Your Healthcare Community Interest Company

Community health services for adults

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Our findings

Community health services for adults

Good 

Your Healthcare CIC provides adult community health services to all patients registered to a Kingston GP. This inspection focused on community nursing, the matrons team, rapid response team, and tissue viability services.

The community nursing service provided skilled nursing care to adults aged over 18 years in their own homes, residential homes or in a clinic setting. The community nursing teams were attached to GP surgeries, working as part of their integrated teams. The community nursing team supported people with a disability or long-term condition to live independent lives. They provided a range of services and treatment to enable individuals to avoid unnecessary hospital admissions and to facilitate early discharge where hospital admission was necessary. Community nurses also provided care to patients requiring palliative and end of life care. The community nurse teams were led by district nurses (specialist practitioners in this area of work).

Community matrons provided expert care for patients with one or more long term conditions, such as diabetes, coronary heart disease, Parkinson's disease, and multiple sclerosis.

The rapid response team provided advanced clinical assessment and intervention for patients presenting with acute illness/deterioration. They provided an urgent two hours response and could access a range of nursing and therapy support.

The tissue viability service supported community staff, in the prevention, early identification and treatment of pressure ulcers and complex wound management.

Our rating of services stayed the same. We rated them as good because:

- We rated the service as outstanding for caring and good for safe, effective, response and well-led.
- Feedback from patients, relatives and carers was overwhelmingly positive about the competence and compassion of the community nursing staff. They said staff respected and valued them as individuals, and worked with them as partners in their care, both practically and emotionally. They described dedicated staff who went the extra mile to support them. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to understand their conditions. They provided sensitive emotional support to patients, families and carers.
- Staff provided a high standard of care and treatment, checked that patients ate and drank enough, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and supported them to make decisions about their care.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk appropriately, including appropriate precautions to address the Covid-19 pandemic.

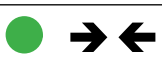
Our findings

- Staff assessed risks to patients, acted on them and kept good clear care records. They managed medicines well. The service managed safety incidents well and learned lessons from them to improve the service.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued.
- Your Healthcare CIC had planned, carried out and published a wide range of research. Recent research projects included improving the timeliness of referrals for end of life care from care homes; using National Institute for Health and Care Excellence guidelines to empower patients to self-administer intravenous therapy at home; and remote working with people with learning disabilities.

However:

- Although staff were keeping patients safe, vacancies and staff absence (largely relating to the Covid-19 pandemic) had led to staff working extra hours and some exhaustion within the teams. An increase in patient referrals and complexity of patients was also putting pressure on the service. The provider was actively working to recruit to staff vacancies and develop staff to progress within the organisation.
- Sixty-three per cent of eligible community nursing staff, and 64% of rapid response staff were up to date with clinical risk assessment training. Remaining staff may not have been up to date with risk management priorities for patient care.
- Staff did not label equipment used in people's homes to show when it has been cleaned.
- The service did not have a sufficiently robust process in place to monitor NHS prescription stationery issued and used by staff.
- Sample sizes of internal audits carried out within the service were not always sufficient to provide meaningful learning, and audit action plans could have been more robust with clear measurable actions.
- Although staff reported having regular and helpful supervision sessions with their line managers, the provider did not have a robust system for monitoring the frequency and quality of staff supervision provided.
- Although patients we spoke with said that the service responded quickly to informal feedback or complaints, the service did not have a robust system for keeping an overarching record of this information, in order to identify themes and potential areas of improvement and learning. We recommended this be considered in the 2016 inspection.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Our findings

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service had high training compliance rates overall and was working to improve compliance with clinical risk assessment training.

Nursing staff received and kept up-to-date with their mandatory training. Training was delivered through a combination of face to face sessions and e-learning. Staff described good access to mandatory training and most indicated that they were up to date with all mandatory training.

The community nursing team had compliance of over 80% (of approx. 80 staff) in most areas including 84% in moving and handling, 98% in data security and 83% in anaphylaxis.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers advised that there had been some delays in accessing face to face training in courses such as resuscitation and moving and handling. However, they had put in place extra courses to address this. At the time of the inspection, compliance with resuscitation was 79% for the community nursing team.

In the rapid response team training in moving and handling was at 73%, resuscitation at 91% and anaphylaxis at 82% (of 11 staff). Most other training had compliance of above 91%. There were also high levels of compliance with mandatory training in the tissue viability nurses team and amongst the matrons.

The lowest level of compliance was for clinical risk assessment training, with only 63% of community nursing staff and 64% of rapid response staff up to date with this. Managers were aware of this and had plans in place to improve compliance in this area.

The range of mandatory training courses was comprehensive and met the needs of patients and staff. For example, clinical staff completed training on dementia, wound care, diabetic foot care, conflict resolution, and end of life care.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. In the community nursing team, 99% of staff had completed safeguarding adults and children training to level 1, and 97% to level 2. In the rapid response team compliance in adult safeguarding training was at 91% for levels 1 and 2, 92% in safeguarding children level 1, and 82% in safeguarding children at level 2. The service aimed for full implementation of level 3 adult safeguarding training to the teams over the forthcoming year 2022-23.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They were aware of their responsibility to keep people safe and, when needed, report any safeguarding concerns they had.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They gave examples of when they had identified possible abuse, including financial, and physical abuse, as well as neglect.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding lead for the service, and staff told us that they provided them with appropriate support to follow up on issues of concern. Staff said that they discussed any learning from safeguarding incidents during team meetings and handover meetings.

One of the community nursing teams had received an award in September 2021 from the National Safeguarding Council for its collaborative approach to safeguarding a patient.

The service safeguarding report published in April 2022 noted that there were 108 safeguarding alerts made within the last year of which eight directly related to Your Healthcare CIC.

Your Healthcare CIC adult safeguarding had built a strong partnership with a neighbouring NHS trust, had a joint safeguarding committee and aligned safeguarding data recording. The two organisations were working together to implement safeguarding and Mental Capacity Act requirements.

Recent information sent to all staff to enhance awareness of safeguarding issues included information about a Covid-19 passport scam, county lines (where illegal drugs are transported from one area to another) and cuckooing (where a person's home is taken over), virtual hate crime, hoarding and self-neglect. Staff also attended training and a conference about modern slavery and had a briefing on domestic abuse.

Staff used learning from anonymised cases and had individual de-brief and reflection sessions when this was felt to be beneficial for their learning and development. Learning from cases was also included in policy reviews. Staff told us they had received feedback from safeguarding concerns and referrals they had made.

There were safeguarding policies and procedures, and the service's pressure ulcer prevention and management policy included a decision guide for when a safeguarding alert should be made.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment clean and managed clinical waste well. There were some gaps in recording of when equipment had been cleaned, but this was addressed swiftly after the inspection.

Staff had completed training in infection control and were aware of the protocols in place to keep patients, themselves and others protected from infection. In the community nursing team 93% of staff were up to date with level 1 infection control training, and this figure was 100% in the rapid response team.

Staff followed infection control principles including the use of personal protective equipment (PPE). They told us that they had adequate supplies of PPE. At the time of the inspection, the provider's guidance in terms of Covid-19 protocols, was for staff to wear masks when moving around the office, but not necessarily when sitting at their desks. We noticed that in some handover meetings, some staff sat closely together around desks without wearing masks. We discussed this with managers, who undertook to review this issue, noting that sometimes staff were discussing sensitive issues, such as the death of a patient they had been working with. Staff told us that it was difficult to obtain transparent masks for patients who found it difficult to understand staff when wearing masks including those with dementia, hearing loss or learning disabilities.

Our findings

Staff carried a crate in their car when on visits, divided into clean and dirty areas, to ensure that clinical waste, and used equipment was kept separate from clean items. Staff told us that they cleaned all equipment after patient contact. Equipment used in patients' homes was returned to the office and cleaned by administrative staff before being returned to stock. However, we noted that equipment was not routinely labelled to show when it was last cleaned. Following the inspection, managers advised us of a new system to improve recording of when all equipment was cleaned.

Monthly audits were undertaken to check the clinical environment, hand hygiene, and that staff were bare below the elbow. Your Healthcare CIC had a joint infection prevention and control sub-committee with a neighbouring NHS trust. The infection prevention and control report of January 2022 showed that regular audits had been undertaken. Hand hygiene audits for community district nursing were recorded at 100% for October, and 96% for November 2021. The PPE audit indicated 100% compliance in October, 93% in November, and 100% in December 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The service had enough suitable equipment to help them to safely care for patients. The clinical nursing store was well stocked, with all equipment in date including blood bottles, swabs, dressings, and syringes. All staff were able to prescribe equipment for patients.

Equipment was logged in and out, with a log folder kept next to the equipment. Syringe driver boxes were cleaned, restocked and wrapped in clear plastic bags sealed with a knot before being placed back on the shelf ready for use. Following the inspection, the provider advised that they would be updating the record to include the date the equipment was cleaned, and labelling equipment with the date of cleaning, indicating it was ready for use. They also undertook to introduce, a column including the date of first use of equipment in the equipment inventory documentation, so that the length of time equipment was in use could be easily identified. Staff removed the batteries from equipment in patients' home when returned after each use.

Staff disposed of clinical waste including sharps safely. Nurses could return clinical waste to a facility at the office, if it could not be disposed of in a patient's home.

Community nursing staff said there were no problems getting equipment such as standard pressure relieving cushions and hospital style beds, pressure relieving mattresses and commodes in a timely manner. They had recently changed equipment provider. They described effective equipment such as hover jacks (inflatable patient lifts) to support patients, if the team needed to change a mattress. The rapid response team had a raiser chair to support people when they had a fall at home.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted to support patients at risk of deterioration. Staff recorded patient's physical observations when they had concerns about their health.

Staff completed risk assessments for each patient after referral, and reviewed this regularly, including after any incident.

Our findings

Staff told us about the initial information they checked with new patients including any social support needs, key safes, and medication arrangements. All records had up to date risk assessments on file, either within the assessments section or within progress notes (for very new referrals). These included pressure ulcer assessments and checklists, clinical frailty scores, and nutrition and hydration assessments.

Records showed examples of staff responding to increased patient risk. For example, one patient had a clear plan with review dates following a risk assessment for falls. Another patient had a tissue viability nurse assessment following identification of a new wound, with a plan in place for treatment and regular review. A patient identified as having communication difficulties, was supported with the use of a white board to communicate.

Staff knew about and dealt with specific risk issues. For example, staff noticed that a patient was not taking their prescribed medicines and referred them to a social worker to address concerns about their mental capacity. Following a best interests decision, the doctor changed medicines to be administered twice daily to fit in with care worker visits. In the case of a patient who was assessed as at risk when using bedrails, staff ordered crash mats instead to keep them safe.

Staff were clear about the observations necessary and processes to follow to prevent patients developing sepsis, deep vein thrombosis, and pressure ulcers. Staff shared key information to keep patients safe when handing over their care to others such as relatives, carers, or for a hospital admission.

We attended five staff handover meetings and noted that these included all necessary key information to keep patients safe, and it was clear that staff knew patients' needs well, as well as those of their relatives/carers.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The provider had guidance in place for recognising a deteriorating patient. The NEWS2 tool was used by the community nursing team and community matrons when required in the event of a patient appearing to be acutely unwell. Staff had access to the NEWS2 App developed between the Royal College of Physicians and the North West London Collaboration for Leadership in Applied Health Research and Care. However, staff were not routinely recording baseline results of patients' observations, to compare in the event that they became unwell.

When needed staff referred patients to other health professionals, for example we saw examples of patients being referred to their GPs for advice, as well as for urology, podiatry, dietitian, and psychology services.

The service did not have direct access to acute mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). They were looking into forming closer links with the mental health trust covering the local area.

The 'Single Point of Access' team had developed clear triage processes and the use of key words to trigger escalation of cases to qualified staff such as pain relief for patients at the end of their lives. GP meetings were held regularly to discuss care of patients at the end of life and any other complex cases.

The service had lone working policies and guidelines and staff were provided with lone worker alarms. Where risks had been identified prior to a visit, staff took appropriate measures including working in pairs, and alerting other staff of where they were to ensure they were safe.

Our findings

Staffing

Although the service had some staff vacancies for staff, the staff in place had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, and agency staff a full induction. Managers were undertaking active recruitment to fill vacancies.

Almost all staff we spoke with in community nursing told us that staffing vacancies was an issue, particularly over the last two years. In November 2021 CQC was contacted with whistleblowing concerns about the safety of the service, given the staff shortages. Senior staff acknowledged that district nurses had been completing over 30% more visits daily than they had capacity for. They observed that this was a nationally recognised position at the time of the pandemic. In late October to early November 2021 the service was operating with more than one in four district nurses absent, some of which was likely to be due to workforce exhaustion, leaving staff vulnerable to physical and mental health challenges. When absences reached 25%, an extraordinary senior nurse meeting was held to ensure that internal and external support networks were available.

During the inspection some staff reported that they frequently worked over their hours to meet the needs of the service. Some staff also told us they often completed patient records, in their own time. They observed that weekends in particular could be short staffed. Staff noted that the volume of referrals had increased, and they could not turn down referrals. Staff did not think this had an impact on the safety of patients, but some felt this was having an impact on the quality of care provided, for example limiting the number of holistic assessments they could carry out given the high workload.

Senior staff confirmed that recruitment was a challenge and were undertaking active ongoing recruitment. They had taken steps to address this including inviting newly qualified staff into the team and upskilling them so that they became valuable members of the team. Staff confirmed that there were good pathways for career development for new nurses to develop skills and progress to higher grades. A number of staff told us that they had worked in the community team as a student nurse and chose to return to the setting after qualification.

We observed five community team handover meetings, and a scheduling meeting, and saw that staff allocation and skill mix was agreed for each shift. We were told that caseload allocation was based on 10 minute units. Staff were usually allocated 30 units per day depending on the acuity of the cases, this did not include travel time. Your Healthcare CIC worked to the ratio of 60:20:20, experienced: newly/recently qualified: non-registered staff. This was in line with the safe staffing benchmark recently published by the Queen's Nursing Institute.

At the time of the inspection, the service had 8.3% vacancies in community nursing out of a total of just under 58 posts. This included 3.6 WTE (whole time equivalent) band 5 nurse vacancies out of an establishment of 14.6 WTE and a band 8a deputy lead post. The total staff turnover for community nursing in 2021/22 was 15.8% (13 leavers, with nine replacement staff). A small number of bank or agency staff were used, In March 2022, two Band 5 agency staff, and 2.48 WTE Band 5/6 bank staff were used. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

In the rapid response team, there were 11.8% vacancies (1.5 out of a total of 12.8 WTE posts). There had been three staff leavers in 2021/22 (21.4%). The tissue viability nursing team was fully staffed with 1.8 WTE posts.

Staff sickness absence between 1st May 2021 - 31st October 2021 averaged at 5.1% which was lower than the average national figure of 6%. However, in October 2021, Your Healthcare CIC staff sickness was higher than the average national figure for all except band 3 staff and significantly higher for band 5 staff at 18.4%.

Our findings

Community Nursing teams were managed by a Band 7 qualified district nurse with a specialist practice qualification. Senior managers noted that the current resource may not be enough to manage an increase in demand and complexity and were intending to address this with South West London Integrated Care System funding partners in 2022/23.

Records

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

Patient notes were clear, including all important information, and all staff could access them easily.

The majority of records were maintained electronically, with a small number of paper records kept in patients' homes. All staff had laptop computers, so that they could record patient notes whilst out doing visits. A small number of staff described intermittent issues with IT connectivity. However, this had improved since the last inspection in November 2016.

At the previous inspection in November 2016, we noted that updates to records could be improved to ensure patients' safety. At the current inspection we looked at records for 35 patients. We noted that all patients had risk assessments in place, and these were kept up to date. However, new assessments were not always completed when a patient started a new referral. All patients had care plans in place, unless newly referred. Care plans included wound and pressure area management, long and short-term condition management, medicines management and chronic disease management. Care plans were clear, detailed, and person-centred with goals and actions, making them clear to staff who were not familiar with any particular patient. However, although all staff said that they did this, in two cases, staff had not recorded that they reviewed all areas of potential pressure area damage for patients at high risk of pressure ulcers.

Palliative care plans were detailed, clear and involved palliative end of life care for the holistic management of symptoms including bladder and bowel issues, pain, pressure areas, shortness of breath, poor sleep, and emotional support.

When patients transferred to a new team, there were no delays in staff accessing their records, as the records system was shared across the organisation. Records were stored securely, with all electronic devices encrypted and password protected.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, systems for auditing of NHS prescription stationery were not robust.

Staff undertook training and competencies in prescribing or administering medicines according to their role. Training included high risk procedures involving medicines such as the intravenous administration of antibiotics. In the community nursing team 89% of staff were up to date with medicines training, and 82% of staff in the rapid response team had completed this training. Of the seven staff across the two teams that were not up to date with this training, five of them were on long term leave.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a medicine management policy in place and employed nurses who used patient group directions (PGDs) to administer and dispense medicines. The medicines management committee was responsible for the governance of the PGDs.

Our findings

All of the district nurses were community nurse prescribers, and several were also independent prescribers, which meant they could respond to patients' needs and prescribe appropriate medication in a timely way. Community nurse prescribers are nurses who have successfully completed a Nursing and Midwifery Council (NMC) Community Practitioner Nurse Prescribing Course and are qualified to prescribe only from the Nurse Prescribers Formulary (NPF) for Community Practitioners. Independent prescribers are nurses who have successfully completed an Independent Nurse Prescribing Course with the NMC and are able to prescribe any medicine provided it is in their competency to do so. The nurses worked closely with the patients' GP to keep them informed of the patients' health and prescribed medicines.

Staff stored and managed all medicines in line with the provider's policy. All prescribers undertook supervision for prescribing medicines to ensure accuracy and compliance with guidance. Any concerns were escalated to the medicines management lead. Independent prescribers were commonplace throughout the service and were supported with training and governance.

NHS prescription stationery was used by community nurse and independent prescribers. There was a process in place to order and distribute this to the relevant qualified staff. However, once allocated there was a lack of audit of the stationery issued to staff. We did not find evidence of staff documenting each prescription that they used and keeping a clear audit trail.

Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys were used for clinics, these were supervised at all times while in use and stored securely. We checked storage arrangements for clinics and the community visiting teams, and found medicines were stored safely and securely.

Antibiotic audits demonstrated that the service was mainly compliant with prescribing in line with national and local guidance. Staff followed current national practice to check patients had the correct medicines. The service was working in partnership with the local hospital trust, local hospice and GP practices to support patients who needed end of life support and medicines for palliative care. There was an audit process in place to evaluate prescribing in the service against local and national guidance. The prescribing audit was reviewed by the prescribing governance committee once every quarter.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service received alerts related to medicines issued nationally. The relevant alerts were acted upon and actions were recorded and cascaded to staff where needed. We asked a sample of staff about the policy and procedures related to medicines optimisation. Staff knew where to find the policies and we saw evidence to confirm these were being followed. The medicines safety officer ensured that procedures were amended in line with any National Patient Safety Alerts and changes in guidance.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There were no patients currently at the service who had been assessed as lacking mental capacity and were being given medicines hidden in food or drink (covertly).

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines, checking on patients (and their relatives/carers) views about the effects of medicines on a regular basis.

Patients told us that nurses talked through the use of different medicines with them and gave them advice on self-medication.

Our findings

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us that they raised concerns and reported incidents and near misses in line with provider policy.

Discussion with staff, and observation of staff handover meetings and patient records indicated that staff reported serious incidents clearly and in line with the provider's policy.

Staff understood the duty of candour. Records prompted staff to give patients and families a full explanation if and when things went wrong. Staff received feedback from investigation of incidents, during handover meetings, and at team briefings, and routine general nursing meetings, and were aware of learning from recent incidents. Staff described a positive learning culture, where it was safe to acknowledge when they had made a mistake and share learning about this with the team.

There was evidence that changes had been made as a result of feedback. For example, nurses described learning from a near miss incident when visits were allocated to a member of staff who was not on duty, and steps were taken to ensure that this did not happen again.

Managers reported notifiable incidents to the CQC as required. They investigated incidents thoroughly, using a root cause analysis approach, involving patients and their families in these investigations where possible. Staff confirmed that managers debriefed and supported them after any serious incident. A summary of incidents in the last six months indicated that the most common incidents related to skin integrity, followed by medicines, abuse/harassment, discharge/transfer and accidents. A thematic review of the investigation reports indicated that the overall themes were mainly related to care documentation. This included gaps in timelines and lack of clarity around terminology and anatomical descriptions of sites of individual pressure ulcers. This review also picked up that pressure relieving mattresses delivered to patients in the community were not always adjusted to the patients' weight correctly, leading to clarification over whose responsibility this was.

There was a business continuity plan regarding major incidents which was reviewed annually. It identified key contact details and a process for staff to follow. The plan covered electrical failure, telecommunications failure and IT failure.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Our findings

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed National Institute for Health and Care Excellence (NICE) guidance and received regular bulletins and emails from managers regarding updates to NICE guidance. Organisational policies and procedures quoted NICE and other professional guidance.

The community nursing and rapid response teams included independent prescribers. At staff handover meetings, staff displayed a good understanding of treatment in line with current best practice and were aware of when they needed to seek further specialist guidance. Staff also gave due prominence to the psychological and emotional needs of patients, their relatives and carers.

The tissue viability service provided visits to community patients, as well as giving advice after discussion with community nursing teams and reviewing photos of wounds. They also offered regular in-house teaching to teams. For example, they recently held a face to face workshop for district nurses on compression bandaging. The lead nurse was part of the London and South tissue viability nurse forum and received clinical updates and information with good links with the tissue viability nurse at the local hospital. The lead nurse was very experienced in her field, and reviewed articles for the journal 'Wounds UK.' She attended conferences including a sharp debridement in wound management course in 2019, before the pandemic.

Your Healthcare CIC recently purchased devices used for early detection of peripheral arterial disease. The use of these devices meant that assessments could be carried out by a single nurse/support worker in five minutes, instead of taking two staff over an hour to complete an assessment. The leg ulcer clinic had also introduced on-line ordering for non-prescription bandages, which had previously been a time-consuming manual process. With an increased focus on digital wound care management, Your Healthcare CIC were also looking to purchase relevant applications which would help with wound care documentation.

The two tissue viability nurses, district nursing manager and safeguarding lead held a pressure ulcer review group (PURG) every week. We attended one of these meetings, in which the group reviewed reported pressure ulcers against the decision guide for safeguarding referrals, definition of serious incidents and duty of candour. There was detailed discussion, with all present contributing constructively, and the needs of each patient as the focus.

The rapid response team aimed to prevent unnecessary and long attendances at accident and emergency departments. They aimed to contact all referred patients and triage by phone within two hours. Following the telephone triage, a member of the team would visit the patient (if appropriate) as soon as possible within 24 hours, but usually within two to four hours. They conducted a full assessment, diagnosed the patient and prescribed (if an independent prescriber) or referred back to the GP for treatment. They could take bloods and electrocardiograms (checking the heart rhythm and electrical activity). They also had a falls pathway with training and equipment to help people up from the floor (receiving direct falls referrals from the London Ambulance Service).

Your Healthcare CIC held a research and audit event annually at which teams could present their work. This event showcased the research, audits and quality improvements taking place across the organisation to highlight the value of these initiatives, and to motivate and inspire a wider staff group to become involved. Despite Covid-19 pressures, this was rerun in autumn 2021 provided on and offline to support safe and secure participation. This initiative had been very successful in bringing audit levels up to levels higher than seen over the preceding three years and providing a learning opportunity for staff. At the last event the tissue viability nurse specialist won the presentation award for her leg ulcer audit which led to a change in provision and a positive impact for staff, patients and service budgets.

Our findings

Staff from the service had been involved in a number of research initiatives, many of which had been published. For example, 'Ageing well with diabetes', published in 2022 and 'Intervention for sleep' published in 2019.

A community nurse devised a cross-sectional study on 'Stress, psychological distress and support in a health care organization during Covid-19.' This study identified health and wellbeing resources which were helpful for health care workers wellbeing and their work including in-house counselling, and access to yoga sessions. This work was subsequently published in a nursing publication.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook for or feed themselves.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff monitored patients' fluid and nutrition where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

At the previous inspection in 2016, we noted that assessments of patients' nutritional and hydration status were not always carried out consistently. Staff told us they used the Malnutrition Universal Screening Tool (MUST) scale to help identify patients who may be at risk of malnutrition. We reviewed some examples of this assessment being used in patient records and found patients' nutritional needs were being met effectively. Staff had not used the specific MUST tool with all patients at risk but had made records in progress notes showing that they had asked patients about their food and fluid intake.

We found that one patient was referred urgently to their GP on the day when they were noted to have been unable to eat /drink. Staff arranged a professionals meeting for another patient at risk of weight loss and dehydration. The meeting including the GP, psychiatrist, and social worker.

Staff could refer patients for specialist support from dietitians and speech and language therapists when needed, and we saw examples of these referrals. Catheter care plans included instructions to drink a specified amount of water daily, and to monitor bladder and bowel function daily. We found examples of healthy meal planning and support with meals noted where relevant in case records and care planning, including whether patients had carers to support with this.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff undertook pain assessments and pain management interventions. Patients told us that staff were quick to respond to requests for support with pain relief and consulted them about their preferences.

We observed records of pain monitoring by staff asking patients about their pain levels on each visit. Patients received pain relief soon after requesting it. Patients and relatives/carers we spoke with said that staff went out of their way to ensure that there was no delay in patients receiving appropriate pain relief.

Our findings

Staff prescribed, administered and recorded pain relief accurately. Records showed that options for pain relief were discussed with patients and their family. In one case a patient's self-management of pain was discussed, including use of a patch to enable a patient to have more sustained relief from pain. Information was also provided about action to take if pain relief was not sufficient.

Staff requested permission from patients to discuss their pain with their GP or a specialist. Community nurses were supported by the specialist palliative care team and support from the local hospice for pain management. In a multi-disciplinary meeting, we observed professionals discussing options for pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, some audits involved small sample sizes which may not have been statistically significant, and some would benefit from more robust action plans.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Information about the outcomes of people's care and treatment was routinely collected and monitored to improve patient care. Staff used outcome measures to monitor patient progress including pressure ulcer risk and nutrition scoring.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included a range of infection control audits, environmental risk assessment audits, and clinical/care record keeping audits. We noted that the number of cases reviewed in audits, were not always statistically significant, for example the most recent record keeping audit only covered five cases. We also noted that some of the audits did not result in specific, measurable, achievable, realistic and timely (SMART) action plans. Managers advised that whilst some national audits specified the number of cases to be reviewed, they were now reviewing the numbers used within internal audits. They noted that as part of a review of existing workstreams, audits were currently in review with the aim of improving participation, skill and quality to include more robust and SMART action plans.

Your Healthcare CIC also participated in national audits including cardiac and respiratory rehabilitation audits. Managers shared and made sure staff understood information from the audits. The audit lead was devising a sequence of Lunchtime Learnings to support sequential and accessible learning for clinical staff who struggled to access the existing three-hour training due to work pressures.

Managers and staff used the results to improve patients' outcomes. For example, quarterly record keeping audits, had resulted in an improvement in recording of assessments and consent for interventions from patients (albeit in a small sample size of five cases). In the quarter four audit report for 2020-2021 recording of consent scored at 63%, while all relevant assessments including risk assessment were at 76%. In the subsequent quarter two audit Q2 2021-2022 audit, consent for interventions was scored at 92% and all relevant assessments including risk assessments were scored at 80%.

The pressure ulcer related thematic review 2020-2021 (which included data for the provider's inpatient ward) looked at the seven root cause analysis reports from this period. Themes identified included clinical care, clinical documentation, administrative/communication issues, and referral. Compared with results from 2018, the number of clinical problems had declined from 11 to two. The number of administrative/communication problems identified decreased from 11 to one. There was a small increase in documentation issues from 11 to 13. Lessons identified included completion of Waterlow assessments (for skin integrity) and putting care plans in place. Actions taken included giving a pictorial anatomical guide to all teams to assist with identifying pressure ulcer scores and improving consistency of terminology.

Our findings

Performance reports were used to review and monitor service delivery standards such as referral, acceptance rates and face to face contacts. There was a dashboard showing weekly average rapid response times of 43 minutes at the time of the inspection. With 100% of the 87 cases being contacted within two hours. In quarter four of 2021-2022, the rapid response team responded to referrals in two hours 98-100% of the time.

At the time of the inspection the open caseload for community nursing was 1129 patients, and 100 patients for the rapid response team.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the frequency of staff supervision provided was not recorded consistently.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Registered nurses, healthcare assistants, and other staff providing community services were competent and knowledgeable when we spoke with them. Managers gave all new staff a full induction tailored to their role before they started work.

Staff were required to complete competency assessments in a number of relevant areas before undertaking tasks independently. These included venepuncture (to take blood samples), interpreting blood results, male and female catheterisation, compression bandaging, vaccination, ear syringing, verification of expected deaths, and setting up syringe drivers for analgesic medicines. Analgesic medicines are medicines that relieve pain.

Managers supported staff to develop through regular, constructive clinical and management supervision of their work, and yearly appraisals. All staff we spoke with told us that they had regular supervision sessions with their line managers, had the opportunity to discuss training needs and were supported to develop their skills and knowledge.

However, records we looked at showed that staff did not record supervision sessions consistently. This meant the provider could not monitor the frequency and quality of staff supervision. Managers confirmed that some of the supervision sessions provided were informal.

The rapid response team described receiving group clinical supervision once a month. At these meetings someone would present a topic such as safeguarding or catheter care. The team said that they were well supported by managers, and that managers and colleagues came out on visits with them to observe their practice.

Managers made sure staff attended team meetings or had access to full meeting minutes when they could not attend. Team meetings were used to provide peer group supervision and case study discussions.

Staff told us they were supported to gain further qualifications relevant to their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that managers were good at supporting individual staff to focus on areas they were passionate about, such as dementia care. Training courses staff had recently completed included training on domestic abuse, improving cancer outcomes for people with learning disabilities, health and wellbeing workshops, motivational interviewing, and assertiveness training.

Our findings

Managers made sure staff received any specialist training for their role. We saw that senior community nurses held specialist qualifications, and we spoke with a number of staff who had been supported to become independent prescribers. Student nurses spoke highly of the learning opportunities made available to them in their placements within the community nursing team. Several nurses in the team had returned to work at the service, following completion of their nursing training. Staff were supported to complete nursing associate programmes (apprenticeships).

All community matrons had completed the clinical reasoning in physical assessment course and independent prescribers training. Ten district nurses held the specialist practice qualification, and all were community nurse prescribers (with four also qualified as independent prescribers). Nine district nurses and 12 senior community nurses (band 6) had completed the clinical reasoning in physical assessment course. Two senior community nurses were also independent prescribers.

Managers identified poor staff performance promptly and supported staff to improve, including providing support to staff who were struggling from anxiety and exhaustion during the Covid-19 pandemic.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

All the community staff we spoke with told us that they worked effectively with acute hospital services and general practice and other health and social care providers**.** They told us that they were able to refer patients into secondary care when needed. Community matrons focussed on patients with long term conditions and complex needs. They held regular meetings with their patients' GPs to discuss and agree their care and treatment.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. We attended a routine multidisciplinary meeting with a local GP, district nurse, community nurse, community matron, social worker, local social prescribing agency, and high intensity user service lead (member of staff reviewing high intensity users of the emergency department). The meeting was effective in considering a joint approach to supporting patients with complex needs collaboratively.

Handover meetings were held daily for each community nurse team, and we were able to attend four of these during the inspection. Each involved a clear detailed discussion of all patient visits completed that day including issues around wound management, skin integrity, pressure ulcers, medicines management, pain, and diabetes management. They also discussed issues relating to carers (paid) and family members supporting patients. Staff discussed liaison with other agencies including social workers, occupational therapists, dietitians and GPs. We noted that there was good discussion between the team members, who clearly felt able to challenge each other in a supportive, non-hierarchical way.

We found examples of effective multidisciplinary working both within and across teams. Staff we spoke with at all levels described good multidisciplinary working amongst colleagues and local health professionals including the local hospital. Different teams helped each other when needed, for example helping out other teams who were short staffed or had very high acuity caseloads.

Staff said that having services based in the same building at Hollyfield House made it easy to consult and work together with the learning disability, dementia, urology (bladder) and colorectal (bowel) and tissue viability services. The community nursing team staff also linked closely with the rapid response team.

Our findings

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed that there was evidence of patients being asked for verbal consent recorded in their care records. Staff we spoke with explained procedures for gaining consent from patients before delivering care and treatment. The service providers' policy on recording mental capacity assessments, detailed what information had to be recorded in case notes. Patients we spoke with also confirmed that their consent was checked before any treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. At the previous inspection in 2016 we noted that some staff needed training in how to record best interest decisions when patients were not able to consent to treatment. We found an improvement in this area at the current inspection. For one patient who was unable to give consent, their wife and daughter were spoken with about their wishes for the future including considering a DNACPR (medical decision not to attempt resuscitation in the event of cardiac arrest). This was recorded in the case notes with a reminder to follow up and a request to the GP to send out an information pack. We observed that staff made a decision to make a social work referral for a patient following a professionals meeting where staff discussed concerns about fluctuating mental capacity, and there were concerns around weight loss and food choices.

Staff made sure patients consented to treatment based on all the information available. In the case of a patient on end of life care, it was clearly recorded that they had capacity to consent to care and treatment and this was noted within the alerts on the front page of patient record. Notes indicated that they were made aware of the different options of treatment and care available to them.

Staff clearly recorded consent in the patients' records including when they sought the consent of patients ahead of each intervention. We saw good examples of this, with the reason for the visit and intervention explained clearly and recorded in patient notes.

There was evidence of Mental Capacity Act (MCA) assessments being completed where appropriate with clear information for follow up visits. For example, in one case where a patient had difficulty following instructions, actions included making sure instructions were very clear and given in person.

Staff received and kept up to date with training in the MCA and Deprivation of Liberty Safeguards. In the community nursing team 92% had up to date training in this area, and in the rapid response team, 100% of staff had completed this training.

Managers monitored how well the service followed the MCA and made changes to practice when necessary. Quarterly audits were undertaken. The action plan for the quarter four audit report indicated that there is going to be a new consent audit project. Senior staff confirmed that this was planned.

Your Healthcare CIC adult safeguarding team were members of the South West London Health Leads forum and Mental Capacity Act sub-group and Kingston Vulnerable Adults Multiagency Panel. They supported staff with responding to safeguarding and MCA concerns/questions.

Our findings

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and went the extra mile to take account of their individual needs.

Patients were truly respected and valued as individuals and empowered as partners in their care, both practically and emotionally, by dedicated staff who went the extra mile. Feedback from people who used the service, and those close to them was overwhelmingly positive about the way staff treated people. We spoke with 22 patients and 17 relatives/carers of patients using the service. Without exception they told us that they could not fault the staff who were supporting them, and although they had a number of different staff visiting them, they were all excellent.

Patients and relatives used a wide range of superlatives to describe the support they received from the community nurses. Amongst many other terms, staff were described as 'marvellous', 'absolutely wonderful', 'you can't fault them,' and 'it is a joy to see them.' They all described staff as kind, warm, and friendly, treating them as a person, and having a two-way conversation with them. One patient told us, 'I feel I'm being looked after.' One patient told us that a member of staff came to visit them, despite having been attacked by a dog on the way. When they asked them why they had not gone to seek treatment, the staff member told them that they did not want to let them down.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that no matter how busy staff were, they made time to find out how they were, and how relatives/carers were managing.

Patients said staff treated them as individuals and with kindness. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

People told us that the care and support they received had exceeded their expectations. Relationships between people who use the service, those close to them and staff were clearly strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by the team leads. People using the service felt really cared for and that they mattered. Patients and relatives told us that they really made a difference when they were feeling low. They were quick to come in an emergency, contacted the GP for them when needed, and explained everything. All said that the teams had never missed a visit, although they could sometimes come later than expected when busy. One patient told us that on one occasion they had to wait a long time for a nurse to come and address their blocked catheter.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Speaking to staff and observing them discussing patients at handover meetings we noted a strong, visible person-centred culture. Staff were highly motivated to offer care that was kind and promoted people's dignity. For example, staff had discussed a patient's concerns, and suggested and arranged to replace their catheter ahead of time, before they went away on a trip, in order to make it less likely that they would have any problems with it whilst away.

Our findings

Staff recognised and respect people's holistic needs. People's emotional and social needs were seen as being as important as their physical needs. Community nurses involved patients in their care. They communicated well with them and provided them with clear information on how to manage their condition and options of treatments available. Patients and relatives told us that staff answered all their questions, and if needed would ask another member of the team to telephone them to explain further.

Patients were involved in planning of their treatment and nurses acted on patients' wishes. A relative told us that during lockdown, the nurses, at the patient's request, trained them to take over some of the care, increasing the patient's independence. They noted that they kept an open dialogue, with support available whenever needed. Staff arranged for another relative who was unable to leave their family member alone during lockdown (due to poor health) to be given a prescribed injection, whilst the nurses were visiting the patient, so that they did not have to go out leaving their relative alone. One patient told us that the service had saved their life twice during the pandemic when they had been ill with Covid-19 and they arranged for them to go to hospital.

Staff followed the organisation's policy to keep patient care and treatment confidential, checking with patients before sharing any details with their relatives.

Emotional support

Staff were highly motivated and inspired to provide emotional support to patients, families and carers to minimise their distress. Patients and those close to them strongly valued their relationships with staff, and staff sensitivity to their personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were particularly proud of the work they did with patients having end of life care. The service had developed a specific end of life care plan, which was individualised, including the patient's preferred place of care, things that were particularly important to the patient and their family, and communication and support needs. On each visit staff looked at the comfort, communication, hydration, nutrition, and any spirituality needs of the person, recording support provided in each area. Relatives of patients who were recently deceased, spoke of the immense support provided by the community nurses in their relative's end of life care, and how their relatives had looked forward to their visits.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients and carers felt emotionally supported and reassured by the community nursing visits. One patient who had suffered a family bereavement, told us that staff had brought them flowers when they visited.

Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns. A relative told us that staff went the extra mile by phoning to see how they were, on days that they were not visiting.

Understanding and involvement of patients and those close to them

Staff were fully committed to supporting and involving patients, families and carers to understand their condition and make decisions about their care and treatment. Staff were fully committed to working in partnership with people. People who used the services were active partners in their care.

Staff made sure patients and those close to them understood their care and treatment. Patients, families and carers told us that staff talked to them in a way they could understand and used communication aids when necessary.

Our findings

Staff were fully committed to working in partnership with people and making this a reality for each person. People who used the service and those close to them were active partners in their care. One patient told us that staff had given them a printed rota to support them in using the cream they needed. A relative told us that staff would ring them before they visited, to see if their relative wanted to take a pain killer before they came. Patients told us that staff would always make an extra visit if needed. Staff supported patients to make informed decisions about their care, including making advanced decisions about their care where appropriate.

The views of patients were noted in their case notes recorded by staff, including their views on treatment interventions, visit times, and date preferences, and the views of family/carers were also included where relevant. We noted discussions with patients' relatives recorded in patient's notes, including the use of information provided in another language. Patients' views including their wellbeing on each visit were routinely noted and recorded. Staff made adjustments when possible and safe to do so in accordance with people's wishes. For example, in one case we noted that a patient asked for their wound not to be checked that day, and the nurse agreed to check it at the next visit instead. In a case where a patient was reluctant to attend a dietitian appointment, staff arranged for the dietitian to visit them at home in order to encourage engagement.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used the Friends and Family Test (FFT), a short standardised service user experience survey, to collect patient experiences of care. This could be delivered in a range of formats designed to meet the needs of different patient and service user groups. Data generated from these surveys, was presented at the Frontline Effectiveness Committee.

Paper questionnaires were the preferred option for most users of community nursing services and these were distributed and could be returned by freepost. The rapid response FFT feedback was generated using a simplified localised form. The team worked briefly with service users and gathered this information as part of their short intervention. The overall provider wide results for the FFT surveys in the third quarter of 2021/22 indicated 95% satisfaction rates, 99% felt treated with respect, and 96% reported being involved in planning their care. The rate of return for FFT surveys was higher for the rapid response team than the general community nursing services. Eight surveys were returned for the community nursing team in 2021-2022 compared to 97 for the rapid response team. To address this the service was reviewing its feedback mechanisms. Staff had an application on their electronic devices that patients and family members could use to give feedback after any visit. They were also planning to have feedback, and 'you said, we did,' as a standing item on the community nursing meeting agendas.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the changing needs of the local population. The service covered 21 GP practices within the Royal Borough of Kingston, using nine district nurse teams, as well as a twilight and rapid response service, and other specialist services.

Our findings

Patients' needs were assessed, and care planned accordingly. Where appropriate, care planning involved joint visits with staff from other specialties or GPs. Patients with complex needs were discussed between services and a coordinated multi-disciplinary plan of care was agreed. Patients could access community nursing services directly and request visits and appointments.

The rapid response service prevented hospital admissions including; where clinically appropriate, facilitating transfers of care back to home environment from the hospital emergency department. The rapid response service also developed urgent packages of care at home for people who are at risk of falling. The district nursing service facilitated early discharges from hospital wards. Both services ensured appropriate nursing care was in place.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients needing support with pressure ulcer care could access support from the service's tissue viability service. The service had a team of matrons to support people with long-standing conditions and complex needs. The service also had a wide range of specialist services including those for services for people with dementia, learning disabilities, diabetes, at risk of falls, needing speech and language support, requiring cardio and neuro rehabilitation, in need of physiotherapy, and continence support.

The urgent care and support service provided support to registered nurses in care homes within the borough to meet all activities of living including end of life care and assessment and diagnosis of acute illness. The service also provided education and training to care home staff.

Staff told us they worked with local service commissioners, including local authorities, GPs, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from local mental health services or social services.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The provider had produced written information for people accessing the community health service. For example, information was available on different health conditions. Written leaflets could be requested, when required, in a different language or format. Staff told us that there were significant Korean and Sri Lankan communities within the borough. They also had a number of staff who spoke other languages including Portuguese and Cantonese.

Staff liaised with mental health, learning disability and dementia services when needed to ensure that patients received the necessary care to meet all their needs. Staff had mental health first aid training available to them, to support them in working with patients in crisis. They could arrange for easy read care plans to be prepared for patients with assistance from the learning disability service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service could arrange for information leaflets to be translated into languages spoken by patients in the local community. They could also arrange for staff, patients, and relatives/carers to have help from interpreters or signers when needed.

Staff told us about how they communicated with patients who had communication difficulties. This including using keypads, or a white board, to communicate in a written format, when patients had a hearing impairment.

Our findings

Staff told us how they accommodated religious and cultural diversity of patients and how it had informed individual care plans of these patients. For example, staff told us that they tried hard to arrange for the families of Muslim patients having end of life care, to receive all documentation promptly after their death (if they wished for this), so that a swift burial could be arranged.

Any identified cultural needs were recorded in a patient's records as part of the care and treatment plan. For example, shoe coverings were provided for staff visiting the homes of patients who requested that shoes should not be worn in their home.

Mandatory training for all staff included equality and diversity awareness. All of the rapid response team staff had completed this training, and 90% of the community nursing team. All staff we spoke with could demonstrate an understanding of how they supported patients with diverse needs including protected characteristics. Staff had attended a recent information session on gender identity. Staff spoke about how they supported LGBTQ+ patients including patients who identified as gender fluid.

Staff were flexible with visits and adjusted appointments to accommodate patient needs. For example, nurses arranged to change visit days for a patient when they had family commitments.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Staff told us they responded to urgent referral requests the same day and could respond within two hours if required. Non-urgent referrals would be followed up the next day. Triage arrangements were in place to ensure referrals were prioritised appropriately.

There was a single point of access to the service between 8am to 6pm daily, an overnight service provided by the local hospice team, and a twilight district nurse service from 7pm to midnight. Referrals were triaged immediately and the workload allocated accordingly. The community nursing service prioritised patients on a daily basis, particularly those requiring time-sensitive medicines, and end of life care. Managers worked to keep the number of delayed visits to a minimum. Records for September and October 2021 did not show any missed visits, but showed that six visits were 'deferred' due to patients being admitted to hospital unexpectedly before a visit was due, seven cases where patient requested appointment rebooking for another day, 48 appointments reallocated to another nurse on the same-day (within eight hours), and six patients whose referral needs had changed and no longer needed a visit.

The rapid response team took referrals from a variety of sources (GPs, social workers, the London Ambulance Service, 111 service, urgent care team, community matrons, and self-referral (for known patients)) via the single point of access. They also took referrals from the district nurses if patients' needs were out of their scope of practise. The team worked from 8am – 8pm taking referrals up to 6pm. The rapid response team were meeting their target of contacting all referred patients and triage by phone within two hours. They aimed is to prevent unnecessary and long attendances at accident and emergency departments.

Staff planned patients' discharge from the service carefully, particularly for those with complex physical, mental health and social care needs. Staff supported patients when they were referred or transferred between services. Staff told us about a particular concern at the time of the inspection, with patients being discharged from hospital, without the district nurse service being informed. Managers were working to address this issue with the local hospital. The tissue viability nurses provided care to patients in the community and a hospital inpatient setting. The two nurses in the tissue

viability service provided a leg ulcer clinic at a local centre, as well as domiciliary support and advice, covering care homes, and an inpatient ward. This included working alongside and supporting district nurses in wound care and management. Since January 2022, the service was providing a two-hour urgent response service to care homes in the area.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, the service was not monitoring issues raised in informal concerns, to improve the quality of the service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us that they knew who to contact if they wanted to make a complaint and there were leaflets in information packs provided to patients on how to make a complaint about the service.

Managers investigated complaints and identified themes. Between April 2021 and March 2022 five complaints were received, all of which were investigated, and responded to. None of these complaints were upheld, although learning was taken from each complaint. Learning largely related to improving communication with patients and their relatives/ carers. During the same period 161 compliments were received.

Informal complaints related to rescheduling of visits or staff running late were not recorded formally but dealt with individually by the district nurses. This meant that the service was not able to monitor patterns in concerns in order to bring about improvements in the service. We recommended that this be considered at the previous inspection in 2016.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. None of the patients we spoke with had made formal complaints about the service, but those who had raised informal concerns were happy that the service acted swiftly to address the issues they raised.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers discussed information about complaints during staff meetings to facilitate learning. Staff could give examples of how they used patient feedback to improve daily practice. For example, staff were checking on patients due to be discharged from hospital, as they could not always be sure that the hospital would notify them of patients' discharges.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Our findings

All staff we spoke with said that senior staff were very approachable. Local team leadership was effective and staff said their direct line managers were supportive. We found that staff were consistently positive, friendly, helpful and approachable. Staff morale within the teams was generally good despite many staff being exhausted from working long hours over the Covid-19 pandemic and to cover staff shortages. Several staff who had been working in community nursing over many years told us that this was the post in which they were happiest, and many told us how lucky they felt to be working in their posts.

Senior managers took responsibility for governance and risk, and clinical leadership, Staff felt there was clear leadership from the community nursing lead and frontline service lead. They noted that both of these leaders (who were qualified nurses) had helped out with patient work directly during the pandemic, setting a clear example to staff. The community nursing lead had led on vaccination work. There remained a vacancy for a deputy community nursing lead, and senior managers were working to fill this position.

Staff were less familiar with other members of the senior executive team. Senior leaders told us that this was part of the organisation's flat hierarchy structure with fewer levels of management, allowing each team the autonomy to run independently and innovate. The base team of senior leadership, although sited in the same building, therefore did not get involved in the nursing service on a day to day basis, unless requested or required due to concerns raised (such as through staff or audit results).

Staff told us about opportunities to participate in bench marking, peer review, accreditation and research, was proactively encouraged by the service leadership.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood the vision and strategy and how to apply them and monitor progress.

Your Healthcare CIC's vision was to be a leading provider of integrated health and social care, delivering a range of high quality services that allowed their community residents to lead the best quality of life. Their mission was to work in partnership to innovate as a provider of integrated services for the benefit of all service users in the local community.

There were clear priorities to help deliver the vision as a social enterprise with the freedom to use their resources to improve patient care.

Staff were aware of the vision and values of the organisation in putting people first and took pride in what they did. The three objectives were people focus, community partnership, and valuing staff. There was a clear focus on patient care through the development and implementation of the provider's commitments. Initiatives were put in place to improve the efficiency of the service and the quality of care which staff were proud of.

Staff spoke of the five freedoms the organisation had to change things for the better. These included, freedom to ask questions; tell their stories to help grow the business; innovate; and talk to partners about aligning services for greater gain for the community and best value for commissioners.

Our findings

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a strong culture of teamwork and a focus on key outcomes such as reducing hospital admissions or pressure ulcer incidence. In several teams, new staff members said it was the best team they had worked in, and that the team appreciated the different skills each staff member brought. Staff told us that they were proud to work for their team and enjoyed their role.

All staff we spoke with felt supported by colleagues and managers. They told us that their teams would go above and beyond for patients, and that they had room for professional growth. Staff who had experience of working in NHS trusts felt that this Community Interest Company gave them more autonomy, and freedom and flexibility to innovate, with less bureaucracy in place. They described the service, as less task orientated, and more personalised. They also told us that there was a culture where it was safe to be open if you made a mistake and speak up if you did not agree with something.

Staff had access to regular virtual equality, diversity and inclusion (EDI) events in the workplace. These included events summarising the organisations' equality objectives, feedback from an EDI staff survey (completed by 225 staff members in September 2021). There was active bystander training, and bespoke EDI workshops. There were sessions on Networking for Success, and 'Race Ahead' (an NHS Big Conversation regarding leadership that makes a difference, positively transforming the culture of the NHS through leadership). In February 2022 there was a workshop on why pronouncing someone's name correctly is important.

The Your Healthcare CIC Covid-19 Response and Wellbeing Questionnaire Highlight Report led to the implementation of a number of wellbeing initiatives to help staff health and wellbeing and ease of work. During June and July 2020 and March 2021, the provider asked members to give feedback on the resources and facilities that were provided during the Covid-19 crisis to enable them to understand what worked well and to learn about what could be improved. There were 187 staff members who took part in the online questionnaire. Areas covered within the questionnaire included working from home, fruit and snacks, Covid-19 testing, daily briefing emails, personal protective equipment and guidance, wobble rooms, wellbeing guidance, psychology support, occupational health, high intensity interval training, and yoga classes. Your Healthcare CIC introduced a counsellor to support staff during the pandemic. Staff were very positive about the support provided by the counsellor.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to frontline staff. Your Healthcare CIC committees included Data and Information Governance, Emergency Planning, Finance Investment and Contracting, Frontline Effectiveness, Health and Safety, Medicines Management and People and Development. The committees reported into the Integrated Governance Committee, which provided assurance for the Audit and Assurance Board on care quality, information governance standards, and the establishment of effective risk management. Your Healthcare CIC held joint committees with a local NHS community trust for Child and Adult Safeguarding including the Mental Capacity Act, and Infection and Prevention Control.

Our findings

We looked at agendas and meeting from recent committee meetings, including quality and risk assurance, and quality updates.

Each team across the service had weekly and monthly meetings to review incidents, performance issues and planning, amongst other topics. The service leads met every week, to discuss operational issues, and monitor performance indicators, and rates of reporting of incidents, complaints, and any other issues of concern in the different teams. We saw evidence that serious incidents such as pressure ulcers and falls were fed through the board reporting structures by the quality committee. Sharing of feedback from incidents drove improvement in the quality of the service. The service was planning a quality review of the clinical and care supervision pathway.

Frontline staff had daily handover meetings in the community nursing teams where all relevant safety information was shared with the teams and these were supplemented by weekly briefings and approximately monthly team meetings. Staff told us they found team meetings very useful as it was a means of keeping up to date with local and organisational matters. Staff were positive about team meetings and valued them as a source of feedback and the opportunity to discuss and escalate issues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At the previous inspection in November 2016, we found that that improvements were needed in organisational risk management. This was because frontline staff were not always aware of key risks to the organisation. At the current inspection, we found that nurses and other frontline staff were very aware of the key risks affecting their practice, and mitigations put in place to address them. The key risks described to us (which matched those on the service risk register) were staffing and succession planning, staff sickness and absence, and increased demand for the service, both in patient numbers and acuity.

Senior managers were very aware of these risks and worked to minimise them as far as possible with ongoing recruitment, and staff development programmes in place. They monitored overtime completed by staff, and staff wellbeing, and reviewed the contracted staff establishment. They spoke of preparing to meet further increases in demand due to undiagnosed conditions for patients in the community who had not sought healthcare advice during the pandemic. Other risks identified included incidents and near misses that were recorded not being addressed promptly enough.

In November 2021 CQC was contacted with whistleblowing concerns about the safety of the service, and impact on the safety of patients, given staff shortages. Concerns included missed visits and medicines errors. **T**he organisation looked into these issues with the service, and did not find evidence to substantiate them, whilst acknowledging significant pressures on staff due to staff vacancies and absences.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

At the previous inspection in 2016, we noted that IT connectivity problems were impacting on staff accessing patient records. Staff reported that significant improvements had been made since that inspection. All nurses and healthcare

assistants had laptops, which they used to record patient notes, attend virtual meetings and access organisational documents and applications. They noted that IT systems worked well, and there was good connectivity when out on visits. The only exception was one particular area in Chessington, which staff knew about and could take steps to work round.

On rare occasions when there were problems with the IT system, it was difficult to access care notes. When this happened, administrative staff emailed notes to the team. Some staff also said that the IT system could be slow at times, and that the staff laptop battery life did not last long enough. They had raised these issues with management, who were looking into solutions.

Staff showed us where they could find the providers' policies and procedures on the intranet. We reviewed information on the providers' intranet and saw the information was clear and accessible. The intranet was available to all staff and contained links to current guidelines, policies and procedures.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

At the previous inspection in 2016 we recommended an improvement in public engagement. The provider carried out friends and family tests; an NHS England feedback tool to help organisations to assess the quality of their services by asking people who used the service whether they would recommend the service.

The provider also asked people living within the community served by Your Healthcare CIC to join as a member and provide their views on services. A membership council was held four times a year and fed into the main board. The provider was committed to working with a range of partners and stakeholders in the local community to ensure the highest levels of healthcare delivery to patients and service users. This included system health and social care partners such as the local council; and third and voluntary sectors. Patient/service user surveys and carer surveys were available for people to complete electronically. Managers advised that seeking patients' and carers' views through phone call interviews had not proved to be an effective way of gaining people's views about the service, with few people wishing to engage in this way. There remained room for further development in the organisation's public engagement to ensure the local population had a voice about the services provided.

Senior staff in community nursing teams told us that communication with staff was seen as a priority. A newsletter had helped to keep staff informed of what was happening across the organisation. Staff also had access to monthly broadcasts from the leadership team to keep them up to date with developments in the organisation.

The Your Healthcare CIC staff survey of 2020 had a 71% response from staff (above average for a similar organisation). It had high scores for the friends and family test at 98% (if staff would recommend the service to their friends and family) and leadership integrity 94%. The highlights showed excellent staff engagement and that staff felt they could contribute to important team decisions, future planning and service priorities, and staff felt recognised and valued for their work. Staff rated equal opportunities and progression at 80%. The lowest score was for opportunities for career progression at 59% (although this had improved by 4% since the previous annual survey). Improvements were also noted in communication, IT provision and facilities. It noted that 10% of staff had experienced bullying/harassment/or abuse in their work in the last year, 9% of which was from patients or the public, which was an area for further exploration.

Our findings

Staff told us they had regular team meetings, which provided them with an opportunity to express their views, share experiences, discuss challenges in their day-to-day work and learn from one another.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Your Healthcare CIC had a lead for research and had had a research support function since 2020. The main success of the organisation's research fund had so far been to publish research and pursue funding bids. The team had asked for expressions of interest in research from staff and where possible, worked with those staff on the research. The organisation had an annual research and audit day, organisation wide, to present different projects across the organisation.

Whenever a member of staff, at any level, wanted to start a project or a pilot, they could approach the team for support and advice. The team could support them with identifying any barriers in research such as ethics. At the time of the inspection two members of staff were undertaking an MSc alongside their Your Healthcare CIC job. One MSc student was looking at improving the timeliness of referrals for end of life care from care homes. Another MSc student was looking at anticipatory injectable medicines for end of life care.

A member of staff explored how community nurses used NICE guidelines to empower patients to self-administer intravenous therapy at home and had submitted the research to a journal. One community nurse was doing a PhD looking at remote working with people with learning disabilities.

The research support team could support staff with identifying research supervisors and obtaining research funding. They could also support with identifying whether a change being considered was a research opportunity or a quality improvement initiative and provide support accordingly. The research committee met quarterly to discuss current and future projects including approving, reviewing and planning them. They worked with Health Education England and were a founding and active member of the Transform Research Alliance, which offered fee free PhDs. They were aligned with several universities where clinicians could potentially undertake PhDs.

Other recent projects and research included a tissue viability nurse looking at cost reduction of bandages by using an online system which could reduce cost and time. There were plans to look at vaccine hesitancy in healthcare workers, recruiting participants nationally to this project. There was an artificial intelligence (AI) project collaborating with an external organisation in bids to national funders with the aim to support the development and evaluation of an AI tool. The tool aimed to recommend interventions for hard to heal chronic lower limb wounds.

The organisation was participating in VenUS 6, a multi-centred, pragmatic, parallel group, randomised, controlled, three arm trial to assess the clinical and cost effectiveness of compression therapies for the treatment of venous leg ulcers. They were collecting data funded by The National Institute for Health Research Health Technology Assessment Programme.

Our findings

Outstanding practice

We found the following outstanding practice:

- Feedback from patients and relatives/carers was overwhelmingly positive about the competence, and compassion of the community nursing staff. They told us that staff respected and valued them as individuals, and worked with them as partners in their care, both practically and emotionally. They described dedicated staff who went the extra mile to support them.
- Your Healthcare CIC had planned, carried out and published a wide range of research. They had a research lead, who led a team who supported staff to plan research ideas and obtain funding bids. The organisation had an annual research and audit day to present different projects across the organisation. Recent research projects included improving the timeliness of referrals for end of life care from care homes; looking at anticipatory injectable medicines for end of life care; using National Institute for Health and Care Excellence guidelines to empower patients to self-administer intravenous therapy at home; and remote working with people with learning disabilities.

Areas for improvement

- The provider should continue to recruit staff to address nursing vacancies, and address shortages in the current staff resource following an increase in patient demand and complexity.
- The provider should ensure higher staff compliance with clinical risk assessment training,
- The provider should ensure that all equipment used in people's homes is labelled to show when it has been cleaned.
- The provider should review its policy and processes to ensure there is a robust audit trail to reconcile NHS prescription stationery issued and used by staff.
- The provider should review the number of cases sampled in internal audits and develop more robust and measurable action plans for audits.
- The provider should improve recording and monitoring of the frequency and quality of staff supervision provided.
- The provider should ensure that informal concerns raised by patients, relatives and carers are monitored and analysed in order to bring about improvements in the service.

Our inspection team

Our inspection teams comprised of four CQC inspectors (one of whom was a medicines specialist), two inspection managers, a specialist advisor with expertise in providing adult community health services and two experts by experience.

During our inspection of adult community health services, the inspection team:

- spoke with 22 patients and 17 relatives/carers of patients using the service by telephone
- visited the Hollyfield House site and observed the work environment
- spoke with six senior leaders in the service including the lead nurse for the tissue viability service, the community nursing clinical service lead, the frontline service lead, medicines management lead, the lead for business and performance, and lead for research and behaviour analysis
- spoke with 26 other members of staff including district nurses, community nurses, student nurses, healthcare assistants, a matron, administrators (including the single point of access senior administrator and nurses from the urgent care support service for care homes, and rapid response team
- reviewed 35 patient care and treatment records
- carried out a specific check on the prescribing, administration and disposal of medicines
- observed five shift handover meetings
- attended a multidisciplinary team meeting with a GP practice, a pressure ulcer review group meeting, and a community nurses scheduling meeting
- looked at a range of policies, procedures and other documents related to the running of the service

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.