East Coast Community Healthcare C.I.C.

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community adults	Hamilton House	1-286186558
Children and young peoples services.	Hamilton House	1-286186558
Community inpatients	Laurel Ward	1-2718482102

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection of East Coast Community between the 1st to 4th Novmeber2016, with an unannounced inspection on 17th November 2016.

This community enterprise company provides a number of NHS community services to the people of Great Yarmouth, Lowestoft and surrounding areas as well as some services across Norfolk and Suffolk. During our inspection we visited the a number of registered locations as well as a number of small clinics and services run across the provider.

Prior to undertaking this inspection we spoke with stakeholders, and reviewed the information we held about the provider. The provider had undergone change since its inception in 2011 including the reduction of the number of inpatient beds it provided alongside an increase in the provision of GP services. We visited the Beccles Minor Injury Unit (MIU) and found that this service was operating as an extension to primary care rather than an MIU as laid out in guidance. There was an ongoing consultation about the service.

We inspected three core service; community health services for adults,

Our key findings were as follows:

- An organisation that was changing to meet the needs and commissioning environment of healthcare in Great Yarmouth and Waveney and surrounding areas.
- Staff engaged with the organisation they worked for with over 70% owing a share of the company, above the average for a community interest company.
- There was an open culture for reporting incidents. Learning from incidents were identified and actions taken to reduce the chances of them reoccurring. However, we found that not all staff were made aware of learning from incidents.
- Good infection control, practices were evident across the services. Staff were aware of safeguarding principles and had the appropriate level of training.
- Mandatory training was above provider target in almost all areas.
- Care was evidence based and followed national guidance and best practice.
- There was effective multidisciplinary working throughout the services both within the organisation and with external professionals, services and partners.
- We found staff to be very caring. Patients were always treated with dignity and respect. We saw some examples of staff offering flexibility in their services to meet the emotional needs of patients.
- Friends and Family Test scores were positive across the series though sometimes on a low response rate.
- Services were designed to meet the needs of local people. Staff frequently flexed their service to meet individual needs of patients on an ad hoc basis.
- Access to services was good. There were drop in services for some clinics and other services such as Hospice at Home and community nursing seeing many patients within 24 hours of referral.
- Staff respected local leadership and felt well supported. They all spoke highly of senior management during the inspection though staff survey results showed they felt a lack of engagement from the executive team.
- There was a governance structure in place that enabled directors and senior leaders to monitor and manage risk, plan and strategise and provide assurance to themselves as well as stakeholders.
- There was a clear vision and strategy for the provider and its services. Senior leaders were aware of the risks facing the organisation which the strategy reflected.

We saw several areas of outstanding practice including:

- There was an increased use of self-management programmes in some services with a focus on patient outcomes.
- Staff in the hospice at home service demonstrated a sensitive, compassionate and caring approach to patients in their care. Staff gave us examples of how they went 'the extra mile' to meet each patient's individual needs and preferences.

Summary of findings

- There was increased integration of services particularly in palliative care and partnership working with acute trusts. The diversification into other services such as GP's offered greater scope for the integration of services.
- Free baby life support training was offered by the health visiting teams.
- There was a breast feeding peer support team which offered support out of hours via telephone.

However, there were also areas of poor practice where the provider needs to make improvements.

The provider should:

- Ensure there is documentation regarding the distribution of multivitamins in line with the Governments "Healthy Start Programme".
- Ensure completion of the child's health record, "red book", and note taking procedures when on home visits are consistent.
- Ensure the waiting area for children attending speech and language therapy (SaLT) at Shrublands is child friendly and children do not have easy access to stairs through a set of unsecured double doors.
- Ensure LAC are meeting targets for initial health assessments and annual reviews.
- Ensure staff were aware of audit outcomes such as harm free care.
- Ensure that all patients risk assessments are properly reviewed.
- Ensure all equipment is properly checked and calibrated.
- Ensure all staff are aware of incidents which have occurred across the CYP team and evidence sharing and learning from incidents.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Fiona Allinson, Care Quality Commission

The team included six CQC inspectors, an inspection manager, and a range of specialist advisors including: senior nurses in health visiting and children's care, community nursing, minor injuries nursing and a specialist nurse.

Why we carried out this inspection

We inspected East Coast Community Health C.I.C as part of our schedule of inspections of community independent health providers. We also rated the services and the provider at this inspection

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other

organisations to share what they knew.

We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

During the inspection we held a drop in session with staff. We visited clinical areas across the services, observed patient care and treatment. We talked with people who used services, their relatives and carers and reviewed records.

We carried out an announced inspection visit from 1st to 4th November 2016 and carried out an unannounced inspection to two locations on 17th November 2016.

Information about the provider

East Coast Community Health Community Interest Company provides services across the area of Great Yarmouth and Waveney, Lowestoft and surrounding regions. It has recently taken on additional speech and language services for children across Norfolk. The provider is also responsible for five GP practices that were not inspected as part of this inspection. It provides the following core services:

Community Adults

Community Childrens, young people and families

Community Inpatients

East Coast Community Health was formed in 2011 from the provider arm of Great Yarmouth and Waveney PCT. It is a community interest company, is limited by shares and is employee owned with 70% of employee's as shareholders. The organisation now provides services to more than 70000 registered users with a turnover of approximately £40 million.

Summary of findings

What people who use the provider's services say

Patients, families and carers were very positive about the care they received from staff. Friends and Family Test responses were almost uniformly positive though this was sometimes on a low response rate.

The provider also undertook other service evaluations. Again, patient responses from these were positive

Good practice

- There was an increased use of self-management programmes in some services with a focus on patient outcomes.
- Staff in the hospice at home service demonstrated a sensitive, compassionate and caring approach to patients in their care. Staff gave us examples of how they went 'the extra mile' to meet each patient's individual needs and preferences.
- There was increased integration of services particularly in palliative care and partnership working with acute trusts. The diversification into other services such as GP's offered greater scope for the integration of services.
- Free baby life support training was offered by the health visiting teams.
- There was a breast feeding peer support team which offered support out of hours via telephone.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should:

- Ensure there is documentation regarding the distribution of multivitamins in line with the Governments "Healthy Start Programme".
- Ensure completion of the child's health record, "red book", and note taking procedures when on home visits are consistent.
- Ensure the waiting area for children attending speech and language therapy (SaLT) at Shrublands is child friendly and children do not have easy access to stairs through a set of unsecured double doors.
- Ensure LAC are meeting targets for initial health assessments and annual reviews.
- Ensure staff were aware of audit outcomes such as harm free care.
- Ensure all equipment is properly checked and safety tested.
- Ensure all staff are aware of incidents which have occurred across the CYP team and evidence sharing and learning from incidents..
- Ensure that all patients risk assessments are properly reviewed and updated.

East Coast Community Healthcare C.I.C.

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as good because:

- Staff were encouraged to report incidents. Staff told us they were confident in identifying incidents and felt able to report them.
- There was good infection control practice across the services. Staff used appropriate protective equipment, maintained good hand hygiene and ensured equipment was clean.
- Safeguarding practices were good. All staff were aware of how to raise a safeguarding.
- There were processes in place such as early warning scores to ensure patients had their care escalated if they were unwell.
- Mandatory training rates were generally at or above provider target.
- Most records were accurate and up to date.

However:

- Whilst incidents were properly reported and investigated, not all staff were aware of learning from incidents in the area in which the worked. A small number of the root cause analysis we reviewed lacked detail.
- There was inconsistent use of the 'red book' across children's services which were frequently not completed fully.
- Some nursing vacancies were impacting on community nursing ability to provide 24 hour care.

Our findings

Duty of Candour

- Almost all staff were aware of the duty of candour and could explain what it meant and its implications for their work.
- We saw several examples where the duty of candour had been triggered. Patients had been contacted, informed of the concerns and offered an apology.

Safeguarding

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- Staff had a good knowledge of safeguarding principles and were aware of how to make a safeguarding referral. There was a lead for safeguarding in the organisation trained to the appropriate level (level 4) who was able to support staff if required.
- Safeguarding training formed part of mandatory training. There was good levels of safeguarding training which met the trust target. Staff working in different services had been trained to the correct standard of safeguarding. For example, staff in children services had been trained to level 3 in line with national guidance.

Incidents

- Staff were encouraged to report incidents and there was an open culture regarding incident reporting.
- Incidents were properly investigated on most occasions though a small number of root cause analysis we reviewed lacked detail making the identification of learning points difficult. Most staff undertaking root cause analysis had received training to do so.
- We found in children's services that whilst incidents were reported and investigated, staff were not always aware of the learning from any incidents.

Staffing

- Staffing levels in inpatient areas and children's services were at mostly at establishment. Speech and language therapy staff were concerned about the size of their caseload as compared to national professional guidance though senior leaders showed us a new model of care they were working towards.
- Staffing in community nursing was more variable with some vacancies in some areas such as Lowestoft. The level of vacancies had meant there was a reliance on the out of hospital team to provider support to community nursing between the hours of 6pm and 8pm.
- Where there was the use of bank staff we found they were properly orientated to the area they would be working in. There was very little agency use across the provider.

Are services effective?

Good

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

Summary of findings

We rated effective as good because:

- Across services care was provided in accordance with best practice and national guidelines. Policies and procedures reflected best practice.
- Local audits were carried out across the services. Plans were drawn up in response and reaudit took place to measure improvement. However, not all staff were engaged with audit at a local level.
- Staff were competent to carry out their roles and some were supported to undertake additional qualifications.
- There was good multidisciplinary working across ECCH both within and also external stakeholders and partners.
- Consent was appropriately sought before intervention. Staff were aware of the Mental Capacity Act 2005 and also implications of Fraser and Gillick competence.

However:

- The Looked After Children's team were not meeting the national guidance for timeliness of initial assessments and reviews.
- Although we saw evidence that an audit of clinical notes in the minor injuries unit was carried out no audit tool was used. This meant that the audit was not replicable and outcomes may not have been consistent.

Our findings

Evidence based care and treatment

- Care pathways followed best practice and national guidance. For example, pathways in the management of leg ulcers and palliative care and other clinical protocols were all under pinned by evidence.
- There was a full programme of audit across the services we inspected. Where audits were completed action plans were formulated and reaudit undertaken. Not all staff were engage locally with audit programmes.
- There was innovative use of self-management programmes and analysis of outcomes. Research had identified self-management as particularly effective for patients with certain health needs.
- Policies and procedures were based on clinical evidence and best practice.

Patient outcomes

- Patient outcomes were audited and many formed part of contractual key performance indicators (KPI's) and commissioning for quality and innovation (CQUIN).
- There was positive performance around KPI's for example with improved (reduced numbers) of community acquired pressure ulcers.
- Children's services performed consistently well against national benchmarks. For example, ECCH health visiting team saw 96% of expectant mothers before 28 weeks in Q2 2016. ECCH was performing consistently better than the target of 90% with 93% of all new babies seen before day 14 in Q4 2015 to Q2 2016.

Multidisciplinary working

- We saw excellent examples of multidisciplinary working within ECCH and with external professionals and services.
- Health visitors, physiotherapists, speech and language therapists regularly liaised. Nursing teams regularly communicated with external local and national health providers. There were referral pathways in place for the further assessment of children if required.
- Inpatient staff attended a multidisciplinary team (MDT) meeting every Wednesday. The meeting was attended by therapists, nurses, GPs and a social worker. There was good communication between different professionals at the meetings which effectively planned care for patients to be discharged.
- Staff in the hospice at home team told us they attended monthly Gold Standards Framework meetings at local GP surgeries. District nurses also attended these meetings. The meetings involved multidisciplinary discussion of patients on the palliative care register. This meant that all staff involved in end of life care had an opportunity to discuss patients' care with other members of the multidisciplinary team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Are services effective?

Good

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

- Staff appropriately gained consent before carrying out procedures.
- All staff we spoke with were aware of the implications of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- MCA and DoLS formed part of mandatory training. There was good rates of training above that of the provider target. We observed that during handover patients mental capacity was discussed and a formal assessment completed if required.
- In children's services all the staff we spoke with had an excellent understanding of Fraser and Gillick competence and their application.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Friends and Family Test (FFT) results were consistently positive across the services.
- Feedback from people who used the services was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff.
- Staff helped people cope emotionally. People had their social needs understood. People were supported to maintain and develop their relationships with social networks and community. People were enabled to manage their health and care when they could, and to maintain independence.
- Patient's relatives and loved ones were included in care planning with patients needs at the centre of care planning.
- Staff offered individualised care. We saw examples of this across the services but particularly in the Hospice at Home Service.

Our findings

Compassionate care

- Results from the NHS friends and family test showed consistently positive results. From September 2015 to August 2016, there were eight months where data was collected the services scored 100% in all eight months.
- Health visitors regularly went above and beyond their roles for the families they supported. For example, liaising with church charities to provide furniture and essentials for families in financial difficulties**.**
- Staff took the time to explain and interact with patients and relatives, they were sensitive to patients needs offering explanations and being supportive when patients expressed concerns.
- Staff went the extra mile to meet patients' needs. For example, a patient who had wanted to come to the area to visit their family for Christmas. The patient was near the end of her life and needed support with personal care, equipment and medications. Staff told us how they worked with the local specialist palliative care team and GP to arrange for the patient to be supported over the Christmas period. This meant that the patient was able to spend Christmas with her loved ones.
- Staff adapted their assessments and treatments to meet the individual needs of each patient. For example, there were times when certain standardised assessments might not be appropriate, as they could be distressing or invasive for a patient in the last days of their lives. Staff considered each patient as an individual and made sure the patient's wellbeing was their first priority.

Understanding and involvement of patients and those close to them

- Staff involved patients and their families in planning care and treatment. Staff caring for patients with life limiting and long term conditions discussed the individual needs with patients and developed the best and most effective plans for addressing their needs in partnership with patients and their relatives.
- Staff included patients and their families in decisions about their care. For example, we saw one member of staff talking to a patient about different options for support. They told the patient "We'll be guided by you and your family" when discussing what level of support the patient needed. This was in line with the Leadership Alliance for the Care of Dying People: five priorities for care, which recommends, "The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants."
- Staff training was focused on improving understanding of the patient experience. We saw individualised advance care plans in patients' homes, which reflected the choices and preferences of the patient.
- Staff asked questions in a sensitive and non-judgemental manner, and built a positive relationship with parents. Parents appeared to be open and honest with staff as a result.

Emotional support

- We observed staff offering emotional support with a patient with had received difficult news and another supporting a patient who had reservations regarding a planned admission for a surgical procedure. In both

Good

Are services caring?

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

episodes staff gave the patients time to present their concerns and fears and offered advice on managing their concerns such as talking with relatives and friends and accepting physical help where needed.

- Personal, cultural, social and religious needs were addressed. Staff we spoke to were aware of their patient's specific needs such as those with strong religious feelings and some staff had developed links with local clergy to help support patients.
- The hospice at home service offered short respite visits for patients' loved ones in situations where care responsibilities were having a negative impact on their wellbeing. This meant that patients' loved ones were supported to take some time off from their role in providing care for the patient.
- The Myalgic Encephalitis/Chronic Fatigue Syndrome (ME/CFS) team emotionally supported a large volume of patients across Norfolk and Suffolk both in patient's homes and in clinic to learn to recognise their 'triggers'. They also used basic cognitive behavioural knowledge and a graded exercise programme to help patients manage their condition.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. Facilities and premises were appropriate for the services being delivered and flexibility, choice and continuity of care was reflected in the services.
- The OOH team operated a triage system to ensure that people were assessed and treatment planned in a timely manner.
- The hospice at home service provided visits to patients that were flexible dependent on patients' needs and preferences.
- Staff had access to translation services for patients who did not speak or understand English. Staff could access face to face or telephone translation services dependent on the patient's needs.
- The community matrons worked closely with the wider multidisciplinary team for example social workers and GPs to ensure patients in vulnerable circumstances had support to remain independent or stay in their own homes.
- Staff received training and had been supported by an Admiral nurse when caring for patients living with dementia.

Our findings

Service planning and delivery to meet the needs of local people

- The ECCH staff worked with other providers, including children's centres and voluntary organisations, to provide support and services to parents and their families. Clinics and support groups were set up and based in local communities to meet the needs of local people.
- The breastfeeding support service offered breast-feeding support groups facilitated by breast feeding coordinators, breast-feeding peer supporters and health visitors.
- At the time of our inspection, Beccles ward was being renovated in order improve the environment and facilities that were available for patients. Patients were being temporarily cared for on Laurel Ward.
- The hospice at home service offered visits of up to an hour in length and up to three visits per day. This meant that staff could take the time to provide care to patients in a sensitive way. Frequency of visits was directed by patients and their loved ones and was dependent on each patient's individual needs.

Meeting needs of people in vulnerable circumstances

- The community matrons worked closely with the wider multidisciplinary team for example social workers and GPs to ensure patients in vulnerable circumstances had support to remain independent or stay in their own homes.
- One of the matrons told use that she worked with all disciplines within the community to manage patients with complex needs. She gave examples of liaising with social workers to adjust social care packages to meet the increased needs of patients. She also told us that the matrons, community nursing, and therapies staff worked closely to manage patients in vulnerable circumstances.
- Staff supported parents (particularly mums) with learning difficulties. Health visitors used videos to demonstrate good baby handling techniques, pictures and flash cards, and the use of "tummy balls" to demonstrate the size of a baby's tummy to reduce the anxiety of how long feeding should take.

Access to right care at the right time

- The OOH team band four assessors liaised with referrers and visited patients whilst still in hospital s to assess their needs on discharge. This ensured that the right package of care was in place when needed.
- Speech and language therapy (Norfolk) offered drop in sessions with a speech and language therapist on the last Friday of every month. Parents who had concerns about their child could access advice, have their child's speech assessed and be given access to the SaLT services if required.
- Children's services particularly health visiting performed well against local and national standards to review children and families in a timely way.
- The minor injuries unit had recently reduced its opening hours due to a shortage of staff and was now open daily from 10am to 6pm where previously the service had been open 8am to 8pm. Patients told us that they appreciated the short waiting times in comparison to local accident and emergency departments.

Good

Are services responsive to people's needs?

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

- The hospice at home service measured the response rate to patient referrals. This service had set a goal to see patients within one week of referral. From November 2015 to October 2016, 96% of patients were seen within one week. In this period, 65% of patients were seen within 24 hours.

Learning from complaints and concerns

- At a provider level there had been a small increase in complaints. Analysis had shown these to be linked to the acquisition of new services such as speech and language and primary care services.
- Staff were aware how to manage complaints and attempted local resolution in the first instance.
- We saw that complaints were managed appropriately and that I lessons were learnt. Consideration was given as to whether a complaint triggered the duty of candour requirement.

Are services well-led?

Good

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

Summary of findings

We rated the provider as good for well led because:

- The executive team had a clear vision and strategy in place for the development of the services and provider as a whole. This included the diversification of services such as the provision of GP practice
- There was a governance structure in place that enabled directors and senior leaders to monitor and manage risk, plan and strategise and provide assurance to themselves as well as stakeholders.
- Staff spoke highly of the leadership on inspection though it was noted that executive engagement scored poorly on the staff survey.
- There was a culture of openness and transparency at the provider.
- Staff were committed to the organisation. As a community interest company staff could purchase a share of the organisation. Over 70% of staff had done this.

However,

- The Fit and Proper Persons process did not fully meet the requirement at time of the announced inspection. However, the provider took action to address these shortcomings during our inspection.

Our findings

Leadership of the provider

- ECCH was led by a chair and chief executive. There were four additional executive directors and non-executive directors.
- The senior leaders of the organisation had the capacity, capability, and experience to lead effectively. During this inspection directors demonstrated a good understanding of the issues facing the organisation. They were committed to the strategy of the organisation and developing their staff and new models of care. For example, they were aware of the need to increase the recording and auditing of preferred place of care for patients receiving palliative care.
- Staff we spoke with were very positive about the leadership and how approachable senior leaders were. This was at odds with the staff survey that showed many staff did not feel valued by the executive team.

Vision and strategy

- The executive team had a clear strategy for the future of the organisation and services it provided. There was an understanding of a challenging commissioning environment; the organisation had added additional services such as GP surgeries to balance the service portfolio without reliance on a single contract.
- There had been the development of innovative care planning and pathways, for example in end of life care. The directors where aware that innovation was key to sustainability and the recommissioning of contracts.
- East Coast Community Health (ECCH) was actively engaged with one sustainability and transformation plan (STP) with the executive director of quality sitting on the executive committee. Due to director capacity they were unable to be as involved with the second STP that bordered the organisation.
- ECCH was committed to forwarding the staff ownership structure of the organisation. More than 70% of staff were shareholders which was well above the average for a community interest company.
- Most of the staff we spoke with were aware of the vision and strategy of the organisation and were committed to its values.

Governance, risk management and quality measurement

- ECCH had developed a governance structure that brought together the clinical and nonclinical aspects of the business together.
- Seven committees including the strategic HR Education and training group, safeguarding committee, medicines management committee, health and safety committee and infection prevention and control committee fed directly into the Integrated Governance Committee (IGC). The IGC was chaired by a non executive director (NED) and was responsible for patient safety, risk management and, patient involvement and complaints. The IGC met every two months.
- IGC minutes reviewed showed that there was good challenge at the meeting and that appropriate papers were brought. Clear actions were identified and these were followed up at successive meetings.

Are services well-led?

Good

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

- The IGC along with the remuneration committee and the audit committee fed into the board.
- Board papers and minutes showed good attendance and that relevant risks were discussed. The audit committee reviewed all audits and the accompanying audit report and action plan. Minutes showed that audit outcomes were considered and plan agreed in response to findings. The board also included staff representation from the shareholder council and two staff directors.
- Each specialty had a clinical risk register. Risks that scored greater than 15 after mitigation went on to the corporate risk register.
- The corporate risk register, rating risks from low through to very high and were reported to each IGC meeting. Risk were clearly documented with summary updates, ownership of risks and actions taken to mitigate risk. Directors and senior managers had a good knowledge of the risks on the register as well as the mitigation in place. We identified two older risks and questioned why they were still rated as high when they had been on the register for many months. There was a clear explanation as to the ongoing going risk (recruitment in this case) but as it remained fundamental to the business, despite mitigation, it remained on the register.
- There was additional oversight from commissioners. ECCH had a positive relationship with the CCG. Monthly meetings (Clinical Quality Review) were held between directors and the CCG to measure quality and performance against the key performance and quality indicators in the contracts.
- There was evidence of leaning from incidents. Quality audits were developed into action plans to address any items identified in the audit. These in turn led on to additional reaudit to ensure improvements had been embedded.

Culture within the provider

- ECCH directors and other leader's role modelled the values of the organisations. Staff we spoke with were aware of and positive about the values of the organisation.
- There was a clear organisational development (OD) plan. Executives told us their greatest asset was their staff. The OD plan had a focus on staff development to allow flexibility in the services being provided.

Fit and proper persons

- At the time of inspection ECCH did not have a distance Fit and Proper Persons policy in place. There had instead been a reliance on the usual forms of pre-employment checks but there was no process in place to reconsider the fitness of directors. We raised these concerns with the provider and they immediately took action to draft a dedicated policy which was due to be ratified shortly following our inspection.
- We reviewed three files and found that the appropriate checks had been completed for directors joining the organisation but additional work was required to meet the regulation.

Staff engagement

- As a community interest company staff that purchased a share in the organisation (for one pound sterling) became owners of the company. Over 70% of staff had chosen to purchase a share in the organisation in this way which was above the average for community interest companies.
- Senior directors endeavoured to visit teams and bases frequently though acknowledge it was sometimes a challenge as the organisation grew geographically.
- Directors were aware and at times frustrated that they could not share information about contracts with staff at the earliest opportunity. Due to contracting and commercial reasons, decisions were made before these could be communicated to staff. The executive team acknowledged that some staff felt they were not properly engaged because of the ways commissioning and contracting decisions were made. They felt this was one of the reasons for some of the poor reasons for executive engagement in the staff survey. There was a staff engagement plan in place following previous staff survey results.
- Two staff directors also attended the board and were elected by shareholding staff.
- The shareholder council had been 'refreshed' and was again functioning. This allowed shareholding staff to voice their opinions, concerns and ideas. The chair of the council also sat on the provider board

Public engagement

- ECCH was developing a 'local voices questionnaire' to gather the views of patients and their relatives in conjunction with GPs and the local acute hospital.
- In addition to the Friends and Family Test, ECCH carried out service evaluations. For example in children's

Are services well-led?

Good

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

services the service evaluation report for June 2016 showed 100% of children and young peoples' service users thought the staff were friendly and helpful, were happy with the length and time of their appointment and felt health visitors treated them with dignity and respect.

Innovation and Sustainability

- As a community interest company, East Coast Community Health was required to financially break even and not be in deficit. They had achieved this since the organisations inception.
- East Coast Community Health was active in research with eight studies being run during our inspection.
- The provider also had a commercial arm, profits of which were reinvested into services. They provided training and opened a children's nursery shortly before our inspection.
- ECCH was working towards greater integration of services including in palliative care to provide seamless care.
- ECCH was aware of the potential risks of focussing on a narrow range of services. They had taken active steps in broadening the services they provided from speech and language services in Norfolk to the acquisition of 5 GP surgeries over the last 18 months.
- There was an increased use of self-management programmes in some services with a focus on patient outcomes.