

# Central Essex Community Services C.I.C. HQ

## Quality Report

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

# Summary of findings

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# Summary of findings

## Overall summary

Central Essex Community Services C.I.C. is a provider of integrated health and social care and supplies a broad range of community services across Essex, Cambridgeshire, Peterborough, and the London boroughs of Waltham Forest and Redbridge.

The provider HQ is based at St Peter's Hospital in Maldon, Essex. Whilst registered with the Care Quality Commission as a location, the majority of services that were reviewed at this inspection are carried out within community settings, such as community clinics, schools, nursing homes and primary care settings, as well as within people's own homes. The services provided to people include: diabetes management, continence advice, speech and language therapy, physiotherapy, wound care; respiratory care, child health assessment, immunisation and end of life care.

In general, we found that Central Essex Community Services C.I.C. HQ provided safe care. Most areas had processes in place to recognise and investigate patient safety incidents. However, there was an underreporting of incidents and an absence of shared learning following

review of reported incidents. There were inconsistencies in staff practice regarding the practical application of these systems and an absence of learning both within and across services and teams.

We found some examples of good leadership and most staff felt they were well supported by their managers. Many said they had good training and development opportunities.

The vast majority of people we spoke to were positive about their care but especially in regards to services provided to children and families. We found some good examples of innovative practice not least the care given to patients by the children's speech and language therapists. The service had won a national innovation award for contribution to their profession.

In general we found that community services were safe, with pathways of care effectively used to meet the needs of patients, families and carers. The exception to this were end of life care services, where the planning and delivery of service provision was not coordinated in the same way between inpatient and community teams delivering end of life care.

# Summary of findings

## The five questions we ask and what we found at this location

We always ask the following five questions of services.

### **Are services safe?**

Services are generally safe for patients at the point of delivery. However we had some concerns around safeguarding awareness and systems for adult services, along with End of Life service risks around syringe driver administration of medications.

Governance arrangements have been seen to be weak, with system failures around monitoring, escalation and learning from risk.

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### **Are services effective?**

In general we found services were effectively meeting the needs of patients, families and carers through evidenced based practice, guidance and care pathways. However, in children's universal services, there were issues in waiting times and appropriate resources.

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### **Are services caring?**

Patients, families and carers feel services are high quality. They feel staff support them with their treatment and display compassion, kindness and respect at all times.

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### **Are services responsive to people's needs?**

Front line staff work hard to tailor care to meet the needs of patients, families and carers ensuring it is individualised and person centred care.

However, strategic planning and development of services generally lacks the direct involvement of and feedback from patients, families and carers.

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### **Are services well-led?**

Operational teams feel well supported and display a commitment to the values of the organisation and best quality care. This is reinforced by a visible leadership who help to motivate staff.

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# Summary of findings

## What we found about each of the core services provided from this location

### Community services for children and families

Services for children, young people and families were well-led. The combination of visible senior leadership with supportive caring team managers resulted in staff reporting confidence of an open, honest and transparent and positive culture in which to work.

All the children, family members and staff we have spoken with would recommend children and family services to their own family and friends.

Staff were well trained around child protection systems and triggers and were confident of their own roles and responsibilities within these areas, working jointly to safeguard children and young people.

However, service managers and staff were less clear around the reporting and escalation of risk, and this contributed to the over-arching developments required across the organisation.

Front line services responded to the feedback of children and families, and we have seen examples of service developments because of feedback. However, we did hear about some difficulties due to written information for families not being available in alternative languages.

At the point of delivery we have seen caring and compassionate care that is family-centred and personalised to best meet the needs of the child and family. This was not always backed up with detailed up to date care plans signed by children and families. We have heard that for some services this could be as a result of resource and capacity issues.

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### Community services for adults with long-term conditions

Overall, across all services and teams, patients with long term conditions received safe care. Patients and relatives told us they were treated in a caring and friendly way and were kept well informed. Services are responsive to the needs of patients.

We saw some excellent practice from the district nurse team and in the clinics we visited, where compassionate and individualised care helped to promote independence. However, we were concerned about the procedures and practices around safeguarding, including prioritisation of training and the lack of awareness of appropriate escalation process for those who work alone in the community who may observe safeguarding concerns.

Whilst we did see appropriate monitoring, reporting and learning from incidents including never events, there were weaknesses in systems to use lessons learned to develop practice and a lack of strategic drive in this area.

Staff demonstrated understanding around the Mental Capacity Act. However, there was not a consistent approach in delivering services for those patients presenting with dementia and this can be directly linked to a lack of formal training and awareness in front line staff.

Information sharing and risk escalation systems were weak and this impacted on the effectiveness of leadership, governance and associated service improvements.

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### End-of-life care

We saw good practice and dedicated services for people nearing and during the end stages of life. We saw and were told about some outstanding practice, in particular from the district nurse team

All of the patients and relatives we spoke with told us that community staff were caring, informative and compassionate. Patients felt they received effective care and treatment both in the community and as in-patients.

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# Summary of findings

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The response to patients' end of life care wishes was very positive. The staff enable patients to die in comfort, in their preferred place and in a dignified manner.

However we saw that governance arrangements and high level systems to ensure learning from risks and the feedback from patients and families were weak.

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# Summary of findings

## What people who use the community health services say

In 2012/13, according to the provider's quality accounts, customers were surveyed from each of its services. Whilst the results were reported to be generally favourable, as the survey was for Central Essex Community Services C.I.C. only, it is not possible to benchmark the results against other similar organisations. There have not been any patient comments through the NHS Choices or Patient Opinion websites. There was one Share Your Experience form submitted to CQC (in June 2012) raising concerns about staffing levels and sickness.

The provider's Board minutes include a customer experience report which looks at trends in complaints, compliments, feedback from visits by the Executive Team and other patient feedback. The latest organisation wide report (November 2013), looked at complaints from April

– September 2013. No trends were identified but the main areas of concern were: care, accounting for 30 out of 87 complaints, and communication, accounting for 18 out of 87 complaints.

A total of 37 comment cards were collected from locations where services were provided by Central Essex Community Services (excluding inpatient wards). The majority of these were collected from the Rapid Assessment Unit (eight responses) and Moulsham Grange (21 responses). The overwhelming majority of patients who completed a comment card felt that they had been listened to and cared for with respect and dignity in a clean environment that met their needs. Patients and relatives who completed comment cards were unanimous in their praise for the staff that had looked after them.

## Areas for improvement

### Action the community health service **MUST** take to improve

- Ensure effective arrangements are in place to identify, assess and manage risks.

### Action the community health service **SHOULD** take to improve

- Ensure detailed and up to date care plans are in place for children and young people and that children, young people or families have signed up to their plan of care.
- Ensure detailed and up to date care plans are in place for children and young people and that children, young people or families have signed up to their plan of care.
- Ensure action is taken to increase staff awareness regarding formal child protection escalation processes. Including escalation of alleged abuse that does not reach the local authority's reporting threshold.

- Include dementia training as a component of the mandatory staff training programme.
- Ensure a written plan regarding the development of adult safeguarding practices is developed and implemented
- Ensure availability of written information concerning vulnerable adult safeguarding reporting processes in all community team offices.
- Ensure all syringe drivers are supplied with tamper proof, lockable covers and that risk assessments are conducted prior to the provision of such equipment.
- Review the availability of guidance to staff concerning equipment access out of hours.
- Ensure collaborative review of the strategy for end of life services and monitor implementation and compliance with national guidance.
- Ensure staff are given the opportunities to receive clinical supervision and processes are in place to monitor these arrangements.

# Summary of findings

## Good practice

- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The positive feedback received from patients across all services regarding the quality of care received; especially in regards to services provided to children and families.
- The care given to patients by the children's speech and language therapists. The service had won a national innovation award for contribution to their profession. The annual Giving Voice awards, run by the Royal College of Speech and Language Therapists (RCSLT), highlighted the life-changing work of speech and language therapists and celebrated the creativity and commitment to the profession.
- The allied health professional-led initiative that provided additional support to parents whose children experienced sleeping problems.
- The care being provided to people within their own homes was person centred and focussed on maintaining peoples' independence.



# Central Essex Community Services C.I.C. HQ

## Detailed findings

### Services we looked at:

Community services for children and families; Community services for adults with long-term conditions; End-of-life care

## Our inspection team

### Our inspection team was led by:

**Chair:** Tracy Taylor, Chief Executive, Birmingham Community Healthcare NHS Trust

**Head of Inspection:** Amanda Musgrave, Care Quality Commission

The team included CQC inspectors, an analyst and a variety of specialists: District Nurse Team Leader, District Nurses, Community Matron, Specialist Community Public Health Nurse (Health Visitor), Physiotherapist (adults and children), Children's Nurse, Pharmacist and patient 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

## Background to Central Essex Community Services C.I.C. HQ

The provider HQ is based at St Peter's Hospital in Maldon, Essex. Whilst registered with the Care Quality Commission as a location, the majority of services that were reviewed at this inspection are carried out within community settings,

such as community clinics, schools, nursing homes and primary care settings, as well as within people's own homes. The services provided to people include: diabetes management, continence advice, speech and language therapy, physiotherapy, wound care; respiratory care, child health assessment, immunisation and end of life care.

## Why we carried out this inspection

This location and provider as a whole were inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

# Detailed findings

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

Where provided the inspection team will always look at the following core service areas on each inspection:

- Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
- Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
- Services for adults requiring community inpatient services
- Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider.

We carried out an announced visit on 21, 22 and 23 January 2014. During our visit we held focus groups with a

range of staff (district nurse team leaders and community matrons, district nurses, health visitors, school nurses, specialist children's nurses, health care support workers, community ward staff, adult allied health professionals and children's allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service. We visited health centres, community clinics and accompanied the provider's staff on visits to patient's homes.

We carried out an unannounced inspection to two community nurse localities on 23 January 2014. As part of the visit we looked at how the community services were operated out of hours and what staff were available.

The team would like to thank all those who attended the focus groups and listening event and were open and balanced in the sharing of their experience and their perceptions of the quality of care and treatment at Central Essex Community Services C.I.C.

# Community services for children and families

## Information about the service

Children and families services include health visiting, school nursing, community children's nursing, specialist children's diabetes, dietetics, speech and language therapy, physiotherapy, sexual health, safeguarding, Looked After Children and consultant community paediatrics.

The inspection team included two compliance inspectors, a specialist health visitor, registered children's nurse and an expert by experience. During our inspection; we spoke to approximately 90 staff and eleven families. We visited three children's health centres, observed clinics and visited two hospitals, observed therapy sessions and attended two home visits and a school visit. We also used information provided by the organisation and information that we requested, which included feedback from children, young people and families using the service about their experiences.

## Summary of findings

Services for children, young people and families were well-led. The combination of visible senior leadership with supportive caring team managers resulted in staff reporting confidence of an open, honest and transparent and positive culture in which to work.

All the children, family members and staff we have spoken with would recommend children and family services to their own family and friends.

Staff were well trained around child protection systems and triggers and were confident of their own roles and responsibilities within these areas, working jointly to safeguard children and young people.

However, service managers and staff were less clear around the reporting and escalation of risk, and this contributed to the over-arching developments required across the organisation.

Front line services responded to the feedback of children and families, and we have seen examples of service developments because of feedback. However, we did hear about some difficulties due to written information for families not being available in alternative languages.

At the point of delivery we have seen caring and compassionate care that is family-centred and personalised to best meet the needs of the child and family. This was not always backed up with detailed up to date care plans signed by children and families. We have heard that for some services this could be as a result of resource and capacity issues.

# Community services for children and families

**Are community services for children and families safe?**  
(for example, treatment is effective)

## Safety in the past

Children, young people and families were protected from abuse and avoidable harm. Speaking with staff, combined with training compliance figures (95% across the organisation) demonstrate that children's staff were appropriately trained in and were clear of their own responsibilities in safeguarding. Lead safeguarding nurses were well known and accessed when needed for advice. Staff were less confident of formal escalation mechanisms where cases of concern were not deemed to meet the thresholds of the local authority. Whilst there were plans in place across children's services, current practice results in significant variability in the provision of safeguarding supervision and this could present risk from the non-identification of cases. Staff gave several examples of appropriate tenacity to ensure the safety of children and families when faced with cases of concern.

## Learning and improvement

The systems in place allowed for appropriate escalation to the National Patient Safety Agency, including never events. Staff were familiar with, and could give examples of developments in response to the reporting of safety incidents, such as; an enhanced checking system for biopsy results, improved communication systems with parents and efficient responses to risks identified for lone working staff.

## Systems, processes and practices

The vast majority of staff reported that their managers were supportive and they felt comfortable to raise issues.

"I can be honest and confidential with [my manager.]"

"Someone actually listens"

Policies and procedures were in place regarding incident reporting. However, there was no robust system in place to ensure that less serious events were learnt from. Staff told us that they did not often receive feedback from incidents that they had reported. In addition, there was limited team manager exposure to formal risk and root cause analysis training. As such, there was a culture of underreporting incidents and risks and instead these were verbal discussions within teams. For example, continuous delays

in waiting times for specific outpatient diabetic clinics and manual handling risks around nurses carrying transportation kit and vaccines had not been formally escalated or added to the risk register.

Electronic systems (System One) ensured records of children were available across multiple locations. This enabled effective multi-disciplinary working and timely information sharing. However, some staff told us that some GPs did not allow access to their records via the shared system, in order that the complete record (for a child) could be viewed if required. This meant that the complete record was not always available.

## Monitoring safety and responding to risk

Skill mix of teams and comprehensive training supported safe practice. All staff spoken with had received an annual appraisal of their performance and the majority of teams had access to regular clinical supervision, which had been conducted in groups. The exception being the immunisation team who had not received regular clinical supervision.

Mandatory training and robust monitoring systems supported safe practice and staff felt accommodated when they had requested specific training. One member of staff told us, "It's the best organisation by far for training. They encourage you."

Effective systems were in place to promote the safety of staff when lone working, including thorough assessment of environmental risk factors. As a result, staff felt safe and secure when working in the community alone. However, challenges remain when using mobile devices in regards to lack of connectivity or signal when out of office. Teams have implemented differing systems to support each other and promote the safety of colleagues.

## Anticipation and planning

The organisation had the ability to deliver on government driven, best practice initiatives, for example, the Healthy Child Programme. There had been a full review of staffing to meet these needs and the Health Visitor implementation programme had ensured a full complement of Health Visiting resource.

Whilst there was under resource issues for qualified school nurses, this had been recognised with two practitioners undergoing training to ensure full resource.

# Community services for children and families

## Are community services for children and families effective?

### Evidence-based guidance

Staff working with children and young people delivered care in accordance with national guidelines and standards, ensuring effective treatment. They were confident of the national best practice to which they were working.

We observed that services were compliant with best practice and national standards. For example, breast feeding rates, visits to new born babies in their family setting, developmental reviews on one and two and a half year old children.

Staff were clear of roles in care pathways and worked well with multi-disciplinary colleagues to ensure optimum health and wellbeing of children and families.

We looked at informed consent and capacity to consent practices and saw the involvement of children and young people in planning their own care. Staff worked confidently to Fraser guidelines on consent and this, combined with mandatory mental capacity act training ensured a thorough approach to consent and capacity issues where there may be complexities.

### Monitoring and improvement of outcomes

Governance arrangements were in place that ensured a robust, cyclical process of information sharing between operational services and the board. Performance and delivery of children's specialist services was efficiently mapped on a dashboard for senior leaders and this data was used to inform the strategy for future service delivery. We saw that key performance indicators showed overall satisfactory rates of achievement with national targets for children's services and staff told us that they felt fully informed in relation to improvement drives and could link this to national indicators.

The November 2013 monthly performance report for national indicators and public health outcomes showed one key area of underperformance, which was Chlamydia screening for young people aged 15 years to 24 years. There were clear action points in place to improve uptake rates such as: the introduction of partner notification cards for all clients attending for chlamydia treatment which it is hoped will lead to more tests and more positive results. The

organisation also collected feedback from families who used the service and were responsive to the results. For example, baby clinics were moved from one location to another in response to feedback from parents.

### Staffing arrangements

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Mandatory training and study days facilitated up to date evidence based practice and staff told us that they felt the content of mandatory training was appropriate, including safe guarding children practices. January 2014 training attendance records demonstrated 95% mandatory training attendance.

Clinical practice was monitored by record keeping audits, clinical supervision, peer reflection and preceptorship for new Health Visitors and induction for all staff. We spoke with new staff and a student who was shadowing home visits, they noted good supervision, teamwork and peer support was provided to support them in their role. Staff told us that they felt confident and supported in their everyday roles.

### Multidisciplinary working and support

There was good collaboration between all members of the multidisciplinary team across children's services to promote best outcomes.

The team for Looked After Children (LAC) has acknowledged challenges in delays and implemented effective trigger systems to ensure relevant paperwork and documentation from partner agencies. Four nominated paediatricians were well engaged with the delivery of Initial Health Assessments and records demonstrated a flexible approach to engaging and involving children and young people who are looked after.

Feedback from families of children with complex health needs, requiring the input of multiple health professionals, told us that they had confidence that staff communicate well and work effectively together towards obtaining the best outcomes for their family.

### Co-ordination with other providers

Collaboration with partner agencies was generally effective. Multi-agency staff worked jointly together at clinics and in groups and communication systems were effective. This ensured children and young people received care that reflected their needs near to their home. For example, we

# Community services for children and families

heard about school nurses working with specialist teams to support people with mental health needs and health visitors working with speech and language team, (SLT) to support children whose speech was delayed.

One member of staff told us, “We have formal ways we can refer people on for specialist help. If we want a quick bit of advice, we just pick up the phone and chat to the relevant professional.”

## Effective care delivered close to home

Care was planned to ensure that children and young people received a service that met their needs, was delivered as close to home as possible and that minimised disruption to the family unit. Varying forms of these efforts included locality clinics, joint appointments and home visits. Baby clinics had recently been moved from one location to another in response to feedback from parents. This often meant staff were working outside the organisations recognised catchment areas. We heard evidence of cross team working, with therapists, School Nurses and Health Visitors. One member of staff told us, “Parents don’t have to worry. We sort it all out.”

We received consistently positive views from a breadth of families about effectiveness of care and the measures taken by staff to ensure care was delivered close to home. For example, baby clinics that had recently been moved from one location to another in response to feedback from parents.

## Are community services for children and families caring?

### Involvement in care

Children, young people and families were appropriately involved in and central to making decisions about their care and support packages. Observing practice and speaking with families demonstrated the provision of effective and compassionate care based on national standards, guidelines and pathways. However, these high standards of operational practice were not consistently underpinned by detailed and up to date care plans, with little evidence seen of children or families signing up to their plan of care.

We saw examples of children, young people and families being supported to develop skills to manage their own care where possible. For example: The diabetic community

service works closely with the dietician in supporting and educating children regarding diet and leading an active healthy life. There were numerous information leaflets available to help families which were child friendly, although there was a lack of written information available in other formats or languages. Therapists told us about texting alerts to remind children and young people about appointments which was actioned to try and reduce the amount of non-attendees.

The under resource of qualified school nurses presents service pressures in the transference of children’s care across universal services. Professionals work hard to address these challenges. However, the impact could be seen in the prioritisation of child protection work for school nurses, with little resource available for proactive health promotion work.

Children, young people and families are supported by relevant health disciplines to develop the level of skill needed to self-manage care needs, promoting independence and minimising disruption to family life.

### Trust and respect

Children and families we spoke with were confident that staff treated them with dignity and respect and supported their confidentiality at all times. One child told us:

“I have all the information I need, they really help me, I have no concerns about the service”

A parent said: “I have all the choice and support I need and when I’m unhappy people listen to me”.

We received consistently positive views about having choices and control from a breadth of children, young people and families. Families also rated services as good to excellent in relation to the support and respect from staff.

The community nurses provided a Monday to Friday service. Staff told us that this sometimes created a back log of calls over the weekend and that this could impact on service delivery. However, no concerns were raised with us by the children, young people and families we spoke with, in comment cards we received or raised in any of the surveys conducted by the provider.

The mandatory training log of January 2014 noted that 96% of staff had received equality and diversity training. Staff could demonstrate through the care planning process



# Community services for children and families

that they were taking into account each person's culture, beliefs and values. They were all aware where support could be obtained if it was required, for example, a translator if English was not the person's first language.

We received consistently positive views about having choices and control from a breadth of children, young people and families. Families also rated services as good to excellent in relation to the support and respect from staff.

Practice demonstrates children's staff considering individual needs in relation to culture, beliefs and values and gave examples of using interpreting services appropriately.

## **Patient understanding of their care and treatment**

Our observations of practice found that children's specialist staff regularly adapted their style and approach in order to best support children and families to understand and be involved in their care and treatment.

Health visitors reported that with increased numbers of staff they were able to deliver the Healthy Child Programme, visit children more often and develop a therapeutic relationship with them. The children and young people we spoke with knew who their named Health Visitor was and told us they were able to contact them if they had any concerns or issues they wanted to discuss about care and treatment. We saw therapists providing care and treatment to children with communication difficulties in an age appropriate way. Carers were provided with information and explanations where appropriate, such as the need to share records with the named key worker. Five families stated they could express their opinions and would not hesitate to raise concerns about care and treatment if necessary.

Staff and families referred to the website set up by the provider to support children and young people with long term conditions. Information was available on health promotion and there were opportunities for free one-to-one consultation and telephone support where necessary to help children and young people understand their care and treatment.

## **Emotional support**

The importance of additional emotional support for children, young people and families presenting with

additional vulnerabilities or complexities of health needs was displayed through observations of practice and discussions with staff, who respond appropriately by offering enhanced levels of support.

Ante-natal home visits from health visitors ensured relationship building and support prior to the birth of a child. We saw sound examples of increased levels of support where service assessments indicated additional levels of vulnerabilities. For example, if the mother was alone, young or there was already a child at risk in the family.

However, it was reported that there was a lack of suitable resources to fully provide emotional support for the siblings of those presenting with life limiting and end of life conditions. The provider told us that they were not commissioned to provide these services; access to these services was via local hospices.

## **Compassion, dignity and empathy**

We found in practice and heard positive feedback from families that staff provide compassionate care, based on the individual needs of children and young people. Children across all services were treated with dignity at all times and families spoken with considered staff were sensitive to their individual needs. This view was reflected by the staff we met, who felt passionate about delivering best care for children and families, with one stating they:

"Had the best job in the world."

**Are community services for children and families responsive to people's needs?**  
(for example, to feedback?)

## **Meeting people's needs**

We met dedicated staff across universal and specialist children's services, committed to tailoring services to best meet the needs of children and families. These services were seen to be in line with national standards around, for example breast feeding rates, visits to new born babies, developmental reviews and delivery of the healthy child programme.

Multi-disciplinary staff worked flexibly to ensure joint approaches to care delivery to combine the meeting of identified needs with minimal disruption to family routine.

# Community services for children and families

However, we noted that there were still some capacity issues that created delays to services provided to children and young families. We saw and staff told us that there were regular extended waiting times for children and young people attending the diabetic clinics at Broomfield Hospital. There was no evidence of a provider response to address the waiting times, however, staff had introduced a form “what do you want to discuss this time,” which was improving consultation times.

We also saw that there was a backlog of health assessments for Looked After Children; however the provider was taking actions to address this including engaging with partners to improve service provision. We saw that a training package was being actioned in the next month to ensure the backlog would be addressed. There were also quarterly meetings of the Looked After Children’s leads to support and develop services to meet children’s needs.

## Access to services

Staff told us that they had received special training to reflect the needs of the community they served. For example, supporting young people who were self-harming or those who required help and advice with sexual health needs. Staff also described delivering services to more hard to reach groups such as traveller’s sites. Generally access to services to ensure children and young people received the care they required was good and was able to be accessed in a timely manner.

However, staff reported difficulty reaching some specialist services provided by the local authority such as those related to children and young people with mental health needs.

The Board were kept informed regarding access to services through the Monthly Performance Management Report. For example, the report for November 2013 showed 100% compliance with the maximum six week wait for audiology tests and breast feeding checks were within target range. There was also monitoring information regarding the number of referrals into the service from 20% of the most deprived and/or marginalised groups.

Staff gave examples of working flexibly to improve access to services. Such as: staff from the looked after children’s team, in an attempt to improve engagement, offering to meet with young people in places convenient for them such as coffee shops in town centres; the Immunisation

Teams telephoning non-attenders and encourage them to attend the clinics, offering times to suit them where possible; and the eye catching information created by the sexual advice team about access to their services.

However, it is noted that despite identified concerns with levels of childhood obesity, staff continue to face challenges in accessing specialist dietetic support for children.

## Leaving hospital

Community children’s staff work effectively with ward colleagues and families to promote seamless and well planned discharge pathways home. For those with ongoing complexities this included on-call support systems and open access ‘card’ system back to the ward in line with local guidance.

For example, we looked at the diabetic service provided to children and young people which included hospital admission of new patients to set up treatment plans to manage their care in the community. Our discussions with staff and review of records found that there was good liaison between hospital staff, the community diabetic nurses and the dietician to plan for the child’s discharge from hospital. Information provided to children, young people and families on discharge was good and the diabetic community teams provided an on call out of hour’s service to ensure 24 hour support and avoid hospital readmissions where possible.

Access to the wards for community children’s nurses (CCN) and diabetes specialist nurse’s was facilitated by their acute base. Children’s specialist staff told us they felt well informed and involved around both admissions and discharges of those with ongoing health complexities.

We saw the CCN team planning visits for an afternoon, of which one was a visit to the ward to meet with the family of a baby to facilitate and support discharge planning for going home.

Of concern to families and community children’s nurses were the constraints of offering a service Monday to Friday 09.00-17.00 only. One child who had a long wait for recurring day leave based on the resources of Community Children’s Nurse’s told us “they might want to find some more community children’s nurses so there wouldn’t be as many maybes. If they had found some sooner, I could have come home sooner, but I think it’s good now”



# Community services for children and families

## Support in the community

Children and young people with diabetes were actively involved in their care both in the hospital and in the community from diagnosis onwards. The dietician provided educational literature which encouraged them to take control of their condition and manage it through a healthy life style. We saw clinical guidelines and monitoring systems including the best practice tariff for diabetes management which showed a good service was being provided. The patient experience satisfaction questionnaire showed consistently positive views from a breadth of children, young people and families and those close to them which were supported by the views of staff working in this specialism. Staff we spoke with highlighted the benefits of a collaborative approach to planning and delivery of care and treatment across services for children and young people.

Obese children were monitored and national guidance was available for staff reference to ensure that a plan of treatment and care was put in place on discharge from hospital. Physiotherapists noted that equipment provision such as hoists and adaptations to the home were available. There was close liaison with the health visitor and healthy eating team to ensure referral to the dietician and other professional bodies when needed.

## Learning from experiences, concerns and complaints

During our visit we spoke to eleven families and received consistently positive views on the children and young people's services. Families reported feeling listened to and heard. They said they were satisfied with the levels and quality of services provided by the children's community services. These findings were supported by the national and local surveys produced by the provider. We looked at the results of six national surveys. The overall levels of satisfaction were good; the few negative comments action points were mainly to feedback to teams.

Senior managers were visible and there was a culture of open communication, encouraging staff and families to express concerns. Where concerns were raised, we heard examples of learning and practice developments, including:

- Enhanced levels of domestic violence training

- Young people in the care council reported that health care plans were too long. Action was taken to develop health care plans to meet the brief of "short and snappy" provided by the young people.
- Families had concerns about the waits for equipment (example given was specialist boots recommended by a physiotherapist). When traced through, these were waiting to be agreed and signed by a senior member of staff. Action was taken by amending the process for operational sign off, which minimised delays.
- One family was concerned that supplies needed for a child who required complex treatment at home would not be available. There was a delay because the department responsible for supplying them sent incorrect items due to lack of knowledge of the child's clinical need. Action was taken so that community nurses now check complex equipment orders on behalf of families. This has minimised the stress to the family.

Senior managers were open in acknowledging the lack of formal consultation with children and families and associated learning and service design.

## Are community services for children and families well-led?

### Vision and governance framework

Staff were clear about the organisation's vision and noted that the corporate induction for all new staff included the provider's core values and objectives for the organisation. They told us that the board and senior managers were visible and approachable and were often seen out in different areas around the community talking with patients and staff.

Performance and delivery of children's universal services was mapped efficiently on a dashboard for senior leaders. This included new birth assessments, child review assessments and infants being breast fed at 6-8 weeks. If any of these targets were not reached, required action was noted or exception reports provided to explain the deficit, such as families not attending their booked appointments. This data was used at a strategic level to ensure the Board were aware of the timely delivery of service. These monitoring systems show that the board and senior managers were informed on quality issues, risk and general performance regarding children and young people across the organisation.

# Community services for children and families

Senior staff were clear about priorities for their services in line with the Joint Strategic Needs Assessment and Public Health priorities including the management of child obesity and the support mechanisms for teenage mothers and pregnancy. We saw examples of partnership working to improve care outcomes for children and young people, such as meetings being arranged to improve communication practices with social services around safe guarding thresholds for reporting. This meeting also included looked after children to improve health assessment practices.

## Promoting innovation and learning

Professionals understood and were aware of best practice initiatives and key performance indicators and consider the organisation is supportive of new initiatives. The sexual health team leader gave examples of new approaches to information provision and marketing the service which had resulted in 100% increase in attendees over the last three years. Children's speech and language therapists have also successfully won a national innovation award for contribution to their profession for creative and committed working.

All the staff we spoke with were aware of the implementation of best practice initiatives such as Maternal Early Childhood Sustained Home-Visiting (MECSH) and there was awareness and knowledge of these strategies throughout the service delivery team.

Staff were aware of the relevant key performance indicators with regard to national initiatives to improve child health and they told us that the provider was supportive of new initiatives. The sexual health team leader gave examples of new approaches to information provision and marketing the service which had resulted in 100% increase in attendees over the last three years.

Further examples of staff led innovation were evident in the children's speech and language therapists national innovation award for contribution to their profession for creative and committed working and the introduction of sleep training workshops for parents, an allied health professional led initiative.

## Leadership development

Children's and young people's staff considered their voice was presented at board level via well-developed

communication systems and that child safe guarding practices were seen as a high priority by the board. Vacancies for lead roles in children services were filled quickly where possible.

Staff told us that their managers were visible, accessible and approachable and that senior managers supported them in difficult situations. For example, the Chief Executive had supported staff to resolve a difficult situation by liaising directly with the family involved. We also saw information leaflets for families encouraging feedback on their healthcare experience and completed service specific satisfaction questionnaires at some of the clinics we visited.

The children's community nurses survey October 2013 showed the six customer satisfaction rated questions for parents in the survey were rated as excellent. These included positive responses about involvement in decisions, the organisation of appointments, contact details and cleaning of hands. Individual comments noted a good service, that staff were friendly, helpful and caring and knowledgeable and they see the child and not just the medical issue. This shows that the board seek opportunities to hear the voice of children and families to drive improvements in quality.

It was acknowledged by senior managers that more consultation is needed with families regarding the development of services.

## Staff engagement

The majority of staff told us they felt well engaged with the organisation and were communicated with in a variety of ways, for example meetings, newsletters, emails and briefing documents. We saw evidence of this. The exception to this was the immunisation team who did not have formal team meetings or clinical supervision.

Staff told us they were made aware when new policies were issued. They felt included in the organisation's vision. One told us:

"People travel a long way to come and work here, as it's known as a good place to work."

The vast majority of staff were very positive about working for the organisation and told us they felt valued and supported. Some staff who were new to the organisation

# Community services for children and families

and a student nurse who was on placement, told us that the induction programme was good, that the Chief Executive Officer was actively involved and had provided a good over view of the organisation and its core values.

There were no complaints about stress in the work place or extreme levels of work overload. Staff told us that their managers were supportive regarding ensuring an equitable work/life balance was reached.

The community teams use System 1 computer records to improve data collection which they rated as a good system.

# Community services for adults with long-term conditions

## Information about the service

Those with long term conditions receive services from support workers, district nurses and community matrons in their own home. There are also a range of clinics in the community offering specialist services.

The inspection team included three compliance inspectors, a compliance manager and three specialist advisors. During our inspection; we spoke to over 37 patients and 17 carers and relatives. We visited many of the clinics, a care home where district nurses were providing care and we accompanied district nurses to a small number of people's homes to talk to patients and their relatives about their experiences. We also used information provided by the organisation and information that we requested. To inform our inspection we also looked at paper and electronic medical records in all of the areas we visited.

We interviewed over 60 staff across all designations and roles. This included qualified nursing staff, specialist nurses, health care support workers, team leaders and administrative staff. Some interviews were conducted on a one to one basis; other group discussions were arranged as focus groups.

## Summary of findings

Overall, across all services and teams, patients with long term conditions received safe care. Patients and relatives told us they were treated in a caring and friendly way and were kept well informed. Services are responsive to the needs of patients.

We saw some excellent practice from the district nurse team and in the clinics we visited, where compassionate and individualised care helped to promote independence. However, we were concerned about the procedures and practices around safeguarding, including prioritisation of training and the lack of awareness of appropriate escalation process for those who work alone in the community who may observe safeguarding concerns.

Whilst we did see appropriate monitoring, reporting and learning from incidents including never events, there were weaknesses in systems to use lessons learned to develop practice and a lack of strategic drive in this area.

Staff demonstrated understanding around the Mental Capacity Act. However, there was not a consistent approach in delivering services for those patients presenting with dementia and this can be directly linked to a lack of formal training and awareness in front line staff.

Information sharing and risk escalation systems were weak and this impacted on the effectiveness of leadership, governance and associated service improvements.

# Community services for adults with long-term conditions

## Are community services for adults with long-term conditions safe?

### Safety in the past

The majority of staff we spoke with were aware of the safeguarding policy and were confident about reporting serious incidents and providing information to the community matron or senior manager if they suspected poor practice which could harm a person. However, staff working alone within the community did not retain telephone escalation details on their person, there was a lack of clarity across teams about who they would report their concerns to and some staff were unaware of the processes by which they would escalate concerns.

In addition, information regarding safeguarding, safeguarding processes and procedures, including escalation and reporting, was not readily available in all community offices. Although historically acknowledged by a senior manager as unsatisfactory, there has been no action taken to improve the quality of safeguarding training provided to staff.

Mechanisms were in place to monitor and report safety incidents, including never events. For example falls, pressure ulcers and medication errors. However, other than community matrons and team leaders, staff had received little feedback in regards to the quality of their reporting, or were aware of any actions taken after reporting such incidents.

The District Nurses team worked to promote the minimisation of hospitalisation for those with long term conditions and our observation of practice and discussions with patients and their relatives confirmed that to be the case. For example, the Rapid Assessment unit at Braintree Community Hospital, where patients are seen, assessed and referred as appropriate to alternative community services to support the treatment of their conditions whilst avoiding acute admission if possible.

Patients were confident of support systems out of hours and all staff spoken with were clear of emergency protocols, including their own roles and responsibilities in these. Emergency protocols were clearly displayed around the clinics and in the community hospitals and district nurse bases.

### Learning and improvement

Root cause analysis was effectively led by community matrons and associated action plans had been implemented at team level. However, practices to share information and learn across the organisation were variable, with some teams, particularly those that worked out in the community from satellite office hubs, unaware of lessons learnt and improvement actions to implement.

Information was collected from patients around safety of services but we saw little evidence of analysis and learning from this valuable source of information.

### Systems, processes and practices

Systems were in place at team level promoting the delivery of safe care and within teams staff sought to improve practice. This included a culture of healthy challenge and the confidence to raise concerns amongst staff internally. However, there was inconsistent practices between community teams in regards to what should be reported and when. For example, when staff became aware of missed patient visits, although the matter was dealt with immediately, such incidents were not broadly considered or reported as 'near miss incidents' or 'incidents'. Under reporting of such risks impacts on the accuracy of any trend analysis in regards to the quality of service provision and missed opportunities for improvement.

Professionals told us of their passion to deliver effective care and this was demonstrated in the well-established working relationships across multi-disciplinary teams and with multi agency colleagues, supporting the delivery of safe care.

We found high standards of cleanliness; hygiene and arrangements for the management of clinical waste were robust across all service environments, including the patients' homes.

Effective systems were seen to be in place for the efficient transfer of records. This ensured that generally staff had access to the right information at the right time. We did see occasions where some teams were not able to access or view parts of patient records from other internal teams and GPs did not always share information via the 'System 1' electronic records system which occasionally caused inconvenience.

Patients had access to teams with the appropriate levels of skill mix to ensure safe clinical care from those best trained and equipped to meet their individual needs.

# Community services for adults with long-term conditions

## Monitoring safety and responding to risk

Systems were in place to monitor safety and respond to risk. However, there was variation in practice in regards to the application of these systems. The variation in practice concerning the reporting of 'missed visits' being one example. Our observation of practice and discussions with staff confirmed a culture of under reporting incidents seen by staff as 'minor' in favour of management at local team level. For example, we discovered that the district nursing teams were concerned about a care home where patients had received a higher than average number of skin tears. There had been communication with the home and an attempt to resolve locally, but this had not been reported to the local authority as a concern and was reported to the regulator as part of this inspection.

In addition, whilst policies and procedures were in place to enable staff working alone within the community to obtain advice, resources and make referrals to other staff, some staff did not know how to activate escalation processes or when it would be relevant to do so. This included where there may be safeguarding concerns. In addition, patients were also not always informed of the systems in place to support them where there may have been concerns of abuse.

## Anticipation and planning

Whilst a flexible approach was taken to the delivery of care, staff also told us that planning can occur up to a week in advance of the planned care being delivered. As such, any consideration to the evolving needs of patients in the scheduling of visits is limited and could present staff with additional pressures at the time of the actual visit.

Staff told us that they manage this locally through information sharing with each other and flexible time management. For example, one member of staff told us that they would rearrange their day, with the support of their colleagues, where unanticipated needs were identified at the time of the visit.

**Are community services for adults with long-term conditions effective?**  
(for example, treatment is effective)

## Evidence-based guidance

Individual roles and responsibilities were well understood by staff in the delivery of evidence based care, often in line

with national guidance and pathways. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to adults with a long-term condition. It is however noted that the level of involvement varied in accordance with the level of seniority of the staff we spoke with.

We heard examples of positive approaches to improvements across care delivery, enhancing the quality of care and treatment for patients. This included the roll out of mental capacity act awareness. Consideration of the act was noted in care plans.

However, the lack of formal dementia training for staff is of concern and creates inconsistencies in practice. All staff we spoke with told us that they had not had any formal dementia training. They did display an understanding of how to care for people living with a dementia. Formal training in this area may help staff to better support these patients and improve their experience of the care and treatment they receive.

## Monitoring and improvement of outcomes

Clinical staff felt confident that they were appropriately skilled and trained to deliver the highest quality care in order to meet the clinical needs of, and promote, best outcomes for patients.

All staff we spoke with were aware of the reporting and monitoring processes in place in regards to tissue viability, pressure ulcers and frequency of falls. They told us that they reported such incidents in accordance with the organisation's pressure ulcer prevention strategy and that this included wound assessment and development and assessment of treatment plans. This meant that patients were kept under review and preventative measures were applied in accordance with these assessments.

However, there was variation in practice amongst staff and within different community teams in thresholds applied to escalation of incidents to senior managers. For example, some staff told us they might not report an incident if it could be handled by them and without management support. Other staff said they would report any incident, including 'minor' events, as they thought it was important for managers to know what issues were arising so that they could be supported in their work.



# Community services for adults with long-term conditions

## Staffing arrangements

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. They told us that there was access to mandatory training and that the content was appropriate to their roles and responsibilities.

Staff confirmed they had regular performance reviews and there were opportunities for development. Staff told us that they were “proud” of the work they do and considered that they delivered a “first class” service which they would happily recommend to friends and family.

The community matrons monitored workloads and when required re-allocated work. This ensured that all staff had a manageable caseload.

We identified that variety in leadership cultures resulted in inconsistencies for staff around accessing clinical supervision and this was not always in line with the policy of the organisation. However, it is noted that the provider has already taken action to improve performance in this area through the review and introduction of a revised clinical supervision policy. Further work is needed to ensure effective implementation and monitoring of compliance with the standards set within this policy.

Effective systems were in place to promote the safety of staff when lone working, including thorough assessment of environmental risk factors. As a result, staff told us that they felt safe and secure when working in the community alone.

## Multidisciplinary working and support

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices were in place. Patients were placed at the centre of their care and teams worked together well to deliver a good quality of care. This included efforts to offer joint appointments for those with a multitude of staff involved, minimising disruption to daily life. Patients and those close to them told us about the positive effects of consultation in care planning, feeling listened to and being treated as an equal partner amongst staff. For example, a number of patients we spoke with attended both the continence and Parkinson’s clinic for treatment. They told us that both consultants corresponded with each other to make sure their overall treatment was conducive and that medication management was coordinated. Another patient

told us that they had had a meeting with their consultants when deciding on the best treatment for them and they were impressed by how this was arranged to coincide with expected surgery for another related condition.

Whilst we did consider some care plans required an update or lacked the detail required, records were generally comprehensive and reflective of the positive experiences expressed by patients and those close to them.

## Are community services for adults with long-term conditions caring?

### Compassion, dignity and empathy

We found in practice and heard positive feedback from patients, their relatives and those close to them, that staff implement compassionate care, based on their individual needs. We observed that patients were afforded dignity and empathy by the community teams responsible for the delivery of their care.

One patient told us:

“Staff here are excellent. They are very caring.”

Patients told us they were confident that staff would respect their confidentiality at all times, that they were given choices about their care and that these choices had been respected.

### Involvement in care

Adults with long term conditions were involved in and central to making decisions about their care and the support needed. Care was person centred and supported by individualised health care plans. Patients told us they felt able to ask any questions as they had good relationships with the nurses delivering their care.

Person centred care encouraged the involvement for those assessed to lack capacity and we saw appropriate use of advocacy services to best support these patients. Patients were confident that they understood their care and told us they felt comfortable with where and who to go to with questions.

### Trust and respect

We observed staff treating patients and their relatives with dignity and respect when attending to care needs. One patient told us of the “utmost respect and dignity” shown by staff.

# Community services for adults with long-term conditions

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care.

The mandatory training log of January 2014 noted that 96% - 97% of staff had received equality and diversity training. Staff could demonstrate through the care planning process that they were taking into account each person's culture, belief and values. They were aware where support could be obtained if it was required.

## Emotional support

Patients and their relatives told us they were supported emotionally, particularly when they received a new diagnosis or their condition changed. One patient told us about a difficult time in life and how the district nurse's had "gone the extra mile" to ensure their condition could be managed at home.

Staff told us that they had confidence in referral systems to other agencies where they consider patients to require additional support. For example, working with the local authority to provide support packages to those people assessed as needing additional support packages from the local authority.

## Are community services for adults with long-term conditions responsive to people's needs?

(for example, to feedback?)

## Meeting people's needs

Staff and patients confirmed that services and treatments were planned as close to home as possible and that these were always informed by the views and wishes of the patient. For example, staff in the Rapid Assessment Unit would ensure that they liaised, where possible with the closest acute unit to the patient's home if a patient was assessed as needing to be transferred to hospital.

Senior staff we spoke with told us that they did engage with local commissioners around the planning and funding of services and expressed confidence in executive level decisions regarding service development initiatives to meet the needs of the local community. However, some senior staff told us that they felt excluded from the high level meetings where decisions about services were made.

## Access to services

Patients and relatives told us that services were accessible and tailored by staff to meet their individual needs, at the times and in the places to best suit their lifestyle. This included those patients who lacked capacity or presented with hearing or visual complexities.

Staff told us that they had a wide range of prompts and tools to support people who may find it difficult to communicate and we observed staff adapting their communication style to ensure people fully understood their care and treatment, including next steps.

## Vulnerable patients and capacity

Staff adopted a flexible approach to the delivery of care to patients. Our observations, review of records and discussions with staff confirmed that vulnerability factors and capacity concerns were taken into consideration when planning and delivering care to patients in their own homes.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as the safeguarding lead.

## Leaving hospital

There was effective collaboration between staff, working in hospital and the community, in planning and facilitating the safe and effective discharge of patients. Discharge processes also included advice around out of hours support, with patients being well informed of how to access these services.

Patients and relatives we spoke with told us that they were kept informed of and were involved in decisions about their readiness for discharge or transfer. That these discussions started at the time of admission and included any equipment that may be needed at the time of their discharge.

We have seen and heard examples of individualised approaches to discharge, with one patient explaining the comfort and assurance offered when they arrived home and found the District Nurse waiting outside for them.



# Community services for adults with long-term conditions

## Learning from experiences, concerns and complaints

During our visit we received consistently positive views from patients and relatives of patients with long term conditions. Patients and relatives reported feeling listened to and heard. They said they were satisfied with the levels and quality of services provided by the community team. These findings are supported by the local survey, conducted by the provider in 2013. The overall level of satisfaction was good; with particular reference made to the professionalism of staff and effectiveness of care and treatment.

There were inconsistencies in practice amongst the different district nursing teams in regards to high level learning in relation to concerns and feedback and staff were unable to give any examples where patient's views had been utilised to inform service design.

## Are community services for adults with long-term conditions well-led?

### Vision, strategy and risks

The vision of the organisation was widely understood and supported by community teams. The board and senior managers were considered visible and approachable.

Information relating to core objectives and performance targets were visibly displayed in the areas we visited.

Staff told us the priorities for the coming year were around patient safety and care delivery. These were around working with other relevant organisations. In relation to long term conditions the drive was to develop a holistic and integrated frailty pathway and to avoid unnecessary admissions to hospital.

We looked at performance and quality data held by the organisation. The risk register, which included key risks for the organisation, did not include things we would expect. For example, missed visits by district nurses, falls analysis or complaints, which should be monitored at both board and community level.

### Quality, performance and problems

Despite there being a clinical governance system in place, which should be used to escalate risks to senior management, this was not always being used effectively by local staff.

Problems or concerns affecting the performance of teams were not escalated to the cyclical communication channels between Board level and operational practice. This resulted in a disconnect for the strategic understanding of quality and performance at the Board level.

According to senior managers, there were provider-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. The data from 'national patient safety alerts' to identify risks, as falls and pressure ulcers featured on the end of life risk register and the organisation was moving towards one risk register. However, we could not see an effective system in place for identifying and capturing risks at team, directorate and organisation level. This was being managed at community matron level rather than being an overall strategy for the whole organisation. We concluded that the way the risk register was organised meant that where risks were being fed to the directorate level, it was not being appropriately escalated and was one way only. There was little or no feedback to staff working below the community matron level.

### Leadership and culture

Services at the point of delivery are nurse led and overseen by Community Matrons, who also hold an active caseload. Staff told us that they are left to "get on with the job". We were told by team members that this helped to boost morale as they felt valued as autonomous practitioners. Teams worked together to deliver a clear philosophy of high quality, compassionate and responsive care for patients and families and staff felt supported to do this by their direct line managers.

### Patient experiences and staff involvement and engagement

Without exception, all of the patients we spoke with told us they received an excellent service in the clinics they attended and from the district nurses who made home visits.

The staff we spoke with were passionate about the care they offered to patients. However, the inconsistency and variability in practice in regards to communication with staff meant that some staff did not feel well engaged with senior managers within the organisation.

# Community services for adults with long-term conditions

## **Learning, improvement, innovation and sustainability**

Staff new to the organisation received a two day induction, which included e-learning. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data demonstrated a 92% to 100% mandatory training completion rate for staff working within the integrated care teams.

We noted that the majority of mandatory training was done through e-learning; this is a computer generated way of learning. Staff watch a video or briefing and have to answer

questions on a specific subject. Whilst the e-learning included modules around dementia, staff told us that there were gaps in knowledge and understanding of how to best support patients presenting with dementia and would welcome training in this area.

Information technology challenges were widely acknowledged for staff working in the community and we found that plans were in place to address connectivity issues for these staff members. Agency staff did not always have access to update electronic records which meant that staff had to support the agency staff to input reports to system 1 which impacted on their own time.

# End-of-life care

## Information about the service

End of life services are nurse led and are provided within patient homes and from four in-patient beds. Two beds located at Braintree hospital and two beds at Halsted hospital.

The inspection team included one compliance inspector and a district nurse team leader with specialist experience in end of life care. During our inspection; we spoke with 19 staff; two patients receiving care from community teams; and three relatives. We visited two hospitals and attended two home visits and observed community.

We also reviewed information provided by the organisation and information that we requested during the course of the inspection visit.

## Summary of findings

We saw good practice and dedicated services for people nearing and during the end stages of life. We saw and were told about some outstanding practice, in particular from the district nurse team

All of the patients and relatives we spoke with told us that community staff were caring, informative and compassionate. Patients felt they received effective care and treatment both in the community and as in-patients.

The response to patients' end of life care wishes was very positive. The staff enable patients to die in comfort, in their preferred place and in a dignified manner.

However we saw that governance arrangements and high level systems to ensure learning from risks and the feedback from patients and families were weak.

# End-of-life care

## Are end-of-life care services safe?

### Safety in the past

The majority of staff we spoke with were aware of the safeguarding policy and were confident about reporting serious incidents and providing information to the community / ward matron or senior manager if they suspected poor practice which could harm a person. However, we found that some 'minor' incidents were not reported at Braintree Community Hospital ward and staff working alone within the community did not retain telephone escalation details on their person. There was also a lack of clarity across community teams about who they would report their concerns to and some staff were unaware of the processes by which they would escalate concerns.

In addition, information regarding safeguarding, safeguarding processes and procedures, including escalation and reporting, was not readily available in all community offices. Although historically acknowledged by a senior manager as unsatisfactory, there has been no action taken to improve the quality of safeguarding training provided to staff.

Patients were confident of support systems out of hours and all staff spoken with were clear of emergency protocols, including their own roles and responsibilities in these. Emergency protocols were clearly displayed around the clinics, in the community hospitals and district nurse bases.

### Learning and improvement

Staff were familiar with the reporting systems for incidents. However, staff were not confident of or in the processes for cascade of lessons learnt across the organisation. Staff were unaware of incidents that had been reported within the organisation or any lessons learnt following review of such incidents.

### Systems, processes and practices

We found that mechanisms were in place to monitor and report safety incidents, including never events. Staff were familiar with the reporting systems and told us they were encouraged to use such systems to report incidents. Qualified staff were trained to perform root cause analysis (RCA) and these were seen to be reported to managers in a timely manner.

We found high standards of cleanliness; hygiene and arrangements for the management of clinical waste were robust across all service environments, including the patients' homes.

Effective systems were seen to be in place for the efficient transfer of records in the community and for the safe storage of records within the community hospital wards. This ensured that generally staff had access to the right information at the right time. We did see occasions where some community nursing teams were not able to access or view parts of patient records from other internal teams and GPs did not always share information via the 'System 1' electronic records system which occasionally caused inconvenience.

### Monitoring safety and responding to risk

Skill mix of teams and training supported safe practice. The majority of staff spoken with had received an annual appraisal of their performance and the majority of teams had access to clinical supervision. However, it is noted that the clinical supervision arrangements required further development.

Specialist equipment is available in the home for those requiring palliative care, for example the timely provision of syringe drivers in the home environment to support discharge home. Whilst this system ensures seamless care to meet the needs and wishes of patients and families, we have identified concerns around risk management of syringe drivers for use with controlled drugs in the community. We observed were told by nurses that lockable covers on syringe drivers were infrequently used because they were bulky and heavy. Following the investigation of an incident when a patient had tampered with a syringe driver, staff were instructed to conduct a risk assessment and put in place a tamper proof lockable cover when the risk assessment indicated the need for its use. Our observation of practice found risk assessments had not been completed for all patients that had a syringe driver in situ and some of the syringe drivers had been supplied without the tamper proof lockable cover. This system could present risks to patients or family members.

### Anticipation and planning

There was a lack of monitoring of end of life care service provision. Systems to ensure that care was effectively coordinated across other providers of end of life care were not in place and we saw limited evidence of joint working with partner agencies, or partner organisations in the

# End-of-life care

provision of palliative care. This included local hospices. Communication and collaboration in regards to end of life arrangements between community teams was limited, and lead to individual team, rather than cross team problem solving.

## Are end-of-life care services effective? (for example, treatment is effective)

### Evidence-based guidance

End of life care services were not provided in accordance with national guidance. The arrangements were not uniform or coordinated and were not managed by collaborative multidisciplinary working. We observed differences in the care provided within the inpatient facility from that provided to patients in their own homes. This included the different approaches taken by staff to manage physiological symptoms such as pain, breathlessness, nausea and fatigue. Neither staff groups were aware of the differences to working practices, including access to equipment.

Following recent independent review, the National Institute for Health and Clinical Excellence (NICE) guidance is being written to remove reference to the Liverpool Care Pathway (which sets out methods for palliative care for terminally ill patients). Whilst we were advised that staff practices reflected this change in national guidance, some of the staff we spoke with continued to reference this as the pathway they were following when managing the care of a patient who was at the end of their life.

There were gaps in localised policy and process for end of life care in the community, including access to and collection of controlled drugs out of hours.

### Monitoring and improvement of outcomes

Governance arrangements around the routine monitoring of end of life services and systems to ascertain regular feedback were both weak. Whilst staff confirmed that positive letters and cards were often received from patients and families, systems lacked formality, analysis and subsequent improvements or action planning. One example being that staff and patients we spoke with were unaware of any surveys that had been conducted or any other forms of providing feedback in regards to the quality of care provided.

### Staffing arrangements

End of life services were nurse led and provided by community nursing teams and in-patient nursing teams. These teams were supported by an end of life care facilitator who was responsible for policy development, staff training and provision of advice to staff in regards to end of life care. The post holder did not hold a case load. As such, other than the end of life care facilitator, the organisation did not have a separate staffing resource that had a specific focus on the care and management of end of life care services. When functioning to full capacity, staffing levels met the clinical and care needs of patients. Whilst there are current vacancies across the teams, these shortfalls were being met through the use of agency staff and without exception patients we spoke with and other patient feedback was consistently positive in regards to both the continuity, quality and care they had received.

Patients were allocated to beds according to the level of observation they required. For example, patients who were identified to be at risk of falls were accommodated in beds closest to the nursing station so that they could be closely observed and monitored. There were four rooms that had been identified for the use of those patients who were at the end of their life and wanted to be cared for in hospital. The design of these rooms encouraged family centred care towards and through the end stages of life as they were larger than other rooms and included facilities for relatives.

We identified that variety in leadership cultures resulted in inconsistencies for staff around accessing clinical supervision and this was not always in line with the policy of the organisation. However, it is noted that the provider has already taken action to improve performance in this area through the review and introduction of a revised clinical supervision policy. Further work is needed to ensure effective implementation and monitoring of compliance with the standards set within this policy.

Policies and procedures were in place to ensure the safety of staff working alone within the community. The staff we spoke with expressed confidence in these systems.

### Multidisciplinary working and support

Multi-disciplinary staff work closely with patients and families to ensure a holistic understanding of need. This results in the provision of individualised, person centred care planning, including around preferred places of care and death. This work was underpinned by sound implementation of approved care pathways.

# End-of-life care

Visible team leaders ensured clear and effective staff handovers. This included daily communication with community teams, ensuring patients received continuity of care across services.

## Are end-of-life care services caring?

### Compassion, dignity and empathy

We observed that all staff treated people with dignity, compassion and respect regardless of whether the care was delivered in hospital or within the patient's own home. Patients told us they felt safe and that their privacy was always respected.

### Involvement in care

Patients and families felt involved in and informed throughout the end stages of life. They told us that staff took time to ensure that they were fully informed and understood their diagnosis and were actively involved in the development of care plans in regards to their care and treatment.

Care was person centred and supported by individualised health care plans. Patients told us they felt able to ask any questions as they had good relationships with the nurses delivering their care.

We reviewed Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders for both in-patients and those patients who received end of life care services within the community. Without exception we found that they had been completed in line with guidance from the General Medical Council. We also noted that these documents had been reviewed following transfer of care to community teams. Staff told us that the patient's general practitioner conducted such reviews to ensure all required information was documented and a joined approach with patients and families was ensured.

A relative commented to us:

"[X] is not for cardio-pulmonary resuscitation if he has a heart attack, but does want to be treated for infections and recoverable side effects, we have a good quality of life and want to make the most of the time we have left."

This was clearly documented in the care plan and on the DNACPR form.

### Trust and respect

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering end of life care.

The mandatory training log of January 2014 noted that 96% - 97% of district nursing team staff and 100% of ward staff had received equality and diversity training. Staff could demonstrate through the care planning process that they were taking into account each person's culture, belief and values.

### Emotional support

Staff we spoke with told us that specialist bereavement services were provided by charitable services working within the community. In addition, members of the community nursing team also offered a maximum of three bereavement visits to families. However, the community nurses that provided this service did not hold a recognised qualification in this field of practice nor were they given preparation time to deliver this service and this could result in additional emotional pressures for ill prepared team members.

However, it was reported that there was a lack of suitable resources to fully provide emotional support for the siblings of those presenting with life limiting and end of life conditions. The provider told us that they were not commissioned to provide these services; access to these services was via local hospices.

## Are end-of-life care conditions services responsive to people's needs? (for example, to feedback?)

### Meeting people's needs

We have not seen any evidence to suggest the service to be directly mapped to the identified needs of the local population. Whilst plans were in place for the end of life care facilitator to ensure this information is appropriately captured to inform service design, to date the end of life care facilitator has been focussed on the development of the end of life strategy. This strategy has been developed without consultation with service users, families or operational staff. This demonstrates overarching concerns around consultation with patients, families, staff and colleagues from partner agencies.



# End-of-life care

Feedback from staff, coupled with exploration of current systems presents concerns around responses for symptom control. We have heard examples of poor anticipatory management plans, including around complex medication regimes. On occasions these failing systems have resulted in the transference of patients from their homes to ward environment for symptom control. Staff had raised this issue to senior managers and continued to await a response or formal guidance on how to develop services and address this area of concern.

## Access to services

Accessibility to end of life services within the two inpatient facilities (Braintree Community Hospital ward and St Peter's Community Hospital ward) was good as services were provided on the first floor level at both sites, with lifts and stairs and free parking available. Patients and families expressed confidence in the systems in place to access support and this included access to support out of hours. The systems in place meant that patients received appropriate care in a timely manner.

## Vulnerable patients and capacity

Staff adopted a flexible approach to the delivery of care to patients. Our observations, review of records and discussions with staff confirmed that vulnerability factors and capacity concerns were taken into consideration when planning and delivering care to patients.

All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, community hospital ward staff had received training for caring for patients with dementia and those who displayed challenging behaviour.

## Leaving Hospital

There was effective collaboration between staff, working in hospital and the community, in planning and facilitating the safe and effective discharge of patients.

Discharge planning documentation facilitated the rapid discharge of patients who wanted to end their lives at home. Multi-disciplinary staff worked well together through this stage to support these wishes. However, we have heard from staff the occasions when discharge has been so rapid they have received very little information prior to a home visit. This communication breakdown had been presented to senior managers but frontline staff continued to await an action plan or guidance to address this area of concern.

From the perspective of patients we have heard the positive view of rapid discharge:

“Once I decided I wanted to go home it took less than a day to organise.”

## Learning from experiences, concerns and complaints

All of the patients and relatives we spoke with expressed very high levels of satisfaction with their end of life care. Patients and relatives reported feeling listened to and heard by the staff that provided care to them. They said they were satisfied with the levels and quality of services provided by the community and community hospital teams.

There were inconsistencies in practice amongst the different district nursing teams and community hospital teams in regards to high level learning in relation to concerns and feedback and staff were unable to give any examples where patient's views had been utilised to inform end of life service design.

## Are end-of-life care services well-led?

### Vision, strategy and risks

Governance arrangements across end of life services were weak. Whilst we observed the nursing teams to be both compassionate and considerate in their delivery of end of life care services, we found little evidence of high level planning or developments in line with localised need.

Staff did not understand the vision and values of the organisation in regards to end of life care services, nor did they feel consulted or involved in strategic design and development for end of life care.

### Quality, performance and problems

Despite there being a clinical governance system in place, which should be used to escalate risks to senior management, this was not always being used effectively by staff.

Problems or concerns affecting the performance of end of life care services provided by district nursing and community hospital teams were not escalated to the cyclical communication channels between Board level and operational practice. This resulted in a disconnect for the strategic understanding of quality and performance of end of life care services at the Board level.

# End-of-life care

According to senior managers, there were provider-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. The data from 'national patient safety alerts' to identify risks, as falls and pressure ulcers featured on the end of life risk register and the organisation was moving towards one risk register.

## Leadership and culture

All of the wards we visited were well-led at the point of daily operations. Community nurses felt well supported by their immediate team managers and visits were seen to be well planned, with patients kept informed of visit times and associated care plan activities.

Nurses had a clear philosophy of care and a commitment to ensuring patients receive high quality, compassionate and responsive care and treatment. They all spoke of their commitment to ensuring patients ended their life in a dignified way in the place they preferred.

Ward team leaders had a very visible presence, and staff and patients reported the impact of this to be a high level of trust and understanding that staff would take a team approach to patient allocation based on dependency.

## Patient experiences and staff involvement and engagement

Without exception, all of the patients and relatives we spoke with expressed very high levels of satisfaction with their end of life care. Patients commented:

"I am cared for by staff that know what they are doing"

"The care is excellent"

"The staff are exceptionally kind"

"The care is wonderful, very caring staff".

One patient told us the staff visiting him at home was his life line. He had a poor experience in hospital and was grateful to be home with support. His comments included "I am so happy to be home and pain free."

"I know how to contact the nurses out of hours if necessary but they always make sure everything is sorted before they leave."

The staff we spoke with were passionate about the care they offered to patients. Whilst ward staff reported that they were communicated with in a variety of ways, for example

newsletters, emails and briefing documents, there was inconsistency and variability in practice in regards to communication with district nursing teams. This meant that some staff did not feel well engaged with senior managers within the organisation.

## Learning, improvement, innovation and sustainability

Staff new to the organisation received a two day induction, which included e-learning. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data demonstrated a 92% to 100% mandatory training completion rate for district nursing teams and 93% to 98% mandatory training completion rate for ward staff.

We noted that the majority of mandatory training was done through e-learning; this is a computer generated way of learning. Staff watch a video or briefing and have to answer questions on a specific subject. The e-learning training included modules around dementia and safeguarding adults, which also included managing patients with challenging behaviour. However, district nursing team staff told us there were gaps in knowledge and understanding of how to best support patients presenting with dementia and would welcome training in this area.

There was an open culture that supported learning whereby staff were trained in performing root cause analysis (RCA) and were encouraged to report incidents and errors. Risk assessment training was included as a component of mandatory Health and Safety training.

Systems to ensure learning were not robust, resulting in dedicated front line staff lacking clarity from senior managers of how to improve areas of end of life practice they knew to be unsatisfactory. For example, following the investigation of an incident when a patient had tampered with a syringe driver. The directed action was to conduct a risk assessment and put in place a tamper proof lockable cover when the risk assessment indicated the need for its use. Our observation of practice found risk assessments had not been completed for all patients that had a syringe driver in situ and some of the syringe drivers had been supplied without the tamper proof lockable cover.



This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

#### Regulated activity

Diagnostic and screening procedures

#### Regulation

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Regulation 10(1)(b) and 10(2)(c)(i)

#### Regulated activity

Family planning services

#### Regulation

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Regulation 10(1)(b) and 10(2)(c)(i)

#### Regulated activity

Nursing care

#### Regulation

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Regulation 10(1)(b) and 10(2)(c)(i)

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Compliance actions

Surgical procedures

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Regulation 10(1)(b) and 10(2)(c)(i)

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Regulation 10(1)(b) and 10(2)(c)(i)