Primecare - Primary Care - Northampton

Quality Report

Primecare - Primary Care – Northampton
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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

Overall summary

Nestor Primecare Services Limited is the registered provider for Primecare Primary Care – Northampton (Primecare). Primecare provides community end of life care for adults over and under 65 years in Northamptonshire. The service is commissioned by Nene and Corby Clinical Commissioning Groups to provide dedicated care and support to patients, who are registered with a Northamptonshire GP and are thought to be in the last eight weeks of life and wish to die in their own home or in a care home.

We carried out an announced inspection of Primecare on 13 June 2017. During our inspection, we visited all clinical areas in the service. We spoke with the relatives of six patients, and six members of staff. We observed care and treatment and looked at 10 patient care records and we reviewed the service's performance data.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- The service monitored and provided harm free care. There was a formal system in place to monitor and track incidents, investigations, and actions taken for sharing of learning.
- There were arrangements in place to safeguard adults and children from abuse that met relevant regulation and local requirements.
- Information about the outcomes of people's care and treatment were routinely collected and monitored and outcomes were generally positive and used to drive improvements.

Summary of findings

- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment.
- Services were planned and delivered to meet the needs of local people. The service was flexible and enabled patient choice and continuity of care.
- Patients had timely access to initial assessment and urgent treatment.
- The service had a clear vision and set of values based on the quality of patient care. There was an effective and realistic strategy, which prioritised quality care.
- There was an effective governance framework to support the delivery of the strategy and high quality care.
- There was evidence of strong national and local leadership, with accessible and responsive managers.

We saw several areas of excellent practice including:

- We observed a strong, person-centred culture. Staff treated patients with compassion, kindness, dignity, and respect.
- Staff understood and respected patients' personal, cultural, social, and religious needs, and these were taken into account and were reflected in how their care was delivered.
- Relatives we spoke with were consistently positive about the care their loved ones had
- Staff were committed to providing compassionate care not only to patients but also to their families.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		• There were effective systems in place to keep patients safe. Staffing levels were maintained in line with national guidance to ensure patient safety. Nursing staff levels met the needs of patients. Effective processes were in place for the provision of medicines. • There was evidence of strong national and local leadership, with accessible and responsive managers. All staff and patients were positive about the service. • We observed a strong, person-centred culture. Staff treated patients with compassion, kindness, dignity, and respect. Staff were committed to providing compassionate care not only to patients but also to their families.

Summary of findings

Contents

Primecare Primary Care

Services we looked at
Community end of life care.

Summary of this inspection

Background to Primecare - Primary Care - Northampton

Nestor Primecare Services Limited is the registered provider for Primecare Primary Care – Northampton (Primecare). Primecare provides community end of life care for patients over 18 years in Northamptonshire. The service is commissioned by Nene and Corby Clinical Commissioning Groups (CCG) to provide dedicated care and support to patients, who are registered with a Northamptonshire GP and are thought to be in the last eight weeks of life and wish to die in their own home or in a care home. The service works alongside existing NHS care providers, the local acute NHS hospitals, district nursing service, GP's, voluntary patient support organisations and the local NHS ambulance trust and is an integral part of the Northamptonshire multi-agency end of life pathway.

There are two distinct aspects to the service:

- Advanced nurse practitioners, based at the two local acute NHS hospitals, provide discharge planning and support for patients who are nearing the end of life and wish to be cared for at home or in their own care home.
- Advanced nurse practitioners and healthcare assistants also provide a rapid response between 8am and 1am to people who are receiving end of life care in their own home or care home and are experiencing symptoms.

The service registered 1,309 patients between April 2016 and March 2017. The service had supported over 1330 patients to receive their end of life care in their chosen place of care from March 2016 to March 2017. The numbers of people receiving the care from the service changed daily as patients used the service when they required urgent relief of their symptoms. The rapid response community nursing service provided 6,418 visits to patients from March 2016 to March 2017. This was a 15% increase in patient visits from the previous year.

From March 2016 to March 2017, the service consistently met their key performance indicator (KPI) set by the CCG of supporting 700 people per year to die in their own home or care home as preferred place of care. The service was able to demonstrate 961 patients were supported to die in their preferred place of care or death. This was a 5.83% increase from the previous year.

Care Quality Commission (CQC) registered Primecare to carry out the following regulated activities:

- Nursing Care
- Personal care

Primecare has been registered with CQC since 1 October 2010.

The date of last CQC inspection visit was 18 May and 4 June 2015, where the service was found fully compliant in all areas inspected.

The service has a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is managed. The registered manager understood their responsibilities and demonstrated this by managing all aspects of the service to provide high quality care.

Our inspection team

Our inspection team of two inspectors was led by:

Lead Inspector: Claire D'Agostino, Inspector, Care Quality Commission

The inspection was overseen by Inspection Manager: Phil Terry, Care Quality Commission

Summary of this inspection

Why we carried out this inspection

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

We regulate independent community end of life care but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

How we carried out this inspection

This inspection was carried out as part of our routine planned inspections of independent community health services.

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

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

We reviewed a range of information we hold about the service and asked other organisations to share what they knew. We completed an announced inspection on the 13 June 2017. During the visit, we spoke with the service lead, staff members and reviewed information relating to the development of the service, business plans and service specific policies and records. We spoke with the relatives of six patients, and six members of staff. We observed care and treatment provided to patients.

What people who use the service say

The overall feedback from the cards and letters received from March 2016 to March 2017 showed confidence in the service. Care was delivered with compassion, gratitude for the service, and a strong theme that people and their families felt supported, well informed, and involved which enabled them to fulfil a family member's wishes to die in their own home.

Examples of feedback included:

- "Thank you all so much for your support, calmness, knowledge but most of all for caring."
- "J was right to want to die at home, but it would have been much less 'easy' without your back up."
- "I know it's what the service is for but so few services do what they say, it has been extra special."
- "Thank you a thousand times"
- "In order to facilitate my Mum's wishes to remain at home the Primecare Rapid Response service, provided support, which, exceeded all expectations and without exception every member of the team from caring staff to nurses treated both my Mum my wife and I with dignity and respect ….. in simple terms they were all marvellous and a credit to their profession."
- "A staff member who waved her emotional magic wand and kept our spirits high."
- "They provided light when it was most needed and we will not forget their contribution to Mum's passing."

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?

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- The service monitored and provided harm free care. There was a formal system in place to monitor and track incidents, investigations, and actions taken for sharing of learning.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns, and near misses.
- Incidents were reviewed and monitored by mangers to identify where trends had occurred and systems were put in place to prevent similar occurrences.
- Staff were aware of the duty of candour regulation. We saw that when an incident had occurred, the principles of the duty of candour regulation were followed.
- There were arrangements in place to safeguard adults and children from abuse that met relevant regulation and local requirements.
- Care records were written and managed in a way that kept people safe from avoidable harm.
- Staff were trained in safety systems, processes, and practices.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment.

Are services effective?

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- Information about the outcomes of people's care and treatment were routinely collected and monitored and outcomes were generally positive and used to drive improvements.
- The effectiveness of the service was measured by the provider and by the clinical commissioning group. Policies were reflective of national guidance.
- Patients were treated without discrimination, and this was evident from the diversity of patients treated by the service.

Summary of this inspection

- Staff had the right skills, knowledge, and experience to do their job when they started their employment and took on new responsibilities.
- Staff worked effectively to assess and provide ongoing care and treatment in a timely way.
- The service had access to all the information needed to deliver effective care and treatment.
- Staff had an understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. There was 100% compliance with Mental Capacity Act 2005 training.

Are services caring?

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- We observed a strong, person-centred culture. Staff treated people with compassion, kindness, dignity, and respect.
- Relatives we spoke with were consistently positive about the care their loved ones had received and how caring the staff were.
- Staff understood and respected people's personal, cultural, social, and religious needs, and these were taken into account and were reflected in how their care was delivered.
- Staff were aware of the importance of maintaining patient's privacy and dignity.
- Staff communicated with people in a way that they would understand their care and treatment.
- Staff understood the impact a person's care, treatment, or condition had on their wellbeing and on their relatives, both emotionally and socially. Patients we spoke with said they felt staff acknowledged their emotional needs.
- Staff were committed to providing compassionate care not only to patients but also to their families.
- The experiences of patients and their relatives were important to staff. They took time to interact with the people using their service and knew where to find additional support for people as needed

Summary of this inspection

Are services responsive?

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- Services were planned and delivered to meet the needs of local people. The service was flexible and enabled patient choice and continuity of care.
- Services were planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability.
- Patients had timely access to initial assessment and urgent treatment.
- Complaints were handled effectively and confidentially. Relatives we spoke with told us they knew how to make a complaint or raise concerns.

Are services well-led?

We regulate independent community end of life care services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- The service manager was visible and approachable and had the appropriate skills, knowledge, and experience.
- Staff felt supported and listened to by their line manager.
- The service had a clear vision and set of values based on the quality of patient care. There was a robust and realistic strategy, which prioritised quality care.
- There was an effective governance framework to support the delivery of the strategy and high quality care.
- The risk register was current and reviewed regularly.
- There was a systematic programme of internal audit, which was used to monitor quality and systems, to identify where action should be taken.
- Staff told us they felt respected and valued. Staff we spoke with were passionate about the care they delivered.
- The culture within the service encouraged candour, openness, and honesty.
- There was clear learning from incidents.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

Safety performance

- The service had an electronic system for the recording of incidents and patient feedback, which fed into service development and learning.
- The organisation did not participate in the patient safety thermometer to monitor harm free care, as it was not applicable for this service. The NHS Safety Thermometer was developed for the NHS by the NHS as a point of care survey instrument: the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses. Systems, processes and practices, which were essential to keep patients safe had been identified, put in place, and communicated to staff.
- There were no never events reported during the period from March 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service reported no serious incidents from March 2016 to March 2017.
- We were unable to review any root cause analysis reports as there had not been any serious incidents. However, staff we spoke with were able to describe an effective process. We reviewed the policy and found it to be thorough, with appropriate recommendations for ensuring learning was shared with all staff.
- Staff reported incidents regarding events that adversely affected patient care or outcomes for patients and staff, and they were open, transparent, and honest about reporting incidents. There was a positive attitude towards incident reporting and staff were actively encouraged to report. Incidents were reported using an electronic system. Staff had access to the reporting system on secure laptops provided by the service. Once reported, the manager reviewed the incidents and investigations were carried out where necessary.
- We saw evidence of lessons learned and actions taken as a result of incidents that had occurred. All staff we spoke with provided examples of learning from incidents. Staff attended meetings where information and training was provided on safety alerts, equipment updates and learning from incidents.
- The service used the intranet to maintain up to date knowledge of safety alerts. We saw copies of alerts, which had been reviewed by staff in the team.

Duty of Candour

- From March 2015, all independent healthcare providers (including adult social care, primary medical and dental care) were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident.
- The service had a policy in place that defined when the principles of duty of candour should be followed and when Duty of Candour was triggered (for example, moderate harm).
- All staff we spoke with were able to apply the principle to a recent incident. We saw that when an incident had occurred, the person involved was told when they were affected, given an apology, and informed of any actions taken as a result.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. We saw an up to date safeguarding policy that met national legislation and local requirements.
- There had been no safeguarding alerts or concerns reported to the CQC from March 2016 to March 2017.
- The service had a safeguarding lead. The safeguarding lead had the required level three training and was attending level four safeguarding training on the day of the inspection.
- We saw staff had access to information about the safeguarding lead and contact details and safeguarding flow charts. The flow chart demonstrated the local safeguarding process for staff to follow in the event of a safeguarding concern.
- The local policy and process for reporting safeguarding concerns was well established. We saw each staff member had access to copy of the process flow chart. Concerns were reported locally and using the provider's electronic reporting system. Close liaison with the local authority safeguarding team occurred on a case-by-case basis.
- 100% of staff were compliant with safeguarding children level two and safeguarding adults' level two.
- All staff we spoke with understood their responsibilities to raise, record and report safeguarding concerns. Staff we spoke with gave us examples of when they had identified a safeguarding concern and how they had reported it correctly. They had received feedback from the local authority and this had been shared as a learning opportunity with the team.
- The local authority's safeguarding team were responsible for safeguarding within the local authority area. The end of life care team accessed local information through the local authority safeguarding team and the local Commissioning Group (CCG) safeguarding leads.

Medicines

- Arrangements for managing medicines and medical gases kept people safe from avoidable harm. We saw that staff obtained, prescribed, recorded, handled, stored, dispensed, administered, and disposed of medications safely and in line with current guidance.
- Medicines' management arrangements were appropriate and adapted for care provided in people's homes.
- Staff directly corresponded with patients' GPs, if they identified a need for any changes to medications.
- Patient's families usually collected medication, or the local pharmacy delivered medications directly to the patient's home. On occasion, when a patient required additional medication due to a rapid change in their symptoms, staff would collect medications on behalf of the patient and their family from a pharmacy who had that medication in stock. Medication was transported appropriately following the service protocol, which met national guidelines.

Environment and equipment

- Equipment was appropriate and fit for purpose so that people were safe from avoidable harm. All equipment, such as syringe drivers, hoists, and beds was provided, delivered, and maintained by a local equipment loan service. Equipment was delivered straight to the patient's home. No delays in the provision of equipment had been reported.
- Equipment seen in patients' homes had been safety tested and conformed to safety standards. Staff reported any equipment safety issues in people's homes through the electronic reporting system and to the equipment provider.
- The end of life care team owned three syringe drivers, which could be loaned in an emergency while delivery was arranged via the approved provider. These were maintained through a service level agreement with one of the local hospital equipment services.
- The service provided appropriate uniforms and equipment to complete the tasks identified.

- The service ensured safe manual handling practices in people's homes. Staff who visited people in their own homes had access to hoists and other manual handling equipment in people homes. Staff had received the correct training to issue and use the equipment safely.
- All new staff received training on equipment regularly provided as part of their induction. On-going training was provided to maintain competence and confidence in using the equipment. Staff we spoke with told us they felt confident and competent in using this equipment. There were no concerns raised about the provision of equipment during our inspection.

Quality of records

- Care records were written and managed in a way that kept people safe from avoidable harm. Staff wrote a brief update of care provided in the patient held district nursing notes, which were stored in the patients' home.
- Primecare's records system was paper free. Staff used an electronic patient record system, which provided a record of the assessments, care, and treatment required by and provided for patients. The system could be accessed from office bases or remotely through the use of mobile computers when in the community. These notes were shared with the patient's GP.
- We reviewed 10 electronic patient records and we found that staff had recorded accurate information and all records had a timed and dated electronic signature. Records were found to be descriptive of actions taken and treatment administered.
- Staff were required to ensure patient notes were completed within 12 hours from visit. In the notes we reviewed all notes had been completed in the agreed timescale. An audit carried out in April 2017 reported 96% patient notes had been written within 12 hours. The manager had fed back this information to the staff members and they were looking at reasons where the agreed time scale had not been achieved.
- The service had a robust system in place to ensure the quality of records. Records were audited regularly. New starter's patient records were audited after two weeks of starting to write notes, after three months and then six monthly and following this annually. All clinicians' notes were audited every six months. However, if they scored 90% or above on two consecutive audits this was changed to an annual audit. The audit pass rate was 75%. Any clinician who scored less than 80% was monitored more closely and clinicians who scored between 75 to 79% were placed upon the audit concerns register. This means that the clinician was monitored by the provider's safety and quality team.
- All staff members were given direct feedback following each audit, and provided with areas for improvement and what they had done well. The service manager carried out random spot checks throughout the year to follow up on previous audit findings to ensure learning had taken place.
- Good practice was disseminated across the organisation in the form of a three monthly patient safety newsletter.

Cleanliness, hygiene and infection control

- Staff were responsible for the provision of safe clinical practice. Staff complied with infection prevention and control policies. Clinical staff adhered to the provider's 'arms bare below the elbow' policy to enable good hand washing and reduce the risk of infection. We observed staff wash their hands immediately before and after every episode of direct patient contact or care.
- There was access to hand washing facilities in patient's homes and a supply of personal protective equipment (PPE), such as gloves and aprons. PPE was used for all interventions and disposed of appropriately after use. We saw PPE was also used when attending patients' homes.
- Dressings were stored securely at the service base office or the patients' home.
- Staff had access to appropriate clinical waste facilities, using colour coded refuse bags for soiled dressings. Patients, who received treatment within their homes, had routine refuse collection arranged through their GP and local waste provider.
- Another provider managed the maintenance of cleanliness and hygiene needs at the office base. Patients did not attend the office base and all patients were seen in their preferred place of care such as own home or residential home.
- No incidents pertaining to infection control had been reported in the past year.

Mandatory training

- Mandatory training covered a range of topics, which included health and safety, manual handling, infection prevention control, information governance, fire safety, equality and diversity and basic life support.

- All staff were aware of the need to attend mandatory training.
- Information provided by the service demonstrated at the time of inspection there was 88% compliance with mandatory training. This was due to none of the staff having undertaken conflict resolution training which had only recently become mandatory. However, we saw evidence this training was being arranged and would be completed by all staff by October 2017.
- Training was completed as e-learning modules with some face-to-face sessions, such as safeguarding, basic life support and mental capacity awareness. Staff could access e-learning from home or at work to suit their availability.
- The team manager was able to provide mandatory training compliance figures for the service. They were aware of the reasons for non-compliance for example conflict resolution and could demonstrate training was booked to ensure compliance was achieved.
- The service manager maintained oversight of staff training requirements and informed staff of training they needed to attend. Staff were provided with alerts via email and telephone when their mandatory training updates were due. We saw evidence of this during our inspection.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance.
- Risk assessments were completed on the electronic patient records. Staff we spoke with were aware of the individual risks associated with the patients they saw.
- Patients had Waterlow scores (a risk assessment for skin care) and a Malnutrition Universal Screening Tool (MUST) assessment completed whenever there was a change in their condition. Referrals to other services, such as tissue viability and dieticians, were made if staff were concerned about the patient and felt they needed more specialist advice.
- Staff completed moving and handling assessments as well as a falls' risk assessment, when there was a change in patient condition. We saw these had been completed in all records seen.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and well-being, medical emergencies or behaviour that challenges. The team did not use a specific tool, other than the base line assessments in the initial assessment, to help assess whether people needed urgent medical attention or referral for additional support/treatment.
- Staff formed close professional relationships with the patients and their families due to the nature of their work and this meant they were able to immediately identify changes in the patients' physical or mental health.
- Staff had access to patients' records, which highlighted to staff any recent changes to information or treatment.
- Staff were able to contact patients' GPs or district nurses if they had any concerns. Staff would document the changes in the electronic notes and in the patient held notes in the home to relay any urgent concerns and to ensure all staff attending the patient were aware of their concerns.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed so patients received safe care and treatment at all times, in line with relevant tools and guidance,
- We saw that actual staffing levels reflected the planned levels, and there was sufficient staff on duty to manage the caseload. Staffing levels met patients' needs at the time of the inspection.
- From March 2016 to March 2017, the service employed 9.03 whole time equivalent (WTE) qualified nurses and 4.13 WTE nursing assistants.
- The service had one WTE nursing assistant vacancy from March 2016 to March 2017. The service told us all vacant shifts were covered by existing staff. Sickness and absence cover was provided by existing team staff.
- The service has not used bank or agency staff in the last 6 years.
- There had been three (0.8%) substantive staff leavers from March 2016 to March 2017.
- The service had 3.41% total percentage of permanent staff sickness from March 2016 to March 2017.

Managing anticipated risks

- Potential risks had been taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.

Community health services for adults

- The service had plans in place to ensure patients with greatest needs would receive care in the event of service disruption.
- The service had an effective lone working procedure. The service had measures in place to protect the safety of staff who worked alone and as part of dispersed teams working in the community. All team members who had finished their shift were required to call in to the office to say they had finished and they were on their way home. A team member was allocated to ensure all staff were accounted for at the end of each day.
- There was a procedure to follow which included the process to raise the alarm if staff had not heard from their colleague. All staff felt this was an effective system and they had confidence in it.
- The service had a system for identifying patients who should not be visited alone, for example, where they had been alerted that the patient or their relatives could be aggressive. A 'flag' was put on their electronic progress notes and arrangements would be made for two people to visit that patient or attend at the same time as another health professional such as the district nurse.

Major incident awareness and training

- The service was not part of the whole system major incident planning for Northamptonshire. The service was not expected to be called upon to assist the local acute hospital in the situation of a major incident such as a terrorist incident or a major road crash.

Are community health services for adults effective?
(for example, treatment is effective)

Evidence based care and treatment

- Guidelines and policies we reviewed were based on national guidance. The service used current evidence based guidance, standards and legislation to develop the service and provide safe care and treatment. For example, the national 'End of life care for adults Guidelines Quality standard 13' (published date: November 2011, last update March 2017). In addition, guidance was followed from the Royal College of Nursing.
- Guidance on practical skills was sought through internal skills training or external specialist training. For example, the health care assistants were trained using the skills for health competency documents specifically for end of life care.
- There was an effective system in place to ensure policies and guidelines were reviewed to reflect current national guidance. Policies and guidance were reviewed at the service's monthly governance meetings. All policies we reviewed were in date and reflected current practice. All staff could access the service's intranet to access policies and procedure documents.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. All patients received a robust initial assessment based on relevant national guidance.
- Base line assessments were carried out on all patients referred to the service. The patient was supported to identify their care and treatment needs. These care needs were clear and personalised. Staff planned, implemented and evaluated care and treatment regularly to ensure effectiveness. Where necessary, treatment was changed to address changes in clinical condition.
- Patients attending the service were assessed on referral and personalised treatment was provided to meet the patient's specific care need. When staff implemented a rapid response approach, treatment was changed to address the rapid changes in clinical condition.
- Patients were treated without discrimination, and this was evident from the diversity of patients treated by the service.
- Staff were aware of the Mental Health Act 2005, and were able to describe how this affected patient care and treatment planning.

Pain relief

- Pain management was a high priority for the rapid response team. Staff assessed pain during each visit and provided advice and treatment accordingly. The patient's level of pain was recorded within the patient's records on each visit.
- Relatives we spoke with told us the service supported their loved one with pain management, they felt their pain was well-managed.

Nutrition and hydration

- The district nurse team assessed patients' nutrition and hydration needs, and they identified if patients were not eating and drinking enough. Staff at the service followed the plan of care set by the district nurse team and provided feedback to them if a patient's needs changed.
- Staff followed national end of life care guidelines to ensure that people continued to eat and drink for as long as possible.
- A Malnutrition Universal Screening Tool (MUST) assessment completed whenever there was a change in their condition.

Technology and telemedicine

- The service had no technology or telemedicine services at the time of inspection.

Patient outcomes

- The service routinely collected and monitored outcomes of patients' care and treatment.
- We saw that 1,309 patients had been registered with the service from April 2016 to March 2017. The service had supported over 1330 people to receive their end of life care in their chosen place of care from March 2016 to March 2017. The numbers of people receiving care from the service changed daily as people used the service when they required urgent relief of their symptoms. The rapid response community nursing service provided 6,418 visits to patients from March 2016 to March 2017. This was a 15% increase in patient visits from the previous year.
- From March 2016 to March 2017, the service consistently met their key performance indicator (KPI) set by the CCG of supporting 700 people per year to die in their own home or care home as preferred place of care. The service was able to demonstrate 961 patients were supported to die in their preferred place of care or death. This was a 5.83% increase from the previous year.
- From March 2016 to March 2017, 589 patients were referred to the primary care link nurses at the two local acute hospitals. 76% of those referred died in their preferred place of care with 2.7% dying in hospital as preferred place of care and 73.3% being discharged from hospital and dying as they wished at home, their own care home or a hospice.
- From March 2016 to March 2017, 263 patients were discharged home as preferred place of care, 151 patients were discharged to a care home as preferred place of care, and 34 patients were discharged to a hospice as preferred place of care.
- The service monitored information about people's outcomes and used it to identify improvements that could be made. We saw the service had identified the number of patients who died in hospital due to rapid deterioration as an area for improvement for 2016 to 2017. The number of patients who died in hospital due to rapid deterioration prior to discharge had decreased by 5% in 2016 to 2017. However, the service had identified they needed to support the acute hospitals to assist as many patients to be discharged to their preferred place of care or death for example where it was home or their own care home. We saw the service had a plan in place to address this which included:
  - The discharge link nurse to have dedicated time working with wards and departments, discharge teams and hospital end of life facilitators, to support staff to identify patients in a timely manner.
  - Monthly meetings with acute hospitals end of life leads to ensure continuing durable partnerships, good working relationships and maintain effective communication.
  - Involvement in teaching with nursing and medical staff regarding identification of people who were entering the last phase of their life
  - Regular reporting to acute hospitals the number of patients who were referred to the service too late to arrange safe and appropriate discharge home.

Competent staff

- Staff had the right skills, knowledge and experience to do their job when they started their employment and take on new responsibilities. Staff continually maintained their competence.
- The service employed three advanced nurse practitioner prescribers (ANPP), two advanced nurse practitioners (ANP), two nurse practitioners (NP) five health care assistants (HCA) and three nurse practitioner hospital link end of life discharge nurses, were based at the local NHS acute hospitals.
- The ANP and NP had relevant post registration qualifications. For example: advance training in

palliative care such as independent nurse prescriber, specialist practitioner – adult nursing, advanced nursing practice (Masters Level Module), palliative care degree module,

- The service had good staff retention. At ANP level, the combined length of service meant the service was able to develop and maintain staff skill and experience. The ANPs had between 11 and 40 years of nursing experience. Each had knowledge and experience of working in palliative and end of life care in a number of settings, which gave the team a broad level of skills and knowledge.
- The service had a comprehensive four-week induction programme for newly appointed staff. It was tailored to their roles. This included a range of mandatory training courses and role specific training courses, such as use of specific equipment, carrying out assessments and verification of death training.
- Unqregistered staff completed a range of core competencies to ensure that staff were equipped with the necessary knowledge and skills so they were able to deliver care in line with current policy. These competencies were based on 'Core Competencies for End of Life Care: Training for Health and Social Care Staff' (DH, 2009). This was monitored continuously.
- All staff had received an appraisal in the past year. The appraisal was one of the methods used to identify learning needs of staff. We reviewed an annual appraisal report and this showed us that there was a system in place to monitor and maintain the competencies of staff.
- Staff and the service manager told us staff received informal supervision regularly. However, this was not documented and therefore it was difficult for the service to provide assurance that it had occurred. Staff told us support and supervision occurred on an as and when basis, it encouraged reflective practice and planning for future needs. Staff had the opportunity to discuss events and individual cases that have been beneficial or detrimental to the outcome and to improve the quality of patient care from the lessons learnt and to identify areas of good practice. Staff told us the support and supervision was effective and they found it beneficial.
- The service supported staff training and development. For example, two members of the nursing team had completed a nurse-prescribing course at the local university.
- Staff said they had received appropriate training to meet their learning needs and were encouraged and given opportunities to develop their skills and knowledge within end of life care. Staff said there were excellent training opportunities that they could access through the local end of life care practice development team, such as advance care planning, care in the last days of life, and communication skills for people who are worried and/or distressed.
- The local end of life care practice development team carried out the training for syringe drivers. Staff could also attend refresher courses to maintain their competence as needed. All qualified staff were up-to-date with their syringe driver competency, which included symptom assessment and management.
- The service carried our checks with relevant professional bodies to ensure all staff had current registration.
- Revalidation was introduced by the nursing and midwifery council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration. At the time of inspection, all of the end of life care discharge coordination staff based the local NHS acute hospitals had successfully completed nurse revalidation. Three out of thirteen (23%) of the rapid response community team had successfully completed nurse revalidation. All staff yet to complete their revalidation were aware of their revalidation dates and the process they had to take. Staff felt the organisation was supporting them to complete the revalidation process.

Multi-disciplinary working and coordinated care pathways

- The patients' GP had overall responsibility for the management of the patients' condition, their treatment and they coordinated any necessary activities or referrals to manage the individuals care needs.
- Care was delivered in a coordinated way when different teams or services were involved. Staff who were visiting patients with other care providers would work alongside carers involved to identify and communicate progress the patient had achieved and the ongoing support the patient required. The staff member would document any changes in the patient held notes. For example,

changes to the patient's nutrition and hydration needs or medication changes. The service liaised directly with the GP and pharmacy to ensure adequate supplies of the necessary medications.
- Liaison with GPs, district nurses and the two local acute NHS hospitals was robust. Primecare had end of life care discharge coordination staff, based at the local NHS acute hospitals. Primecare treatment notes were shared with patients' GPs and were accessible to the district nurses. The service had an information sharing agreement with the two local acute NHS hospitals, GPs and district nurses.
- The discharge nurses based at the two local acute hospitals worked closely on a daily basis with key hospital departments such as palliative care teams, senior hospital leads for nursing and end of life care, hospital discharge teams,' health and social care, bed managers, transport teams and continuing health care.

Referral, transfer, discharge and transition

- All patients received a robust initial assessment based on baseline assessments guidance from NICE national 'End of life care for adults guidelines: Quality standard 13'.
- Acute hospital staff, GPs or district nurses referred patients directly to the service via the Primecare care coordination team centre 24 hours a day or via the discharge nurses based at the two local acute hospitals. Between 8am and 1am, the call was passed immediately by the centre to the Primecare rapid response community nursing team. Out of these hours, the referral was passed directly to Northamptonshire's out of hour's medical service.
- From March 2016 to March 2017, 263 patients were discharged home as preferred place of care, 151 patients were discharged to a care home as preferred place of care, 34 patients were discharged to a hospice as preferred place of care.
- Staff were able to increase the number of visits if patients' needs suddenly increased, or if a patient deteriorated suddenly.

Access to information

- The service had access to all the information needed to deliver effective care and treatment. This included risk assessments, care plans and case notes. Patients' notes were held on an electronic records system.
- All staff had access to the records either at the office base or via their work laptop through a secure connection, this ensured staff had access to up to date care records when they were working out in the community.
- Where nurse practitioners were working in patients' homes and another care provider was providing domiciliary care, the nurse practitioner would document a summary of the care being provided in the patient-held records.
- Special Patient Notes (SPN) completed by other care providers when a patient was registered with the service were scanned and stored on the electronic records system to allow all staff access to these.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had an understanding of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There was 100% staff compliance with Mental Capacity Act 2005 training. Staff could access information on these via the intranet.
- Patients were supported to make decisions regarding the care and treatment they received. This included the frequency of appointments. Staff we spoke with were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected
- We reviewed ten sets of care records and saw patients were supported to make decisions regarding the care and treatment and this was obtained in line with legislation and guidance, including the MCA.
- The service made no DoLS applications from March 2016 to March 2017.

Are community health services for adults caring?

Compassionate care

- We observed a strong, patient-centred culture throughout our inspection. Staff were committed to doing whatever they could to ensure a patient's wishes for their end of life care were met.

Community health services for adults

- Staff understood and respected people's personal, cultural, social, and religious needs, and considered these when planning all care. Staff we spoke with gave us examples of how patients' personal, religious, cultural, and/or social needs for their end of life care were met.
- Staff spoke about their patients with empathy, compassion, and courtesy. Many referred to discussions they had had with patients and family members.
- We observed a nurse with a patient and we saw compassionate, kind and respectful care undertaken. The nurse demonstrated good awareness of the patient's needs and gave them the time they needed.
- Staff responded to patient's experiencing physical pain, discomfort or emotional distress in a compassionate, timely and appropriate way. Staff told us they spent as long as was needed with patients and their relatives. Comments received from relatives demonstrated this. For example, one relative commented that, 'the telephone response was excellent, with a call back within minutes. This was mostly to reassure me of the current situation with my wife. As regarding the nurse visiting my home, this could not have been better in my opinion, never clock watching, giving the maximum time to the visit'. Another relative commented that, 'I cannot fault any of the care you gave my father and how quick you came out, and the call service was brilliant'.
- We spoke with six relatives during our inspection. Patients and relatives were consistently complementary about staff attitude. Comments received from patients and relatives demonstrated that staff provided compassionate care, which was patient-centred and met individual needs and wishes. An example of a patient's description of the care provided was, 'phenomenal'. A relative commented that, 'thank you so much for your support, calmness, knowledge, but most of all caring…I know it's what the service is for but so few services do what they say, it has been extra special'. Relatives told us the service was "excellent" they had appreciated the consistency they had received, the same staff were visiting, "we got to know them and they got to know our mum" and "We had amazing support, staff were helpful, kind and they responded immediately which is what you need at this time".
- Staff ensured that patient's privacy and dignity was respected at all times. Staff and relatives we spoke with gave us examples of how staff had protected patients' dignity when providing physical or intimate care, including when relatives were present.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and relatives so that they understood their care, treatment and condition. Patients and relatives were overwhelmingly positive about their care and the way staff communicated with them. They told us they felt involved in the decision making process.
- Relatives told us that staff communicated in a sensitive and unhurried way to ensure they understood the information given to them. Staff encouraged patients and relatives to contact the service at any time if they had any questions or needed any support.
- One relative commented that "the explanation of everything made our experience more understandable…helped her understand her own situation". Another relative commented that "your communication with us as a family and in particular with dad was so lovely. He understood and was grateful".
- Patients and relatives told us they were involved in planning and making decisions about their care and treatment.

Emotional support

- Staff understood the impact a patient's care, treatment or condition had on their wellbeing and those close to them, both emotionally and socially.
- The service empowered and supported patients to maximise their independence, by helping them ensure their wishes for their end of life care were met. Comments received from relatives supported this. For example, one relative commented that "with the fantastic team of nurses and carers we were able to carry out mum's wishes of staying at home". Another relative commented that "it was his dearest wish to die at home and the support he received from you made this possible".
- Staff provided emotional support for patients, relatives, carers and friends. They would refer them to other

agencies for further support if needed. For example, if there were bereaved children or young people following the death of a parent, they would be referred to the local child and adolescent bereavement service.

Are community health services for adults responsive to people's needs? (for example, to feedback?)

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people. The service had been commissioned by the local clinical commissioning group (CCG) to provide dedicated care and support to patients, who are registered with a Northamptonshire GP, are thought to be in the last eight weeks of life, and wish to die in their own home or in a care home.
- Information about the needs of the local population was used to inform how services were planned and delivered. The CCG had identified two work streams: a domiciliary service, where rehabilitation was provided to people in their own home (i.e. domestic, sheltered housing, residential or nursing care) and an in-patient rehabilitation service for patients who cannot be supported in their own home to receive rehabilitation.
- The service had clear admission criteria, which were closely monitored. The care needs of patients on the caseload were reviewed weekly and staff discussed their future care needs to ensure they received the correct service at the appropriate time. Patients were referred for additional services to other health and social care providers as the need arose.
- The service was flexible and enabled patient choice and continuity of care.
- The facilities and premises were appropriate for the services that were planned and delivered.

Equality and diversity

- Primecare were contracted by the local CCG to provide rapid response end of life services for people who are thought to be in the last eight weeks of their lives and wish to die at home or in their own care home without regards to their age, gender, religious beliefs, or ethnicity.
- Patients were offered written information about the service, their treatment and given copies of their care plans. The information was only available in English. However, the service had access to the local community NHS trust translation services which could translate information into a number of different languages and formats.
- The service had access to telephone translator services and staff provided an example of when this had been used.
- The service had a current equality and diversity policy. This set out the service's approach to equality, which encouraged, supported and valued diversity. The policy addressed the need and right of all service users to be treated with dignity, respect, equality and fairness. The service recognised that systems and structures existed in society, which led to inequalities in access to care.

Meeting needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take into account patients with complex needs, such as those living with dementia or those with a learning disability.
- We saw a range of information leaflets for patients, carers, and relatives. The leaflets had been produced by national organisations such as Age UK and Macmillan Cancer Support, and included; 'When someone dies: a step-by-step guide to what to do', 'Preparing a child for loss', and 'After someone dies – coping with bereavement'. These leaflets were available in other languages and could be ordered in Braille or audio tapes and discs.
- There were no exclusion criteria for the service, other than it being for those over 18 years of age. The service was available to anyone registered with a Northamptonshire GP, and were thought to be in the last eight weeks of life and wish to die in their own home or in a care home.

Access to right care at the right time

- Primecare aimed to make phone contact following a phone referral within 20 minutes. In April 2017, the service reported they had managed to do this in 95% of cases. The response rate had been consistent over the last six months.

- The service aimed to visit the patient within one hour of the phone call to request a visit. In April 2017, the service reported they had managed to do this in 95% of cases. The response rate had been consistent over the last six months.
- The service reviewed the response rate information and reviewed the reasons for why the response had not been met to address any issues that could improve their response. This information was shared with the CCG.
- From data In April 2017, we saw the reasons for non-compliance were due to treating another patient and unable to take the call and being in another area of Northamptonshire and heavy traffic had prevented the response time to be met.
- As far as possible, patients could access care and treatment at a time to suit them. The service provided a rapid response seven days a week between 8am and 1am. Outside these hours, patients would be seen by the local area out of hours' medical service.
- Visits generally ran on time. If there was any delay, for example when a staff member needed to stay with another patient for longer than anticipated, staff called the patient to inform them of the delay and confirm their estimated arrival time.

Learning from complaints and concerns

- Complaints were handled effectively and confidentially. The complainant was kept updated regularly. Formal records of all complaints were kept. The service had a clear complaints' policy and procedure.
- Relatives of those who had used the service we spoke with told us they knew how to make a complaint or raise concerns.
- The service did not always meet the target set to acknowledge receipt of complaints within two working days. The service had three complaints between April 2016 and June 2017. The service had not meet the target set to acknowledge receipt of complaints within two working days for one of these complaints. On this occasion because they were unable to contact the complainant within two days as they did not have an address or a contact number for them. 100% of formal complaints were responded to within 28 working days, which was in accordance with the service's policy. The team manager was working to improve the response to the acknowledgement this quarter.
- The team manager reviewed compliments, complaints, and queries. They ensured learning from all events was shared across the service through team meetings and via emails.
- The service received very few formal complaints. There had been three complaints about the service from March 2016 to March 2017. We reviewed all three complaints. We saw the complaints had been investigated promptly with actions taken to resolve the issue to relative and patient's satisfaction. Lessons learnt from the complaint were fed back to the team. We saw a slight change to the information leaflets had been made following feedback from a relative.

Are community health services for adults well-led?

Leadership of this service

- A registered nurse who had the appropriate skills, knowledge, and experience managed the service. Staff we spoke with told us that there was effective leadership of the service. The manager was visible and approachable. Staff felt supported and listened to by their line manager.
- Senior staff told us that they had an excellent relationship with the management team and attended regular governance and quality meetings.
- The service had bimonthly senior leadership team meetings. This meeting was attended by the regional director (North) Primecare (division of Allied HealthCare) and dedicated leads for finance, medicines, people, safeguarding, and communication. This meeting received feedback from safeguarding, medicines management, infection control, health records, information governance subcommittees, and the clinical governance committee. Incidents and complaints were also reviewed. The meeting provided overall assurance to the provider's board through the effective oversight of finances, performance, and governance and to set the strategy for the service going forward.
- The regional director, met with the service manager on a monthly basis to discuss the quality of the service.

Service vision and strategy

- The service had a clear vision and set of values. It was based on principles of the 'NHS Next stage review high quality care for all' report (Darzi 2008). There were clear links between the vision, strategy and the overall organisation strategy.
- The nursing strategy had four key strategic objectives:
  - Getting the basics right - delivering high quality care with dignity and respect
  - Helping staff to do their job by embedding a culture of lifelong learning
  - Valuing and developing our workforce so that everyone is a Leader and we have the right people doing the right job in the right place at the right time
  - Prepare Everyone to lead – building and strengthening Clinical Leadership
- Staff fully understood their role in achieving the strategy. Progress against delivering the strategy was monitored and reviewed through the governance meetings.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and good quality care. Staff told us they knew how to escalate concerns relating to clinical governance and patient safety. All concerns were raised with the service manager.
- The service had a risk register that was current and reviewed regularly. Staff were aware of risks within the service. There was an alignment between the recorded risks and what people said was 'on their worry list'. For example, not meeting the key performance indicators set by the clinical commissioning group and the impact this would have on patient care.
- The service lead was aware of their role and responsibilities and understood their accountability. There were clear lines of accountability and clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line.
- The service maintained contact with the clinical commissioning group through a designated individual. The service attended a quality review meeting every two months to discuss their activity and performance. The service also produced a quality schedule every three months to update the service's progress.
- We saw up-to-date copies of the corporate governance structure and local staff structure in place.

Culture within this service

- Staff told us, they felt respected and valued. Staff felt the service was committed to provide safe and caring services.
- Staff we spoke with were passionate about the care they delivered. One member of staff we spoke with felt it was a privilege to work for the service and provide end of life care.
- Staff told us they could access support regularly from their manager.
- The team manager stated they had regular opportunities to meet with the staff. They used these conversations to provide support and if necessary, as an opportunity to address behaviour and performance that was inconsistent with the vision and values of the service.
- The team culture was centred on the needs and experience of patients. Information received from patients was shared with staff and used to make changes within the service.
- The culture within the service encouraged candour, openness, and honesty. Staff were aware of the importance of openness and honesty when communicating with patients and their relatives.
- The service provided care for people where the focus was on helping people to return to their own home to die as their preferred place of death and this was embedded in the culture of this service.

Fit and proper persons

- We reviewed five staff files and saw all had relevant checks such as two references, photograph identification, disclosure and barring service (DBS) checks, medical checks, qualification checks and registration checks completed. An appropriate policy was in place.
- The registered manager for the service met the criteria for fit and proper persons' regulation.

Public engagement

- The service asked for feedback from the relatives of the patients who had used their service. However due to the nature of their work, the response rate was low.
- The service was keen to try to develop a more effective method of collecting patients' and relatives' views and experiences to enable them to use the information to shape and improve the services and culture. The service

sent a card of condolence to the families of patients to whom they had provided a service. They asked for feedback regarding the service in this card. The same request for feedback was included in their information leaflet, which was given to all patients registered with the service.

- Primecare regularly received cards and letters from the family's and carers of patients following a patient's death. They utilised this feedback and any complaints the service had received to obtain qualitative analysis from the comments and responses. The service used this to inform improvements and learning.

Staff engagement

- Views of staff in the service were sought and acted on. In addition to the regular informal supervision sessions, staff were sent a staff survey to complete.
- We were provided with the results for the last audit carried out in April 2016. Six out of 17 eligible staff (35%) responded to the survey. 100% of staff who responded would recommend the Primecare as a place of care or place to work.
- Themes from comments included:
  - 'Staff were 100% patient focused and cared about doing the best for them'.
  - 'The team was highly skilled and professional, and all had a can do attitude'.
  - 'Good out of hours care at weekends, bank holidays and nights'.
  - 'Brilliant opportunity'.
  - 'Gave patients and their family reassurance that support was available if needed at home'.
  - 'Excellent leadership and management'.
  - 'Patients were able to get a rapid response when they were in pain or discomfort rather than waiting for an out of hours' doctor or being admitted into hospital'.
  - 'Supportive team committed to delivering high standards of care'.
  - 'All staff worked towards the same goal, delivering a gold standard service'.
- The service leaders were aware of the low response rate and were keen to try to develop a more effective method of collecting staff views and experiences to enable them to use the information to shape and improve the services and culture.
- Staff we spoke with were positive about working for the service and had no complaints about their experience for working at Primecare. They said their manager was very accessible and they felt happy to about raising any issues they had with them. They felt any concerns that they had were taken seriously and responded to quickly and effectively.

Innovation, improvement and sustainability

- The service was in discussions with the commissioning group to identify how the service could further expand and improve.

Outstanding practice and areas for improvement

Outstanding practice

- We observed a strong, person-centred culture. Staff treated people with compassion, kindness, dignity, and respect. Staff understood and respected people's personal, cultural, social, and religious needs, and these were taken into account and were reflected in how their care was delivered.
- Relatives we spoke with were consistently positive about the care their loved ones had
- Staff were committed to providing compassionate care not only to patients but also to their families.
- The experiences of patients and their relatives were important to staff. They took time to interact with the people using their service and knew where to find additional support for people as needed.
- While the service was a rapid response service, staff considered the holistic needs of the patients and the support for family and friends.
- The culture of the organisation is very patient centred.

Areas for improvement

Action the provider SHOULD take to improve

The service should ensure when a person makes a verbal complaint that an address and contact number is taken so that they can meet the target set to acknowledge receipt of complaints within two working days, in accordance with the service's policy.