deliver specialised care effectively, safely and in line with best practice guidance. For example, the speech and language therapy (SaLT) team used the risk management outcome measure for dysphagia to ensure 91% of patients referred for dysphagia had their risk of aspiration reduced, which exceeded the service's clinical target of 80%.
- The quality team and therapies staff worked together to introduce the Therapy Outcomes Measures to help improve the health and wellbeing of patients they cared for.
- Each service performed well against targets set in their clinical effectiveness service quality improvement goals and results demonstrated a continuous commitment to improving service and patient outcomes.
- Staff were positive about their training and 98% of staff in the integrated care team said training helped them to remain current in professional practice and to deliver a better service to patients.
- The diabetes, HIV and SaLT teams had established programmes of health promotion and prevention that improved patient outcomes. This included a structured education programme for patients with pre-diabetes and training and advice for GPs. This had resulted in a 96% achievement of national targets for blood test results relating to HBA1c (glycated haemoglobin). The HIV team delivered training to local health professionals on the potential interactions between HIV medicine and worked with the health improvement team to reduce new diagnoses through safer sex health promotion. The SaLT team had worked with dieticians to deliver a training programme to social care providers on improving nutrition options for their service users. This was a specialised, targeted programme and an evaluation was underway to assess its impact.
- Staff sought specialist training to ensure they could meet the changing needs of the local population. For example, diabetes nurses undertook training in a diabetic foot care pathway and a tissue viability nurse completed an advanced chronic oedema course.

Good

Community health services for adults

- Staff in all services demonstrated consistent coordination with other service providers to ensure patients received coordinated, specialist care.
- Systems were in place to ensure effective sharing of information between services where consent was obtained from patients. This enabled GPs to access multidisciplinary notes provided by Bromley Healthcare staff and enabled the HIV team to coordinate care with the local sexual health provider.

However, we also found:

- None of the five service teams in adult community health met the provider's minimum target of 85% for up to date appraisals. Overall 66% of staff had an appraisal in the 12 months prior to our inspection.
- An audit of the completion of Mental Capacity Act 2005 (MCA) documentation in patient records in October 2016 showed low levels of compliance, with 9% of the 554 records audited including a completed MCA 2005 template. This reflected an issue with documentation as staff were completing assessments consistently but did not always record them. An action plan was in place for completion in January 2017 and we saw evidence in all of the patient records we looked at that staff consistently completed mental capacity assessments and recorded consent.

Detailed findings

Evidence based care and treatment

- Each service had completed a key local audit between March 2016 and September 2016 to establish the standards of service provision in specific areas. In podiatry, an audit took place to benchmark the use of the electronic patient records system against the National Clinical Record Keeping Standard set by the Society of Chiropodist and Podiatrists. Staff in HIV services audited the care provided to HIV positive pregnant women, community nurses audited pressure ulcer prevention and management and the speech and language therapy team audited compliance with the provider's prevention and management of choking policy. In addition, community teams participated in an end of life care audit and a falls prevention audit.
- A programme of 14 audits was in place for the period September 2016 to March 2017. This included at least one audit for each clinical service and four audits led by the quality team. Two planned audits included specific focus on the duty of candour and the Mental Capacity Act (MCA) 2005 and were planned to ensure staff adhered to the principles of both appropriately.
- Staff used audits to benchmark the standard and quality of their work against national professional guidance. For example, the podiatry team had implemented an audit to establish the standard of patient records against standards set by the Society of Chiropodists and Podiatrists.
- In addition to the established audit plan, individual services had completed scoping exercises to enable them to begin taking part in national audits. For example, the physiotherapy team planned to begin contributing to the National COPD (chronic obstructive pulmonary disease) Audit from January 2017. The rehabilitation team planned to use this to strengthen results already gathered from the 2015 Royal College of Physicians COPD Pulmonary Rehabilitation audit. In addition, the diabetes team planned to begin contributing to the National Diabetes Foot Audit from January 2017. A diabetes specialist nurse had initiated participation in the national Insulin Pump Audit from January 2016 to establish pump use against National Institute of Health and Care Excellence (NICE) guidance. Results from this audit were due to be published in February 2017.
- The diabetes service participated in the national audit for diabetes and used a 15-point care essentials dashboard to monitor patient care and treatment standards against national indicators. This included a measure of the number of patients with eye screening, foot screening and cholesterol monitoring as part of their care. The service had noted a decrease in average patient blood pressure and cholesterol as part of the monitoring.
- In February 2016 the podiatry service implemented daily monitoring of the completion of diabetic foot risk assessments. Between February 2016 and November 2016, the monitoring tool identified a 90% improvement in completion of the checks.
- Staff managed access to the podiatry service using NICE guidance. This meant staff triaged patients following a referral to make sure the service could meet their needs and that the care available was appropriate, based on NICE guidelines.
- A dedicated member of staff in the quality team led a programme to establish the effectiveness of care that

was provided across services from a health and wellbeing perspective. This included the introduction of the national Therapy Outcomes Measures (TOMs) quality tool for therapists and training for them to embed this in their work. This team was also establishing measurements to assess effectiveness in clinical care of impairment reduction, psychosocial gain and overall wellbeing for patients receiving progressive neurotherapy. New patients entering the speech and language therapy (SaLT) service were scored according to TOMs on their level of impairments in activities, participation and wellbeing. Staff conducted this assessment with the input of each patient.

- The SaLT team were developing an in-house choking prevention policy in line with national guidance that would help them to structure targeted support when preparing patient care plans. This team also used a range of recognised tools to ensure patients had appropriate needs and risk assessments. For example, staff used the voice handicap index to assess the needs of a patient who found communication difficult. The SaLT team used this tool alongside multidisciplinary referrals with a GP and counsellor to triangulate care and treatment planning.
- The integrated care team had introduced the SSKIN care bundle (a tool that records care provided) to ensure they provided effective skin integrity preventative care.
- The HIV services team conducted a notes audit and one clinical audit in 2016. The notes audit indicated staff were 88% compliant with record keeping standards and highlighted areas for improvement in the use of the new electronic record template to record urinalysis, cervical screening and flu vaccination status. The clinical audit was used to check staff adhered to established guidance on Hepatitis B, but results were not yet available at the time of our inspection. In addition staff in this service conducted a retrospective review of late HIV diagnoses four times each year. This process identified where patients with a late diagnosis were initially tested and how the service could work with them to ensure people with risk factors in the local community were engaged with earlier.
- In 2015, HIV nurses had conducted an audit of the care offered to HIV positive pregnant women. This audit indicated a need for more coordinated care between maternity, gynaecology and HIV services and as a result the clinical nurse specialists created a birth plan to be used by consultants and other clinicians as a care and treatment pathway.
- Adult services had a clinical audit plan of 21 audits between February 2016 and July 2016. This included patient record audits for each service and clinical audits to benchmark services against national standards. For example, one audit looked at the national falls and fragility fracture audit programme indicators. At the time of our inspection the outcomes of these audits were not available.
- The diabetes service audited compliance with the requirement that each patient have a documented diabetic foot risk assessment. Between May 2016 and December 2016, the service performed consistently, with 99% of patients each week receiving this assessment.

Pain relief

- The integrated care team could begin end of life care, including pain relief and syringe drivers, within 24 hours of referral.
- The integrated care team had two independent prescribers and the HIV lead nurse was also a prescriber. These members of staff could prescribe pain relief where required.

Nutrition and hydration

- The speech and language therapy (SaLT) team worked with community dieticians and care home staff to ensure patients with swallowing and nutrition needs had appropriate access to adequate food and drinks. For example, the SaLT team provided printed information to patients on diet that had been approved by the dietician team and adhered to guidance published by the National Patient Safety Agency. We observed the advice and guidance SaLT therapists gave to care home staff was specific to patients needs and therapists checked carer's existing level of understanding before providing this.
- The SaLT team had access to a nutritional nurse who helped them provide targeted support for patients who used feeding equipment, including percutaneous endoscopic gastronomy (PEG) tubes and radiologically inserted percutaneous grastronomy (RIG) tubes.

Technology and telemedicine

- District nurses each had an electronic tablet they used to update patient records and type notes while on home visits. They could also use this to order equipment for patients and to make referrals. For example, if a nurse identified a pressure area on a patient, they could take a medical photograph with the tablet and send this instantly to a tissue viability nurse for review and assessment.

Patient outcomes

- The diabetes service used a 'failsafe' auditing system to ensure patients always received appropriate follow-ups. This included reviewing electronic records to ensure that when a patient needed a follow up, this had been booked.
- The integrated care nurse team had access to the medical response team and home pathway team. These were specialist resources aimed at ensuring patients had the best possible outcomes when they needed urgent care and treatment at home.
- Clinical nurse specialists in the diabetes service followed an abnormal blood pathway tool during daily blood results checks to ensure patients received appropriate and timely follow-ups.
- Integrated care matrons led a proactive care pathway that meant patients were monitored and reviewed according to their individual needs. Staff offered patients preventative care and treatment to prevent them becoming unwell or needing hospital admission.
- Staff in the diabetes service had introduced individual scorecards for each patient in the service. This helped staff track their blood results and other diagnostics over time and monitor their treatment and progress. The service audited the number of patients with an up to date blood glucose measurement, called HbA1c, against a target of 85% of patients. Between May 2016 and October 2016 the service performed better than the target as an average of 89% of registered patients had this measurement recorded.
- The diabetes service aimed to improve the outcomes of their patients through use of a structured education programme for pre-diabetic patients. This encouraged individuals to take ownership of their condition and included a project called 'Walking away from diabetes'. Staff delivered teaching and learning sessions as part of this project in community settings, such as in a leg club for patients with wound care needs. This model of care resulted in improved patient outcomes, including 87% achievement of national targets for blood test results relating to HBA1c (glycated haemoglobin) for those who took part in the nationally recognised dose adjustment for normal eating (DAFNE) and diabetes education and self management for ongoing and newly diagnosed (DESMOND) programmes. In addition 80% of local GP practices referred diabetic patients to the service for education, compared with 16% nationally, and 71% of local GP practices had signed up to the team's enhanced services.
- Staff in the HIV service worked with primary care services to improve testing within NICE guidelines and within their remit of reducing new HIV diagnoses. The team worked with colleagues in the health improvement team to achieve this alongside increased testing rates through a health promotion campaign. This team had delivered teaching sessions at a local mental health hospital to educate staff there on the possible interactions between HIV medicine and common mental health medicine.
- HIV specialist nurses were able to prescribe post-exposure prophylaxis (PEP) for patients who presented urgently and reported a potential exposure to HIV. PEP is a medicine therapy that reduces the risk of HIV infection after an exposure if taken immediately after a possible exposure.
- The 2015/16 quality account set out clinical effectiveness service quality improvement goals for the SaLT and HIV teams and the tissue viability service that supported the integrated care nursing team. The HIV team target was for a minimum of 95% of patients who met three out of four psychological needs indicators be referred to a specialist service. In each quarter the service achieved 100% of the target. The target for the integrated care team and tissue viability nurse was for 95% of patients with a venous leg ulcer to achieve healing within 5.7 weeks. In 2015/16, the service achieved 90% compliance with the target, which included two months where they exceeded the target and two months where they did not meet it. The SaLT team did not meet the target that 80% of patients with swallowing problems show an improvement in one score in their outcome measures although the service demonstrated a significant and continuous overall improvement. For example, in quarter one 21% of patients demonstrated an improvement in one outcome, which was followed in subsequent quarters by 33%, 44% and 70% of patients, respectively.

Good

Community health services for adults

Competent staff

- Staff worked within competency frameworks and a senior Darzi Fellowship therapist was conducting a review of these to ensure they were fit for purpose and met the needs of the service.
- Appraisal rates were variable between services, and 92% overall. This included 92% of staff in podiatry with an up to date appraisal compared with 70% of staff in the diabetes team and 80% of staff in the SaLT team. This was below the provider's target of 85%. In addition, district nurses had fortnightly one-to-one meetings with the interim service lead as a strategy to improve staff development. Appraisal rates were reflected in results from a March 2016 staff survey in the integrated community care team, in which 30% of respondents said they had not had an appraisal or development review in the previous 12 months. In addition, 15% of respondents said they had not had training, learning or development opportunities in the previous 12 months. In the survey, 80% of respondents said their appraisal had been helpful in improving their work but 21% said they felt their work was not valued as a result. In the previous 12 months service leads had implemented plans to increase appraisals to the target level following a period of short staffing and relatively high staff turnover. The current appraisal rates reflected this and all of the staff we spoke with were positive about their supervision arrangements and last formal one-to-one meeting.
- One senior nurse in the integrated care team was a qualified specialist practice teacher and provided mentoring and education support to district nurse students.
- Staff in the diabetes service had access to regular education evenings offered by specialist clinicians. A diabetic specialist nurse had been seconded from a local hospital to deliver a year-long dedicated education programme to staff, including for student nurses. This was part of a wider programme to up-skill the diabetes team.
- Staff in each service attended a monthly meeting that included presentations and education sessions from colleagues and specialists. For example, a diabetes team day during our inspection included support and advice from an adult safeguarding advisor about appropriate use of MCA assessments and a training session on interpreting blood results led by a consultant.
- Clinical teams provided additional training for staff as the needs and demands of the local population changed. For example, diabetes nurses had been trained in the use of a diabetic foot pathway following an increase in the number of patients with foot problems. A tissue viability nurse had successfully completed an advanced chronic oedema course.
- Results from a March 2016 staff survey amongst the integrated care team indicated a high level of satisfaction with the standard of training. For example, 98% of respondents said training had helped them to do their job effectively, stay up to date with professional practice and to deliver a better patient experience.

Multi-disciplinary working and coordinated care pathways

- Staff in all services demonstrated consistent coordination with other service providers to ensure patients received coordinated, specialist care. For example, nurses working in HIV services coordinated care of a patient whose partner received treatment from another provider to ensure the information given to both individuals was individualised and consistent. The operations manager of the community team had experience working in mental health and organisational psychology and provided support to staff. The safeguarding adults lead was an approved social worker with a background in mental health and provided support through the vulnerability panel to support staff caring for patients with complex mental health problems. This meant staff who needed to refer patients to secondary mental health services had a range of support to do this.
- Staff in each service demonstrated an understanding of the benefits of health promotion in addition to targeted clinical treatment. For example, nurses working in HIV services worked with patients to improve their diet and more effectively manage alcohol consumption and smoking. Services maintained up to date information of local community support services, such as smoking cessation, which could be used to signpost patients to.
- SaLT staff had worked with community dieticians to secure a grant to provide targeted, specialised dietary and nutrition training to social care staff working in care

homes and nursing homes. The 'Making Mealtimes Matter' programme was designed to improve the knowledge and skills of social care staff to enable them to provide a higher standard of care to people who had swallowing, eating and drinking needs. A SaLT therapist and dietician worked together to deliver a training programme to staff at all but two care homes and nursing homes in the borough. This included detailed guidance on the correct use of the malnutrition universal scoring tool (MUST). In addition, the team provided practical training on feeding techniques and managing instances of choking. MUST is a risk-based recording tool used to map a person's food and drink intake to protect them from malnutrition. At the time of our inspection, the training programme was complete and staff were reviewing the feedback given from care home staff and people who lived there as part of a structured evaluation process. This included pre-training and post-training knowledge checks by care home staff, reflective writing on their experience and a survey to identify if people who lived in the care homes had found an improvement in their food and drink options.

- Clinical nurse specialists in the diabetes service liaised regularly with GP practices to provide information and support to doctors and practice nurses. This included reviews of their patients to ensure diabetes management met their needs. Following a successful programme of engagement with GPs, the diabetes team had categorised local practices based on the level of support they needed in providing care to their patients with diabetes. This included access to a diabetes support line. This enabled the team to identify how to direct resources and in which areas patients needed more intensive support from the team.
- Staff used a weekly multidisciplinary meeting to review patients with complex needs, those on a palliative care pathway, receiving intravenous therapy or who had a pressure ulcer. We attended a meeting, which included representation from physiotherapists, technicians, occupational therapists, district nurses and service managers. Staff reviewed each patient's treatment goals and symptom management and also ensured appropriate other services were involved in their care planning, including for social care.
- A tissue viability nurse was available to all adult teams and conducted home visits or patient assessments on request by the referring professional.
- The specialist HIV team delivered bi-monthly training sessions to health and social care staff in the local borough that reflected the changing needs of the location population.
- HIV nurses had written specific guidance for health visitors in the care of babies born with HIV and how to manage treatment alongside childhood vaccinations.
- Specialist HIV nurses worked with public health professionals to provide care across organisational boundaries such as an inreach service with a local hospital sexual health team.

Referral, transfer, discharge and transition

- Nurses working in HIV services completed a follow up plan for each patient that included regular blood tests for their CD4 count based on individual need. A CD4 count is a check of how well a person's immune system is working and was used as a predictor of HIV progression.
- Adult services staff routinely coordinated referral, transfer, discharge and transition with other health and social care providers and services. For example, SaLT therapists worked with local social carers to establish individual care packages and provided detailed reports for GPs when patients needed prescriptions for food supplements.
- The integrated care district nurse team had assigned two community matrons to support patient discharge processes. One matron was based in a nearby hospital to facilitate timely discharge during the 'winter pressures' period and one matron worked with a hospital inreach team to ensure discharge and rehabilitation were integrated into care plans. This meant patients were discharged at an appropriate time with a care package and follow up plan for the community team.

Access to information

- Where other services in the hospital did not have direct access to the electronic patient records system, staff worked with colleagues to facilitate access in other ways. For example, nurses in HIV services often needed to work with colleagues in the adjacent sexual health clinic to provide coordinated care. The sexual health service was provided by a different organisation and so did not share a patients record system. However, where both services cared for a patient, staff recorded both clinic numbers for a patient in their own records. This

meant they could request, with patient consent, the most recent treatment details from each other. This reduced delays in accessing information to help provided coordinated care.
- GPs had access to the electronic patient records system, which meant they could access treatment information and care plans more efficiently. It was planned that Bromley Healthcare staff would have reciprocal access from February 2017. This would enable referrals and follow-ups to be fully integrated and coordinated between community teams and GPs.
- Joint team access did not apply in the HIV service to ensure patients received confidential care. Staff asked each patient if they wanted their HIV status and treatment plan to be disclosed to their GP and nurses encouraged patients to agree to this to improve their overall care .However, this was not enforced and the service did not share any information patients requested them not to.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- All clinical staff had completed training in the MCA 2005 and district nurses had completed training in the Deprivation of Liberty Safeguards (DoLS).
- As part of our inspection we observed staff conducting home visits. Where this took place in a care home or nursing home, staff always checked patients' DoLS status in case this affected the treatment they could provide.
- Staff in HIV services worked with patients to ensure information was only passed to GPs with their consent. Where patients with a recent HIV diagnosis did not wish staff to communicate this to their GP, staff worked with them towards future disclosure when they felt comfortable.
- Staff recorded the communication preferences of patients to ensure their privacy and confidentiality were maintained at all times. This included whether or not the patient had given consent for staff to leave a voicemail message, send a text message or communicate by e-mail.
- The integrated care team had undertaken an audit of the use of the MCA 2005 in October 2016 and introduced a redesigned template as a result. This provided a more structured way for staff to assess and record mental capacity, which the audit showed as an area for improvement.
- An audit of the completion of MCA 2005 documentation in patient records in October 2016 showed low levels of compliance and 9% of the 554 records audited included a completed MCA template. The same audit showed 89 patients had consented to care documented by another person but without confirmation of a lasting power of attorney in place. An action plan was in place as a result of the audit and was due to be completed in January 2017. This included an improvement to the recording template in the electronic records system and increased input from the safeguarding lead in multidisciplinary working. There was evidence the action plan had improved standards as all 25 patient records we looked at included a fully completed mental capacity assessment.

Are community health services for adults caring?

Outstanding ☆

We rating caring as outstanding because:

- Staff consistently demonstrated their ability to exceed expectations by providing highly individualised care.
- There was a consistent focus on providing care that was holistic and went beyond immediate clinical need. For example, speech and language therapists worked with care home staff to make sure people had access to food that was important to them and that also met their dietary needs. Staff in the HIV service worked with newly diagnosed patients to help them understand the diagnosis, which included helping them with relationships and disclosure within their families and to their friends and partners.
- Staff, including receptionists and clinical staff, demonstrated kind and compassionate care during all of our observations.
- All services had a track record of high levels of performance in the NHS Friends and Family Test, which asks patients whether they would recommend the service to a member of their family or a friend.
- All the patients and relatives we spoke with gave positive feedback about the service. The HIV service held an extensive collection of thank you cards and

letters from patients and relatives. Patients noted the personalised and timely care of staff that extended beyond immediate clinical treatment to help them establish fulfilling lives.

- Staff in the HIV service demonstrated sensitivity when working with patients to establish their care needs and improve their understanding of an HIV diagnosis. This included ensuring they understood the risks of HIV transmission through dedicated education sessions and liaising with other service providers and relatives where appropriate.
- During home visits staff took the time to provide practical guidance and education to people that would help the delivery of care. This included supporting relatives in the management of care plans and helping them to understand how to provide a healthy diet. Staff we observed were acutely aware of social needs in peoples' homes and responded discreetly to the needs of carers, including involving them in care planning.
- Nurses in the HIV service held counselling qualifications and could refer patients to multidisciplinary support services, including for needs relating to alcohol and drugs. In addition, the team had set up a peer support service for patients newly-diagnosed with HIV to give access to others who were experienced in using health and social care services.

Compassionate care

- Staff demonstrated kind and compassionate care during all of our observations. For example, a receptionist reassured a patient who had missed their appointment and was very anxious about it. The member of staff was able to calm the patient down and offer an alternative appointment. In another instance a diabetes nurse offered gentle reassurance to a patient who was concerned about their blood sugar level. The nurse explained what the reading meant and discussed how they could reduce it using clear language and giving the patient time to ask questions.
- Each service performed consistently well in the NHS Friends and Family Test (FFT). Between April 2016 and December 2016 90 responses were submitted to the FFT. Of these 100% of speech and language therapy (SaLT) patients said they were extremely likely or likely to recommend the service. The HIV service had received a 100% "extremely likely to recommend" rating in every FFT data release since the service was implemented. The most recent results for the integrated care nursing team indicated 100% of patients would recommend the service. The most recent results for the diabetes service indicated 99% of patients would recommend them.
- All the 20 patients and relatives we spoke with said they were happy with the level of care and treatment. One relative said, "[The service] is way beyond my expectations. These are lovely people and they do a fantastic job. [Patient] is very independent and doesn't like to accept help but the nurses seem skilled in psychology and they always work very well even with resistance."
- Staff consistently thought of ways to make sure people were supported beyond their clinical needs. For example, when a patient was discharged following a long hospital stay, district nurses ensured they had milk at home and turned their heating on so they did not come home to a cold house. In another example, an HIV specialist nurse supported a nervous patient to attend a drug and alcohol support group by attending the first session with them. The nurse was able to support the patient in being open about their HIV status, which resulted in a significantly improved experience within the group for the individual.
- District nurses provided patients with FFT forms during home visits and the quality team was able to visit them at home if they wanted more information on the process.
- During our observations of nurses and therapists conducting home visits we found in all cases they treated people with dignity and respect. Staff modified their communication technique to the level of understanding of each patient and had a notably kind and engaging manner. For example, during an observation of a SaLT therapist, we saw the member of staff explained to the patient who they were and made sure they understood this before proceeding. The therapist also asked the patient if they were happy to have a swallowing assessment in the communal lounge where they were or if they would prefer the privacy of their room. Staff also used gentle encouragement to help patient assessments, such as when a patient with limited capacity became tired or distracted.
- The SaLT team had successfully achieved a patient satisfaction target as part of the 2015/16 quality account. The target was for 95% of patients and carers

to be satisfied with the service and feel that staff understood their problems. During the reporting period, 100% of patients and carers agreed the team met this criteria.

- Patients and relatives in the HIV service had written cards and messages of thanks to the team for their service and care. Patients and relatives noted the dedication of the team and their personalised service. One patient thanked staff for acting as an advocate on their behalf and others referred to staff as, "amazing" and "caring" and noted their kindness.

Understanding and involvement of patients and those close to them

- Nurses working in HIV services demonstrated sensitivity when speaking with patients and their relationships, including with family members. For example, when a patient was diagnosed with HIV, staff identified there was a risk a young person in the family might also be infected and ensured discussions around this were sensitive and involved the patient in decision-making.
- Staff engaged with people in the wider community through multidisciplinary teams to understand how their needs could be better met. For example, as part of a diet and nutrition training programme in care homes and nursing homes, SaLT therapists worked with dieticians to survey the needs of people who lived in the homes. This included a survey before the staff received extra training and a survey after the training to find out if people thought the choice and quality of food offered to them had improved. At the time of our inspection staff were evaluating the post-training survey results and were preparing to return to each care home and speak with people about their diet and nutrition individually.
- All the staff we spoke with and observed demonstrated a commitment to involving patients and those close to them in their care. For example, during home visit a SaLT therapist identified that the relative of a person with multiple needs was struggling to provide them with an appropriate diet. The therapist spent time with the relative, explained the nature of the patient's conditions and they worked together to establish how their dietary needs could be met. The therapist also explained the different roles of each health and social care professional involved in the person's care package so the relative knew who to contact under what circumstances.
- During our observations of home visits, staff took the time to provide practical guidance and education to people that would help the delivery of care. For example, during a home visit we saw a district nurse give guidance to a relative on how to manage a percutaneous endoscopic gastronomy tube. The relative told us they felt confident in its use because of the previous help given by nurses and they appreciated the extra support whenever they needed it. When one patient expressed anxiety about the use of medical equipment in their home, a district nurse showed them pictures of the equipment they wanted to use and explained what each item did so they could make a more informed decision and understand their treatment.
- During our observations of care we saw staff explained to patients what they were doing and why they were doing it and did so in a way each patient could understand. For example, a SaLT therapist asked a patient if it was okay to add a thickener to their cup of tea and used humour to facilitate this. For example, they said to the patient, "Don't worry, it has no flavour and no calories!"

Emotional support

- HIV service patients had access to a peer support group. This was a group of patients living with HIV who were used to support and medical services and could provide newly-diagnosed patients with emotional and practical support. Both nurses in this service held current counselling qualifications. In addition, specialist nurses could refer patients to emotional support and counselling services, including those specialising in rehabilitation from drug and alcohol addiction. Staff encouraged patients who received an HIV diagnosis to reflect on their experience and life path as an emotional tool to help them understand their diagnosis. This included encouraging people to produce reflective creative writing and poetry.
- District nurses consistently included each patient's social circumstances when planning care and used this information to coordinate emotional support and needs with the multidisciplinary team. For example, one patient wanted a relative to be able to stay with them after their health deteriorated and district nurses worked with both individuals to make sure this could be achieved.

Good

Community health services for adults

- District nurses who supported patients at the end of life had used positive feedback they received from relatives about the standard of their emotional support as a benchmark for service development.

Are community health services for adults responsive to people's needs?

(for example, to feedback?)

Good

Overall we rated responsive as good because:

- Staff developed services to meet the needs of the local population, including when these changed. This included the provision of international travel advice for patients living with HIV and collaborative community-delivered education sessions for patients living with diabetes. Musculoskeletal orthotics, neurological rehabilitation including stroke rehabilitation for patients and relatives and SaLT for patients living with Parkinson's disease were also provided.
- The integrated care district nurse team provided a four-hour rapid response service for urgent need including syringe drivers and blocked catheters.
- Nurses in the integrated care district nurse team worked with patients to ensure they were available for booked home calls and appointments. This resulted in a very low missed appointment, or 'did not attend', rate of less than 0.5% between November 2015 and November 2016.
- Staff in the diabetes service could facilitate rapid access to a diabetes psychologist at a nearby hospital for patients with complex needs. The HIV service had increased its ability to provide specialist care for HIV positive patients who had complex needs relating to drug use.
- Staff in each service developed support and health promotion materials to meet the needs of their population groups. This included collaborative working between the HIV team and community non-profit organisations to provide specific HIV information alongside advice on diet, alcohol and drug use and psychosocial support. The speech and language therapy team had developed a leaflet for voice patients to take with them to ear, nose and throat (ENT) appointments to help them to communicate confidently.
- Interpreters were available and could be booked in advance to attend appointments with patients.
- Staff in all services demonstrated a commitment to respecting the cultural, religious and social needs of patients. This was evident in patient record documentation and in adaptation to services. For example, the HIV service had established a care pathway specifically for young gay, lesbian, bisexual and transgender people. This included a flu vaccination, a review of their psychosocial and psychosexual needs, partner notification, a cultural needs assessment and safer sex education.
- The speech and language therapy team demonstrated a detailed understanding of the needs of patients with dementia and ensure their approach to communication, care and treatment was tailored to meet their needs. For example, the team used large print and visual communication aids to explain conditions such as dysphagia to help patients with cognitive problems understand their treatment.
- Staff from each service attended a monthly multidisciplinary vulnerable adults panel to coordinate care and pathways for patients considered to be at risk.
- Staff in each service had access to a centralised booking database that meant staff on site could book follow up appointments for patients during their visit.
- Staff facilitated access to services as flexibly as possible. This included weekend drop-in clinics for integrated care and 'nurse of the day' drop-in clinics for the diabetes service. Both the diabetes and HIV services achieved their target time of referral to assessment in the 12 months prior to our inspection. Waiting times for a podiatry appointment had significantly reduced in the previous 12 months and the service's 'did not attend' rate reduced by 14% as a result of improved communication with patients.
- There was evidence of learning from complaints, such as the introduction of a new medication administration chart and improved bladder scanning training for nurses.
- Staff demonstrated a consistent focus on reducing social isolation and improving the overall social wellbeing of their patients, in addition to meeting their physical needs. For example, integrated care nurses

were able to issue a 'social prescription' to patients at risk of social isolation so they could access day centres that offered the opportunity to meet new people, make friends and take part in activities.

Detailed findings

Planning and delivering services which meet people's needs

- The service standard of HIV services included initial blood tests to establish viral load and CD4 count, a consultant appointment, a physical assessment to identify any symptoms, a referral to peer support and to patient-centred information services within 2.5 weeks of initial diagnosis.
- Staff in HIV services maintained an up to date record of international travel vaccination recommendations and UK government travel advice for patients who planned to travel abroad. As part of this, staff checked future travel plans with patients who had recently been diagnosed with HIV. This followed the death of a patient who had been diagnosed with HIV and then travelled to a country with endemic malaria. Although this was outside of the remit of this provider, staff introduced the inclusion of international travel advice to patients to prevent such avoidable deaths in the future.
- Nurses in the diabetes service worked with community dieticians to deliver a patient education programme that aimed to help people better manage their condition and diets. The service offered day courses for the diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme, and week courses for the dose adjustment for normal eating (DAFNE) programme. Courses included time for patients to ask questions, learn about the role of key nutrients in their diets and learn from the experiences of staff. Staff and patients ate lunch together as part of the training, which helped patients to identify foods that would meet their dietary needs.
- Clinical nurse specialists in the diabetes service offered a younger adult clinic and the HIV service was able to provide young adult services collaboratively with the sexual health service.
- Printed information and support materials were provided to patients and their relatives in each service. When a patient was referred to the diabetes service for the first time, staff sent out diabetes care information and a food diary for them to keep before they attended. The SaLT team had developed a leaflet for voice patients to take with them to ear, nose and throat (ENT) appointments to help them to communicate confidently.
- Interpreters were available and could be booked in advance to attend appointments with patients.
- Individual services provided a wide range of specialist clinics, care and treatment. These included musculoskeletal orthotics, neurological rehabilitation including stroke rehabilitation for patients and relatives and SaLT for patients living with Parkinson's disease.
- HIV nurses had established links with a specialist mental health care provider to ensure the needs of HIV positive patients using their service had their needs met, including in relation to medication.
- The diabetes service did not have a formal arrangement for the care of patients with diabetes and mental health needs. However, clinical staff could refer patients with complex needs to diabetic psychology services at a nearby hospital and the lead consultant was trained in psychology interviewing techniques with patients to support them in managing their condition.
- HIV specialist nurses used a partner notification protocol that adhered to the best practice guidance of the British HIV Association. This meant staff worked with patients who received a new HIV diagnosis to communicate with their partners to assess risk and minimise future transmission of the virus within a 12 week framework. The service had a target that 90% of partner notification contact would have an outcome or documented update within 12 weeks. In October 2016 the service achieved 100% against this quality standard.
- HIV nurses had rapidly increased the service capacity to care for patients affected by a significant escalation in recreational drug use. This included monthly supervision from a psychologist and the provision of motivational interview clinics for HIV positive men who engaged in high-risk chemically-enhanced sexual activity. This approach helped the service to address the mental health and physical health needs of patients and work to reduce the risk of health deterioration as a result.

Equality and diversity

- The electronic patient record template included a requirement for staff to complete an assessment of each patient's personal, cultural and religious needs in the course of providing care and treatment.

- Information available to patients in the HIV service was specific to a wide range of sexual identities and types of relationship to ensure all patients had equitable access. Staff in this service adapted their care and treatment plans to meet the individual needs of patients. For example, when a religious patient wanted to receive spiritual treatment for HIV rather than medical intervention, the service worked with them in a way that maintained their dignity and also ensured they took prescribed medicine.
- The HIV service had established a care pathway specifically for young gay, lesbian, bisexual and transgender people to ensure their specific needs were met. This included a flu vaccination, a review of their psychosocial and psychosexual needs, partner notification, a cultural needs assessment and safer sex education.

Meeting the needs of people in vulnerable circumstances

- HIV services were commissioned for adults but where a child was considered to be at past risk of infection, such as through mother-to-child transmission during childbirth outside of the UK, staff could provide HIV tests for anyone aged two and above. This included in-home testing and referral to the paediatric HIV service at a nearby NHS trust was also readily available.
- The SaLT team demonstrated a detailed understanding of the needs of patients with dementia and ensure their approach to communication, care and treatment was tailored to meet their needs. For example, the team used large print and visual communication aids to explain conditions such as dysphagia to help patients with cognitive problems understand their treatment. This team also provided education to the relatives of patients with swallowing needs who were also living with dementia. This included a discussion of how dementia could affect peoples' ability to manage their own diet as well as strategies to support regular eating, such as leaving out soft finger food.
- A multidisciplinary vulnerable adults panel took place monthly and staff from each service attended this. The meeting was used to review the needs of patients with complex needs in challenging social situations.
- Integrated care nurses were able to issue a 'social prescription' to patients at risk of social isolation so they could access day centres that offered the opportunity to meet new people, make friends and take part in activities. Social prescribing also enabled staff to support patients to work towards specific goals, such as to be able to cook their own food or to run a marathon.
- The speech and language therapy team worked collaboratively with dieticians as part of an innovative education and health improvement programme to work with care home residents and their staff to improve nutrition and diet.

Access to the right care at the right time

- Each service provided care across community settings including in outpatient clinics, hospices, multidisciplinary clinics and to patients in their own homes or in care homes.
- Each service area monitored measures specific to them against established targets on a monthly basis. For example, the SaLT team had a clinical effectiveness target that 75% of patients referred would be seen within two weeks. In October 2016, the service exceeded the target by 13%. In addition this team had a clinical target that 80% of patients referred for dysphagia would have their risk of aspiration reduced through contact with the team. In October 2016, the service exceeded the target by 11%. This was achieved through the use of established tools such as the risk management outcome measure for dysphagia.
- Appointments to each service were through referrals from a GP, secondary care or community care provider. Staff in each service had access to a centralised booking database that meant staff on site could book follow up appointments for patients during their visit. Staff contacted patients in advance to remind them of upcoming appointments to reduce the risk they would miss it. This could be done by text message or phone call. The diabetes clinic aimed to see all patients within four weeks of their initial referral. This was audited and in the 12 months prior to our inspection, 98% of patients were seen within this timeframe.
- The integrated care district nurse team had provided 42,430 appointments in the year to 2016. A rapid referral system was in place that meant patients could be seen the same day if their need was urgent, such as where a patient needed a syringe driver or had a blocked catheter. In such cases a nurse would visit a patient within four hours. Activity in the integrated community

care team was monitored, including appointments. However, response times did not form part of the service's commissioned key performance indicators and so the service did not monitor these.

- The senior team in the integrated care district nurse team monitored activity on an annual basis, including appointments wasted due to patients not attending. Between April 2016 and November 2016, the service accepted 96% of referrals made and discharged 2348 patients following completion of their care plan. There was a very low rate of patients who did not attend booked appointments, at less than 0.5%.
- The integrated care district nurse team provided a weekend dressing clinic that patients could access by referral from their GP. The service was offered on Saturdays and Sundays from 2pm and 3pm, including bank holidays. Services included wound care and injections.
- A 'nurse of the day' clinic was offered in the diabetes service. This was staffed by a clinical nurse specialist (CNS) and meant they could treat drop-in patients or emergency cases. This service enabled patients to access dietary advice and book follow-up appointments and staff also triaged new referrals to offer appointments at appropriate times. The CNS reviewed blood results daily and referred abnormal results to a consultant the same day to ensure an appropriate urgent follow-up appointment was offered.
- The diabetes service offered a telephone advice line Monday to Friday from 9am to 5pm.
- The integrated care district nurse team worked with GP practices to visit patients at home to support them with intravenous antibiotics and reablement. This increased capacity and services for GP practices whose nurses were not trained in this area of care and was available to any GP practice in Bromley.
- Waiting time for a podiatry appointment had significantly decreased in the previous 12 months, from 65 weeks to nine weeks at the time of our inspection. Staff had achieved this with the introduction of two sessions per week for high-risk patients and two additional sessions at another location. The service did not have a waiting time standard for general appointments but used a target of 70% of patients seen within four weeks as a target for musculoskeletal (MSK) reviews. Between May 2016 and October 2016, an average of 18% of MSK patients were seen within four weeks.
- Podiatry patients with urgent needs such as an open wound were seen within one week. In addition the 'did not attend' rate reduced from 19% of patients booked to 5% of patients booked following the introduction of a self-referral service for patients on the provider's website. Staff in diabetes services identified 'hard to reach' patients as the most likely group to miss booked appointments and used a pre-appointment reminder and recall system to try and avoid this. The SaLT team had a target of 10% for DNA patients. In October 2016, 4% of patients were recorded as DNA in this service. DNA rates in HIV services were consistently low, with an average of 2.5% between April 2016 and November 2016.
- Between January 2016 and July 2016, 87% of patients referred to SaLT were seen in under 18 weeks, which was the provider's maximum target. The team monitored this on a monthly basis to track waiting times. In November 2016, the average waiting time was four weeks, which was a significant improvement on an average of 11 weeks in the previous eight months.
- Specialist HIV nurses worked with public health professionals to provide care across organisational boundaries such as an inreach service with a local hospital sexual health team. This meant the team could work with sexual health staff to assess patients and create effective multidisciplinary care plans. As a reciprocal arrangement, the HIV team provided same-day appointments for referrals from the hospital teams and from GPs who conducted instant point of care HIV tests. This meant patients had rapid access to specialist treatment following an HIV positive test result. If this service could not be provided due to exceptional demand on the service or staff sickness, a nurse always arranged a telephone consultation with the patient within 24 hours as an interim measure.
- Individual service leads set monthly safety targets based on the highest risk patients in their care. We looked at the latest available data for HIV and SaLT services and found them to consistently exceed the targets. For example, the SaLT team had a target that 70% of patients seen for swallowing problems in the community were given an assessment and information pack. In October 2016, the service exceeded the target by 23%. The HIV service had a target of 90% for the number of patients newly diagnosed with HIV to see a clinical nurse specialist within two weeks of referral. In

Good

Community health services for adults

October 2016 the service achieved 100%. In addition, the service had a target that 90% of patients prescribed HIV medicine received an adherence assessment and the service achieved 100% in this measure.

Learning from complaints and concerns

- Between August 2015 and June 2016, adult services received eight formal complaints, of which six were upheld. Five complaints related to community services, two related to the diabetes service and one in speech and language therapy services. In each case a senior member of staff investigated the complaint and provided an apology to the patient involved. The HIV service had received no complaints in the time it had been operational.
- Learning from complaints was used to improve services. For example, a new medication administration chart was introduced and more nurses were trained in bladder scanning. In addition, staff improved efficiency in the assessment of need for incontinence pads and treatment plans that were prepared for patients who received both private and NHS care were improved. In the SaLT team, communication was improved with private therapists so that patients received care from teams whose staff shared the same goals and treatment plans.

Are community health services for adults well-led?

Good

Overall we rated well led as good because:

- Governance and risk management structures ensured risks to the service were monitored, with regular strategy meetings to establish risk reduction policies and practices. There was evidence the senior team used this process effectively, and that action taken to address risks resulted in safer services and better experiences for patients and staff. Clinical governance processes were in place where patients were cared for by multiple services and professionals and ensured that Bromley Healthcare staff maintained oversight of their safety and care.
- Results from a March 2016 survey amongst staff in the integrated care team indicated individuals felt that they were supported to progress their career and that the organisation maintained a focus on patient safety.
- The diabetes and integrated care teams had development plans to enable them to continue to meet the needs of the local population. This included establishing a wider range of preventative diabetic health options in the local community and a six-weekly catheter care clinic.
- The senior team effectively managed risks to the service through the use of a strategic risk register. Risks were proactively identified and were reviewed regularly. Each risk had a named owner and there was evidence action was taken to mitigate each risk. For example, capacity had been increased in podiatry and senior staff were given more clinical training to improve safety for patients with complex needs. To ensure continuity of the community rehabilitation service, a new lead nurse and matron were appointed and the service tracked a decrease in falls incidents as a result.
- Staff in each service worked to a standard operating procedure (SOP). SOPs established the scope of each service and provided guidance to staff in risk management and governance processes, such as inclusion and exclusion triage protocols.

However, we also found:

- Results from a March 2016 survey amongst staff in the integrated care team indicated a need for improved communication between the senior management team and staff, including when important decisions were made. In addition, although results indicated general satisfaction, this service scored worse than the rest of the organisation in all 11 questions related to relationships with managers. Results from this survey also indicated staff felt under pressure to come to work when they were unwell and that the pressure of work had contributed to spells of ill health. This was reflected in 15% of respondents feeling the provider did not take positive action on staff health and well-being.

Detailed findings

Service vision and strategy

- We spoke with the operations manager and clinical lead for diabetes services. This team was focused on providing productive and preventative diabetic health

options in the local community. This strategy was based on previous poor feedback from patients and GPs about the scope for diabetes management. In addition, the diabetes team were preparing a bid to incorporate an improving access to psychological therapies (IAPT) team into the service in response to local demand.

- The integrated care team had a service development plan that included establishing a six weekly catheter care clinic and a weekly peripherally inserted central catheter (PICC) line clinic. The service was in a period of recruitment for new nurses and healthcare assistants who would support these services.

Governance, risk management and quality measurement

- Community health services for adults were organised into five clinical specialties, which were all part of the operations directorate. One service manger was responsible for community teams, adult speech and language therapy and podiatry. HIV services and diabetes services were led by different service managers. The director of operations for Bromley Healthcare was responsible for all services and was supported by the head of integrated care lead and service leads.
- A quality governance committee (QGC) met bi-monthly and maintained oversight of clinical operations, service delivery and quality assurance. We looked at the minutes and outcomes of meetings from June 2016 to October 2016 and found the committee was represented by senior clinical and executive staff. The team discussed each service from a multiprofessional perspective, including identifying risks to service delivery and strategies to ensure service continuity. Other executive, voluntary or user committees and groups were included as part of the QGC and this enabled the group to ensure outcomes from clinical effectiveness, workforce development and patient and public engagement teams were taken into account.
- The provider used a strategic risk register to identify and monitor risks to the service, its staff and patients. As of January 2017, there were 14 risks identified that could affect adult community services. Risks included the impact if services were not recommissioned by local authorities and the need to ensure services were delivered in line with the regulations of the Health and Social Care Act 2008. Other risks related to waiting times in podiatry, short staffing in the community nursing team and the need for consistent Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) compliance in documentation. All risks had been reviewed and updated in the three months prior to our inspection and there was evidence in each case senior teams worked to minimise the risk. For example, the quality team and safer care group implemented auditing of the patient records system to ensure staff always documented consent in line with MCA and DoLS requirements. Capacity had been increased in podiatry and senior staff were given more clinical training to improve safety for patients with complex needs. To ensure continuity of the community rehabilitation service, a new lead nurse and matron were appointed and the service tracked a decrease in falls incidents as a result.
- Each directorate contributed to a 'heat map' that was used to identify the most significant risks to the service. Senior directorate teams reviewed risks on a monthly basis to monitor if preventative action was effective. At the time of our inspection the most significant risks, apart from those relating to commissioning or finance, identified waiting times in podiatry and high vacancy rates in community nurse teams. The waiting times in podiatry had steadily decreased and the integrated care team responsible for community nursing had established a recruitment programme to address this risk.
- Staff in each service worked to a standard operating procedure (SOP). SOPs established the scope of each service and provided guidance to staff in risk management and governance processes, such as inclusion and exclusion triage protocols. We looked at the SOP for each adult service and found each one to have been updated within the previous 12 months. All of the staff we spoke with were aware of the SOP for their service and could demonstrate how their care and treatment was in line with this.
- Staff conducting home visits or appointments outside of the Beckenham Beacon building adhered to a lone working community safety procedure that included a buddy system. This meant staff could be tracked and were required to call in to their base office at regular intervals. This formed part of a wider safety governance system for staff that included an urgent escalation pathway in the event they needed emergency assistance. Although this procedure helped to protect staff during daytime operating hours, district

nurses raised concerns about access to a patient's home that had no outside lighting and was in a secluded area. The service manager agreed to supply torches to the team, but there was not an immediate resolution to how vulnerable staff felt attending this address. The service was piloting a global positioning system (GPS) to track staff that included an integrated panic function. This would enabled staff to locate each other and would summon the help of police in an emergency.

- HIV nurses had adapted the lone working procedure following learning from home visits. For example, they called the clinical referrer for each patient before a home visit to establish if they were aware of any reason they should not be visited alone. Where risks were identified, individual patient protocols were put in place. For example, following one incident at a home visit, the service agreed to continue providing care for a patient on the basis they visited the clinic This followed an incident in which a member of staff had been placed at risk. The senior team responded quickly and appropriately and in the best interests of both the nurse team and the patient.
- The integrated care district nurse team had been restructured to provide three integrated care networks in Bromley, Orpington and Beckenham. The three managers of this service spoke daily by teleconference as part of a safety strategy to review the case load, staffing levels and any other issues that affected service and safety. The team then provided a report to the chief executive. This was indicative of a culture of open communication, in which staff from all levels of the organisation were responsible for governance and risk management.
- The governance structure of the integrated care team enabled other services, such as therapists, to have access to support from managers, and learning opportunities with senior nurses. For example, service leads from speech and language therapy, podiatry, diabetes, occupational therapy and physiotherapy met on a monthly basis to review the service and patient case load.
- Staff demonstrated knowledge of effective information governance processes. They locked computers and removed their digital access cards whenever it was left unattended and the electronic tablets used by district nurses were password protected. Staff also routinely told patients who they needed to share their medical information with and made sure they had permission to do so.
- A dedicated quality team monitored the effectiveness and standards of care and treatment in all services. This included meeting with the medicines management lead and other operational staff to identify where practice worked well as well as areas for improvement.
- Each service team used a monthly meeting to discuss clinical governance, quality and risk management. This included a review of any incidents and changes in policies and procedures as well as a review of health and safety standards and infection control audits. We attended a meeting as part of our inspection and saw it included a discussion of staff wellbeing and opportunities for staff to raise issues and discuss good practice with the senior team.
- When consultants from other providers offered clinics, a risk management and clinical governance structure was in place to ensure continuity of care for patients and ensure established clinical policies were followed. This included monthly leadership meetings and quarterly clinical meetings. For example, a diabetic consultant lead attended quarterly clinical management board meetings that included input from primary care teams. This governance structured enabled the team responsible for the wider diabetes care pathway to jointly review incidents, complaints and patients with complex needs.

Leadership of this service

- The head of integrated care led the integrated community team, podiatry and SaLT. An operations manager led the diabetes team and the assistant director of children and young people led the HIV service. A service lead was responsible for each individual service.
- A staff survey in March 2016 in the integrated community team highlighted that staff were broadly satisfied with leadership and management. However, in all 11 questions relating to leadership, this team performed worse than the provider's average. For example, 87% of respondents said their immediate manager was accessible in a crisis compared to 93% across the organisation. In addition 86% said their manager encouraged team working compared to 92% across the organisation. The survey results indicated there was

room for improvement in communication. For example, 41% of respondents said communication between senior management and staff was not effective, 38% said senior managers did not involve staff in important decisions and 35% said senior managers did not act on feedback.

- We asked all the staff we spoke with about their experience of the leadership structure and team. In each case staff said they found their managers approachable and understanding. Some individuals said it could be difficult to get time with them because they were so busy, but they could always reach them by phone or e-mail, including out of hours or in an emergency. All the staff we spoke with were positive about the visibility and accessibility of the chief executive and the director of nursing. Staff told us both individuals were available out of hours and often came to see them, including at a weekend. One individual said, "This is the first organisation I've worked for where we are on a first-name basis with the very senior team. The director of nursing can't do enough for you and the chief executive is genuinely interested in what we do."

Culture within this service

- We asked all of the staff we spoke with about the working culture of their department or service. Each member of staff was positive. One member of staff described their manager as, "Brilliant and hands-on" and another member of staff said, "Working here is exceeding my expectations." One senior nurse said, "As an organisation they're very transparent. I never feel that they're hiding anything. The chief executive has pushed us to provide data and I was sceptical but I can see how this will help our service in the long run. I think we all trust him in that way."
- Results of a March 2016 staff survey in the integrated care team indicated staff felt under pressure at work that may have affected their health. For example, 40% of respondents said they had experienced musculoskeletal problems as a result of work activities and 61% said they had felt unwell due to work related stress in the previous 12 months. In addition, 100% of respondents said they had put themselves under pressure to come to work despite not feeling well and 36% said they had received pressure from colleagues to do the same. In the same question, 18% said they had experienced pressure from a manager to come to work despite not feeling well. Senior staff we spoke with were aware of the additional pressure on staff due to the workload associated with short staffing. In response the integrated care team had conducted a staff engagement programme to identify how they could help staff achieve a better work-life balance, including through more flexible working. The findings had been used to implement a new shift system, which was in a pilot phase at the time of our inspection.

Public engagement

- Bromley Healthcare offered a monthly leg club for patients who received leg ulcer treatment. This was an informal way for patients to meet each other, discuss their experiences and support each other with staff there to provide facilitation and guidance. Feedback from this club was used to influence the running of the service. For example, staff who facilitated the group recorded anonymous feedback to help them understand how patient's past experiences had influenced their recovery and feelings about the care they received.
- A patient experience group, with a designated lead, liaised with the local Health Watch team and engaged with patients to ensure their needs were met and to gather feedback on the service. This group aimed to maximise the involvement of patients, relatives and carers and to ensure their input was gathered in the strategic development of services. The group met bimonthly and included representation from all clinical service groups. Feedback was used to improve access to appointments, such as the implementation of drop-in sessions and the provision of information to patients on what to do to get urgent care out of hours.
- Clinical staff had worked with colleagues at a local recovery college to co-run a mental health awareness course that involved previous patients. This enabled current patients to understand what to expect from treatment and to speak openly with others who had experienced similar circumstances.
- The provider used an independent patient opinion service to gauge and respond to feedback. Between July 2014 and November 2015, 98 patients submitted opinions. Of the opinions submitted, 81% were positive, 12% were negative and 6% were mixed or unclear. The provider responded to every comment and 10 changes were implemented as a result of the feedback.

Staff engagement

Good

Community health services for adults

- Monthly meetings took place in each service area with all members of the team. All of the staff we spoke with said the meetings were productive and part of a wider culture of engagement with them in which they said they were listened to by the senior team.
- The operations manager had conducted a 60 day consultation with staff about restructuring shift patterns to better meet the needs of patients. As part of this each member of the team was asked to design their own preferred working schedule and managers then considered how this could be used in rotas that met demands on the service and enabled staff to achieve a good work/life balance. A new rota system was in the pilot stage at the time of our inspection. Staff had varying views on this and the interim service manager had met with each person individually to discuss how it could be adapted or improved to help them work effectively.
- Although most staff spoke positively about their training and development opportunities, some individuals felt this was becoming increasingly difficult to access. For instance, nurses told us services usually sent several delegates to an annual nursing conference but in 2016 no-one was funded to go. In addition, senior clinical staff felt more nurses needed to be trained in leg ulcer management but several university courses had been cancelled, which made this more challenging to achieve.
- Nurses in the HIV service engaged with a 'narrative medicine' model during their revalidation and appraisal processes. This gave staff the opportunity to reflect on their experiences of caring for people in a way they could not do in patient reviews and notes.

Innovation, improvement and sustainability

- Staff valued opportunities to take part in pilot schemes and competitive applications for programme funding that enabled them to expand local services. For example, clinical nurse specialists in the diabetes team were taking part in a community diabetes prevention scheme that was part of a national programme. The SaLT team successfully secured funding with community dieticians to deliver diet and nutrition training to care home staff in Bromley. In a March 2016 staff survey in the integrated care team, 100% of respondents said the organisation acted fairly on opportunities for career progression.
- The diabetes team established a virtual education hub for GPs and practice nurses to connect as a group with clinical nurse specialists during training sessions.
- Staff in HIV services had access to a university link research lead who identified patients eligible for participation in new research projects. At the time of our inspection some patients were taking part in the positive transitions through the menopause (PRIME) study to identify the impact of menopause on HIV-positive women over the age of 45. HIV staff had also successfully recruited to the multi-agency 'SUPA' study that aimed to document patient's experiences of taking medicine over time. This team also delivered the findings of a study into the need for continued investment in community HIV nurse teams at the 2015 NHIVA annual conference.
- The integrated services nursing leadership team took steps to ensure services were sustainable and their staff team supported to develop. For example, they secured funding from a local provider to increase their trained nurse development programme provision. In addition, band six nurses were offered a development course and nurses with appropriate clinical experience could undertake a leadership development programme.
- The SaLT team had achieved a Health Innovation Network Award for their 'Making mealtimes matter' education programme with the adult dietetic service.
- There was evidence from the risk register that staff proactively identified opportunities for improvement. For example, the transition team and clinical effectiveness group worked together to improve the patient records templates used in the electronic system and ensure staff had enough training to use these effectively.
- A nurse in the quality team had been funded to undertake a 'six sigma' course. This is an internationally-recognised training programme used to streamline business processes.

Community health services for children, young people and families

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Information about the service

Bromley Healthcare Community Interest Company (Bromley Healthcare) provides community health services for children and families at Beckenham Beacon and at other outreach centres attached to this location.

Services provided for children and families include the health visiting service and the speech and language therapy (SALT) service.

The health visiting team had 22,000 universal contacts a year. There were four teams of health visitors covering geographical patches across Bromley. These included Beckenham and Penge, Orpington, Prince's plain, Mottingham and Bromley North.

Parents could access baby clinics at nine locations across the borough including Beckenham Beacon, Biggin Hill Children and Family Centre, Blenheim Children and Family Centre, Burnt Ash Children and Family Centre, Castlecombe Children and Family Centre, Community Vision Children's Centre, Crown Medical Centre, Cotmandene Children and Family Centre and Willows Clinic.

The speech and language therapy (SALT) team had 19,388 patient contacts between April 2016 and November 2016. The SALT team offer an assessment, diagnostic and intervention service for pre-school and school age children attending mainstream schools aged zero to 11 years who meet the eligibility criteria. This is to meet speech, language and communication needs and eating and drinking (swallowing) difficulties related to a complex or chronic health and developmental difficulty.

The SALT team also offers an extended service for pupils in specialist provisions and for a prioritised limited number of young people in mainstream secondary schools. They work in five community clinics, four special schools and 18 specialist provisions, six children's centres and most mainstream primary schools in Bromley.

The SALT team provide appointments at community clinics including Beckenham Beacon, Mottingham Clinic, Phoenix children's Resource Centre, Eldred Drive Clinic and St Paul's Cray Clinic. The team held six drop in clinic sessions each month, one at each of the Children and Family Centres in Bromley.

We inspected the services on 13 and 14 December 2016. We also conducted an unannounced inspection on 5 January 2017. During our inspection, we spoke to staff across two health visiting teams including Beckenham and Penge, and Mottingham. We visited Beckenham Beacon, Mottingham Clinic and Castlecombe Children and Family Centre. We spoke with 24 members of staff including members of the executive team, service leads, health visitors, therapists and administration staff. We attended a new birth visit and a school visit. We spoke with 12 patients and their relatives and observed care and treatment. We looked at 18 sets of records.

Community health services for children, young people and families

Good

Summary of findings

Overall, we rated services for children and families at Beckenham Beacon as good because:

- Staff knew how to report incidents and the senior team proactively disseminated learning from incident investigations to their teams. There were effective arrangements for safeguarding vulnerable people and staff demonstrated how they fulfilled their responsibilities regarding this.
- Patient records were comprehensive with appropriate risk assessments completed. Staff routinely assessed and monitored risks to patients.
- Universal and specialist services were delivered in line with national good practice guidance. There was effective internal and external multidisciplinary team working and practitioners worked with other staff across services.
- Patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. There were adequate supervision support structures for staff.
- The services monitored patient outcomes to assess children's development.
- Staff provided a caring, kind, and compassionate service and we received positive comments from patients. We observed the way children and their parents were treated in their homes, in clinic settings and at a school. Patients reported they were involved in their care.
- Services were planned and delivered in line with local needs. Clinics were available in different locations across the borough making it easy for children and their families to access the nearest location to them. There were systems and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed in a timely manner.
- Did not attend (DNA) rates were low and staff telephoned families to remind them about their appointment.
- The health visiting team carried out five mandated checks in line with the healthy child programme. Performance against these checks was better than the London average but sometimes lower than the provider's own target.
- We saw positive local leadership structures within the service and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development. There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There was a robust governance system in place, which included a range of committees attended by service leads and members of the executive team. Staff had regular team meetings and received regular communication from the executive team. The management team had oversight of the risks within the services and mitigating plans were in place.

However,

- The health visiting service balanced scorecard showed that the service achieved only an average of 42% for equipment calibration between May and October 2016 against a target of 100%.
- Our review of speech and language therapy records showed staff did not always tick the consent box on the electronic record system to indicate consent had been obtained.

Community health services for children, young people and families

Good

Are community health services for children, young people and families safe?

Good

Summary

We rated safe as good because:

- Staff knew how to report incidents although there were few incidents reported. The senior team disseminated learning from incident investigations to staff.
- There were robust safeguarding policies and procedures in place. Health visitors received regular safeguarding supervision and speech and language therapy staff had access to the safeguarding team when needed. Staff were knowledgeable about their responsibilities regarding safeguarding vulnerable people.
- Patient records were comprehensive, with appropriate risk assessments completed. Staff routinely assessed and monitored risks to patients.
- Equipment was clean and staff complied with infection prevention and control guidelines.

However,

- The health visiting service balanced scorecard showed that the service achieved only an average of 42% for equipment calibration between May and October 2016 against a target of 100%.
- Although there had been an improvement in staffing levels within the health visiting team, the caseload still exceeded recommended levels in line with national guidance.

Detailed findings

Safety performance

- There had been no never events in the 12 months prior to the inspection. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- There were no serious incidents relating to the service, although staff were contributing to the investigation of an incident led by a local trust. This involved the death of a patient under the care of a local trust for depression. At the time of the incident, the patient was a parent under the care of the health visiting team.
- A safer care group led a remit to ensure there were robust systems and processes in place to protect patients and families from avoidable harm. The director of nursing, therapies and quality assurance chaired the group, which also included the head of nursing, pharmacy lead, infection prevention and control (IPC) nurse, the named doctor for safeguarding children, the named nurse for safeguarding children, service leads, representatives from the local clinical commissioning group and the borough. The group held bi-monthly meetings to review incidents and action plans across the services.

Incident reporting, learning and improvement

- The speech and language therapy (SALT) team reported 24 incidents between December 2015 and November 2016. Six of the incidents resulted in low harm whilst 18 of the incidents resulted in no harm. The health visiting team reported 39 incidents between December 2015 and January 2016. Thirty-two had no harm caused, six had low harm caused, and one involved the death of a patient under the care of a local trust. The learning from the incident had resulted in the development of a new perinatal mental health service with the local trust. The health visiting team was represented at the weekly perinatal meeting and case discussion with the local mental health trust. By the time of the inspection, each health visiting team had a perinatal link with the mental health team within the trust.
- Staff reported incidents using an electronic reporting system. All of the staff we spoke with knew how to report incidents. They told us they received feedback on individual incidents they reported and on trends within the service. Senior staff shared information regarding incidents and learning at handovers, during staff meetings and through staff bulletins.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were familiar with the duty of candour

regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. They could not give us a recent example of when they had used the duty of candour regulation as there had been no serious incidents in the last year.

Safeguarding

- The provider had up to date safeguarding policies and procedures. Staff were aware of their responsibilities to protect vulnerable children and adults. They understood safeguarding procedures and how to report concerns.
- The service had a safeguarding children's lead in post who had completed level four safeguarding training. Staff were aware of who the safeguarding lead was. Staff within the health visiting team underwent regular safeguarding supervision with a member of the safeguarding team at least every three months. However, SALT staff did not have regular safeguarding supervision but could access the safeguarding team when necessary. The safeguarding lead engaged staff by sending information to be included in weekly bulletins were necessary.
- The provider had a separate looked after children team consisting of 2.1 whole time equivalent (WTE) nurse specialists. They also had a named doctor for child protection and a designated doctor for looked after children.
- There were 367 children in the area covered were subject to a child protection plan as at the time of the inspection. In addition, there were about 280 looked after children in the borough. This had led to an increase in the time staff spent on safeguarding and case reviews. The safeguarding team had strong links with external agencies and was represented on the Multi-agency safeguarding hub (MASH) team. This ensured that important information was shared between agencies.
- All paediatric staff were trained up to level three children safeguarding training. This included training in relation to harmful cultural practices like forced marriages and female genital mutilation. It also included modules on neglect and alcohol disorders. The PREVENT scheme was incorporated into safeguarding training. PREVENT is a government scheme to safeguard people and communities from the threat of terrorism.
- We observed there were flagging systems on electronic records to alert staff to children subject to a child protection plan and those who were vulnerable. Child protection plans were reviewed within four to six weeks after the initial case conference.
- The provider held bi-monthly children's safeguarding group meetings chaired by the director of nursing. The meeting was attended by the named doctor for safeguarding, named nurse for safeguarding, representatives from paediatric services including health visitors and SALTs. The health visiting team also conducted weekly team meetings where they reviewed all safeguarding cases involving children in their care.
- All health visitors and therapists had completed level two adult safeguarding and level three child safeguarding training.

Medicines

- The provider had policies and procedures in place for the storage and administration of medication. A pharmacy lead chaired a medicines management group that met weekly to review and monitor prescribing processes. However, staff informed us that families and children would usually obtain prescriptions and medication from their GP surgeries. There were no medication cupboards within the units visited.
- About half of the health visitors were nurse prescribers. However, health-visiting staff said they rarely gave out medication and when they did, these tended to be health start vitamins. SALT staff also confirmed they did not give out medication to patients.

Environment and equipment

- Drop in baby clinic sessions were provided at three medical centres and six family centres across the borough, most of which were managed by other providers. We found the environment in two of the clinics visited clean, tidy and suitable for children and their families. The rooms were spacious with an area for parents to park their buggies.
- Health visitors each had their own portable scales and tapes, which they took with them on home visits. Equipment in the baby clinics included a scale and mattress. All the scales we reviewed were calibrated and labelled with the date they were last checked. However,

the health visiting service balanced scorecard showed that the service achieved only an average of 42% for equipment calibration between May and October 2016 against a target of 100%.
- Children could access the SALT service at five locations across the borough. We visited two clinics and found the environment clean, tidy and suitable for children and their families. Children had access to play with toys in the waiting areas and consulting rooms.

Quality of records

- The service used an electronic record system to input and access service user records. This had been introduced over a year before our inspection, however, some of the older records were paper records.
- We reviewed seven health visiting records and 11 SALT records. All records reviewed included details of the patient's GP. They also included assessments carried out and the name and designation of the assessor. Each assessment was dated. Health visiting staff recorded comprehensive assessments including family health assessments, mental capacity and consent. However, we noted that SALT staff did not always tick the consent box on the electronic system to indicate that consent had been obtained for the care provided.
- In addition to the electronic records, health visitors also recorded information about the baby's progress and immunisations in a Personal Child Health Record (also known as the PCHR or 'red book') held by parents. This is a national standard health and development record given to parents.
- We noted the electronic records were secure and password protected in line with data protection guidelines. Both SALT staff and health visitors confirmed they would not take any files with them on visits. SALT staff took a note of advice given during school visits and transcribed them to electronic systems. Health visitors completed an assessment form during home visits and scanned them unto the electronic system.
- We found that records of vulnerable children contained enough appropriate information and were updated in a timely manner. We noted that records had alerts for children in need, allergies and children with child protection plans in place. Staff included details of safeguarding children's meetings where relevant.
- The provider audited the quality of patient records on an annual basis that included a check of the completion of 10 key items of information for each patient with a minimum target result of 90%. Scores for the children and families services ranged from 81% for the health visiting service and 90% for the children SALT service.
- Information governance was part of the mandatory training programme staff were required to complete. Ninety-six per cent of staff in the health visiting team and 87% of SALT staff had completed this training. This was better than the provider's minimum target of 85%.

Cleanliness, infection control and hygiene

- The provider had an infection prevention and control specialist nurse who provided mandatory training, advice and support to staff.
- All areas of the unit including the baby clinics and SALT clinic areas were visibly clean.
- Personal protective equipment (PPE), such as gloves and aprons were available in all clinical areas. All staff observed the 'bare below the elbow' policy and we observed them using PPE when required. Antibacterial hand get was available in all clinical areas. Staff as well as parents in the baby clinic had access to two sinks.
- We observed that staff cleaned the scales and mattresses with a wipe following each use. A disposable towel was laid on the scale and mattress before each use. Yellow bags were available for soiled nappies. This meant staff followed best practice guidance in ensuring the environment was sanitised and fit for use.
- Toys placed on shelves within SALT consultation rooms had "I am clean stickers" on them to indicate they had been cleaned and decontaminated. The rooms also had hand-washing facilities with printed instructions on hand washing techniques in line with the World Health Organisation (WHO) five moments to hand hygiene.
- In November 2016, the SALT team hand hygiene audit results showed that it achieved 96% compliance with the provider's policy. The health visiting team achieved 98% compliance during the same period.
- Ninety five percent of staff in the health visiting team and 81% of SALT staff were up to date with their infection control training.

Mandatory training

- Most staff were up to date with their mandatory training. Overall compliance for the SALT team was 93% whilst the health visiting team achieved 94% compliance. This was better than the provider's target of 85%.

Community health services for children, young people and families

Good

- Mandatory training included moving and handling, infection control, fire safety, information governance, immunisation, adult and child protection, conflict resolution, equality and diversity, health and safety and resuscitation.
- Staff informed us they received email alerts to remind them when training was due.

Assessing and responding to patient risk

- There were mechanisms to identify service users at risk, such as vulnerable women and children. Details were recorded in electronic records to which all clinical staff had access.
- We observed health visitor and community children's nurses conducting risk assessments while on home visits and in clinics. We saw health visitors record the observations of infant development parameters such as height, weight, communication and motor skills. These were recorded in the baby record book and on the electronic record system. Infants were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in notes.
- Speech and language therapists used a parent-completed questionnaire alongside referral information to assess speech or communication issues. This helped ensured children's speech development was monitored and support provided as needed.
- All staff had received basic life support training and in the event that a child became acutely unwell, staff would provide basic life support and contact the emergency services.
- Ninety-five per cent of health visiting staff and 83% of SALT staff were up to date with their resuscitation training.

Staffing levels and caseload

- A head of service led the health visiting team. There were four team leaders covering geographical patches across Bromley. These included Beckenham and Penge, Orpington, Prince's plain, Mottingham and Bromley North. The health visiting team consisted of 44 whole time equivalent (WTE) health visitors, 11 WTE community nursery nurses (CNNs) and 8 WTE administrative staff. By October 2016, 7% of posts were vacant against the provider's target of 8%. This represented an improvement in filled posts from a vacancy rate of 13% in August 2016. The sickness rate was 3.3% against the provider's target of 3%.
- The health visiting service often used bank staff to cover shortfall in staffing. Bank staff had undertaken an induction and had also completed their statutory and mandatory training.
- The total caseload within the four health visiting team consisted of about 20,150 families. This implied an average caseload of about 485 families per health visitor. The Community Practitioners and Health Visitors Association recommend caseloads of 400 in the least deprived 30% of the population and 250 in the most deprived 20% of the population. Health visiting staff caseload exceeded the Lord Lamming 2009 recommended case load level of 300 families per health visitor, however, health visitors were able to visit families as needed.
- Health visitors held a weekly allocation meeting. We observed a weekly allocation meeting with the Beckenham and Penge team. Health visitors discussed antenatal visits, new births visits and targeted two-year reviews. Each health visitor considered their availability and were allocated visits accordingly.
- We looked at a sample of staff rotas between 10 October 2016 and 6 November 2016 for the health visiting service. In this period, 281 shifts were unfilled. These included health visitors, community nursery nurses and non-clinical staff. The service had 86% fill rate in September 2016, 97% in October 2016 and 92% in November 2016. Notwithstanding health visitors were able to visit families as required. Between April 2016 and December 2016, the average monthly patient activity was 1,549. These involved antenatal visits, new birth visits, six to eight weeks review, 12 months review, two and half years review and safeguarding activities.
- At the time of the inspection, two band 8a therapists led the children SALT team in an acting capacity. There were three positions for SALT team leaders and one position was vacant. An adult SALT lead helped with supervision pending recruitment to the vacant position. The SALT team consisted of 35 WTE band three to band eight staff. The SALT team had 4 WTE staff vacancies at the time of the inspection. Three locum staff were employed to cover vacant positions. All locum staff were inducted into the unit and had received training to use the electronic record system.

Community health services for children, young people and families

Good

- The SALT team had an overall caseload of over 3500 children. The team had 40 individual contracts with schools and aimed to visit each school once a month. Senior staff informed us the rota was designed to allow skill mix in each clinic.

Managing anticipated risks

- The service leads were aware of the risk associated with staffing, which were being actively managed locally. Each team had their own weekly meetings, which were mainly allocation meetings to ensure full capacity coverage within services and cover for holidays and sickness.

Major incident awareness and training

- The provider had a major incident plan in place and an electronic copy was available on the staff intranet. It included action cards, which explained roles in the event of a wide variety of incidents and scenarios. Staff were aware of the major incident plan and knew the steps to follow.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Good

Summary

We rated effective as good because:

- Staff delivered universal and specialist services in line with national guidance and good practice.
- There was effective internal and external multidisciplinary team working and practitioners worked with other staff across services.
- Patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. All staff had an appraisal in the 12 months prior to our inspection.
- There were adequate supervision support structures in place for staff that enabled them to maintain their clinical competencies.
- The health visiting team carried out five mandated checks in line with the healthy child programme. Performance against these checks were better than the London average but sometimes lower than the provider's own target.
- Services monitored outcomes to assess children's development.

However,

- We noted that staff speech and language therapy staff did not always tick the consent box on the electronic record system to indicate that consent was obtained for the care provided.
- Only 17% of speech and language therapy staff and completed the Mental Capacity Act training.

Detailed findings

Evidence based care and treatment

- Policies and guidance were accessible on the intranet. We reviewed a sample of these and found appropriate reference to relevant National Institute of Health and Care Excellence (NICE), Institute of Health Visiting, Royal College of Nursing, and Royal College of Speech and Language Therapists guidelines. Staff were aware of the guidelines relevant to their sphere of practice and could access them on the intranet.
- The provider's health visiting guidelines for good practice incorporated all guidance into one document. The guideline covered the service description, organisational structure, training and education, record keeping, performance indicators, quality, the five mandated contacts, child deaths, safeguarding, information governance amongst others.
- The health visiting team offered antenatal visits to all mothers universally after 28 weeks pregnancy. However, senior staff confirmed some parents declined it. In addition, some parents had moved into the borough following delivery.
- The health visiting team provided three levels of service delivery including universal, universal plus and universal partnership plus. Assessments carried out included mood assessments for mothers. Nursery nurses conducted targeted contacts including one and two year reviews.
- Health visitors used the Ages and Stages Questionnaires (ASQ), a parent completed screening tool, that asks

about a child's development in different areas. The SALT service had recently introduced Therapy Outcome Measures (TOMs) to assess the overall effectiveness of therapy interventions.

- SALT staff said they identified children's needs by conducting thorough assessments. Care pathways included speech sound disorder, deaf children and dysfluency. We saw that SALT staff outlined treatment plans in patients' notes. Children completed questionnaires showing various degrees of happy faces or sad faces to communicate how they felt. Children were also made to complete communicative confidence rating scales with one indicating very difficult (not at all confident) to five indicating (very confident).

Nutrition and hydration

- During our inspection, we saw that staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in babies and children. Staff signposted families to breastfeeding support groups in different parts of the borough.
- The health visiting service balanced scorecard showed that 84% of mothers maintained full or partial breastfeeding at six to eight weeks from birth against the provider's target of 92%.
- The United Nations Children's Fund (UNICEF) baby initiative is based on a global accreditation programme of UNICEF and the World Health Organisation. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. The health visiting service had achieved stage two of the UNICEF baby friendly accreditation. It was working towards stage three of the accreditation with an accreditation visit scheduled to take place in February 2017.

Technology and telemedicine

- Staff used electronic diaries to monitor their activities. An electronic recording system was in use and staff scanned all assessments carried out during their visits on the system.
- Therapy staff had access to laptops and electronic tablet were being handed to health visitors in phases to support remote and mobile working.
- At the time of the inspection, the service was implementing live monitoring systems that would provide information on outstanding new birth visits and appointments on daily basis. Senior staff informed us of their goal to have television screens in all service areas so that the public as well as staff are were of how they were doing.

Patient outcomes

- The Healthy Child programme stipulates that new birth visits should take place within 14 days of a child's birth in order to assess maternal mental health and discuss infant feeding and how to reduce sudden infant death syndrome. The Child and Maternal Health Observatory (ChiMat) health visiting quarterly metrics for the first quarter in 2016/17 (April 2016 to June 2016), showed that the health visiting team completed 94% new birth visits within 14 days. This was better than the London average of 91% and the England average of 88%. All the parents we spoke with during our visits confirmed a health visitor visited them at home within two weeks of their delivery.
- During the same period, the service achieved 80% of six to eight week checks within eight weeks. This was also better than the London average of 51% but lower than the England average of 82%. The percentage of 12 months reviews by 12 months was 89%, better than the London average of 46% and the England average of 74%. The percentage of 12 months reviews completed by 15 months was 90%, better than the London average of 59% and England average of 82%. The percentage of children who received a two to 2.5 years review was 69%. This was better than the London average of 43% but lower than the England average of 86%.
- The health visiting service used the Ages and Stages Questionnaire, Third Edition (ASQ-3) which is used to screen children for developmental delays. The questionnaire assessed children's development under five domains including personal-social, problem solving, fine motor, gross motor and communication. Results of the 24 month ASQ3 scores by domain showed that of the 420 children screened between July 2016 and September 2016, 86% were on schedule with their development in the five domains, 8% were close to cut off and 5% were below cut off.
- The results of the 27 months ASQ3 scores in the same quarter showed that of the 345 children were screened, 90% were on schedule with their development in the five domains, 8% were close to cut off and 2% were below cut off. The results of 30 month ASQ3 scores by

domain showed that of the 101 children were screened, 88% were on schedule with their development in the five domains, 8% were close to cut off and 5% were below cut off.
- The service had developed templates on the electronic recording system and recently started using the therapy outcome measures (TOMS) to assess the overall effectiveness of therapy interventions.

Competent staff

- All staff had received an appraisal in the last year. There were clinical supervision arrangements in place and staff confirmed they had one to one sessions with their line manager every one to two months. All health visitors were up to date with their revalidation.
- Newly qualified health visitors went through one year preceptorship training. They were also allocated a preceptor to work with. New therapists went through an induction period and were allocated a mentor. Each of the four health visiting teams had Band 7 health visitors who were also practice teachers. Band 7 practice teachers had specialist qualifications and could train other health visitors. All practice teachers had taken service development training.
- All therapists were registered with the Royal College of Speech and Language Therapists and with the Health Professions Council (HCPC). All staff within the SALT team were education, health and care plans (EHCP) key workers for children with specific language impairment. At the time of the inspection, the SALT team were working to ensure a robust skill mix within specialist teams, for example deafness, dysphagia, speech and language disorder.

Multi-disciplinary working and coordinated care pathways

- There was effective internal and external multidisciplinary (MDT) working and practitioners worked with staff in other agencies to ensure information was shared across services where there were concerns about a child in vulnerable circumstances.
- Staff told us that they had good working relationships with GPs, community midwives, school staff and social services. There was good MDT working between health visitors and SALT staff. SALT also had regular meetings with adult SALT team to share learning.
- The health visiting team was involved in the development of the new perinatal mental health service at a local trust. The team attended a weekly perinatal meeting and case discussion with the local mental health service provider.
- A joint referral form was being developed to include occupational therapy, SALT and physiotherapy. Therapists attended next steps meeting with parents and other professionals involved with children to plan goals. They also attended joint sessions in schools with school staff.
- The SALT team partook in a complex communication diagnostic service to diagnose children with autistic spectrum disorder (ASD). They also worked with a pre-school for deaf children and had joint sessions with their teachers. They were also involved in integrated working with other professionals for the pre-school special education needs (SEN) service.
- The SALT service offered accredited training to parents and staff working with pre-school and school aged children. These included accredited speech and language therapy courses, visual support workshops, language scheme workshops, eating and drinking workshops, picture exchange communication system, intensive interaction workshop, and speech, language and communication skills workshops.

Referral, transfer, discharge and transition

- Health visitors received referrals from midwifery bookings through an electronic record system. They also had access to the Personal Child Health Record(also known as the PCHR or 'red book'). This is a national standard health and development record given to parents.
- There were policies and procedure in place to make sure that as children transferred from health visiting to school nursing, relevant and important information was passed to the receiving clinician. Health visitors worked closely with school nurses to make sure vulnerable children and their families were discussed and important information relayed. However, the school nursing service was being decommissioned by the clinical commissioning group at the time of the inspection.
- Children were referred to the SALT service by their GPs or other healthcare practitioners and through their schools. However, parents could also refer their own children.

Community health services for children, young people and families

Good

- Children were discharged from the SALT service if no abnormality or difficulty was detected after the initial assessment. They were also discharged if speech and language skills were within normal limits or in line with the child's general development following advice or intervention. Children were discharged if the agreed aim of therapy intervention has been achieved.
- All children with the SALT service were discharged by the end of year seven, however, in exceptional circumstances, children in year eight or above could be accepted for an assessment and advice and would then be discharged with recommendations. Children in year eight or above who were already known to the service and who attended a special educational needs provision continued to receive targeted support. School-aged children who had previously used the SALT service could make an advice appointment for up to two years following the child's last appointment.
- Children were discharged from the SALT service with a discharge report stating the child's ongoing needs. Once the child had left full time education in school, they would be passed on to the adult speech and language therapy service if they continued to have therapy needs.

Access to information

- All records were held on an electronic system and staff had access to information about referrals and patient records. The intranet was available to all staff and contained links to current guidelines, policies and standard operating procedures as well as contact details for colleagues within and outside the organisation.
- Staff informed us they sent electronic reports to GPs following clinics. The SALT team sent a summary report about children's needs to their parents, GP, health visitor and school.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards (DOLs) and how this would impact children and their families. Senior staff informed us the adult safeguarding advisor would jointly assess any concerns about parents that lacked capacity with staff.
- Staff obtained consent and recorded these in all seven health visiting records reviewed. SALT staff confirmed they obtained the parent's consent to share information with other agencies and we confirmed this from our review of patient's notes. However, whilst reviewing SALT patients' records, we noted that the consent box on the electronic record system was not always ticked by staff to indicate that consent was obtained for the care provided.
- Senior staff explained that when children were referred to the SALT service a section on the referral form was completed by patients to indicate they had consented to the service. They explained electronic records were implemented in the last 18 months and historical records would not reflect a copy of the scanned referral form. However, only one of 11 children SALT records reviewed had a scanned copy of the referral form with the section signed by parents. These included records created within the last 18 months.
- We noted that parents accompanied their children to clinic visits and follow up clinic visits which signified their implied consent.
- Eighty-one per cent of health visitors and only 17% of SALT staff had completed the MCA training.

Are community health services for children, young people and families caring?

Good

Summary

We rated caring as good because:

- Staff provided a caring, kind, and compassionate service and we received positive comments from families. We observed the way children and their parents were treated in their homes, in clinic settings and in a school. Staff were polite, professional and informative.
- Parents and their children reported they were involved in their care and were given explanations about their treatment.
- Staff sought feedback from families and most families indicated they would recommend the service.

Community health services for children, young people and families

Good

- Staff were aware of people's individual needs and considered these when providing care. Parents and children were treated as individuals and we saw that staff had families had built good working relationships.
- Parents and children were emotionally supported by staff and referrals were made to appropriate community teams.

Detailed findings

Compassionate care

- All parents we spoke with at the baby clinic expressed satisfaction with the care provided. They confirmed staff involved them in the care of their babies. We observed interactions between patients and staff and saw that staff introduced themselves to parents before attending to them. Staff were engaging, friendly, courteous and professional.
- One parent described the health visitor who attended her home as "very helpful". The staff member provided her with information about what was available to her and contact details if she needed help. They described the health visiting service as "perfect" with no area requiring improvement. Another parent described the health visitor that attended her first visit as "very thorough". They described the service as "really good".
- Parents confirmed they felt comfortable contacting the health visiting service for extra support. Parents described the team as excellent and supportive. Our observation of a new birth visit showed staff were caring and professional.
- We observed positive interaction between therapists and children during a school visit. SALT staff maintained children's privacy and dignity by seeing children individually. Therapists received many compliments from parents, which indicated sessions were "positive" and "invaluable". Parents indicated the progress children had made were astounding.
- The service participated in the NHS Friends and Family Test. The latest available results were between April and December 2016 and 100% of friends and families indicated they would recommend the SALT service. However, the response rate for this service was low as only four families responded. During the same period, 92% of families indicated they would recommend the health visiting service. The response rate for this service was 13 families.

Understanding and involvement of patients and those close to them

- We observed that SALT staff involved children in directing games and activities, such as support and prompts given to children to express themselves.
- The SALT team promoted the involvement of parents and schools in the children's care by carrying on out joint sessions and discussing target setting with them whenever possible.
- We were provided with comments from parents, which indicated that the health visitors did not rush through questions. Health visitors were described as "brilliant", very informative " and "supportive".

Emotional support

- Staff provided emotional support to children. For example, when a child became distressed during a therapy session, the therapist reassured them and suspended the session until the child felt comfortable to go ahead with the session.
- Therapists informed us parents could contact them any time in between appointments for further advice or to discuss concerns.
- We observed health visitors sensitively discuss mothers' feelings and emotional well-being during a home visit. They asked about emotional support from families and if the mother needed any additional support, such as counselling.
- Staff signposted parents to organisations that provided additional support for carers, children and families.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

Good

Summary

We rated responsive as good because:

- Services were planned and delivered in line with local needs. Clinics were available in different locations across the borough making it easy for children and their families to access the nearest location to them.

Community health services for children, young people and families

Good

- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day to day tasks.
- There were systems and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed in a timely manner.
- Service users were able to self-refer for some services, such as speech and language therapy
- Did not attend (DNA) rates were low and staff telephoned families to remind them about their appointment.
- Parents also had access to a breast-feeding support group that was sponsored by the Bromley Healthcare Charity. The service also ran baby massage and new parent groups.
- The health visiting team carried out five mandated checks in line with the healthy child programme. Performance against these checks was better than the London average but sometimes lower than the provider's own target.

Detailed findings

Planning and delivering services which meet people's needs

- Health visiting teams were geographically located across the borough making it easy for parents to access the nearest location to them. All GP practices in Bromley had a link health visitor and all early years settings had a link team member. Health visitors received referrals from midwifery bookings via an electronic recording system.
- Health visitors held baby clinics at nine children's centres and medical centres across Bromley. Baby clinics were held twice a week at Beckenham Beacon and once a week at each of the other locations.
- Parents attending the baby clinic were provided with ticket numbers and seen in the order of their arrival. Parents also had access to a breast-feeding support group via a charity sponsored by the provider. The service also ran baby massage and new parent groups.
- The speech and language therapy (SALT) team operated from five locations across Bromley. There were also six drop –in clinic sessions available each month on a first come, first served basis. Any parent concerned about their child's speech or understanding could access the clinic without being referred by a GP. Drop in clinics were held at six children and family centres across Bromley. Each centre also offered language learning sessions.
- The SALT team operated a central booking system with referrals sent in from GPs, schools and other health care professionals. The service then sent a letter to parents to inform them they had received a referral and advised them to phone in for an appointment.
- The SALT service accepted children for an assessment who were of pre-school age and had a Bromley GP or were of primary school age and attended a Bromley school. If a child attended an out of borough school, but had a Bromley GP, children were transferred to the neighbouring borough as they would have a therapist assigned to that school. The service had an agreement with most neighbouring boroughs to see children attending schools in each other's boroughs. The SALT team saw children at clinics where there was no agreement in place.
- The SALT team offered a largely consultative model of delivery to school aged children from their core service commissioned by the local clinical commissioning group (CCG). In addition, the service had expanded as schools used their Special Education Needs (SEN) budget to buy additional time from the service. The team has had a gradual increase in the number of referrals to the service from 75 per month in 2010/11 to 138 per month in 2015/16. The service responded to this by recruiting more staff on permanent and fixed term contracts.
- There were enough chairs in the baby clinics for parents and families to sit and wait for their appointments. The baby clinics had an area marked out for parents to park their buggies. There were also awaiting areas within the SALT clinic area and toys for children to play with.
- There were a number of booklets and leaflets on a variety of topics in all waiting areas within the services. However, we did not see any leaflets in other languages.

Equality and diversity

- Staff across the services had access to interpreting services for patients and families who had difficulty understanding English. This included direct access to interpreters and telephone translation services.
- The SALT service provided age appropriate toys in waiting areas and consulting rooms for children to play with.

Community health services for children, young people and families

Good

- SALT interventions provided within primary and secondary language provisions and provisions for deaf children in schools means children in Bromley can attend school closer to their home to meet their needs.
- The SALT team had been involved in projects to deliver services to hard to reach families. Such projects included the traveller project and toddler talk. Additional resources had been put into the dysphagia service to cope with doubling of referrals in 2015.

Meeting the needs of people in vulnerable circumstances

- The provider held a bi-weekly vulnerability panel for all clinicians to discuss complex cases overseen by safeguarding leads and the director of nursing. Staff attended panel meetings and discussed modalities for supporting vulnerable families.
- Staff prioritised children if they had a swallowing disorder, were a looked after child, subject to a child protection plan, were a child in need or subject to a common assessment framework.
- Assessments carried out by the health visiting team included mood assessments for mothers. Staff sign posted families to supporting organisations for counselling services, parenting services and CAHMS were mental health needs had been identified. Staff could also refer people to the provider's Improving Access to Psychological Therapies (IAPT) service for people suffering from depression and anxiety disorders.
- The SALT team accepted some secondary school aged children for appointment if they had complex needs. For example, young people with a stammer, a voice disorder, a newly acquired communication disorder due to injury or illness or a previously undiagnosed language disorder. Children in year 8 or above who were already known to the service and attended a special education needs provision may continue to receive targeted support.
- The SALT service provided more intensive care pathways for pre-school and primary school age children who have severe speech sound disorders, a stammer, selective autism, who needed augmentative and alternative communication, a severe social communication disorder, a voice disorder and disordered speech as a result of a cleft lip and or palate. A therapist attended a SEN playgroup to assist children there once a week.

Access to the right care at the right time

- The health visiting service's balanced scorecard for October 2016 showed the service achieved 94% new birth visits within 14 days against the target of 95%. The service achieved 87% of eight to 12 months' reviews and 80% of two and a half years' review against the target of 85%.
- The SALT service achieved 100% against the provider's target of 95% to see looked after children within eight weeks of their referral. At time of the inspection, SALT waiting times for initial appointments was between five to nine weeks against the provider's target of 12 weeks.
- The average "did not attend" (DNA) rates for the SALT service between April 2016 and November 2016 were low at 4%. Staff informed us that the administrative team telephoned families to remind them about their appointment.
- In other to reduced DNA rates, the SALT team began to see school aged children for most of their sessions in school from September 2015. This meant children had their care needs met whilst the school was in session.
- The SALT team implemented a centralised booking system in other to avoid increasing the waiting times for new patients. In addition, a cap on the number of appointments sent out each month was removed and staff focussed on seeing new patients during the school holidays. The average waiting times for initial appointments was 22 weeks in July 2014. This had reduced to five weeks by the end of July 2015. However, this gradually increased to nine weeks in November 2016 due to staff shortages.
- Senior staff explained the SALT team had experienced an increase in caseload. Waiting times for follow up appointments for children in mainstream schools and pre-schools was two to five months. Capacity for average appointments per year was two to three per year compared to six per year three years ago.
- The SALT team prioritised children who had a head injury, required time specific interventions (e.g. post-surgery), or were at risk of aspiration.

Learning from complaints and concerns

- There were three formal complaints in the last 12 months. These were in relation to care and treatment, staff attitude and communication. Two of the

Community health services for children, young people and families

Good

complaints were in relation to the health visiting team while one complaint was in relation to the children SALT team. All complaints were upheld and resolved locally within the specified period.

- There were prepaid feedback cards in all waiting areas and baby clinic rooms for families to provide feedback about their care. There were also leaflets in the unit providing information about how to make a complaint, which contained details of the ombudsman service.
- We noted that the provider responded promptly to complaints logged on an online patient feedback website. This allowed service users to share their experience of using Bromley Healthcare services. For example, a parent complained about follow up SALT appointments on the website. The provider acknowledged the complaint within 24 hours whilst requesting for details of the patient. A response was posted within two weeks indicating an appointment had been provided for the child.
- The provider had a dedicated patient experience lead. This was a relatively new role with the remit to get feedback on patient's care and experience.

Are community health services for children, young people and families well-led?

Good

Summary

We rated well led as good because:

- We saw consistent local leadership in the service and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development.
- There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There was a robust governance system in place, which included a range of committees attended by service leads and members of the executive team. Staff had regular team meetings and received regular communication from the executive team.
- The management team had oversight of the risks within the services and mitigating plans were in place.
- Patients were engaged through surveys, feedback forms and on online forums.

Detailed findings

Service vision and strategy

- The service's vision was driven by the wider vision of Bromley Healthcare. This was summarised into three tenets; "To continually improve our services, to treat others as we would like to be treated ourselves and to hit our targets". Staff were aware of the three tenets and we observed that the tenets were included in compact information staff had on their lanyards.
- The service was undergoing a period of change at the time of our inspection, which involved services going out to tender by the clinical commissioning group (CCG). This had impacted on the provider's ability to recruit permanent staff to fill vacant positions. Staff were keen that Bromley Healthcare won the tender and were anxious about what would happen if it was taken over by another healthcare provider.

Governance, risk management and quality measurement

- The executive team and service leads attended bi-monthly quality governance committee meetings. We reviewed the minutes of the last three meetings. Senior staff discussed risks on the risk register, looked after children, safeguarding, the quality account and patient safety. There were presentations made by service leads. The minutes of the meeting from October 2016 showed that the health visiting lead gave a presentation on the role of the health visitor and how the service requirements had changed over time. In addition, senior staff attended monthly leadership meetings.
- The governance structure included a range of sub groups including the clinical effectiveness group, improving safer care group, workforce development group, patient experience group, adult safeguarding strategy and learning group and child protection group. Each service lead represented their service at committee meetings and provided feedback to staff during staff meetings.
- The service maintained a risk register including concerns and assessments of potential risks. Mitigating plans were put in place and risk assessments were

conducted where necessary. Senior staff routinely discussed risks at clinical governance meetings and service leads fed back discussions to the team during staff meetings.

- Risks on the local risk register included the risk of delays in new birth notifications from the local trust. This was a historic risk since 2011 and the risk register showed evidence this was regularly reviewed. Controls were put in place to monitor the risk through incident reports. In addition, the risk was escalated to the senior management team of the local trust and there were several meetings to share data on the incidents and learning from this. The local trust recently implemented an electronic system for all antenatal bookings by December 2016. The risk was scheduled to be reviewed in three months' time to determine the impact of the system.
- Senior SALT staff listed their concerns as a large caseload, many schools to cover, shortage of therapists and waiting times. Risks on the SALT risk register included staff shortage and the impact on follow up appointments. In addition, the service was unable to recruit to permanent positions due to the forthcoming tender. The service had presented a deep dive to the CCG Clinical Quality Review Group were they discussed all of their risks. In order to mitigate this risk, parents were offered telephone appointments in between face-to-face appointments. In addition, the service had recruited two locums by December 2016 and had scheduled interviews to recruit additional bank staff.
- There were bi-monthly SALT team meetings and monthly health visiting team meetings. In addition, care group meetings were held three times a year. Care group meetings focussed on wider clinical issues. This provided an avenue for staff to feedback on the courses they had taken and on areas of therapy and best practice.

Leadership of this service

- The service lead for the health visiting service and the acting SALT service leads reported to the assistant director of operations, children and young people. The assistant director reported to the provider's director of operations.
- Staff said senior managers were visible and approachable. They confirmed there was a positive culture within the service with an open door policy and staff had direct access to the chief executive officer (CEO). Staff said they were comfortable raising questions and concerns. Staff confirmed that the CEO often attended some of their group meetings.
- There was evidence of good communication routes between senior managers and staff members. Meetings were well attended by staff and stakeholders and information relating to service delivery was cascaded to all staff via email and on the intranet.

Culture within this service

- Most staff told us there was a culture of openness and honesty within the service. Staff felt the CEO blog ensured transparency by providing an anonymous platform for staff to express their concerns.
- None of the staff we spoke with had experienced bullying or harassment at work. Most staff indicated they were happy to work for the organisation and had a supportive team. Many staff we spoke to had worked for the organisation for a significant length of time. Staff felt valued and confirmed they could contribute to discussions during meetings.
- Staff informed us they had good relationships with their managers and their personal circumstances were taken into consideration to ensure they had healthy work/life balance.
- The provider had a lone working policy and staff had a good awareness of this. They informed colleagues of their home visiting schedules through a diary on the electronic system. Each member of staff had a buddy and they were encouraged to inform them of any unexpected changes throughout the day. There were procedures in place to escalate any concerns regarding staff safety.
- The staff survey results for children and young people services published in March 2016 indicated 20% of staff would not recommend the organisation as a place to work. This was slightly better than other services within the organisation where 23% of staff would not recommend the organisation.
- The provider had organised listening event in the previous year called "Fix it Fifty" to identify and address staff concerns. Following the listening event, the provider published 50 issues raised by staff and what they had done to address the issues. For example, staff raised concerns about the electronic recording system and IT support. The provider rolled out additional training to support staff.

Community health services for children, young people and families

Good

Public engagement

- Bromley healthcare was involved in a number of charities including a baby café, which provided breast-feeding support in a coffee club environment. We spoke to parents at the drop in baby clinics who confirmed they had been invited to attend the baby café and some of them attended.
- Information on the notice board within the units displayed details of clinic times and locations. There was also information about additional services that patients could access.
- There were prepaid feedback cards in all waiting areas and baby clinic room for families to provide feedback about their care.
- The provider monitored patient satisfaction from patient surveys and an online feedback website that allowed patients to share their experience of using Bromley Healthcare services. We observed the leadership team responded to online postings on an individual basis.

Staff engagement

- The provider had three staff governors who acted as the link between the executive team and staff. One of the staff governors was a health visitor. The staff governors gave a presentation at every corporate induction session to introduce themselves to new staff and explain how they could be contacted. Staff we spoke to knew who the staff governors were.
- Staff received weekly updates from the CEO in addition to a weekly newsletter authored by a director within the business team. There was also a CEO blog where staff could comment anonymously about issues they wanted the leadership to address. We noted that the leadership team responded to each comment. Staff also reported that the CEO often attended induction, training and visited community services.
- The SALT team held bi-monthly staff meetings where they discussed issues relating to performance, safety, incidents (including action plans), concerns, complaints and finance.
- Health visitors held monthly team meeting in their units. They also held quarterly district wide meetings and invited different speakers to educate staff on various topics. This provided an opportunity for people to share practice.

Innovation, improvement and sustainability

- At the time of the inspection, the service was developing a live performance dashboard. This would enable the health visiting team to review the number of mandated checks due at any point in time.

Outstanding practice and areas for improvement

Outstanding practice

- Clinical staff had worked with colleagues at a local recovery college to co-run a mental health awareness course that involved previous patients. This enabled current patients to understand what to expect from treatment and to speak openly with others who had experienced similar circumstances.
- The diabetes team had established a virtual education hub for GPs and practice nurses to connect as a group with clinical nurse specialists during training sessions.
- The adult speech and language therapy team had achieved a Health Innovation Network Award for their 'Making mealtimes matter' education programme with the adult dietetic service.
- Staff consistently demonstrated their ability to exceed expectations by providing highly individualised care. For example, when a patient was discharged following a long hospital stay, district nurses ensured they had milk at home and turned their heating on so they did not come home to a cold house. In another example, an HIV specialist nurse supported a nervous patient to attend a drug and alcohol support group by attending the first session with them.

Areas for improvement

Action the provider SHOULD take to improve

- Continually review systems in place to ensure staff comply with all modules of their mandatory training.
- Ensure consent forms are saved on the electronic record system.
- Ensure each patient has a documented mental capacity assessment.
- Implement a process to ensure the integrated care team can complete contemporaneous patient records that minimises the need for delayed data input.
- Implement a process that ensures staff have regular appraisals or supervisions at least annually.