First Community Health & Care C.I.C.

1-274331683

Community health services for adults

Quality Report

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Date of inspection visit: 20 – 22 March 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-298932083	Caterham Dene Hospital		
1-875238883	Forum House		

This report describes our judgement of the quality of care provided within this core service by First Community Health & Care C.I.C. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by First Community Health & Care C.I.C and these are brought together to inform our overall judgement of First Community Health & Care C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this core service Good

- Staff protected patients from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and staff escalated risks that could affect patient safety. We saw robust systems for reporting, investigating and sharing learning from incidents, which included the duty of candour if necessary.
- Overall, clinics were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that rooms were equipped with sufficient equipment and consumable items for their intended purpose.
- All medical equipment, including those in patient homes were serviced and maintained appropriately.
- Individual patient care records had completed risk assessments. Electronic records always matched with information kept in the patient's home.
- Staff had a good awareness of policies and procedures, which were based on National Institute for Health and Care Excellence (NICE) guidelines and other national standards.
- The organisation participated in national audits, audits requested by commissioners and internal audits. The services used the results to monitor the quality, safety and effectiveness of care.
- There was a holistic and comprehensive approach to the assessment of patients' needs including consideration of clinical needs, mental health, physical health and wellbeing and nutrition and hydration.
- Staff were knowledgeable about assessing patient's mental capacity and consent was obtained in line with policy and guidance.
- Some services collected information about patient outcomes and could demonstrate the effectiveness of their service
- Care was delivered by a range of skilled workers who participated in annual appraisals, clinical supervision and had access to further training as required.
- Multidisciplinary team working was embedded throughout the service and we saw good collaborative working and communication amongst all staff
- Feedback from patients about the care they received was consistently positive. The organisation scored highly in the NHS Friends and Family Test.
- Relationships between patients, their relatives and staff were caring and supportive, and we saw a genuine rapport.
- Care that we observed was truly person centred, with patient's wellbeing at the heart of care.
- We saw staff respected patients' dignity and respect.
- Staff were highly motivated and inspired to offer care that made a difference to their patient's lives.
- Staff explained and ensured that patients and carers had a good understanding of procedures before undertaking them.
- The needs of patients were taken into account when planning and delivering services. Urgent needs were catered for and waiting times and delays were minimal.
- Services were delivered in a timely way with flexibility and continuity of care. There was highly co-ordinated working between other services and teams.
- Reasonable adjustments were made for people with disabilities, learning difficulties and those living in vulnerable circumstances.
- Patients were given information about how to make a complaint or raise a concern. There was a system in place for capturing learning from complaints and we heard examples of changes to the service because of complaints made.
- Services were tailored to the needs of local populations and staff were able to access training specific to the needs of the populations they supported. There was access to interpreters and written information in different languages available.
- Staff felt able to approach their managers with concerns due to the organisation's open and transparent culture.
- There were governance and risk management systems in place. The senior management team were visible and regularly engaged with staff.
- There was a very positive, supportive culture across all staff groups we spoke with.
- Innovation was encouraged and staff felt empowered to make positive changes. The organisation was pro-active in celebrating staff achievements.
- There was strong and visible leadership who together with the staff were committed to improving patient care.

Summary of findings

- Staff were overwhelmingly positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values.

However,

- Recruitment appeared to be a challenge across the organisation, with staff vacancies leading to staff working additional hours, staff covering additional roles and direct impact on patient pathways.
- We saw patients at high risk of pressures ulcers were not being reassessed at correct timeframes.
- There was not a truly consistent approach to pain assessment and documentation. This meant staff could not assure themselves they were managing pain effectively.
- Not all staff knew how to access the translation services and told us they would use the patient's relatives to translate.

Summary of findings

Background to the service

Information about the service

First Community Health and Care CIC (First Community) is a not-for-profit social enterprise, providing community healthcare services to people living in East Surrey and parts of West Sussex. For adults, these services included district nursing, specialist nursing, specialist rehabilitation, phlebotomy and direct access therapies.

First Community delivered these services in people's homes or clinics located in neighbourhood medical centres and community hospitals. Clinics in the community hospital also accepted outpatients discharged from the wards or from other hospitals in the area. In addition, a Rapid Assessment Clinic (RAC) and a minor injuries unit operated from the community hospital.

To help us understand and judge the quality of care provided by First Community, we visited a range of clinics including audiology, pulmonary rehab, dietetics and speech and language therapy. We observed care, watched staff interacting with people using the services and made checks on the environment and equipment.

We accompanied staff, with permission, on 15 home visits to observe assessments and care provided. We spoke with 11 patients and 5 relatives who used the service and reviewed 15 sets of medical records.

We spoke with 48 staff across the service including therapists, district nurses, healthcare assistants, rehabilitation assistants, nurse advisors, dietitians, podiatrists, audiologists, administration staff, students and clinical service managers.

In addition to inspecting the various locations, we reviewed information supplied prior to our visit by First Community and information either provided or requested during the inspection. We also considered feedback from the staff focus groups, online feedback about the service and written communications from stakeholders. We reviewed 12 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection.

We carried out an announced inspection of the services provided between 20 and 22 March 2017 as part of our planned programme of comprehensive inspections of independent healthcare community services.

Our inspection team

Our inspection team was led by:

Team Leader: Terri Salt, Inspection manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: community nurses and matrons, a GP, a governance lead and an expert by experience

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit on 20-22 March 2017. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family

Summary of findings

members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

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 visited community health services for adults in the area serviced by the provider including shadowing community nurses providing care in people's homes and also those supporting the work of residential care homes.

We visited podiatry clinics, a speech and language clinic, a pulmonary rehabilitation class and a falls clinic. We also met with the wider multidisciplinary team and reviewed the work of the intermediate care team and the dietitians, the physiotherapists and the stroke team.

We spoke with 42 patients and 23 relatives who were using the service.

We reviewed 12 feedback comment cards.

We Spoke with 56 staff including nurses, occupational therapists, physiotherapists, podiatrists, Speech and Language therapists, therapy technicians and administrative staff.

We attended multi-disciplinary meetings.

We looked at 22 care and treatment records of patients.

What people who use the provider say

We received 12 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection. Comments were overwhelmingly positive and praised the staff. Patients talked about staff being "kind, helpful, professional and lovely".

Positive examples included:

- 'Excellent service'
- 'The service was good; they listened to me and explained the situation…'
- '…most impressed clean and bright reception. Seen very quickly. Helped and listened to.'
- 'Only a 15 minute wait in a full waiting area…'
- 'The environment is safe and hygienic.'
- 'The hospital is lovely and clean with very friendly staff.'
- 'The nurse allowed me to explain my symptoms and gave me a thorough examination.'

Good practice

- First Community had piloted providing phlebotomy services for local house bound patients. Phlebotomists took blood from patients for testing. The pilot was successful and the local clinical commissioning group (CCG) have recommissioned the service.
- First Community had care home advisors who jointly redesigned the service so their caseload became the nursing and residential homes rather than the individual patients. The aim of the service was to avoid unnecessary hospital admissions.
- The culture of the organisation was exceptionally open and transparent, with staff reporting high levels of satisfaction.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure that staff record that patients at high risk of pressures ulcers are reassessed within the timeframe contained within the policy guidance.
- Ensure all staff knew how to access the translation services and told us they would use the patient's relatives to translate

First Community Health & Care C.I.C.

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safety as good because:

- Staff protected patients from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and staff escalated risks that could affect patient safety. We saw robust systems for reporting, investigating and sharing learning from incidents, which included the duty of candour if necessary.
- Overall, clinics were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that rooms were equipped with sufficient equipment and consumable items for their intended purpose.
- All medical equipment, including those in patient homes were serviced and maintained appropriately.
- Individual patient care records had completed risk assessments and electronic records always matched with information kept in the patient's home.

However,

- We saw omissions of drug fridge temperature recording, which may not give assurance medicines, were being kept at the correct temperature in the Minor Injuries Unit.
- Recruitment appeared to be a challenge across the organisation, with staff vacancies leading to staff working additional hours, staff covering additional roles and direct impact on patient pathways.
- We saw patients with a recorded previous high risk of pressure damage were not being reassessed at correct timeframes.

Detailed findings

Safety performance

- The provider participated in the patient safety thermometer to monitor harm free care. Staff reported they took individual responsibility to capture data during the course of one day each month and looked at harm from falls, pressure ulcers, venous thromboembolism, catheter issues and urinary tract infections. The team administrator submitted this information onto the database.

Good

Are services safe?

- We saw the latest safety thermometer data displayed at the district nursing bases we visited. Staff were aware of safety thermometer data and were able to describe what data was collected and why. This meant that staff were informed and could monitor safety performance data.

Incident reporting, learning and improvement

- First Community Health & Care C.I.C. (First Community) did not report any never events during the reporting period. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- First Community reported eight serious incidents (SIs) last year, of which four occurred in community adults services. SIs are any incidents that caused unexpected or avoidable death or severe harm to one or more patients, staff or members of the public. All four SIs arose from care provided in the patients' homes and related to pressure ulcers (grade 3 and ungradable) and were not attributable to lapses in care.
- The provider investigated all SIs using a process called root cause analysis (RCA). This process identifies root causes for failure and areas for improvement to deliver safer care to patients. We saw four completed RCA reports with recommendations and robust action plans. Completed actions included specialist training on multiple sclerosis to enhance knowledge, the use of teleconferencing to improve the effectiveness of handover and the introduction of a care plan index in patient records to reduce errors.
- We saw that First Community had up to date policies for incident reporting and SI reporting that supported safety performance and fulfilled legal obligations.
- First Community employed a clinical governance manager who reviewed all incidents and escalated to external bodies if appropriate. Staff told us they received direct feedback from the clinical governance lead and received email reminders to complete the action plan. Staff told us they also received direct feedback from the Security Management Specialist Manager when the incident involved an abusive patient.
- First Community recently implemented electronic incident reporting to improve the timescale of incident reporting. Staff filled in a standard incident report template on their computer and emailed this to the clinical governance manager. All staff we spoke to were aware of their responsibility to report incidents within 72 hours of the event. Data provided by First Community showed it had reduced its reporting period from 6.3 working days (between March and May 2016) to 3.6 working days (between October and December 2016). Although this was slightly worse than the provider's target of three working days, we saw ongoing actions to reduce the timescale further.
- We saw a completed incident form and a completed medical devices reporting form about a broken chair. We saw the external equipment supplier examined and reported on the faulty chair. This led to a staff training day on fitting equipment correctly.
- There was a Clinical Quality and Effectiveness Group meeting and meet every month to discuss incidents relating to their service. The service leads disseminated a summary of serious incidents and learning at their monthly team meetings to every member of staff.
- There was a positive attitude towards incident reporting and First Community actively encouraged staff to report incidents.
- Staff told us that they had oversight of all incidents raised by staff in the community teams through departmental meetings, serious incident learning events and handovers. Staff gave examples of recent incidents that related to their speciality and changes to practice. For example, a patient required a wheelchair at their podiatry appointment; however, the department did not have access to wheelchairs. An incident report was completed and action taken to source wheelchairs for the department.
- Another example, involved the IT team whereby current patient records were accidently archived. The IT team reinstated the patient records and put processes in place to prevent reoccurrence.
- District nurses told us they had changed their practice following an incident report about a faulty air mattress in a patient's home. They implemented a schedule to routinely check pressure relieving equipment and also had computer alerts when the checks are due. This ensured patient equipment was safe and fit for purpose.
- Tissue viability nurses told us they had reviewed their clinical incidents and identified a gap in training for new members of staff. They planned to implement training for new members of staff, which included pressure ulcers, wound care and three day leg ulcer course.

Good

Are services safe?

- The end of lifer advisor reviewed all end of life community incidents and was involved in root cause analysis. The learning of the incidents was shared internally and externally with other organisations.

Duty of Candour

- The duty of candour (DoC) requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days.
- First Community had a 'Being Open and Duty of Candour Policy' dated May 2016. All staff we spoke to were aware of this policy and their responsibility to be open and honest with patients.
- We saw the quarterly incident report dated October 2016, which showed the First Community met their statutory duty to make contact with the patient within 10 days and sent the patient a follow up letter informing them of the actions the organisation planned to make.

Safeguarding

- There had not been any serious case reviews relating to First Community patients.
- First Community had a safeguarding adults policy which was in date and included up to date guidance for staff on female genital mutilation and PREVENT.
- Staff attended a PREVENT course as part of their mandatory training. This course taught staff about recognising vulnerable people at risk of being exploited for terrorist purposes.
- Staff received mandatory training in the safeguarding of adults and children (Level 2), as part of their induction and staff were required to renew it every three years.
- At the time of our inspection, the rates for safeguarding adults level two training varied between 95-100%. This was better than the provider's year-end target of 90% for all adult community teams.
- At the time of our inspection, the rates for safeguarding children level one training varied between 83-100%. This was better than the provider's year-end target of 80% for all adult community teams.
- First Community trained all managers who had on call duties to level three adult safeguarding.
- Staff we spoke with could name the safeguarding lead and were knowledgeable about the safeguarding policy and their responsibilities. They were able to give examples of safeguarding referrals they had made and knew the outcomes of their referrals for example if they had been escalated to social services or the police.
- We saw information displayed in all of the community bases we visited of the safeguarding lead's name and contact details, the local social services and police contact details and a flowchart for reporting suspected adult abuse.
- We saw the safeguarding adult dashboard from April 2016 to March 2017. It showed staff raised between three and eight concerns with the safeguarding lead each month. This meant staff were reporting safeguarding concerns and there was senior oversight of safeguarding reports. The dashboard also monitored the number of PREVENT referrals, Deprivation of Liberty Safeguards (DoLs) applications and pressure ulcers.
- The Integrated Governance Committee monitored safeguarding with support from the safeguarding adults and children group who met bi-monthly. Departmental managers also attended these meetings and disseminated shared learning to their teams.
- The safeguarding lead attended quarterly meetings with the Local Safeguarding Adults' Board (LSAB). The safeguarding lead shared learning from this meeting with the First Community Safeguarding Adults' and Children's Group.

Medicines

- District nurses told us it was the responsibility of the patient's GP to review and prescribe medicines for their patients. We reviewed patient medicine charts and in all cases, we saw the transcriber had recorded the patient's allergies and signed and dated the prescriptions.
- The patient's pharmacy delivered the medicines directly to the patient's home or the patient's carers collected the medicines from the pharmacy.
- We saw senior healthcare assistants were able to administer some medications providing they had completed the medicines management training, read and signed the standard operating procedure and completed the relevant competencies.
- Staff administered medication such as insulin to patients in their homes. We observed the correct administration of insulin to a patient, which included checking the patient's name, the prescription and the

expiry date of the medication. Staff documented the administration of insulin correctly on the insulin administration record, which included injection site, dose of insulin and blood glucose reading.

- First Community audited insulin administration quarterly for the community adult service. We saw the latest audit results for quarter three. The overall compliance for all teams was 81%, which was worse than the provider's target of 100%. We saw the action plan for each team, which included staff to attend medicines management training, staff to read standard operating procedure and staff to complete insulin administration competencies.
- Staff recorded the patient's current medication including allergies as part of the initial patient assessment. If the district nurse had any concerns regarding the medication, they called the GP for advice.
- Staff told us the local hospital or hospice supplied anticipatory medication for patients receiving end of life care. Anticipatory medication is prescribed for patients nearing the end of life, ahead of symptoms they may experience. Staff told us they called the GP or local pharmacy if they needed to obtain more medication.
- We saw anticipatory medications prescribed correctly on individual prescription charts such as the syringe driver prescription. Staff told us that they asked the GP to rewrite a prescription if they felt the prescription was 'too old'. For example, we saw anticipatory prescriptions dated May 2016, were rewritten in January 2017.
- We checked the storage of medicines in the Minor Injuries Unit. The medicines were tidy, organised and staff kept the medicines cupboards locked.
- Staff completed daily temperature checks of the drug fridge in the Minor Injuries Unit. It is important medications be stored correctly to maintain their function and safety. We saw there were omissions in the recording of temperatures, which may mean the unit did not have assurances medication was stored at the correct temperature on those days.
- Staff told us they had online access and copies of the British National Formulary (BNF). The BNF provides advice on the selection and use of medicines.

Environment and equipment

- Domiciliary physiotherapists and occupational therapists attended patients in their own homes to assess mobility and provide advice on mobility aids, equipment and manual handling practices.
- District nurses, end of life and tissue viability advisors also supported people in their own homes with the provision of medical devices such as syringe drivers, pressure-relieving mattresses and cushions.
- Staff told us they obtained equipment from an independent equipment supplies company and explained patients could receive equipment the same day if ordered by 2pm. At weekends, equipment was also available but cost more, so staff tended to forward plan.
- Staff told us they also used their own stores to obtain equipment. There was a system in place to log equipment in and out of the stores and order more, which minimised wastage and reduced the loss of equipment. The system also kept information about servicing dates of equipment.
- We saw completed pressure area care plans, which included six monthly checks of air mattresses and three monthly checks of pressure relieving cushions in patient homes. Staff received training on how to check equipment for faults as part of their pressure ulcer training and had two yearly updates.
- The patients and carers we spoke to knew who to contact to report faulty equipment.
- Staff told us they were able to escalate concerns about equipment by completing a medical devices reporting form and sending this to the external company. They received feedback from the external company.
- We saw that all electrical items had electrical safety checking labels attached to show the date of testing. We checked 19 pieces of electrical equipment and all had electrical safety testing within the last 12 months. This is in line with The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) guidelines and provided assurances the electrical equipment was safe to use.
- Staff told us it was the responsibility of the patient to obtain glucose meter readers from their GP. The district nurses had responsibility to perform calibration monthly. We saw documentation of the completed monthly test, which included LOT numbers of the control solutions and strips used.
- At two clinic locations, facilities management was complicated by shared tenancy of the building. We saw First Community clinics were co-located within other health providers such as medical practices and local NHS trust audiology and dietetics services. There had been issues with the airflow at one location. This issue

had been managed by using fans and installing new windows. The audiology service lead continued to monitor room temperatures daily and had bi monthly meetings with the property service manager and the newly appointed First Community estates manager.

- The local NHS trust repaired and maintained the equipment within the clinics. Staff expressed no concerns about the repair or replacement of faulty items.
- First Community had an external contract for the annual calibration for all medical devices. The external company came to the site to perform the tests. We checked three pieces of equipment, which were calibrated within the last 12 months. This provided assurances the equipment was controlled and maintained in accordance with manufacturer recommendations and policy guidelines.
- District nurses told us they had their own supply of syringe drivers. During our inspection, the district nurses at one base told us their syringe drivers were out of use because their service was overdue. They were able to borrow syringe drivers from other bases if required. This ensured they did not use equipment that might not be fit for purpose.
- Staff visited people in their own homes and took equipment needed with them. Staff occasionally left equipment such as dressings in people's homes for regular use.
- All equipment and dressings were stored in well-organised, locked storage cupboards in each community nursing base.
- Staff told us they informally checked their kit bag, which contained items such as a thermometer and single-use consumables before carrying out home visits.
- We saw a defibrillator machine at the Oxted Therapies Unit, which was located in the reception area and was easily accessible by all staff.
- All staff wore identity badges that clearly stated their name and role. We saw First Community provided visitors with temporary badges and had to sign in and out of the building they visited.
- The areas we observed supported the safe performance of therapies and delivery of care. Rooms were well-lit and supplied with sufficient equipment and furnishings. We saw ramps within the clinics to assist wheelchair users or those with limited mobility. Clinics and community hospitals had automated entrance doors led to the waiting areas and lifts as required. Corridors and therapy rooms were spacious with doors wide enough to fit wheelchairs.

Quality of records

- Staff used a mixture of paper and electronic records to record episodes of care. Some staff reported they duplicated paper records onto the electronic system when they returned to the office.
- We reviewed paper records kept in folders in patient homes. We saw the records were comprehensive, legible, signed and dated. We saw staff corrected entries made in error by striking through the error, sign and dating.
- Each patient had a completed general assessment. This involved the healthcare professional recording the patient's answers to key questions such as consent, social circumstances and cognition. Staff also recorded the patient's baseline observations such as blood pressure. Staff uploaded this information on the electronic system, which all staff could then access.
- We saw all folders contained a completed list of signatures, which included profession. This meant First Community could cross-reference all documentation to the correct healthcare professional.
- We saw the folders contained a list of common abbreviations used within the community setting. However, First Community changed its record keeping policy and discontinued the use of a common list of abbreviations. We saw action plans in place to remove these lists in patient folders.
- We saw staff used care plan templates such as glucose monitoring and leg ulcers, which had a personalised area for individual care planning. Staff reviewed and updated all care plans when the plan of care changed.
- Staff recorded every episode of care they delivered in the care and communication records. We saw the records included patient consent with the explained risks and benefits documented.
- Clinic staff used the electronic reporting system to record patient records. Staff told us they had access to standard templates. Although some staff felt the standard templates might inhibit their ability to document consultation adequately, other staff told us they had adapted the templates to suit their needs.

Good

Are services safe?

- Therapy staff adopted a standardised approach to record keeping and used the 'SOAP' format. SOAP stands for subjective, objective, assessment and plan. It was used to document the patient's goals and progress throughout treatment.
- The rehabilitation service kept a goal sheet in the patient's home.
- An internal records audit in November 2016 found all 12 sets of patient records contained a completed malnutrition universal screening tool (MUST) score and Waterlow score. The Waterlow score gave an estimated risk for the development of a pressure sore in a given patient. During our inspection, we also saw documentation of Waterlow and MUST scores for every patient. We saw evidence of advice given to the patient regarding pressure area breakdown and nutritional advice.
- We reviewed the records of patients who were on an end of life care pathway. We saw staff had completed an end of life checklist, which included symptom control, mouth care and spiritual care.
- Patients with a Do Not Attempt Cardio Pulmonary Resuscitation Order (DNACPR) in place, had this filed at the front of their note folder. We saw completed DNACPR forms with details of discussion, date and signature of the consultant.
- We saw documentation, which showed staff, discussed the patient's preferred place of death and documented the discussion in the patient records.
- Community nursing staff told us they completed a checklist of the patient's records after the patient's death, which included DNACPR, advance care plan and preferred place of death. Staff sent this information monthly to the end of life lead who would audit the forms. More than 90% of patients died in their preferred place of death; however we did not see the latest audit results during our inspection.
- District nurses recorded catheter insertion. The record included date of insertion, number of weeks it had been in place, date of planned catheter change and reason for change. This ensured the continuity of care.
- At the time of our inspection, the rates for information governance mandatory training varied from 97 to 100%. These rates were better than the provider's target of 95% for all adult community teams.
- First Community audited each service's compliance with the Information Governance Policy yearly. We saw the latest information governance audit results for community services (10 teams audited), long term conditions service (10 teams audited), direct access therapies service (six teams audited) and bed based care service (two teams audited). Overall compliance was very good. There were completed action plans, which included ordering a keypad for the print room to ensure it was lockable, reinforcing the clear desk policy and discussing the results at the team meeting.
- We saw the latest record keeping audit results for community services (nine teams audited), long term conditions service (12 teams audited), direct access therapies service (four teams audited) and bed based care service. First Community carried out these audits three times a year. Overall compliance was very good. We saw action plans, which included ensuring staff were completing baseline observations in the records on the patient's first visit, the removal of abbreviation lists to prevent staff from using abbreviations and ensuring all staff complete mental capacity section in the records.
- The nurse advisor for care homes worked with care home staff to reduce avoidable hospital admissions. A historic review found staff were inappropriately transferring patients to hospital at the end of their lives. The nurse advisors audited 167 patient records in March 2017. They looked for advance care plans (ACP) and documentation of the patients preferred place of death. The audit results showed the percentage of patients who had an advanced care plan in place was better than the provider's target of 60-70%. The percentage of patients who had died in their preferred place of death was slightly worse than the provider's target of 75-85%. We saw the action plan, which included feedback to the Clinical Commissioning Groups (CCGs), teaching for care home staff on advanced care planning and the prognostic indicator guidance tool.

Cleanliness, infection control and hygiene

- Staff adhered to the bare below the elbows policy and wore gloves and aprons when providing care in people's homes and in the clinics to prevent the spread of infection.
- Hand sanitiser bottles were readily available throughout clinical areas and community staff had hand sanitiser on their person. We saw these used during home visits.
- Clinical waste was separated and handled in line with national guidance, HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.

Good

Are services safe?

- We saw the flooring in therapy and treatment rooms was made from seamless, smooth, slip-resistant material.
- We saw there were no sinks available within the clinical rooms in audiology. Healthcare practitioners had to use the sink in an office room. However, staff used this room occasionally for balance clinics, which meant staff could not access the room to wash their hands.
- There were two sinks in the office room, a stainless steel sink which staff said was not in use and a handwashing sink.
- The estates manager performed water testing on all the sinks weekly to reduce the risk of legionella. The test results for this was not available at the time of our inspection.
- The handwashing sink within the office had an overflow outlet and a plug.
- Staff told us each clinician took responsibility for cleaning their clinic room daily and a housekeeper from the hospital cleaned the department daily. We saw completed electronic cleaning schedules for each clinic room; however we noted gaps in the schedule. Staff reported this reflected weekends when the audiology clinic was closed.
- We saw the audiologist cleaned equipment before and after patient use to prevent the spread of infection.
- We saw the dietitians kept antibacterial wipes in the scales bag to clean the scales after patient use.
- The Oxted Therapies Unit had a cleaning schedule for each service. We saw the cleaning logbooks for the physiotherapy gym, which staff cleaned weekly, and the treatment rooms, which staff cleaned daily. We saw antibacterial wipes were available in every clinical room.
- We saw disposable curtains used in the treatment rooms marked with the date changed. Frequently changed curtains helped to reduce the chances of germs passing from one person or object to another.
- Staff recently replaced the fabric covers on the gym weights with non-fabric ones to allow for cleaning. We observed staff asking patients to clean their weights using antibacterial wipes at the start of the pulmonary rehabilitation class to prevent the spread of infection.
- The Oxted Therapies and the Minor Injuries units had a spill kit available.
- Staff used a paper roll to cover the couch before patient use and this was changed between patients.
- Staff in the district nursing team carried a nurse's bag, which contained items such as a thermometer and single-use consumables. We saw they carried a small stock of disinfectant wipes for cleaning any reusable items or equipment before and after use.
- Staff told us they provided sharps bins and either they or the local council would collect used sharps bins. We observed four members of staff dispose of sharps appropriately using a sharps bin. However, one member of staff wrapped the lancet used to test blood sugar levels inside a pair of used gloves. The staff member then walked to their car to dispose of the lancet in the sharps box in their car. This meant there was an increased risk of needle stick injury.
- Staff showed us the red box they used to transport clinical waste from the patients' homes to their base. An external waste collection company then disposed of the waste.
- Staff were aware of First Community's needle stick injury policy and we saw posters displayed at district nurse bases which included a flowchart of actions to take and the contact details of occupational health.
- We saw a patient leaflet, which asked patients to provide district nurses with paper towels or a dedicated clean towel and a dispensing soap in their homes.
- Staff used aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. This was in line with NICE guidance (QS49).
- We saw district nurses cleaned their hands before and after providing care to their patients in all cases we observed.
- We saw the latest hand cleaning technique audit results for community services (12 teams audited), long term conditions service (nine teams audited), direct access therapies service (four teams audited) and bed based care (two teams audited). First Community carried out these audits six monthly. The compliance rates were between 92% and 100%. We saw completed action plans, which included re-auditing of staff wearing stone rings or staff with long fingernails.
- Two teams also audited essential steps to safe, clean care. This observational audit looked at hand hygiene, the use of personal protective equipment and the disposal of sharps. Overall compliance for the two teams was 100% and 67%.

Good

Are services safe?

- At the time of our inspection, the rates for infection prevention control mandatory training varied from 86 to 100%. This was better than the provider's target of 80% for all adult community teams.
-

Mandatory training

- Mandatory training consisted of 12 different modules and was a mixture of on-line training and face-to-face learning. Subjects undertaken included safeguarding adults, fire awareness, basic life support, manual handling, and information governance and infection control.
- According to First Community data, the target for all mandatory training compliance was 80%, apart from safeguarding adults level two, which was 90%, information governance which was 95% and appraisals which was 100%.
- The records we viewed demonstrated a range of compliance rates between departments and specialities. For example, long term conditions was compliant with all 12 modules, direct access therapies were complaint with 11 modules, community services were compliant with nine modules as of March 2017.
- Staff told us they had no problems booking mandatory training using the online system. They received a reminder when training was due within the next two months then they would receive reminders weekly.
- Managers were able to show us up to date training records of all staff. This meant they were able to identify members of staff that were not compliant with their training.
- Staff told us they attended yearly moving and handling mandatory training, which was face to face. Staff practiced using equipment such as hoists and sliding sheets within the training environment. At the time of our inspection, the rates for moving and handling mandatory training varied from 90 to 98%. This was better than the provider's target of 80% for all adult community teams.

Assessing and responding to patient risk

- Staff told us they received National Early Warning System (NEWS) training. NEWS is an assessment tool used to recognise the deteriorating patient.
- All patients received a full holistic assessment of their needs on the first home appointment. The initial assessment included physical assessment such as baseline observations and pressure area checks, risk assessments and other information such as social circumstances, cognition and medication. District Nurses used the outcome of the assessment to decide the level of care the patient required.
- Staff put the initial risk assessment onto the electronic system so all staff could access it. Staff could include alerts on the electronic version such as the patient's DNACPR status.
- District nurses told us if they had concerns about a patient, they would escalate this to the nurse in charge or the on call manager. Staff told us they had successfully used the on call manager service. We observed a healthcare assistant escalating their concerns regarding a patient's high blood sugar level by calling the registered nurse who provided advice and reassurance.
- Staff assessed all patients' risk of developing pressure ulcers during their first home visit using the Waterlow score. Staff followed action plans depending on the patient's level of risk, for example ordering pressure-relieving equipment and providing advice on repositioning.
- First Community's Pressure Ulcer Prevention and Management Policy stated, "Routine reassessment is recommended monthly for community patients cared for in their own homes". Staff were not always reassessing patients monthly, including those at high risk. This meant staff were not aware when patient risk changed and could not provide assurance they were managing the patient's risk appropriately.
- Staff completed malnutrition universal screening tool (MUST) risk assessment on the patient's first home visit. We saw staff followed action plans depending on the patient's level of risk for example providing advice on nutrition.
- refer clinically appropriate patients who need 24 hour care to the Bed Based Care Team to avoid inappropriate acute hospital admission.
- We saw every patient had emergency contact details for the organisation within their home records. Patients and their relatives told us they knew who to contact in an emergency.
- All patients received a full holistic assessment of their needs on their first therapy appointment. Therapy staff used the outcome of the assessment to diagnose and plan the patient's treatment. We observed two comprehensive initial patient assessments at the Oxted

Therapies Unit. The assessments including physical examinations such as breathing tests and discussion on the patients' medical history, medications and social history. The treatment plans included referral to an exercise group and medical advice.

- Therapy staff referred deteriorating patients to the rapid assessment clinic or to the falls clinic for review.
- Therapy staff told us if they identified a pressure ulcer, they referred the patient to the district nursing team and discuss positioning with the patient. They arranged joint home visits with the district nurse and the Tissue Viability Nurse.
- The intermediate care team used an interactive board to capture all patients receiving services; it was kept updated at all times, and included patient risks for example if a patient lived alone. Staff prioritised these patients on their caseload.
- We observed the intermediate care team handover. Staff were kept informed of any changes to their caseload and changes in a patient's condition or circumstances for example a patient referral to the reablement team. Staff kept a written copy of the handover at the base so they could refer to it later if required.
- At the time of our inspection, the rates for basic life support mandatory training varied from 98 to 100%. This was significantly better than the provider's target of 80% for all adult community teams.

Staffing levels and caseload

- First Community reported it had a 9.2% vacancy target in line with national benchmarking but had implemented a local target of 5%.
- First Community reported the adult community service had 61.74 whole time equivalent (WTE) registered nurses and 9.27 WTE vacancies, which demonstrates a 15% vacancy rate for September 2016.
- First Community reports the adult community service had 14.89 WTE nursing assistants and a total number of 0.4 WTF vacancies, which demonstrates a 2.68% vacancy rate for September 2016.
- In September 2016, there were 5.6 WTE vacancies of qualified nurses and 0 WTE vacancies of nursing assistants in the community nursing teams. First Community explained the team prioritised and distributed the workload amongst the other 45 members of staff.
- First Community has eight District Nursing Teams based at six sites covering four GP Networks (18 GP Practices).
- The Horley District Nursing team felt their staffing levels are adequate most of the time and stated staff across the wider district nursing team would cover sickness if required.
- The Integrated Discharge Team (ICT) carried out a daily conference call with the Ward Matron at Caterham Dene Hospital to discuss discharges and bed states. This enabled the team to assess their staffing levels against the number of patient discharges.
- In September 2016, there were 2.67 WTE vacancies of qualified nurses and 0 WTE vacancies of nursing assistants in the evening and night service. This issue was on the corporate risk register. First Community had taken steps such as completing the off duty three months in advance to highlight potential staffing issues to mitigate the risk.
- First Community reviewed the evening and night district nursing service and identified a high demand for the service between 6pm and 12am. First Community decided to commission a third party to provide additional medical cover between 1am and 7am. This allowed the staff to be redeployed and work during the high-volume period. The service planned to ask for patient feedback after three months of piloting the new structure.
- The Lead for Audiology told us there was a national shortage of qualified audiologist and because of this they had been unable to recruit and used two locum audiologists to cover the vacancies.
- There was no data available for the therapy services. However, staffing levels for this service were added onto the corporate risk register in October 2016.
- Staff felt they could escalate concerns about staffing levels to their line manager or service lead. Staff could also use the 'floor to board' process to escalate significant concerns. Team leaders would cover sickness within their team. Some teams reported they had developed a business plan to increase their establishment so they could manage the increase in the number of referrals they were receiving.
- The organisation used planning tools to identify safe staffing levels. This was kept under regular review.
- Staff told us they felt administrative support was inadequate for their workloads and reported clinical staff were covering additional administrative duties. For example, the Community Neurological Rehabilitation

Team (CNRT) had one administrative staff member working 15 hours a week to support the specialist nurses in stroke, Parkinson's, multiple sclerosis and support outpatients.
- The CNRT told us they used an informal demand and capacity tool to determine caseload management.
- Service leads told us they did not go on annual leave at the same time to ensure each service has a strong support structure at all times.
- The speech and language therapy team told us they had one vacancy, which was having a negative effect on patient pathways. They were managing this by prioritising patients on the stroke pathway, which had a negative effect on patients on other pathways such as neurological conditions and Parkinson's disease.
- First Community reported it had seen an increase in staff sickness in 2016 compared to the previous year.
- The direct access teams told us staff volunteered to work weekends to run additional clinics if clinics were cancelled due to staff sickness. The Integrated Clinical Assessment and Treatment team (ICATs) and the CNRT covered each other's service during episodes of staff sickness.
- Between August and October 2016, the percentage of permanent staff sickness increased due to long term sickness absence.
- Between August and October 2016, 33 substantive staff left the organisation, however First Community explained the higher rate of staff leavers was proportionate to their ageing workforce and the size of the organisation. Retirement or promotional opportunities were the reason for the majority of staff leavers. First Community used succession planning to manage staff retirement and First Community had held a two recruitment days within the last six months.
- First Community had started to offer staff incentives to refer friends to work at the organisation.
- The minutes of the Organisational Development & Workforce Committee meeting dated September 2016, showed the committee discussed all staffing issues and agreed a plan of action.
- The intermediate care team told us they did not use an acuity dependency tool but used a colour rating system, red, amber or green, to indicate the acuity of patients.
- First Community employed one tissue viability nurse and one end of life care advisor to provide training, specialist advice and review of patients at home.
- Senior staff reported concerns regarding band 5 recruitment but stated it was working with universities, creating rotational posts and offering a 'golden handshake' for new starters.
- In the NHS Staff Survey, 78% of staff reported working extra hours. This was worse than the average of 73% for other similar organisations.
- However, despite the pressures on staff, 73% of staff would recommend the organisation as a place to work. This was better than the average of 65% for other similar organisations.

Managing anticipated risks

- First Community had departmental and central risk registers to record and monitor the risk in each service. We saw examples of registers that contained a description of the problem, the risks posed and the underlying cause. Risks were scored and rated using the 'red, amber, green' colour convention and action plan summaries and review dates entered. We saw staff updated the registers regularly.
- Staff completed a risk assessment for all patients on their first visit. After this initial assessment, an alert would be generated to anyone who accessed the patient's records on the electronic system.
- Risks were also discussed and highlighted at weekly multidisciplinary team meetings, which ensured they were shared across the team.
- Staff could carry out home visits in pairs if there was a known risk. Risks included late night appointments or the patient requiring two people for repositioning or climbing the stairs.
- All managers had a list of staff whereabouts either displayed on the whiteboards at the base or stored electronically. We also saw a file containing the staff member's car registration details and their relatives contact numbers.
- First Community provided all relevant members of staff with a mobile phone. No staff raised concerns about mobile phone coverage.
- Staff told us the process for responding to failed access to an adult patient at home. If the visit was not urgent a letter would be posted but if the visit was urgent the nurse would call the police for a welfare check, contact the GP and contact the next of kin. If the visit was still required, the nurse discussed with their line manager, completed an incident report and considered a referral to the safeguarding team.

Good

Are services safe?

- Staff reported they regularly had fire drills. At clinical and community hospital locations we saw firefighting equipment, safety signage and posters on notice boards about fire and other emergencies.
- Staff had access to panic/emergency alarms within clinical rooms. Staff working within an acute hospital called the resuscitation team in an emergency. Staff working within the community hospital called the emergency services.
- First Community had business continuity plans in place and we saw a letter sent by the district nurses to all patients advising them of the winter contingency plans.
- At the time of our inspection, the rates for fire safety awareness mandatory training varied from 94 to 100%. This was significantly better than the provider's target of 80% for all adult community teams.

Good

Are services effective?

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

Summary

We rated effective as good because;

- Staff had a good awareness of policies and procedures, which were based on National Institute for Health and Care Excellence (NICE) guidelines and other national standards.
- The organisation participated in national audits, audits requested by commissioners and internal audits. The services used the results to monitor the quality, safety and effectiveness of care.
- There was a holistic and comprehensive approach to the assessment of patients' needs including consideration of clinical needs, mental health, physical health and wellbeing and nutrition and hydration.
- Staff were knowledgeable about assessing patient's mental capacity and consent was obtained in line with policy and guidance.
- Some services collected information about patient outcomes and could demonstrate the effectiveness of their service
- Care was delivered by a range of skilled workers who participated in annual appraisals, clinical supervision and had access to further training as required.
- Multidisciplinary team working was embedded throughout the service and we saw good collaborative working and communication amongst all staff.

However,

- There was not a consistent approach to pain assessment and documentation. This meant staff could not assure themselves they were managing pain effectively.
- Community teams collected data but missed opportunities to formally audit this.
- Not all community services were compliant with the provider's target for Mental Capacity Act (2005) mandatory training

Detailed findings

Evidence based care and treatment

- The relevant National Institute for Health and Care Excellence (NICE) guidelines, quality standards, service frameworks and other good practice guidance were available. We saw clinical policies were based on the most recent guidance for example the pressure ulcer prevention and management policy made reference to NICE guidance and European Pressure Ulcer Advisory Panel guidance.
- The Integrated Governance Committee (IGC) finalised changes to policies made by sub groups such as the Infection, Prevention and Control group. We saw the minutes of three IG meetings, which showed policies, were a standard agenda.
- First Community updated and reviewed policy documents regularly and made these accessible to all staff through the intranet. We viewed policy documents on the First Community intranet, and staff told us the audit and quality team alerted them when there were changes to NICE guidelines.
- The falls prevention team followed the NICE Falls in older people pathway (published 2016).
- The speech and language therapists (SALT) told us they discussed and reviewed any new NICE guidance at each team meeting. An example given was the Motor Neurone Disease: assessment and management guidelines.
- We saw specific policies related to end of life (EoL) care based on national guidance produced by NICE, the National Palliative and End of Life Care Partnership and the Leadership Alliance for the Care of Dying People.
- First Community recently undertook an audit of the district nurses (DN) compliance with the NICE guideline: The care of dying adults in the last days of life. The results of this audit were unavailable at the time of our inspection.
- We saw the DN team audited patient records against the assessment standards recommended in NICE clinical guidance 147 peripheral arterial disease: diagnosis and management. The audit results from June 2016, showed an overall compliance rate of 73% which was worse than the provider's target of 100%. We saw completed action plans, which included distributing leaflets to all patients with peripheral arterial disease.

Good

Are services effective?

- We saw the DN team audited patient records against the assessment standards recommended in NICE clinical guidance 179- pressure ulcers: prevention and management. The audit results from September 2016, showed an overall compliance rate of 80%. This was a ten percent improvement from the previous audit in 2015. We saw on-going action plans, which included educating patients and their carers on how to reduce the risk of pressure ulcers.

Pain relief

- When pain was assessed as part of the initial consultation, nationally recognised pain scales were used to determine how bad the pain was. We saw a standard pain template, which used the Wong-Baker FACES Pain Rating Scale, a body map and numeric pain scale with a rating of one for no pain and five for severe pain.
- Although we observed staff assessing patient's pain score before carrying out procedures such as compression bandaging, staff did not always document this. The patient records we reviewed showed inconsistencies regarding the timescale of when to reassess a patient's level of pain. For example, staff recorded a reassessment for one patient five months after their initial pain assessment and staff last recorded a reassessment for another patient in 2015. There was no on-going recorded assessment of pain for patients which meant staff could not assure themselves they were managing pain effectively.
- DNs told us they had a small supply of syringe drivers. Syringe drivers help to reduce symptoms by delivering a steady flow of injected medication continuously under the patient's skin. The local hospice or the GP prescribed the syringe driver medication.
- DNs told us they could change the dose of the syringe driver medication if required, providing two registered nurses were present to listen to the doctors instructions over the telephone and both registered nurses had completed medicines management training. This meant the nurses could effectively manage the changing levels of patient pain.
- Staff told us they had not experienced the hospital discharging patients with end of life medication. Community staff were responsible for arranging the prescription and delivery of anticipatory medication. In an emergency, staff told us they would call the local hospice, GP or NHS 111 for advice. We spoke with one patient on the end of life pathway who reported the DNs had provided good effective pain management and the patient was pain free.
- The community nursing service had one nurse with extended prescribing qualifications. However, staff discussed patient medication with the patient's GP to ensure the patient had adequate pain relief.
- We observed therapists assessing pain for patients during their consultation. The assessment included using a pain scale to determine the patient's current level of pain level as well as their medication history relating to pain relief and its effectiveness.

Nutrition and hydration

- First Community had established a nutrition working group which met quarterly to provide advice and guidance on the provision of nutrition to patients.
- First Community had an up to date nutrition and hydration policy in place.
- Staff referred patients with swallowing difficulties to the SALT and referred patients with nutritional needs to the dietitians.

Technology and telemedicine

- First Community had launched an intranet system, which was accessible by all staff. The intranet featured a policy library, First Community news, tweets and patient feedback. Staff were very positive about the new intranet system.
- First Community used an electronic learning and management system for mandatory training. All staff had access to this system and took responsibility for booking their mandatory training sessions. When mandatory training was due to expire, staff and their team leader received a notification two months in advance. The team leader could view her team's progress against training.
- First Community primarily used a confidential electronic system to record and store patient information, which allowed therapists and practitioners to access care records. This resulted in improved continuity of care and multidisciplinary communications for patients visiting the clinics.
- The electronic patient records could prompt staff. For example, it contained prompts when accessing patient records such as whether an advance care plan been discussed with this patient.

Good

Are services effective?

- Practitioners working in people's homes relied on a combination of paper and electronic records. There were plans in place for First Community to become paper light and roll out the electronic system to all services. For example, staff in the minor injuries unit told us, they would start using electronic records at the end of March 2017.
- Some staff such as dietitians used laptops to record their consultations and told us there were multiple security processes to complete before being able to access the patient records.
- Staff used an electronic patient management system to book patient appointments and produce letters. The audiology team had created standard letter templates for specific consultations such as fitting a hearing aid, which improved time management. For example, administration staff could deal with providing new hearing aid batteries for patients as they could review the patient records and determine the correct batteries they required without disturbing the audiologist.
- Staff told us using standard electronic templates made it easier for them to carry out record keeping audits as they could assess the patient records at any time and from any location.
- The SALTs told us that they used assisted technology such as light writers and augmented and alternative communication systems to help them engage with patients with communication difficulties due to neurological conditions.

Patient outcomes

- We saw evidence of a core audit programme, which included hand hygiene, record keeping and health and safety. We saw audit measures included local and national policies, for example, the insulin administration audit used the First Community medicines policy and the Nursing and Midwifery Code of Practice Section 18.
- The clinical dashboard for August and October 2016 showed all services except the Rapid Assessment Clinic (RAC) were meeting their key performance indicators.
- The long term conditions service participated in three national clinical audits from 2016 to 2017. These included pulmonary rehabilitation audit, Parkinson's audit and cardiac rehabilitation NACPR audit. The Department of Health (DH) supported the pulmonary rehabilitation audit with the aim to improve the quality of services for people with COPD by measuring and reporting the delivery of care as defined by standards embedded in guidance.
- First Community participated in two local Commissioning for Quality and Innovation (CQUIN) goals agreed with the CCG. These were the integrated community care model and integrated discharge community pathways. Both of these goals were over a timescale of two years. We saw the CQUIN quality report covering July to September 2016 and found First Community had met its progress milestones to date for both projects.
- The SALTs told us they used the therapy outcome measures (TOMS). TOMS is a universal tool used to assess the difficulties and abilities of patients. The Royal College of Speech and Language Therapists recommend this tool.
- The physiotherapists told us they assessed patient outcomes such as walking test or timed unsupported standing test before and after patients have completed their 10 week course of exercise classes. This meant they could assess the effectiveness of the exercise classes. However, the service did not benchmark their results against other falls prevention clinics but there were plans to audit these outcomes in the future.
- The falls team reported they used to assess patient outcomes by following up patients three and six months after discharge to see how many patient falls had occurred. However, this has recently stopped due to a reduction in administration staff.
- The therapy teams told us they used the modified Rankin Scale, Barthel Index and the BERG balance test to measure the degree of disability in stroke patients.
- The audiology clinic measured patient outcomes by using the Glasgow benefit profile hearing questionnaire. Staff posted this questionnaire to all patients who had a hearing aid fitted at the clinic. The service audited patient outcomes twice a year and presented the results to the CCG. The service lead told us response rates had been low so the team wanted to also conduct telephone interviews.

Competent staff

- According to First Community data, the target for staff appraisal rates within the past 12 months was 100%. Compliance data supplied by the provider showed

compliance rates at December 2016 was 90% for adult community services, 92% for long-term conditions, 94% for Rapid Assessment Clinic (RAC) and major injuries unit and 90% for direct access therapies.

- Staff told us they accessed the learning and management system to review their training records. Staff could search for relevant courses and book themselves onto courses. Managers told us staff took ownership for ensuring they were up to date with mandatory training.
- Staff told us that their managers supported them to attend relevant courses and study days. They could take time off in lieu or arrange study leave to attend. We heard how First Community has supported and funded staff to attend university courses and encouraged staff development.
- The EoL advisor carried out face-to-face end of life care training for new staff as part of their induction, which included advanced care planning and the bereavement pathway. Band five nurses also attended syringe driver training. There were regular end of life workshops for all staff. The Nurse Advisor for End of Life Care (EoLC) kept an attendance list centrally.
- First Community employed a continence nurse who provided face-to-face training and advice to the district nursing teams.
- We saw First Community encouraged healthcare assistants to undertake training to gain their National Care Certificate. We saw two care certificates during our inspection, which showed the healthcare assistants, had completed training in a variety of topics such as communication and nutrition.
- A healthcare assistant told us she was unable to perform compression bandages until she had attended a three-day training course, had clinical supervision and completed the relevant competencies. We observed the healthcare assistant remove compression bandages and waited for the registered nurse to arrive to put on the compression bandages. This demonstrated staff practiced within their scope of competency.
- We saw posters of external training staff could attend at the local hospice such as compassionate care and verification of expected death.
- All of the staff that we spoke with told us they received clinical supervision every six to eight weeks. Staff on induction could select from five types of clinical supervision, which included group facilitated supervision and peer review. Regardless of which option staff chose all staff are encouraged to complete reflective logbooks to evidence their learning. We saw the clinical supervision report for October to December 2016, which showed 77% of staff, had engaged in clinical supervision.
- Staff identified their training needs through clinical supervision, one to ones, appraisal and individual identification. Staff could undertake specialist modules such as end of life care, if that learning need was identified.
- A team leader told us that they identified any staff training concerns at monthly team meetings. For example, staff raised concerns about their competence in managing topical negative pressure (TNP) therapy. Delivering negative pressure (a vacuum) at the wound site through a proprietary dressing helps draw wound edges together, removes infectious materials and actively promotes formation of the granulation tissue. In response to this concern managers arranged external training from the medical device company.
- Therapy staff told us they attended expert meeting events such as the European swallowing awareness day and could access electronic journals to keep themselves up to date with best practice.
- We saw evidence of completed appraisals which included staff strengths and weaknesses, continuing professional development, mandatory training, work life balance and learning objectives with timescales in place.
- We saw evidence of local induction and clinical supervision for agency staff. The record included Disclosure and Barring Service (DBS) checks, professional registration, photographic identification and a list of policies for the agency staff to review. This ensured agency staff had been recruited appropriately.
- There was evidence managers assessed staff on specific competencies before the staff could deliver care. For example, we saw completed competencies for insulin administration and fitting medical equipment.
- Community staff completed a competency framework for EoL care and had access to online and face to face training. We saw the EoLC advisor's teaching plan to community teams for the coming year.
- All staff we spoke to were very positive about their induction and felt very well supported throughout their preceptorship.

Good

Are services effective?

Multi-disciplinary working and coordinated care pathways

- The community neuro rehabilitation team (CNRT) was multidisciplinary and included occupational therapists, physiotherapists, a neuropsychologist, a rehabilitation assistant and a SALT. The team had a referral system in place and multi-disciplinary folder accessible in the office. They held weekly meetings, which alternated between Wednesday and Thursday to capture all staff. The team used the MDT electronic template in each patient's records to record the discussion. We saw completed MDT templates during our inspection.
- The physiotherapists and the occupational therapists additionally had profession specific meetings weekly to discuss their caseload of patients.
- District nurses told us they could call the local hospice or EoLC advisor for advice at any time. The EoLC advisor would carry out home visits at the district nurses request.
- The EoLC advisor and district nurses attended Gold Standards Framework meetings with the GP. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life. The GSF Centre CIC care is a not-for-profit Social Enterprise Community Interest Company. The MDT meeting provided an ideal opportunity to foster inter professional partnership working and facilitated discussions on patient management.
- The EoLC advisor also attended an EoLC forum with local NHS Trusts every three months, which encouraged good collaborative working throughout the area.
- District nurses told us they could contact the Tissue Viability Nurse (TVN) at any time for advice and could refer patients for expert assessment.
- The Tissue Viability Nurse (TVN) established and attended the local wound formulary group. This group was cross-organisational and facilitated a collaborative approach to guidelines and care.
- The Integrated Clinical Assessment Team (ICATs) told us that they had excellent links with the orthopaedic consultants, rheumatologists and radiologists. The physiotherapists sat in on consultant's clinics and held regular case study reviews to discuss patient management.
- The intermediate care team (ICT) consisted of rehabilitation assistants, physiotherapists, occupational therapists and registered nurses. We observed the intermediate care team's MDT handover during our inspection. This MDT meeting was nurse led but each staff member discussed the patients they had seen that morning. The nurse recorded the meeting. Actions to be taken included referrals to other teams such as the mental health team. The handover was effective and the team considered individual patient needs holistically.
- In addition to the MDT handover, the team also held weekly MDT meetings. The reablement team also attended this meeting. Staff discussed the patients on their caseload, the patient's progress, discharge plans and referrals to the reablement team.
- The dietitians told us that if their patient was under the care of other community services, they wrote in the district nursing care records and care records and contacted the other community service to inform them of any changes to the patient's care plan. The dietitian supplied a written copy of the changes to the patient and the other community service for their records.
- Each district nurse base held monthly MDT meetings.
- The service lead for bed based care held daily conference calls to discuss patient discharges from Caterham Dene ward. The ward matron and the integrated discharge team also dialled in. This allowed the service lead to plan caseloads and have an up to date daily bed status.
- The falls prevention team had arranged a MDT meeting to discuss the different falls work streams. This meeting will include GPs, social services and the mental health team.
- We observed a patient express her concerns regarding stitches from a hip replacement surgery. The physiotherapist called the patient's GP and arranged for a DN to visit to remove the stitches on a day which was convenient for the patient.

Referral, transfer, discharge and transition

- Staff received referrals from external bodies and via a range of mediums such as secure email, GP letters, fax, telephone calls and self-referral forms. Some teams had developed a standard referral template and shared this with external bodies to complete.
- The community neuro rehabilitation team (CNRT) liaised with another local rehabilitation unit and attended multidisciplinary team (MDT) meetings

fortnightly. Patients with complex needs were admitted to the other rehabilitation unit and later transferred to the CNRT. The MDT meeting meant the two teams could discuss patients' progress and coordinate their transfer to CNRT. The CNRT used the electronic system to transfer patients to other teams.

- The evening and night DN service received telephone referrals from the DN day team and the local hospice. The service could provide social support for patients discharged from hospital for EoL care.
- The dietitians received referrals from GPs and district nurses.
- The fall prevention team received about 60 referrals a month from GPs, ambulance services and other healthcare professionals. Staff processed the referrals using a checklist and rejected inappropriate referrals.
- The intermediate care team (ICT) team received referrals from GPs, community teams / services and the local hospital. The team prioritised admission avoidance referrals. The team used an interactive board and a colour rating scheme to highlight urgent referrals.
- The ICT team supported patients with exercise and promoted independence for up to six weeks. After six weeks, if the patient had not met their goals they could refer to the reablement team. Upon discharge, the ICT team sent the patient's GP a discharge summary.
- The ICT service lead told us they were working with local GPs by providing teaching sessions about the service they provided to increase the number of referrals. Additionally, the occupational therapist and the physiotherapist had presented their service to the ward manager of a local hospital. This demonstrated the team were proactive in raising awareness of their team's profile to external bodies.
- The ICATs team prioritised urgent referrals and telephoned patients to manage their expectations with regard to waiting times. The duty therapist triaged referrals to either physiotherapy or orthopaedics. The duty therapist forwarded any inappropriate referrals onto other teams.
- The ICAT team explained the service could refer patients for 12 weeks of rehabilitation at the local gym. They could carry out joint sessions at the gym with the patient.
- The podiatry team received referrals from GPs, DNs, other MDT and patients could self-refer to the service. The team prioritised referrals for patients depending on their condition such as pain, neuropathy, ischaemia, impaired circulation and hyperkeratosis.
- The audiology service received referrals from GPs, consultants and practice nurses. The team prioritised referrals for housebound patients and patients on the end of life care pathway. This service is the only one in the local area to provide audiology home visits.
- The Rapid Assessment Clinic (RAC) received referrals from GPs, community teams and stoma nurses. GPs usually referred patients who they felt did not need to go to accident and emergency, but did warrant a second opinion and some further investigation.
- The evening and night DN service provided elements of intermediate care and district nursing outside core hours. The team received and responded to same day patient referrals. If the referral was received before 6pm this was classed as a scheduled visit and referrals made after 6pm were classed as an unscheduled visit.

Access to information

- All community teams, except podiatry and the minor injuries unit used the electronic record system accessed by a laptop or computers at the bases. This ensured that the MDT had access to the same information and could see the most recent activity in a patient record. There were plans in place to roll out the electronic record system to the podiatry and minor injuries unit.
- The ambulance service also had access to the electronic record system so staff could add information such as no further rehabilitation potential.
- Other agencies, except ambulances and GPs, did not have access to the electronic record system. This meant staff were unable to share patient records with other clinicians electronically but also protected the patients information.
- Staff said using an electronic record system had revolutionised how they worked as they could share the record with the 18 GP practices that had joined the scheme.
- The electronic system was only accessible with internet access and staff reported they experienced occasional connectivity problems. This meant staff did not always have access to patient records and pertinent risks

associated with a home visit while with their patient. First Community told us the IT department had installed Wi-Fi, hubs and additional cables to improve connectivity.
- The ICT team kept an interactive whiteboard in the team office with patient details and current plan. This enabled the team to see the daily workload. The whiteboard was not visible outside the office, protecting patient's confidentiality.
- ICT and DNs recorded the detail of the care delivered including administration of medicines on paper records left in the patient's own home. However, staff told us they were duplicating their work by completing the electronic record for the same patient when they returned to base.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- First Community reported two Deprivation of Liberty Safeguards (DoLS) applications within the last 12 months.
- Before August 2016 there were no DOLS referrals. This was identified as a priority by First Community and was reflected as a quality improvement priority for the 2016/17 Quality Account.
- A DOLS audit was launched on 1 April 2016 until 30 October 2016. In conjunction with the audit, the provider ran DOLS training sessions on the ward for all clinical staff. These sessions raised the awareness and understanding of DOLS.
- During August 2016, First Community staff identified two patients requiring DOLS and urgent authorisations and a request for a standard authorisation assessment) was submitted. This demonstrated to us that the action taken by the provider was effective.
- We reviewed the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards Policy and Procedures' dated November 2016. This policy referenced up to date codes of practice for the MCA and DOLs.
- We reviewed 15 patient records and saw that staff had gained patient consent to care during each visit.
- We observed care given in patients' own homes and in clinics and saw that staff consistently gained patient verbal consent before providing care to the patients. Staff documented when they had gained consent from the patient.
- Staff gained patient's consent to share information between First Community and their GP. We saw evidence of this documented in paper records left in the patient's own home. Staff were aware of which patients had not given consent to share records.
- Staff took photographs of wounds and included these photographs within the patient's records. We reviewed three patient records with photographs included and found one photograph did not have written consent from the patient. We escalated this issue and staff took corrective action immediately. The use of photographs meant different healthcare professionals could make comparisons and assess whether the wound was healing.
- All members of staff that we spoke to about the Mental Capacity Act (MCA) 2005 and DoLs had completed this training.
- Staff attended a three-hour face-to-face course on MCA and DoLs. There were also refresher courses available on the learning and management system.
- We reviewed completed templates of the initial patient assessment. They appeared comprehensive and included patient consent to treatment, consent to record share, DNACPR information, cognitive ability and psychological wellbeing. We observed a first patient assessment and saw the staff gained verbal consent before carrying out the assessment.
- At the time of our inspection, the compliance rate for the Mental Capacity Act mandatory training varied between 76 and 85%. The provider's compliance target was 80%.
- A staff member we spoke had an awareness of making best interest decisions and told us they had been involved in a best interest group meeting for a patient who had limited capacity.
- Staff also knew how to contact an Independent Mental Capacity Advocate (IMCA). A staff member gave an example of when they used an IMCA for a patient with brain damage. This demonstrated best practice to mental health guidance.
- A staff member described how they assessed a patient's capacity as the patient declined to use the correct sized sling. Staff deemed the patient to have full capacity to make an informed decision and therefore continued to use the incorrect sling despite understanding the risks.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because;

- Feedback from patients about the care they received was consistently positive. People talked about staff who went beyond their expectations and who were willing to step outside their roles in the best interest of the patients and their families. It was not the individual stories of good care that made the service exceptional, it was the consistency of very positive care and support that people received. We did not hear any negative feedback from patients or carers during our inspection.
- The organisation scored highly in the NHS Friends and Family Test and used additional methods of gathering feedback from as many people as possible. This feedback was used to drive improvements across the organisation. Feedback tools were adapted to enable more people to have a voice and to comment on the care they experienced.
- Relationships between patients, their relatives and staff were caring and supportive, and we saw a genuine rapport. Care that we observed was truly person centred, with patient's wellbeing at the heart of care.
- We saw staff respected patients' dignity and respect. The staff recognised individual preferences and the holistic needs of patients. There were very good signposting systems and good networks that allowed the staff to support the patients in addressing their wider needs. .
- Staff were highly motivated and inspired to offer care that made a difference to their patient's lives.
- Staff explained and ensured that patients and carers had a good understanding of procedures before undertaking them. Carers were supported and considered to be an essential partner in providing care and making decisions where the patient was not able to.

Detailed findings

Compassionate care

- We accompanied staff on 15 home visits and observed staff were respectful of patients' homes, and that matters of dignity were given due consideration. Patients and relatives we spoke to were very positive about the care and attention they received from staff.
- We also received 12 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection. Comments were overwhelmingly positive about the care and treatment they received from First Community. Words and phrases such as "excellent service", "friendly", "a wonderful experience" and "I was listened to", were used extensively in their feedback.
- First Community took part in the NHS Friends and Family Test (FFT). According to published data, the average FFT score for all First Community services between September 2016 and February 2017 was 95-98%. This is the percentage of respondents saying they would be 'Likely' or 'Extremely likely' to recommend First Community to friends and family should they need similar care or treatment. The score was better than the national average for similar services.
- Staff gave patients an information leaflet about the FFT upon discharge from the community service. Staff told us they used a tracking tool monthly to review the FFT results.
- We saw the friends and family tracker tool displayed in clinical areas. We saw patients' comments relating to parking and incorrect voicemail message for the audiology clinic. The audiology lead told us they updated the clinic's voicemail message and employed a second receptionist to decrease the number of patient who could not get through. This demonstrated the service valued patient feedback and was proactive in response to negative patient feedback.
- The service used the IWantGreatCare website which allowed for patients and their relatives to provide real time feedback about individual practitioners. Feedback for individual staff members were very positive and demonstrated staff going the mile for their patients such as, "…she arranged for information relating to care and general matters relating to my disability to be sent to me."
- Other feedback received via the website included "I see my MS nurse every 6 months and without these appointments my management of the condition would be considerately affected. I always feel supported and

listened to. She is an excellent source for help and answers any concerns I have. Keeps me 'on track' and encourages me. A vital role for those with longstanding chronic conditions"

- Another said". I would like to say everything about my care was brilliant. They were friendly, efficient and conversed with me every step of the way".
- In the clinics and in patient homes, we observed examples of compassionate care. Staff introduced themselves to patients and their relatives and addressed the patients by their preferred name. Staff showed kindness to all their patients.
- We noted that staff kept therapy and treatment room doors closed during consultations, and staff knocked before entering rooms to maintain patients' privacy.
- In the home setting, we observed staff ensuring the privacy and dignity of their patients while carrying out physical care such as checking their pressure areas and administering insulin into the thigh.
- Staff from all specialities we spoke to were highly motivated to deliver care that made a difference to patients' lives.
- Staff delivered individualised care and the records we viewed evidenced this. First Community had a strong patient-centred culture and we saw that staff supported patients in a way that ensured they felt understood and valued.
- We observed staff interacting with patients in a respectful and considerate manner and saw staff had developed a strong rapport with their patients and their families. During a home visit, a patient requested to walk to her driveway so she could view her car which had been repaired. The therapist adapted the exercise plan for that day to meet the patient's request.
- One patient's friend told us the therapy team were "always on time" and "there's nothing they could do better".
- One patient in the audiology clinic explained he had not attended his appointment last year but attended the clinic without an appointment yesterday. He explained his current home life situation and the clinic responded compassionately and booked him an urgent appointment the following day. The audiologists maintained the patient's confidentiality throughout the assessment by closing the consultation room door.
- We spoke with 15 patients who used a variety of services provided by First Community and all patients we spoke with felt staff were very friendly, caring and professional.
- Staff gave examples of when they delivered compassionate care. On one occasion a member of staff prepared a patients meal as their carers were running late and the patient was hungry. Staff told us they saw one patient first on the evening list as the patient liked to go to bed early.
- We saw an audiology newsletter, which described how a staff member went the extra mile to fit hearing aids for a palliative care patient in a nearby hospital. The relatives felt comforted knowing their loved one could hear them in her final hours.
- Support for carers was also seen as integral to support for the patient. One carer said, "I know I can leave her a message when things get too much and that they will get back to me".
- The Horley District Nursing team received the First Community runner up award for the best team due to an overwhelming positive report from a relative regarding the excellent end of life care provided by the team to their late father.
- Six patients who attended the pulmonary rehabilitation class were consistently positive about their care. One of these patients told us the staff were "kind and helpful".

Understanding and involvement of patients and those close to them

- We spoke with patients and their families or carers. We were told consistently that staff involved them in their care and explained everything in a way that they could understand. Patients were encouraged by staff to be partners in their care planning.
- There was an extensive range of literature and health education leaflets mounted on purpose-built racks located in waiting areas and therapy rooms. The leaflets were primarily in English but staff could obtain the leaflets in other languages, if required.
- Each patient had a list of emergency contact numbers for the team in their paper records. Patients and their families were aware of who to contact in an emergency.
- We observed home visits and saw staff involved the patient's relatives in planning and decision making about care. For example, we saw one patient's relative raise concerns to staff about the patient having a possible urinary tract infection. Staff took a urine sample and arranged another home visit to review the patient later that day.

Outstanding ☆

Are services caring?

- We also heard a member of staff discussing carer allowance with the patient's relative and offered to obtain the relevant documentation for the relative, which they would deliver on their next visit.
- We observed one district nurse offering to provide an additional home visit the following day to provide encouragement and support to a patient's wife while they administered an injection for the first time to their husband.
- We heard how staff educated patients and their relatives about pressure ulcer prevention. We saw a leaflet within a patient's records on pressure areas, which included advice on diet and repositioning.
- We observed staff explaining test results thoroughly to patients in a way that was easy to understand. For example, we saw a district nurse explain the blood sugar reading to the patient and why the patient could not have their insulin injection until they had eaten and the blood sugar reading was repeated.
- The CNRT told us they visited patients and their families in hospital before the patients were discharged into their care. This allowed the team to introduce themselves and explain the service to the patients and their families.
- In our discussions with patients and their relatives, we found there was an appropriate rehabilitation focus and patients were encouraged to participate in care planning.

Emotional support

- Throughout our inspection, we observed staff giving reassurance to patients and their families.
- All staff were aware of the emotional aspects of care for patients living with long term and complex conditions and provided specialist support for patients and their relatives where this was needed.
- One relative wrote on the IWantGreatCare website, "How wonderfully reassuring it is for me to know that I am no longer totally alone with my mentally ill husband, as I was before."
- DNs told us most patients will contact their local spiritual leader for support, however if a patient wished to see a spiritual leader, they could refer the patient. We saw the DNs had an extensive list of spiritual leaders and their contact details.
- Within the end of life district nursing assessment is a carer's assessment. This identifies the level of support the carer may require and aids the nurses to signpost the carer to relevant support agencies.
- First Community had an adult bereavement pathway. The pathway consisted of a flowchart which indicated what the DNs should do at the different stages of bereavement for example in the patients last days if life, at the time of death, one to five days after death and two to four weeks after death. We saw the flowchart prompted DNs to give the family a bereavement pack, offer a bereavement visit and to signpost the family to the GP or to other agencies for bereavement counselling
- During our inspection, we saw the bereavement pack which contained practical advice for families following the death of a loved one. First Community audited the distribution of bereavement packs as this was linked to one of their commissioning for quality and innovation (CQUIN) goals. The audit, carried out between September and October 2016, found staff offered a bereavement pack to family members or significant others in 54% of cases. This was significantly worse than the previous result of 81% in the audit carried out between February and March 2016. We saw a completed action plan which included an end of life workshop for DNs which was held in February 2017.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because;

- The needs of patients were taken into account when planning and delivering services. Urgent needs were catered for and waiting times and delays were minimal.
- Services were delivered in a timely way with flexibility and continuity of care. There was highly co-ordinated working between other services and teams.
- Reasonable adjustments were made for people with disabilities, learning difficulties and those living in vulnerable circumstances.
- Patients were given information about how to make a complaint or raise a concern. There was a system in place for capturing learning from complaints and we heard examples of changes to the service because of complaints made.
- Services were tailored to the needs of local populations and staff were able to access training specific to the needs of the populations they supported. There was access to interpreters and written information in different languages available.

However,

- Not all staff knew how to access the translation services and told us they would use the patient's relatives to translate.

Detailed findings

Planning and delivering services which meet people's needs

- All community nursing services operated for 365 days per year. They managed long-term conditions, provided support and education to individuals who could perform self-care, provided technical care within the community setting and provided care at home to prevent hospital admission.
- First Community employed specialist nurses for long-term conditions such as heart failure, Parkinson's, multiple sclerosis and stroke. The nurses ran specialist clinics for patients, provided home visits and the community teams were able to refer to the specialist for assessment and advice.
- First Community employed nurse advisors for tissue viability, end of life care and mental health.
- The Rapid Assessment Clinic (RAC) was open between 9am and 5pm, Monday to Friday and patients were referred by a healthcare professional. The centre saw between two and ten patients a day. The clinic provided point of care testing and identified patients who required further investigations such as blood tests or scans to rule out deep vein thrombosis. Staff booked these patients for scans the next day and some patients had the scan on the same day. This demonstrated the service was responsive to the patient's clinical needs.
- The Minor Injuries Unit (MIU) was open between 9am to 8pm 7 days a week including bank holidays. Patients self-referred to the unit. The service provided an alternative to the local accident and emergency departments and saw adult patients with a range of problems including fractures, infected wounds and sports injuries. The unit had an x-ray facility onsite.
- First Community had audiology departments in five locations across Surrey and West Sussex. All clinics ran from 8.30am to 4pm. Staff told us they ran occasional clinics at the weekend depending on demand.
- One audiology clinic that we visited, implemented a walk in repair service in February 2017 following patient feedback and a successful pilot of the walk in clinic. The audiology manager told us the service provided in West Sussex was now reflective of the service already provided in east Surrey, meaning improved equality in patient access to care. We observed an audiologist offering a patient a variety of dates and times for their next appointment.
- First Community had podiatry departments in four locations across Surrey. The clinics ran at different times depending on the location. Staff told us they provided a one-stop clinic for diabetic patients for podiatry and wound care at the local NHS trust and Caterham Dene Hospital.
- First Community had eight district nursing teams based in six sites covering four GP surgeries. Staff told us they scheduled appropriate time for each patient dependent on their needs, and understood when a patient required more time to ensure staff gave appropriate care. For

example, staff allocated more time for complex patients who required wound dressing or had palliative care needs. The maximum package of care available was four times a day and one night visit.

- The DNs told us when the received referrals for patients on the end of life care pathway with days to weeks to live; they aimed to see the patient either the same day or the next day. They would not do this if the patient declined or if the patient was newly diagnosed. This allowed the patient time to come to terms with their diagnosis. The DNs did joint first visits with the community palliative team when possible and out of hours the DNs would arrange for the local hospice to do home visits if required. DNs told us during December 2016, the number of end of life care patients increased so they provided additional visits to provide basic care due to a shortage of carers. DNs reported they had good links with the local authority carers.
- The speech and language therapists told us they arranged joint home visits with other specialities for patient with complex needs. This allowed staff to identify the correct specialist practitioner to take over the patients care.
- The musculoskeletal service told us they were able to provide additional private classes after hours for patients, providing First Community paid a small fee for the use of the local NHS hospital facilities.
- The community neuro rehabilitation team (CNRT) held joint clinics with orthotics at the local NHS hospital monthly. It was a one stop clinic for patients to be assessed and measured for equipment to help them recover from or prevent injury for example ankle supports, shoulder supports and foot splints. The team could also make a direct referral to the orthoptist for patients who were unable to attend.
- The Multiple Sclerosis (MS) service provided a specialist nursing assessment and advice on the management of MS provision for patients and their carers. This included a telephone advice line, home visits where necessary and courses for those newly diagnosed with MS – this course gave patients and carers an introduction to MS with speakers discussing various aspects of living with MS.
- The falls prevention team reported if they had an exercise class that was not full; they telephoned previous participants and offered them the option to attend the class. Staff reported they received excellent patient feedback and patients always said yes to returning.

Equality and diversity

- During our inspection, we saw staff providing individualised high quality care to all patients. Patients' cultural and religious needs were included in the individualised care plans following an ongoing assessment of needs.
- We saw staff adapting their clinical practice to meet the needs of the patient, for example, we observed a healthcare assistant explain to us why she positioned herself directly in front of the patient when she was talking, as the patient was deaf and relied on lip reading. We also observed an audiologist who pulled down the blind in the clinical room to avoid glare on patients face so the patient could lip read.
- All staff we spoke with knew about the interpretation service but not all staff knew how to access this. Some staff told us they would use relatives to translate if this was the patient's preference.
- Staff told us transport to the patients' first clinic appointment was arranged by GP, after this staff arranged transport for patients using local voluntary organisations
- All buildings we visited had disabled parking close to the entrance, had automatic doors, lifts and ramps to make them wheelchair accessible.
- Staff could access information leaflets in other languages if needed and we saw information on the back of patient information leaflets signposting staff to these.
- We observed a district nurse providing a patient with a leaflet about nutrition and pressure ulcers. The nurse checked with the patient if the patient could read print size and understand the leaflet's content.
- We saw the use of hearing loop systems in various departments we visited during our inspection.
- An audiologist told us they offered chaperones to all patients and documented when they used a chaperone.
- We saw DNs had access to a 'Death and dying religion practices' wall chart which informed them of how different religions had varying practices and beliefs when a loved one died.

Good

Are services responsive to people's needs?

- We noted occupational therapists were available to advise on reasonable adjustments that could be made or provided to support disabled people in their own homes or when visiting clinics.
- At the time of our inspection, all adult services achieved the provider's compliance target of 80% for the equality, diversity and human rights mandatory training.

Meeting the needs of people in vulnerable circumstances

- We found First Community had systems available to ensure services could meet the needs of patients in vulnerable circumstances such as those living with dementia or a learning disability.
- First Community employed a specialist nurse for dementia and staff could seek advice and support from this nurse
- Staff had access to additional training (such as dementia awareness) specific to the needs of those they supported
- The falls prevention team told us that when they see patients living with dementia they encourage the patient's relatives or other supporter to be present. They provided the patient with simple and clear instructions for exercise and could provide a leaflet complete with pictures to act as a prompt.
- The speech and language therapists (SALTs) told us that they signposted patients and their families to a local project called Conversation Partner Scheme, which trained local volunteers to support people living with a communication disability who would benefit from befriending in the community.
- The audiology service lead told us the clinic worked with the Dementia Alliance Group. Their next project was to work alongside the Dementia Alliance Group and implement recommendations to make the waiting room dementia friendly. The team also liaised with the local memory clinic and ran one-stop clinics.
- For people with learning disabilities, the audiology clinic has access to easy read leaflets, which included pictures of the waiting room, photographs of the staff and equipment used during hearing tests.
- Staff told us the electronic record system showed alerts for patients with additional needs such as blindness, a learning disability and profound deafness.
- Staff assessed patients on their clinical need and provided services accordingly. For example, a patient had a chest drain and although the patient was mobile and could visit the GP practice for ongoing care, the patient was at higher risk of infection and therefore the service provided district nursing home visits.
- First Community told us they had employed a Darzi fellow to drive on citizen engagement. This was to improve the participation of patients, their carers and families in decisions regarding the provision of health and social care.

Access to the right care at the right time

- We saw that First Community had performance data available to help monitor and manage times taken to access initial treatment. For each of the 'planned care' therapies, we saw reports showing the latest referral figures and average waiting times for appointments.
- The target for urgent appointments was set at two weeks and eighteen weeks for standard appointments. In March 2017, First Community achieved the following averages:
  - Audiology- two weeks wait for an urgent appointment and six weeks for a standard appointment.
  - Dietetics- three weeks wait for an urgent appointment and five weeks for a standard appointment.
  - Integrated Clinical Assessment and Treatment- two weeks wait for an urgent appointment and between three and five weeks for a standard appointment depending on speciality.
  - MSK Physiotherapy- one week wait for an urgent appointment and 14 weeks for a standard appointment.
  - Orthotics- two weeks wait for an urgent appointment and 18 weeks for a standard appointment.
  - Podiatry- one week wait for an urgent appointment and 18 weeks for a standard appointment.
  - Podiatry MSK- four weeks wait for an urgent appointment and 16 weeks for a standard appointment
- These examples showed that First Community met or exceeded its target for urgent and standard appointments, with exception of urgent appointments for dietetics and podiatry.
- The evening and night district nurse service specification required the nurses to respond to

unscheduled calls within four hours; however the provider developed a local target of 2 hours. There was no response time target for planned visits within this service.

- During June 2017, the average response times for unscheduled visits were one hour and nine minutes. This was better than the provider's target. The top three reasons for unscheduled calls were catheter care, palliative care and wound care.
- During June 2017, 100% of unscheduled calls were responded to within four hours and 87% were responded to within two hours.
- The falls prevention team reported they received an average of 60 referrals a month and had reduced waiting times to eight to 10 weeks from 12 weeks by inviting patients to call if they want an assessment.
- The CNRT told us they have experienced longer response times and stated their biggest challenge was meeting the NICE recommendations of offering 45 minutes of rehabilitation five days a week to each patient due to staff shortages.
- The ICATs service had a short waiting list and actively managed the list by filling slots with patients on the waiting list when patients cancelled their appointment.
- The MSK physiotherapy clinic phone lines were open for only two hours each day for patients, which did not appear to be patient friendly. However, we were not made aware of any patient complaints relating to this.
- We saw the physiotherapy outpatient department audited did not attend (DNA) and unable to attend (UTA) rates in February 2017. The DNA rate was 5.4% and the UTA rate was 5.7%. These rates were better than the previous audit in 2016. Overall, the attendance rate had improved from the previous year. We saw an action plan, which showed the service planned to re-audit in October 2017 and to use automated text appointment reminders for patients.
- A dietitian gave us an example when a patient's relative called the clinic in distress but the patient's appointment was not for another three weeks. Administration staff brought this to the attention of the dietitian who called the relative and provided telephone advice.
- The audiology department was nationally accredited. To maintain this accreditation, the service lead had to submit evidence such as current waiting times for benchmarking against other audiology clinics.
- We saw the audiology outpatient department audited DNA rates in April 2017. The average DNA ate per month was 1.8%, which is better than the target of 2% or less and showed an improvement from the previous audit in 2015. The department had recognised there had been a shift in the biggest DNA age group. We saw an action plan, which included discussing the results at the team meeting and agreeing a timescale for re-audit.
- We saw the intermediate care team was commissioned to provide six weeks of exercise and promoted independence. The team collected data regarding the number of weeks a patient required their care but did not formally audit this although plans were in place to do so. If a patient exceeded the six week timeframe, they were referred to the re-ablement service.
- Overall, First Community had robust systems to prioritise care and address referral wait times, which indicated the organisation was responding effectively to ensure people had timely access to care and treatment.

Learning from complaints and concerns

- There were effective systems in place to monitor and respond to complaints. We saw an in-date complaint policy and staff could describe the process on receiving a complaint and how to escalate any concerns
- According to First Community Data, patients lodged 22 complaints in the last 12 months of which the provider upheld 13.
- Patients referred no complaints to the Parliamentary and Health Services Ombudsman.
- The highest number of complaints arose from the district nursing and ICATs.
- Chief Executive Officer (CEO) read all complaints personally. First Community identified trends and themes and used this to bring about improvements. The CEO gave us an example where several patients had complained about difficulty contacting the audiology department. The provider had improved answerphone facilities so that people could leave messages that administration staff followed up. Staff in the audiology department also explained the changes and the rational for making them, which demonstrated shared learning.
- The CNRT team told us they received an increased number of complaints regarding waiting times. The department introduced calling patients to keep them updated on their progress on the waiting list and

Good

Are services responsive to people's needs?

introduced joint assessments with two therapists visiting the patient together. This has reduced patient waiting times and subsequently the number of complaints.

Good

Are services well-led?

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

Summary

We rated well led as good because:

- Staff felt able to approach their managers with concerns due to the organisation's open and transparent culture.
- There were governance and risk management systems in place. The senior management team were visible and regularly engaged with staff.
- There was a very positive, supportive culture across all staff groups we spoke with.
- Innovation was encouraged and staff felt empowered to make positive changes. The organisation was pro-active in celebrating staff achievements.
- There was strong and visible leadership who together with the staff were committed to improving patient care.
- Staff were overwhelmingly positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values.
- Lone working systems were consistent across the organisation and ensured the safety of staff carrying out community visits.

Detailed findings

Service vision and strategy

- First Community's vision was to rejuvenate the wellbeing of the community. Staff expressed strong commitment to the vision and strategy for the service.
- The Core Behaviours Framework dated May 2014, outlined five key behaviours expected from First Community staff. We observed staff reflecting these values in their behaviour and their approach used when caring for patients.
- First Community had made considerable progress in creating an accessible information system which was being rolled out to all services throughout the year.
- Staff told us senior management supported innovation. For example, one district nursing team received runner up for best team award because they had set up wound clinics within the GP surgery. They monitored healing rates of wounds and used this data to show the significant difference the clinic has made for patients. The team are hoping to present this data to the clinical commissioning groups to have the serviced commissioned.
- Many staff we spoke to had worked in the same department previously under the management of other organisations but felt very informed when the First Community changed the organisation to a social enterprise. Staff felt First Community was more personal and more responsive to its employees and service users' needs.
- First Community reviewed the community nursing service specification and reported it is working with the Clinical Commissioning Groups to strengthen the 24 hour community service with a commissioned key performance indicator response time of two hours for unscheduled care.

Governance, risk management and quality measurement

- First Community had departmental and central risk registers to help identify and monitor the risk in each service. We saw examples of registers that contained a description of the problem, the risks posed and the underlying cause. Staff updated these regularly.
- The Integrated Governance Committee' (IGC) examined risk and risk reduction measures as well as progress against strategic objectives. The IGC also monitored quality standards, services and proved assurance to the board. The IGC worked with six sub-committees and submitted bi-monthly performance reports to the board.
- First Community held monthly Clinical Quality and Effectiveness Group meetings. At these meetings any new NICE guidelines were reviewed and a nominated responsible individual took responsibility for updating First Community policies to reflect best practice. Service leads attended this meeting and fed back to their teams.
- In addition to the above, the Clinical Practice Group developed guidelines and protocols with input from operational staff.

Good

Are services well-led?

- The governance and improvement leads had a good relationship with clinical team leads. They attended team meetings regularly at different sites and provided additional training on request. Staff attended a quality improvement study day yearly.
- The governance lead reviewed and had active involvement in all incident reporting and complaints.
- Non-Executive Directors (NEDs) visited services on both a planned and informal/responsive basis. Where there had been a concern about an aspect of any service, the NEDs sought additional assurance through both specific data requests and increased visits. All NEDs had completed training in safeguarding adults and children, information governance, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. They also had coaching from executive team members about specific or complex issues around safeguarding or clinical practice.
- First Community submitted a quarterly safeguarding adults report to the safeguarding adult's board. We saw the annual adult safeguarding report for 2016.
- The evening and night district nursing team discussed all unscheduled calls not responded to within the local response time of two hours at team meetings. They escalated any concerns to the adult service meeting.
- Lone working systems were consistent across the organisation and ensured the safety of staff carrying out community visits.
- The First Community Lone Worker Policy dated September 2016, clearly outlined the need to complete risk assessments and follow the local response plan if a lone worker was missing, or in danger.
- In an emergency, all staff told us they would call their manager or the administrator and quote a standard code phase. Their manger or administrator would then ask them a series of questions and respond as necessary, which included calling the police. Staff carried a 'credit card' on lone working, which discreetly fitted in a purse or wallet and acted as an aide memoire.
- We saw the latest lone worker audit results and action plans for all community services.
- First Community tested the lone worker emergency response phrase six monthly; the last test was completed in December 2016.

Leadership of this service

- First Community had a leadership structure whereby managers and the board supported the function of the clinical services.
- Staff told us about the 'Floor to board in five minutes' system whereby any member of staff could contact the clinical director and raise concerns. We heard how one member staff had used it at the weekend and received a quick response. Another staff member had used it to escalate temperature control in the clinical rooms, which was resolved rapidly.
- We heard that there was an open door policy. Staff said they could chat to members of the senior management team while loading the dishwasher and found them to be easy to talk to. We heard how staff wanted to have a better a quality of coffee, therefore the senior management team decided to discontinue the tradition of sending Christmas cards to staff and the money saved was used to purchase better coffee. The organisation sent electronic Christmas cards instead.
- Staff told us they felt well supported by their managers and felt they could escalate any concerns. Managers encouraged new ideas and supported change.
- The senior peer review group met every six to eight weeks. The group discussed complex cases and reviewed clinical NICE guidelines.
- Service leaders held bi-monthly business meetings where they discussed key performance indicators such as waiting times and Commissioning for Quality and Innovation (CQUIN) goals.
- Staff told us how managers supported them during difficult personal matters. We heard how the organisation had provided counselling and ongoing support to an employee whose spouse had passed away. This demonstrated the organisation looked after staff wellbeing.
- Staff told us managers and members of the board were visible and approachable and this was an important positive part of working for First Community. They felt valued and well supported by peers and line managers, although some expressed concern about staffing.

Culture within this service

- First Community employed a Freedom to Speak Up Guardian to provide staff with a named, senior member of staff with whom they could raise any concerns without fear of reprisal. Staff told us there was a strong message of a no blame culture and managers encouraged staff to raise concerns.

Good

Are services well-led?

- Staff we spoke with were candid and transparent about the challenges they faced and expressed a strong willingness to engage with change.
- Staff were positive about the organisation and told us they were listened to, valued and could influence the delivery of care.
- We saw 'Speak Up' cards during our inspection. The cards signposted staff who wanted to raise concerns to their line manager, the board or the freedom to speak up guardian. The cards also provided alternative external contact details.

Public engagement

- First Community had a community forum, made up of 200 members. The organisation sent an open invitation to anyone with an interest in wellbeing and health. First Community told us that the forum had been used to deliver a dementia workshop, which included services users and their carers.
- There were very effective systems in place for staff and members of the public to provide feedback to First Community. We saw posters encouraging feedback on display at clinic locations as well as the First Community website and on social media.
- The First Community website included prominently marked sections where members of the public or service users could lodge complaints or provide feedback electronically. The website included the organisations complaints handling policy and provided links for independent review of complaints.

Staff engagement

- Staff told us they were shareholders in the organisation. After completing six months of probation, new staff were invited to become shareholders.
- Each service held a monthly team meeting. The manager fed back any learning from incidents, changes to services and any organisational announcements. Staff told us they also held team meetings where non clinical issues were discussed.
- First Community published an electronic newsletter every fortnight for all staff.
- First Community had a Council of Governors (CoG) which consisted of ten elected members of staff who represented all directorates and who acted as a conduit between staff and board. Staff felt the CoG worked well and gave staff issues serious consideration at their quarterly meetings.
- First Community participated in the national NHS Staff Survey for the first time. The organisation told us they wanted to do this to broaden their scope of staff feedback and to make improvements in their Workforce Race Equality Standard (WRES) data collection.
- First Community achieved a 63% staff response rate to the NHS Staff Survey. This was better than the national average response rate of 44%.
- First Community had invested in a new intranet system to improve internal dialogue following staff feedback in the staff survey.
- Staff told us they received lots of recognition for their work. We saw the senior management team nominated and voted for a 'Staff Star for the Quarter'. Also, some staff had been nominated by their managers for other awards such as an emerging leadership award.
- First Community held an annual staff awards ceremony to recognise staff for their contribution to the organisation.
- There were quarterly Joint Negotiating Consultative Committee (JNCC) meetings. At these meetings the senior management team met with union representatives to discuss, consult and negotiate on staff specific topics. We saw the meeting minutes dated February 2017, which showed the committee discussed actions from last meeting, policies and staff engagement.
- Staff in our focus group reported they received a lot of support and training for nurse revalidation. Staff felt their managers were proactive in supporting them through the process.
- First Community told us it was working with other organisations to develop a strategic and tactical response to the Surrey and Sussex Sustainability and Transformation Partnerships (STP). The STP are proposals to make improvements to health and social care and are built around the needs of the local population. First Community were running roadshows for staff to co-produce the STP.
- A student nurse told us they felt very much a part of the team and received a good induction to First Community. The student nurse said the team enabled her to carry out hands on nursing within her sphere of competence.

Innovation, improvement and sustainability

Good

Are services well-led?

- First Community had piloted providing phlebotomy services for local house bound patients. Phlebotomists took blood from patients for testing. The pilot was successful and the local clinical commissioning group (CCG) have recommissioned the service.
- First Community had care home advisors who jointly redesigned the service so their caseload became the nursing and residential homes rather than the individual patients. The aim of the service was to avoid unnecessary hospital admissions. The advisors provided training to the home care staff, monitored ambulances calls, visited patients in hospital to escalate discharges to reduce patient length of stay and maintain a good working relationship with the home managers. They also produced a newsletter which they shared with all residential and nursing homes. It contained contact details, training dates, feedback from staff such as the tissue viability nurse, dates for the diary and stories from other homes. We saw the newsletter dated spring 2017, which featured a story by the falls prevention team about residents who decorated their Zimmer frames which led to a decrease in falls.
- First Community were developing an End of Life Care Quality Improvement Plan at the time of our inspection. This plan was being driven by the nurse advisor for end of life care following the completion of two end of life audits. The local plan aimed to reflect the National Ambitions Framework for Palliative and End of Life Care.
- First Community reported workforce development was a corporate priority for 2017-2018 and were developing a workforce strategy to support their ambition to be a multi-speciality community provider.