

Central Surrey Health Limited

Quality Report

Ewell Court Clinic
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Date of inspection visit: 9 - 12 January 2017
Date of publication: 30/06/2017

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

Ratings

Overall rating for this location

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Outstanding



Are services responsive?

Good



Are services well-led?

Good



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Our judgements about each of the main services

Service

Community health services for adults

Rating

Summary of each main service

We have rated this service as good.

- Overall, patients were protected from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and co-owners could escalate risks that could affect patient safety. We saw systems in place for reporting, investigating and learning from incidents.
- There were sufficient employees (co-owners) with the right skills to care for patients and co-owners had been provided with induction, mandatory and additional training for their roles.
- Co-owners had a good awareness of policies and procedures, which were based on National Institute for Health and Care Excellence (NICE) guidelines and other national standards. We saw evidence of local and national audits undertaken to monitor the quality, safety and effectiveness of care.
- Clinics were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. Rooms were equipped with sufficient equipment and consumable items for their intended purpose. Medicines were managed safely in accordance with legal requirements and checks on emergency resuscitation equipment were performed routinely.
- Care was delivered by a range of skilled co-owners who participated in annual appraisals and had access to further training as required. We found evidence of multi-disciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all co-owners. Patients told us they felt very well supported and informed at all stages

Good



Summary of findings

of their treatment and commented very positively about the care provided to them by the co-owners from the clinics and in their own homes.

- We saw co-owners address issues with tact, diplomacy and in a caring yet professional way. Therapy and treatment room doors were kept closed, and co-owners knocked before entering clinic rooms to maintain patients' privacy.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care. There was a system in place for capturing learning from complaints and incidents and there was very good local ownership of any problems with teams working closely together to resolve any issues that arose.
- We saw good local leadership with an open and transparent culture. There was a very clear vision and focus on the delivery of excellent quality care. Co-owners were overwhelmingly positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values.
- The governance framework ensured employee responsibilities were clear and that quality, performance and risks were all understood. In addition to features of the organisation such as an employee council, the senior management team were visible and regularly engaged with co-owners and patients.

However,

- Training and mandatory training rates were not meeting the targets set by the organisation and we found that the quality of incident investigations varied. We acknowledge CSH were addressing this.
- While care was evidenced based and there was participation in national audit programmes, the range of audits was restricted and some of the information provided to us dated.
- Care was delivered by a range of skilled workers who participated in annual appraisals and had access to further training as required. Whilst the

Summary of findings

Community health services for children, young people and families

Requires improvement



co-owners were supported to undertake training and annual appraisals, compliance rates for both were below the organisational benchmarks.

We have rated this service as requires improvement.

- We identified incidents were under reported in the Children and Young People (CYP) service. We found the quality of incident investigation was varied, and there was a lack of senior management and governance oversight of the quality of incident handling. This meant that that the organisation's ability to learn, improve, and prevent future recurrence was affected. The governance structure was not well understood by co-owners and the flow of information was not effective.
- We identified concerns about senior manager oversight of the Special Education Needs and Disabilities (SEND) service. This related to a lack of timely, proactive service planning to ensure the SEND team could meet the complex needs of those who used the service.
- Data demonstrated very low levels of complaints in the service. However, the complaints we reviewed showed the quality of the investigations, response tone and learning from these was inconsistent.
- Co-owners in the service were found to be stretched across the service. Whilst we recognise an active recruitment drive was in progress, there were high vacancy and workforce turnover rates. Data from the recent co-owner survey suggested low satisfaction levels in response to the question 'do you feel there were enough co-owners in your areas of work to get everything done'.
- Appraisals rates reported in the performance report 2016, showed that the appraisals rates for the service was low. This meant that a significant number of co-owners did not have an annual appraisal. The reason given for this poor performance was current workload, managing vacancies, and long-term sickness.

Summary of findings

- The records we viewed demonstrated that co-owners had achieved a compliance rate of 89% which was not meeting the provider's benchmark of 95%.
- Areas we visited were visibly clean and tidy, and local cleaning records were available. However, we asked the provider for evidence of departmental oversight of hand hygiene and environmental cleaning audits. We were not provided with meaningful data that demonstrated departmental oversight of compliance or evidence of trend and theme monitoring.
- There were significant delays in accessing the tongue-tie service. Tongue-tie can be defined as a condition present at birth that restricts the tongue's range of motion. With tongue-tie, an unusually short, thick or tight band of tissue (lingual frenulum) tethers the bottom of the tongue's tip to the floor of the mouth. This meant the service was not managing to meet the needs of local people.
- Duty of candour was well understood and co-owners understood their role to ensure compliance with this regulation.
- Medications were safely handled, managed, and stored appropriately. However, we requested evidence of medicines audits which was not received.
- CYP were protected from the risk of foreseeable emergencies because suitable equipment and competent co-owners were made available.
- There were appropriate systems and processes to ensure major incidents and foreseeable events were managed effectively.
- The care delivered reflected national guidance and data showed that patient outcomes were favourable when compared to national averages.
- Children and young people were protected from the risk of abuse because there were systems in place to ensure risks were identified and appropriately managed. The service had embedded multidisciplinary working to ensure that service users received the best and most effective care available.

Summary of findings

- Children and young people had their individual healthcare needs assessed and were involved where possible in planning their care.
 - Records were contemporaneous, fit for purpose and available to all members of the MDT which aided care continuity. Where paper records were used, files were held securely and kept confidential.
 - Co-owners were observed providing professional, kind and compassionate care that reflected people's wishes and diverse needs.
 - Working relationships between co-owners was strong, and had a boundless focus on integrity, as well as compassion and support for each other, as well as the children and families they came into contact with.
 - Feedback received from children and young people was entirely positive. CQC did not receive any complaints about this service during the inspection time frame.
 - Co-owners clearly understood and were completely committed to the organisation's values, beliefs, vision and strategy. Morale was found to be very high. There was evidence that staff engagement was meaningful and much valued.
 - There were systems to ensure the views of the public could be sought.
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Summary of findings

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Good



Central Surrey Health Limited

Services we looked at

Community health services for adults; Community health services for children, young people and families.

Summary of this inspection

Background to Central Surrey Health Limited

For a full summary of this inspection, this report should be read in conjunction with the individual location reports for Dorking Community Hospital, The New Epsom and Ewell Community Hospital, Molesey Community Hospital and the overall provider report.

Central Surrey Health Limited (CSH) is a profit for social purpose enterprise, set up by its employees (called co-owners) in 2006. As the first of its type in the country, the organisation re-invests any financial surplus from activities back into the business and local community projects. Around 40 other providers in England have followed this model of healthcare since.

Central Surrey Health Limited is the registered provider.

Dorking Community Hospital provides a community inpatient service on Ranmore ward which has 22 beds. On the day of inspection, an additional four beds had been opened in response to increased demand and 26 beds were in use. The services provided include palliative care and rehabilitation. Patients are admitted to community inpatient services from acute hospital or from their own home. At Dorking Community Hospital the medical services are provided by a local General Practitioner Practice.

The New Epsom and Ewell Community Hospital provides a community inpatient service on one ward which has 20 beds. Four of the beds are designated for neurological rehabilitation, the remaining 16 are for rehabilitation. Patients are admitted to community inpatient services from acute hospitals or their own home. Medical services for the hospital are provided by a local General Practitioner Practice.

Molesey Community Hospital provides a community inpatient service on one ward which has 12 beds. The services provided include palliative care and

rehabilitation. Patients are admitted to community inpatient services from their own home or from acute hospitals. At Molesey Community Hospital the medical services are provided by a local General Practitioner Practice.

The services provided for children and young people (CYP) include health visiting, school nursing including specialist school nursing, services for Looked After Children (LAC), speech and language therapy, physiotherapy and occupational therapy, and dietetics.

CSH provides a range of nursing and therapeutic services to the adult population of mid Surrey. These services included district nursing, physiotherapy and podiatry. Local commissioning bodies purchased additional specialist nursing and therapy services, which included end of life care, frailty and falls, continence, respiratory, heart failure, tissue viability and integrated rehabilitation services.

CSH delivers these services in people's homes, clinics, schools, children's centres and community hospitals. Clinics in the community hospitals also accept outpatients discharged from the wards or from other hospitals in the area. In addition, a wheelchair service operates from one community hospital.

The delivery of care was divided into two main groups, called 'planned care' and 'unplanned care'. Planned care included musculoskeletal physiotherapy, hand therapy, podiatry, wheelchair and continence services. Planned care utilised waiting lists and had targets set in agreement with the commissioning bodies. Unplanned care services included district nursing and domiciliary physiotherapy, community matrons and specialist nursing teams that responded directly to referrals from GPs and local hospitals.

Our inspection team

Our inspection team was led by Shaun Marten and Elizabeth Kershaw, CQC inspection managers and comprised four inspectors and specialist advisors with expertise in community therapy services.

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited Dorking Community Hospital, Molesey Community Hospital, New Epsom and Ewell Community Hospital and looked at the quality of the care environment and observed how staff were caring for patients.

- Visited community health services for adults at the above hospitals plus Leatherhead Community Hospital and other community locations.
- Visited Children, Young People and Families services at the above hospitals and other community locations.
- Spoke with 48 patients and 25 relatives (including parents) who were using the service.
- Reviewed 107 feedback comment cards.
- Spoke with 125 co-owners including nurses, medical staff, occupational therapist, physiotherapist, therapy technicians and administrative staff.
- Attended multi-disciplinary meetings
- Looked at five care and treatment records of patients
- Reviewed a range of policies, procedures and other documents relating to the running of the services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The provider was rated as requires improvement for safe. This was because:

- The quality of investigation of incidents was variable across the services provided.
- Co-owners in children and young people's services had not been suitably trained to investigate incidents.
- Staffing levels within children and young people's services were at a low level and impacted on co-owner wellbeing and patient care.
- Hand hygiene audits in children and young people's services lacked senior oversight and the service was unable to provide evidence of medicines audit activity.

However,

- Despite a challenging environment all areas were seen as visibly clean and staff followed infection control guidelines.
- There were robust processes for the management of safeguarding issues.
- A strong portfolio of mandatory training was available to co-owners although overall compliance was not meeting the organisation's stretch target of 95%.

Requires improvement



Are services effective?

The provider was rated as good for provision of effective care. This was because:

- There was a structure in place to ensure staff competence and this was supported by up to date, evidence based policies and procedures.
- The provider used a range of patient outcome measures to benchmark, monitor and drive service improvement.
- Pain relief was well supported with suitable techniques applied for patients with complex needs.

Good



Are services caring?

The provider was rated as outstanding for caring. This was because:

- Children and young people's services were rated as outstanding, whilst community adult services and all community inpatient services were rated as good.
- Our observations and feedback from patients and carers indicated that co-owners placed privacy and dignity as a

Outstanding



Summary of this inspection

priority. Feedback from patients and carers using the children and young people's service was overwhelmingly positive and we saw numerous examples of co-owners going the extra mile to provide support and meet patients' needs.

- Co-owners across all the services demonstrated an understanding of holistic care and the need to provide emotional support to patients and carers.

Are services responsive?

The provider was rated as good for being responsive. This was because:

- Services were planned in conjunction with commissioners to meet the needs of the local population with appropriate consideration of seasonal pressures.
- The design of facilities and use of communication techniques took account of the needs of vulnerable people.
- Generally, services could be accessed in a timely manner.

Good



Are services well-led?

The provider was rated good for well led. This was because:

- Leadership was visible throughout the organisation and provided vision, demonstrable values and clarity of strategy.
- Co-owners were highly engaged and the culture of the organisation was exceptionally positive.
- Governance was largely robust, although understanding of process was less comprehensive in children and young people's services.
- Although some elements of well led in children and young people's services required improvement, the overall standard of leadership provided outweighed those concerns. We have deviated from our usual aggregation of key ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Good








Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires improvement	Good	Outstanding	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Community health services for adults

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

Central Surrey Health Limited (CSH) was a profit for social purpose enterprise set up by employees (called co-owners) in 2006. As the first of its type in the country, the organisation re-invested any financial surplus from activities back into the business and local community projects. Around 40 other providers have since followed this model of healthcare.

CSH provided a range of nursing and therapeutic services to the population of mid Surrey. For adults, these services included district nursing, physiotherapy and podiatry. Local commissioning bodies purchased additional specialist nursing and therapy services, which included end of life care, frailty and falls, continence, respiratory, heart failure, tissue viability and integrated rehabilitation services.

CSH delivered these services in people's homes or clinics located in neighbourhood medical centres and community hospitals. Clinics in the community hospitals also accepted outpatients discharged from the wards or from other hospitals in the area. In addition, a wheelchair service operated from one community hospital.

The delivery of care was divided into two main groups, called 'planned care' and 'unplanned care'. Planned care included musculoskeletal physiotherapy, hand therapy, podiatry, wheelchair and continence services. Planned care utilised waiting lists and had targets set in agreement with the commissioning bodies. Unplanned care services included district nursing and domiciliary physiotherapy, community matrons and specialist nursing teams that responded directly to referrals from GPs and local hospitals.

Our inspection took place over four days from 9 - 12 January 2017. We travelled to six clinic or community hospitals on one or more occasions. We visited, with permission, five patients at home to observe initial assessments and care provided. In addition to inspecting the various locations, we reviewed information supplied prior to our visit and either provided or requested during the inspection. We also considered feedback from the co-owner focus groups and written communications from stakeholders.

We observed care, watched co-owners interacting with people using the services and made checks on the environment and equipment used. We checked 15 sets of patient records and we looked at policies and procedures, audits, training and appraisal records. We reviewed 68 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection. We spoke with nine patients and 23 co-owners in a variety of roles including heads of departments and managers, registered health care professionals, healthcare assistants and administrative workers.

Community health services for adults

Summary of findings

We have rated this service as good.

- Overall, patients were protected from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and co-owners could escalate risks that could affect patient safety. We saw systems in place for reporting, investigating and learning from incidents.
- There were sufficient employees (co-owners) with the right skills to care for patients and co-owners had been provided with induction, mandatory and additional training for their roles.
- Co-owners had a good awareness of policies and procedures, which were based on National Institute for Health and Care Excellence (NICE) guidelines and other national standards. We saw evidence of local and national audits undertaken to monitor the quality, safety and effectiveness of care.
- Clinics were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. Rooms were equipped with sufficient equipment and consumable items for their intended purpose. Medicines were managed safely in accordance with legal requirements and checks on emergency resuscitation equipment were performed routinely.
- Care was delivered by a range of skilled co-owners who participated in annual appraisals and had access to further training as required. We found evidence of multi-disciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all co-owners. Patients told us they felt very well supported and informed at all stages of their treatment and commented very positively about the care provided to them by the co-owners from the clinics and in their own homes.
- We saw co-owners address issues with tact, diplomacy and in a caring yet professional way. Therapy and treatment room doors were kept closed, and co-owners knocked before entering clinic rooms to maintain patients' privacy.
- People's concerns and complaints were listened and responded to and feedback was used to improve the

quality of care. There was a system in place for capturing learning from complaints and incidents and there was very good local ownership of any problems with teams working closely together to resolve any issues that arose.

- We saw good local leadership with an open and transparent culture. There was a very clear vision and focus on the delivery of excellent quality care. Co-owners were overwhelmingly positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values.
- The governance framework ensured employee responsibilities were clear and that quality, performance and risks were all understood. In addition to features of the organisation such as an employee council, the senior management team were visible and regularly engaged with co-owners and patients.

However,

- Training and mandatory training rates were not meeting the targets set by the organisation and we found that the quality of incident investigations varied. We acknowledge CSH were addressing this.
- While care was evidenced based and there was participation in national audit programmes, the range of audits was restricted and some of the information provided to us was dated.
- Care was delivered by a range of skilled workers who participated in annual appraisals and had access to further training as required. Whilst the co-owners were supported to undertake training and annual appraisals, compliance rates for both were below the organisational benchmarks.

Community health services for adults

Are community health services for adults safe?

Good 

We have rated safety of the service as good.

- Overall, patients were protected from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and co-owners could escalate risks that could affect patient safety. We saw systems for reporting, investigating and learning from incidents, which included the duty of candour if necessary.
- CSH and its co-owners appeared to have mitigated the impact of an increase in referrals against workforce capacity we saw a range of initiatives designed to ensure there were sufficient co-owners with the right skills to care for patients and co-owners had been provided with induction, mandatory and additional training for their roles.
- Clinics were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that rooms were equipped with sufficient equipment and consumable items for their intended purpose.
- Medicines were managed safely in accordance with legal requirements and checks on emergency resuscitation equipment were performed routinely.

However,

- Training and mandatory training rates were not meeting the targets set by the organisation and we found that the quality of incident investigations varied. We acknowledge CSH were addressing this.
- Around three quarters of teams, including those with stable numbers of co-owners and lower sickness rates, had been under establishment in the last year. The total vacancy rate at October 2016 was reported at 16%. While this is considered a high rate for a community provider, we acknowledge that CSH had identified the risk, worked to improve recruiting and generally mitigated the impact of staff vacancies.

Safety performance

- NHS England defines and publishes a list of never events, reviewed annually in consultation with

healthcare providers and stakeholders. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.

- Never events relevant to the community setting include overdose of insulin due to incorrect administration device or settings, falls from poorly restricted windows, chest or neck entrapment in bedrails and hot water scalding of patients. Central Surrey Health (CSH) reported no incidents classified as never events.
- Eight serious incidents requiring investigation (SIRI) were reported last year, of which seven occurred in community adults services. SIRIs are any incidents that caused unexpected or avoidable death or severe harm to one or more patients, co-owners or members of the public. Five SIRIs arose from care provided in the patient's home and two from residential homes in the area. One incident was a treatment delay that met the SI criteria, five incidents were pressure ulcers (grade 3) and one incident when a dose of insulin was given to the wrong resident in a care home.
- We saw that CSH had developed and maintained a number of up-to-date policies that supported safety performance and fulfilled legal obligations. In addition, CSH employed a 'quality and governance' team that focused on training, audits, policy preparation and action plans arising from complaints and incidents.

Incident reporting, learning and improvement

- Co-owners reported incidents on an organisation-wide computerised system. People we spoke to confirmed they had received training and felt confident using the software. Co-owners providing care in peoples' homes had limited access to the intranet and told us they initially reported any problems to their team leader by telephone and then completed an incident report on return to their base location.
- Some co-owners had laptop computers as part of a trial to test the use of mobile electronic systems to streamline reporting and record keeping. According to managers, the six-month trial, commissioned by the CSH had been "successful" and was due for review shortly after our visit.

Community health services for adults

- According to CSH data, between 13 to 38 incidents were reported weekly during the last quarter. These are incidents not already classified as SIRIs. We asked for the last month's record and noted 107 incidents reported in total from clinical and administrative areas of the organisation. Sixty-nine incidents occurred in adult community or rehabilitation services and of this figure, 27 were classified as 'no harm caused' (39%), 35 as 'low harm' (50%) and seven incidents as 'moderate harm' (10%). Four of the moderate harm incidents were pressure ulcers reported on admission, one was a pressure ulcer reported since admission and two were adult safeguarding concerns: one of severe self-neglect and an allegation of inappropriate touching reported to a co-owner visiting a patient residing in a care home. We saw quality report papers showing a 7% reduction in incident reports over the last quarter, which was consistent with our observations.
- Overall, the data indicated that incidents were routinely reported in community adult services and we saw evidence that processes were followed and concluded within agreed timescales. CSH executives had access to monthly 'performance boards', which included incident report figures. These spreadsheets used colours to indicate performance and therapeutic team. This meant that the senior management had access to timely and clear information to help them identify trends and areas for attention. We saw an Incidents Trends Report (dated December 2016) which summarised clinical and non-clinical incident trends, safeguarding concerns and slips, trips and falls. Each incident included a brief commentary detailing location and service.
- Our findings were consistent with the results of the last staff survey (2016) when 99% of co-owners answered 'yes' to the question "I would know how to escalate concerns around professional practice, quality or patient safety in CSH". This was a creditable improvement of 9% compared to 2015.
- We saw a copy of an in-date 'Incident & Near Miss Reporting Policy and Procedure' (RM4) which was accessible via the CSH intranet and guided co-owners and managers on the processes involved. We noted that 24 co-owners had attended root cause analysis training over the last quarter. This provided team leaders and managers with the skills to analyse incidents and identify causes for remedial action.
- We saw that twenty-eight of the incidents listed had been investigated and lessons learned had been

identified. However, the quality of the commentary varied, with some comprehensive and clear investigation reports (such as RCA 2016-4955 and 2016-5518) while others on the main file we saw comprised one-line comments.

- This led us to conclude that while systems were in place and processes followed, CSH was still missing an opportunity to fully improve practice and strengthen organisational learning. We acknowledged feedback systems existed and noted an example of a good critique provided to an investigating manager (2016/8233). We also saw that managers held monthly team briefings supported by 'core briefs' and we saw copies of presentations and training materials that indicated the organisation was addressing these issues.

Duty of Candour

- The duty of candour (DoC) requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days.
- We saw an in-date policy 'Being Open and Duty of Candour Policy and Procedure' (CG1) made available on the CSH Intranet. CSH had developed an e-learning DoC package directing co-owners through the principles and concepts and we saw that DoC was included in the template used by the incident reporting software, which automatically alerted investigating managers and blocked progress if the relevant section was incomplete.
- We reviewed two records of DoC meetings, which demonstrated DoC had been correctly applied and co-owners we spoke to had good awareness of the duty and their responsibilities under it.
- We noted that CSH had last audited the DoC process and documentation in November 2016 and had addressed actions arising from the audit. This indicated the organisation had effective processes in place to monitor and support the DoC policy.

Safeguarding

- Co-owners we spoke with had safeguarding training at the appropriate levels for their roles and were alert to any potential issues with adults or children. We were told that safeguarding training was delivered as part of the annual mandatory training programme and embedded into the co-owners' induction.

Community health services for adults

- According to data provided by CSH, safeguarding training had been updated in line with the Care Act (2014) and compliance rates for level 1 (91%) met the CSH target of 95%. Safeguarding level 2 compliance had significantly improved from 70% in 2015 to 88%, although this was still below target. Managers we spoke to acknowledged this, and said that 'big day' training sessions had commenced to give co-owners protected time to complete mandatory training. One manager said this would be complemented by focusing on individual performance of co-owners who missed the training events.
- We saw executive reports that showed monthly monitoring of safeguarding incidents from all services (children and adults). In December, for instance, 11 incidents were reported that related to safeguarding adults and two to children. This data indicated that co-owners were actively reporting concerns and there was senior oversight of safeguarding reports.
- CQC received five safeguarding notifications from CSH last year, the last being in April 2016. No serious case reviews had been triggered.
- There were two adult safeguarding advisors who reported to the Director of Quality who has the overall responsibility for adult safeguarding. We saw safeguarding flow charts displayed on clinic noticeboards that showed co-owners what to do in the event they suspected any abuse. This meant co-owners would be able to follow procedures in the event of an allegation or suspicion of abuse.
- We asked what checks had been made on co-owner suitability to work with vulnerable people and we saw summary records that showed those working in peoples' homes had disclosure and barring checks. This meant the provider had taken necessary steps to help ensure they only employed people suitable to work with vulnerable adults or children.
- The CSH public website displayed a safeguarding link in a prominent position for members of the public to raise a safeguarding concern.

Medicines

- During our home visits, we saw that co-owners did not hold a patient's medication. The patient or their relative arranged storage, administration and repeat prescriptions. A less-mobile patient explained that their pharmacy had a home delivery service.

- We looked in the storerooms where district nursing teams' stored items related to people's treatment such as dressings and catheter bags. Items were in-date, neatly arranged and labelled for ease of access and identification.
- We checked three medication refrigerators in two CSH locations. Each refrigerator was lockable with a built-in digital temperature display and alarm designed to alert users if the temperature went out of specification. Co-owners told us these were sensitive and demonstrated this using one refrigerator. We saw evidence that each device was tested, serviced and calibrated in line with national guidance.
- District nursing teams primarily stored influenza vaccine and control strips for medical device calibration in the refrigerators.
- We saw one medication refrigerator located in an open-plan team office, which was unlocked while in use by co-owners. The medication fridge was kept unlocked all day with the key in the fridge lock. We were told that the refrigerator was locked at night, although no co-owner could confirm who was responsible for securing the refrigerator or where the key was kept. While access to the office was restricted, the possibility remained that medicines could be moved or damaged without detection.
- Team administrators were responsible for recording temperature readings but worked Monday to Friday. We noted gaps in temperature records, which meant it was possible that readings indicating a fault developing could be missed. We acknowledge that the temperature alarm reduced the possibility of medication rendered ineffective through heat or cold damage. Co-owners described the procedure followed in the event of a 'fridge breakdown and knew the name of the CSH pharmacist to call.

Environment and equipment

- Overall, the areas we observed supported the safe performance of therapies and delivery of care. Rooms were well-lit, air-conditioned where required and supplied with sufficient equipment and furnishings.
- Security of access was achieved where necessary by entry phone and keyless door locks. All co-owners wore identity badges that clearly stated their name and role. We saw that visitors such as the inspection team were provided with temporary badges and these were checked by co-owners on entry to each clinic.

Community health services for adults

- We saw that each clinic location had dropped kerbs or ramps to assist wheelchair users or those with limited mobility reach the entrance. Clinics and community hospitals had automated entrance doors led to the waiting areas and lifts as required. Corridors and therapy rooms were spacious with doors wide enough to fit wheelchairs.
 - There was access to emergency equipment, including portable oxygen, suction and automated defibrillators. We saw first aid kits mounted on walls in clinic offices and posters explaining whom to call and where they were located in the building. In some cases, another provider managed the first aid and emergency items. Reception staff checked these daily with a provided checklist. This meant all items were ready for immediate use should an emergency occur.
 - Patient treatment couches, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provide assurance to CSH that items were controlled and maintained in accordance with manufacturer recommendations and policy guidelines.
 - The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices and maintenance tests. We checked a sample of devices in each of the clinics we visited. These were labelled with the dates of the most recent electrical testing, which provided co-owners with a visual check that the items had been examined to ensure they were safe to use.
 - At two clinic locations, co-owners explained that facilities management was complicated by shared tenancy and ownership of the building. We saw CSH clinics were co-located with other health providers such as medical practices, dental surgeries and local NHS trust audiology services. We heard examples of difficulties encountered such as getting toilets repaired and we observed a faulty lift that had been broken "for a year". Managers acknowledged the difficulties experienced and said that CSH had escalated concerns to NHS property services and continued to monitor progress.
 - Limited parking was provided free but in one location co-owners said commuters taking up spaces to avoid local parking charges abused this facility.
 - Domiciliary physiotherapists and occupational therapists attended patients in their own homes to assess mobility and provide advice on mobility aids, equipment and manual handling practices. District and tissue viability nurses also supported people in their own homes with the provision of medical devices such as pressure-relieving mattresses and cushions. Co-owners and patients told us that appropriate equipment was readily available and none expressed any concerns about repair or replacement of faulty items.
- ## Quality of records
- We saw co-owners using electronic records system except for those caring for people in their homes, who continued to use care notes contained in folders.
 - Care note folders were accessible to patients in their own homes, which co-owners said was normal practice and part of involving and informing patients in their care.
 - CSH was working towards mobile electronic systems and this was being piloted. The electronic and paper records we viewed appeared to be accurately completed, legible and up to date and stored securely.
 - We were told that records were routinely audited to help identify any improvements in practice required. We saw an example of a record keeping audit for the hand therapy service, which showed between 80% to 100% compliance with 38 separate items ranging from completeness of the record to identifiable signatures. The audit included recommendations for improvement and an action plan, which illustrated the organisation's commitment to continuous improvement.
- ## Cleanliness, infection control and hygiene
- All of the areas we inspected were visibly clean, tidy and free from clutter. In therapy rooms, we saw that trolleys, couches and medical equipment were visibly clean and stored correctly.
 - The flooring in therapy and treatment rooms was made from seamless, smooth, slip-resistant material that complied with Health Building Note (HBN) 00-09: Infection control in the built environment (Department of Health, March 2013).

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- Co-owners participated in infection control training as part of their annual mandatory training programme and all co-owners we saw were 'bare below the elbow' when dealing with patients.
- We saw antimicrobial hand-rub dispensers mounted on the walls of clinic and community hospitals at strategic points and reception areas. These contained gel and we observed co-owners using the product as they moved around the premises.
- We checked patient and staff toilets in a selection of clinics, which were visibly clean.
- Personal Protective Equipment (PPE) such as gloves and aprons were available and we saw these items being used. Mobile co-owners carried small stocks with them for use in people's homes if required.
- We saw disposable curtains used in some physiotherapy rooms marked with the date changed. This complied with HBN 00-09. Frequently changed curtains helped to reduce the chances of germs passing from one person or object to another.
- We saw evidence of local audits to monitor the standard of cleanliness across the clinics. This included environmental and handwashing audits. For example, the podiatry team at Bourne hall achieved 100% compliance in the last hand hygiene audit, as did the continence team at the Leatherhead community hospital base (December 2016). According to CSH data, IPC audits were undertaken every three months in the community setting.
- We noted clinical waste was separated and handled in line with national guidance, HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.
- Co-owners in the district nursing team told us they carried a nurse's bag, which contained items such as a thermometer and single-use consumables. We saw they carried a small stock of disinfectant wipes for cleaning any reusable items or equipment before and after use.
- In addition, mobile workers carried portable containers of antimicrobial hand-rub. We saw these used during home visits.

Mandatory training

- According to CSH data, the target for all mandatory training compliance was 95%, apart from safeguarding which was 90%. Co-owners completed mandatory

training using a combination of online learning and taught sessions. Compliance rates were reported monthly on performance reports and co-owners advised when necessary by their line managers.

- Mandatory training modules included incident reporting, fire safety, health, safety and welfare, infection control, conflict resolution and equality and diversity.
- The records we viewed demonstrated a range of compliance rates between departments and specialities. For example, the wheelchair service achieved a compliance rate of 91%, district nursing 87% and podiatry 92% as at October 2016. Managers stated that efforts had continued and we saw local figures indicating a shift closer to CSH targets.
- The duty of candour (DoC) and Mental Capacity Act 2005 were integral parts of the mandatory training programme. Compliance rates were lower and in March 2016 reported at 80% with consent training at 79%.
- The co-owners we talked with said they received adequate training, although those working shifts or in people's homes said that increased workloads and work patterns made accessing taught sessions difficult. We noted that CSH had placed mandatory training on the risk register and managers reiterated that 'big day' training events had commenced to help co-owners had protected time to complete mandatory training.

Staffing levels and caseload

- CSH reported 726 substantive employees across the organisation. The total vacancy rate at October 2016 was 16%. Of these figures, 346 co-owners worked in Community Adults. CSH provided detailed figures for each therapy team, which indicated CSH maintained effective records.
- There was some variation in vacancy and sickness rates between therapy groups, which we attributed to the size of specialist teams. For example, the heart failure service had recently recruited a new specialist nurse, which reduced the vacancy rate for that team by 45%. Of the 24 community adult teams reported by CSH, six reported zero vacancy rates and nine zero turnover in the last 12 months. CSH also had good visibility of sickness and vacancy rates for each service. CSH set a target for 2.5% sickness rate and results varied between departments and specialities. Overall sickness among permanent co-owners was 4%. Thirteen teams reported sickness rates within CSH targets.

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- Around three quarters of teams, including those with stable numbers of co-owners and lower sickness rates, had been under establishment in the last year. This was consistent with comments made to us by managers and co-owners alike, who cited employee levels and caseloads as a cause of concern. We noted similar commentary in the last co-owner survey, when only 30% of respondents answered 'yes' to the question "are there enough co-owners in my area of work to get everything done". In the same survey (2016), just over half of respondents felt they had an "acceptable workload".
- We saw that CSH had included workforce capacity and caseloads in the risk register, which accurately reflected the impact of increased referrals and co-owner vacancies. We saw data showing that CSH closely monitored waiting times and referral numbers and these reported to the board monthly. For example, managers and clinician co-owners had access to live reports from an electronic system, which enabled forward planning and quick responses to unexpected changes.
- Bank and agency staff were used to fill shifts and CSH managers described recruiting initiatives such as local radio, student fayres and employment stands at supermarkets and community centres in the area. CSH had targeted recruiting for newly qualified nurses and offered further development including 'golden hellos' incentives, advanced training opportunities and university support programmes.
- We noted that only one incident was reported relating to staffing levels, which suggested that CSH had mitigated the impact of staff vacancies.
- Community adult service delivery divided into 'planned' and 'unplanned care'. Planned care comprised services such as podiatry, wheelchairs and continence support while unplanned care included services such as district nursing and domiciliary physiotherapy, community matrons and specialist nursing teams that responded directly to referrals from GPs and local hospitals.
- Planned care utilised waiting lists and had targets set in agreement with commissioning bodies, while unplanned care services responded to referrals from GPs and other agencies. Both categories had experienced significant increases in referrals. For example, the target set for hand therapy (planned) was 21 referrals per month but accepted over twice this rate.
- CSH closely monitored waiting times for appointments as well as waiting lists. Each planned care team also recorded the number of patients waiting over 18 weeks for a first appointment. The target for urgent appointments was set at one week and eight weeks for standard appointments. We saw that CSH had implemented a number of measures to reduce the risk and inform service users. These included daily situation reporting and electronic reporting systems, patient education on how to self-care and avoid readmissions, waiting list updates and educational posters sent to GP surgeries as well as additional funding obtained from the CCG for podiatry and musculoskeletal services.
- From the data provided, CSH broadly met its targets for urgent referrals last year. Most planned care therapy teams reported longer waits for standard appointments and about half of the teams reported patients waiting longer than 18 weeks, although the number of patients in the last category was relatively low. This indicated that CSH had effective systems in place to monitor and address referral wait times. CSH and its co-owners appeared to have mitigated the impact of the increase in referrals despite lower than establishment figures in some therapy areas. Senior managers acknowledged co-owner concerns and appeared to be working towards sustainable solutions in terms of engaging proactively with referrers, reducing missed appointments and local recruiting.
- We noted that despite these figures, 70% of co-owners were still likely to recommend CSH as a place of work and this indicated that the service benefited from the good will and commitment of its co-owners.

Assessing and responding to patient risk

- We saw examples of risk assessments carried out for service users in line with national guidance, such as physiotherapy, podiatry and heart disease assessments along with frailty checks and pressure ulcer assessments. Where risks were identified, co-owners had access to support, guidance and equipment to help manage these risks.
- Co-owners described examples of identifying and responding effectively to changing risks in home locations such as deteriorating patients and medical emergencies.

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- We observed part of an evening shift handover that included commentary on cases and we saw co-owners reviewing electronic case notes prior to departing their base locations and again in people's homes, where paper records were used.

Managing anticipated risks

- CSH had departmental and central risk registers to help identify and monitor the risk in each service. We saw examples of registers that contained a description of the problem, the risks posed and the underlying cause. Risks were scored and rated using the 'red, amber, green' colour convention and action plan summaries and review dates entered. We saw the registers were updated regularly and recently.
- The community nursing and physiotherapy risk register reflected the impact of increased referrals compounded by co-owner vacancies, which resulted in longer waiting times. The register summarised actions to mitigate these concerns. Co-owners told us that district nursing teams had much larger caseloads than anticipated. Managers stated that referrals had increased from 950 a month to over 1600. As an 'unplanned' service, waiting lists were not applicable and rapid response requests had affected the services' ability to manage risk. Risk reduction measures included close liaison with the referral management centre and GP practices designed to ensure patients were appropriately prioritised. In addition, workloads had been shared between district nursing 'hubs' and community matrons during times of high seasonal demand.
- One of the highest risks identified in the podiatric and wheelchair services register was lone working. This was consistent with comments made to us by co-owners from this and other services who visited people's homes. Co-owners knew the lone working policy that was available on the intranet and had been recently reviewed (October 2016).
- We saw evidence of specific procedures for lone working including agency staff and volunteers. Conflict resolution training was mandatory for all people designated as lone workers and we saw examples of risk assessments specifically designed for co-owners working in the domiciliary setting. We were shown a small electronic location device issued to workers. The device communicated the worker's location using global satellite technology and included duress or SOS buttons that activated a police response via a 24-hour

monitoring centre. Co-owners had 'dom buddies' allocated and arrangements to ring team leaders of colleagues at the completion of visits to monitor safety. We also saw evidence that torches had been issued to those working twilight shifts. These actions indicated that CSH had anticipated risks and had introduced effective measures to manage them.

Major incident awareness and training

- Overall, we found that CSH had effective systems and processes to help ensure major incidents were managed effectively.
- We saw that CSH had major incident and adverse weather policies in place and accessible to co-owners. Mobile workers recounted examples of how they maintained the service during adverse weather events such as snow affecting the local road transport system.
- At clinical and community hospital locations we saw firefighting equipment, safety signage and posters on notice boards about fire and other emergencies. We checked a random sample of fire extinguishers and saw labels indicating they were tested and serviced. Data provided by CSH showed that annual fire assessments and environmental audits had been performed. Managers stated that evacuation drills were practiced annually.
- We saw that fire safety was part of mandatory annual training and we returned to one clinic location in time to observe CSH co-owners concluding a fire evacuation. We learned from CQC colleagues inspecting the adjoining community hospital that the response to the alarm had been "excellent". This indicated the effectiveness of CSH emergency planning and training.

Are community health services for adults effective?

(for example, treatment is effective)

Good 

We have rated effectiveness of the service as good.

- Co-owners had a good awareness of policies and procedures, which were based on National Institute for

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Health and Care Excellence (NICE) guidelines and other national standards. We saw evidence of local and national audits undertaken to monitor the quality, safety and effectiveness of care.

- Patients' pain, nutrition, and hydration needs were assessed and addressed in line with national guidance.
- We found evidence of multi-disciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all co-owners.

However,

- While care was evidenced based and there was participation in national audit programmes, the range of audits was restricted and some of the information provided to us dated.
- Care was delivered by a range of skilled workers who participated in annual appraisals and had access to further training as required. While co-owners were generally supported to undertake training, compliance rates for annual mandatory training and appraisals were below organisational benchmarks. Appraisal rates in some of the district nursing teams appeared to be the lowest of the community health services.

Evidence based care and treatment

- Overall, we found that relevant NICE guidelines, quality standards, service frameworks and other good practice guidance were available. We saw examples in use such as pressure ulcer assessment and treatment guides as well as diabetes and heart disease management pathways.
- We viewed policy documents that had been written and updated regularly. These were available on the CSH intranet as well as clinic files.
- Care was supported by local and national audits which included clinical topics such as the sentinel stroke national audit programme (SSNAP) as well as environmental, handwashing and infection control checks. The results of these were shared among co-owners. We observed examples shared in team meeting notes and displayed on clinic notice boards.
- Individual care plans were clear, up to date and in line with the relevant guidance. For example, domiciliary physiotherapy treatment plans included clear outcome goals, which were personalised and monitored using nationally recognised measurements such as

patient-reported outcome measures (PROMs). PROMs are a method of capturing the patient's opinion on the impact of their disease or disorder and the effect of the treatment.

Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection, however we found a recognised pain assessment tool available for use, which reflected national guidance.
- Care plans included pain assessments. According to patients we spoke to, this aspect was well managed. Likewise, we saw an example of a nutrition and hydration assessment that contributed to a care plan and had been discussed with a family member who provided additional support.

Technology and telemedicine

- CSH primarily used a confidential electronic system to record and store patient information, which allowed therapists and practitioners to access care records. This resulted in improved continuity of care and multidisciplinary communications for patients visiting the clinics.
- Practitioners working in people's homes relied on a combination of paper and electronic records, although we saw that mobile electronic systems had already been piloted and more widespread use was in prospect with the merger between CSH and the adjoining service.
- CSH did not operate care homes or sheltered accommodation. Accordingly, telemedicine services were not applicable to this inspection.

Patient outcomes

- We saw evidence that nursing and therapy services routinely collected and monitored information about the outcomes of peoples care and treatment.
- We saw good examples of local outcome measurement, such as a series of audits of physiotherapy pre-assessments for patients undergoing elective knee replacement surgery and a study of outcomes from the podiatry department about the detection, prevention and early management of diabetic foot ulcers (NICE guidelines NG19: Diabetic foot problems: prevention and management (2015)).
- According to data provided by CSH, audits in progress included NICE quality standards, medicines management, pulmonary rehabilitation and PROMs.

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- These indicated that CSH was monitoring outcomes locally and participating in some national benchmarking. We saw that CSH participated in the national COPD audit programme from inception in 2015, SSNAP (as part of the neuro-rehabilitation service) and a national heart failure audit. However, data provided on request was incomplete or old and it remained unclear what benchmarking had been achieved or if lessons learned had been disseminated fully.

Competent Co-owners

- According to managers and co-owners we spoke to, CSH was committed to ensuring employees had the right qualifications, skills, knowledge and experience for their roles.
- CSH provided two days of mandatory training for new co-owners, which included a range of topics such as basic life support, health and safety, fire training, conflict resolution, moving and handling and safeguarding. In addition to line management supervision and one to one sessions, CSH used mentor and 'buddy' systems to provide support to new colleagues.
- More experienced co-owners felt encouraged to acquire additional skills and qualifications to help them take on new responsibilities and had their learning needs identified through performance and development (appraisal) processes.
- Combined data supplied to us indicated 83% of co-owners had completed mandatory training last year and 67% had appraisals. CSH set targets of 100% and 95% respectively.
- Monthly performance reports showed a variation in appraisal rates between differing departments. For example, physiotherapists ranged between 79% and 100%, while podiatry and wheelchair services achieved 100% compliance.
- Some district nursing teams reported lower appraisal rates. Managers acknowledged the low compliance figures and outlined strategies for improvement that focused on workload and referral management as well as protected time for training. We saw that appraisal rates had been included in performance reports distributed to senior managers and the executive, which indicated that all levels of the organisation were aware of the status and monitoring progress towards full compliance. We noted reports that indicated the overall trend was one of improvement. For example, current data showed that one district nursing team exceeded

90% compliance; two teams over 80% and one at 70%. One team had deteriorated to 50%, which was attributed to a change in line management arrangements and was being actively addressed.

Multi-disciplinary working and coordinated care pathways

- We saw good examples of multi-disciplinary working within CSH. Co-owners described instances of how they worked with other members of the multidisciplinary team to meet the needs of service users and we observed practical instances of this when we watched care provided in both clinics and peoples' homes.
- Our observations were supported by remarks from service users.
- Good relationships existed with GPs, neighbouring hospital trusts and other agencies such as local councils and emergency services.
- We saw from care notes and assessment sheets that referrals to services were handled effectively with clear criteria and a multi-agency approach to ensure people got access to the right care.
- Referrals into CSH were actively scrutinised by managers to improve the appropriateness of the referral and again we were given examples where good multi-disciplinary relationships meant that identified problems were quickly addressed.
- We also reviewed a sample of electronic records that demonstrated good multidisciplinary working. The electronic records we reviewed showed that information was readily shared between the different therapy and care groups. This indicated a coordinated approach was achieved for people with complex needs.
- Co-owners also described using the system to help identify who held overall responsibility for each individual's care and seemed clear in their understanding and explanations to us.

Referral, transfer, discharge and transition

- Co-owners and managers across nearly all therapy areas reported inward referrals increasing over the year and in some cases significantly above target. We saw monthly performance figures demonstrating this and managers described CSH actions to mitigate demand and address inappropriate referrals from GPs or other health providers.

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- There were protocols in place for occasions when a patient's needs suddenly increased. Co-owners we spoke to were clear on the circumstances and procedures for referral to hospital, GP or the emergency services.
- We saw examples of clinic discharge letters sent to GP's which were sent on completion of therapy.

Access to information

- We saw examples of care and risk assessments, care plans, case notes and test results that were held on the CSH electronic record system. The system meant that people moving between teams and services had the information needed to manage ongoing care.
- In the domiciliary setting, we saw that paper care records supported co-owners in delivering care and we acknowledge that CSH was actively preparing to enhance this aspect by adopting mobile electronic records.
- We saw that co-owners could access current guidelines, policies, procedures via the internet. Those working in the domiciliary setting had time allocated at their 'base' on each shift to update the electronic records and review documents. This indicated that co-owners could access advice and up to date guidance easily.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- According to information provided by CSH, MCA/DoLS and consent training compliance was low. Delivered as part of adult safeguarding training by the delivered by the adult safeguarding advisors' team, compliance rates for consent training was 79% and MCA/DoLS 80%. This meant the organisation targets were not being achieved.
- We saw reports indicating CSH had made this a priority as compliance levels for this training had not increased in the last year. The topics were included in the 'Big Day' training events to provide additional sessions. We were told that an additional two days had been programmed in 2016 and more were intended for 2017. This indicated that senior managers were aware of the issue and addressing the shortfall.
- Co-owners we spoke to demonstrated awareness of how the Mental Capacity Act 2005 related to their practice and were aware of whom to contact if they

required guidance. We saw that CSH had introduced a number of publicity materials to promote awareness of the Mental Capacity Act which included credit card sized reminders, computer mouse mats and posters.

- The patient records we reviewed showed that consent was obtained prior to therapy. The provider had an in-date policy to guide co-owners in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA). We also saw a recently introduced standard operating procedure (SOP) for community co-owners that addressed a person's mental capacity in cases of self-neglect and refusal of treatment.
- We did not observe any situations where this policy needed to be applied during the inspection and no instances were reported arising in community services in the last year.

Are community health services for adults caring?

Good 

We have rated the care delivered in CSH as good.

- Patients told us they felt very well supported and informed at all stages of their treatment and commented very positively about the care provided to them by the co-owners from the clinics and in their own homes.
- Co-owners exhibited a strong commitment to holistic and individualised care. This was firmly incorporated into the philosophy of the organisation. Co-owners were highly motivated and inspired to offer care that was kind, respectful and individualised.
- We saw co-owners address issues with tact, diplomacy and in a caring yet professional way. Therapy and treatment room doors were kept closed, and co-owners knocked before entering clinic rooms to maintain patients' privacy.
- Working relationships between co-owners were positive and focused on the values of the service.

Compassionate care

- CSH took part in the friends and family test (FFT), a survey that asks patients whether they would recommend the service they have received to friends

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and family who need similar treatment or care.

According to published data, the average FFT score for all CSH services in 2016 was 96.6%, up from 93% the year before. This is the percentage of respondents saying they would be 'Likely' or 'Extremely likely' to recommend CSH to friends and family should they need similar care or treatment.

- In the clinics and homes, we observed examples of compassionate care and co-owners being empathetic and reassuring.
- Patients and relatives we spoke to were very positive about the care and attention they received from co-owners. We also received 68 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection. Comments were overwhelmingly positive and praised the co-owners (please see the section 'What people who use the service say' for more information).
- We noted that therapy and treatment room doors were kept closed, and co-owners knocked before entering rooms to maintain patients' privacy. In the home setting, we observed co-owners ensuring the dignity of their patients while helping them to mobilise.
- Co-owners from all specialities we spoke to were highly motivated to deliver care that was kind and compassionate to their patients and their families.
- Individualised care was delivered and the records we viewed evidenced this. CSH had a strong person-centred culture and we saw that co-owners placed a high value on positive relationships with patients and their families and supported them in a way that ensured they felt understood and valued.

Understanding and involvement of patients and those close to them

- Co-owners introduced themselves by name and wore ID badges at all times. We saw co-owner photographs and names were displayed on the waiting room walls in three clinics we visited, which helped visitors identify who was responsible for the services delivered in those localities.
- We observed an extensive range of literature and health education leaflets mounted on purpose-built racks located in waiting areas and therapy rooms. The leaflets were primarily in English, although we noted a small variety in other languages.
- Co-owners told us they encouraged their patients and family members to be involved in the planning of their

care as much as possible. This was confirmed by family members we spoke to, who said they felt involved in discussions about treatment options and could ask questions about the care they were receiving.

Emotional support

- Throughout our inspection, we observed co-owners giving reassurance to patients both over the telephone and in person.
- Patients told us that their nurses and therapists were approachable and made time to explain and answer questions.
- We saw relatives being included in conversations in people's homes and invited to accompany patients into therapy rooms.

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

Good 

We have rated the service as good.

- The clinic environments provided were appropriate and patient centred, with sufficient seating, access and toilet facilities. Facilities for patients and their families were enhanced by free car parking. Services were tailored to the needs of local populations and co-owners were able to access training specific to the needs of the populations they supported. There was access to interpreters, however, written information in different languages was not readily available.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care. There was a system in place for capturing learning from complaints and incidents and there was very good local ownership of any problems with teams working closely together to resolve any issues that arose.
- There was sufficient equipment to ensure that people with disabilities were able to access services and buildings complied with the Disability Discrimination Act 1995.

However,

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- While there was a system to monitor and respond to complaints, co-owners were not able to provide consistent examples of service changes or learning because of comments or complaints. We found the responses to the complaints varied in quality. This meant the organisation was missing an opportunity to use comments and complaints to improve the services it delivered.

Planning and delivering services which meet people's needs

- We saw that CSH adapted to meet the needs of the local community through a variety of services purchased by the CCG. Through this process, we saw examples of when clinics and specialist nursing services operated and engaged with local GP surgeries, stakeholders and other NHS providers to ensure services provided met the needs of the local community.
- Clinics and specialist nursing service operated during normal business hours Monday to Friday, while other home nursing services were provided up to 11.30 pm seven days a week
- The clinic environments we saw were appropriate for the services planned, with comfortable and sufficient seating, toilets and in some cases refreshment facilities.
- The district nurses worked within larger multi-disciplinary health and social care teams called Community Hubs. Their aim was to work together to provide an integrated service for patients. one example of the service provided included liaising with GP's for medication reviews and the collection and deliver of prescriptions.

Equality and diversity

- We saw that services were planned to take account of the needs of different people such as those requiring extra mobility support. This included a wheelchair service located in one of the community hospitals.
- We learned that arrangements were in place to access phone-based translation services for people whose first language was not English. Co-owners we spoke to knew of the service and described how to access it when required.
- We noted occupational therapists were available to advise on reasonable adjustments that could be made or provided to support disabled people in their own homes or when visiting clinics.

- We saw a good example of a patient with limited mobility who was unable to access the second floor of the building because the only working lift had broken. Podiatry co-owners arranged with the GP downstairs to make a room available so the treatments could continue.

Meeting the needs of people in vulnerable circumstances

- We found CSH had systems available to ensure services could meet the needs of patients in vulnerable circumstances such as those living with dementia or a learning disability.
- Co-owners described examples of working closely with local GPs to provide ongoing support to patients in vulnerable circumstances. They expressed confidence in their ability to meet the needs of patents referred to them in these circumstances and spoke positively of the multidisciplinary support that was available to help identify and respond to these needs.
- We saw that co-owners could access additional training (such as dementia awareness) specific to the needs of those they supported.

Access to the right care at the right time

- We saw that CSH had performance data available to help monitor and manage times taken to access initial treatment. For each of the 'planned care' therapies, we saw reports showing referral figures and average waiting times for appointments.
- The target for urgent appointments was set at one week or two weeks and eight weeks for standard appointments. Over the last year, planned care services achieved the following averages:
 - Hand therapy services - 1.7 weeks wait for an urgent appointment and 6.5 weeks for a standard appointment.
 - MSK physiotherapy services - 1.4 weeks wait for an urgent appointment and 7.4 weeks for a standard appointment.
 - Podiatry services - 1.2 weeks wait for an urgent appointment and 12 weeks for a standard appointment.
 - Both Wheelchair and continence services maintained 1.2 weeks wait for urgent appointments (two-week target) and 7.5 weeks for standard appointments.

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- These examples showed that CSH broadly met targets for urgent appointments, despite increased referrals. Podiatry exceeded the target for standard referrals and we saw evidence of actions taken to remedy this.
- CSH also monitored those planned care patients that waited longer than 18 weeks for their first appointment:
 - Hand therapy services averaged 47 referrals over the last quarter reported, which was 209% above the target of 21 referrals per month. Of these, 16% waited longer than 18 weeks for their first appointment.
 - MSK physiotherapy services averaged 1082 referrals over the last quarter, which was 77% above the provider target of 840. Of these, 2% waited longer than 18 weeks for their first appointment.
 - General podiatry services averaged 53 referrals over the last quarter reported, which was within the provider target of 100. Of these, 5% waited longer than 18 weeks for their first appointment.
 - Wheelchair services averaged 56 referrals over the last quarter reported, which was within target (55). Of these, 20% waited longer than 18 weeks for their first appointment. CSH managers told us this service was reviewing capacity and workflow and had appointed an additional administrator to help focus on follow-ups.
 - Continence services averaged 116 referrals over the last quarter reported, which was 56% above the provider target of 65. Of these, only 0.5% waited longer than 18 weeks for their first appointment.
- One of the measures taken to reduce waiting lists was an active focus on 'do not attend' (DNA) rates. CSH used mobile phone texts to remind patients attending clinics and implemented a DNA policy to help reduce serial non-attenders. The target set for podiatry, for example, was 8% and according to figures we saw, had been reduced from 10% to 6% in the last year.
- District nursing services represented the bulk of the 'unplanned care' provided by CSH. By agreement with service purchasers, routine referrals were divided into priority order using 'time bands'. Referrers could select the appropriate band based on clinical need: seen within 48 hours, within one week or within two weeks.
- Managers stated that patients were seen and managed by the flexible use of co-owners across time slots and teams, the use of prioritisation tools and by employing bank and agency staff at times of peak demand. The average waiting time for a routine referral was 2.8 days.
- Urgent referrals could also be made and were called 'rapid response' referrals. According to data provided by CSH, up to 400 such referrals were made each month and in the last year, all were seen on the same day. Managers explained that most were seen within four hours of referral. The number of rapid response referrals appeared relatively constant throughout the year, despite efforts by CSH to increase awareness with the wider GP community regarding the impact of inappropriate referrals.
- Overall, CSH had robust systems to prioritise care and address referral wait times, which indicated the organisation was responding effectively to ensure people had timely access to care and treatment.

Learning from complaints and concerns

- We found systems in place to monitor and respond to complaints. We saw an in-date complaint policy and co-owners could describe the process on receiving a complaint and how to escalate any concerns
- According to CSH Data, 56 complaints were lodged in the last 12 months of which 26 were upheld and one was referred to the Parliamentary and Health Services Ombudsman.
- The highest number of complaints arose from the district nursing and physiotherapy departments.
- We reviewed a sample of complaints during the inspection and found that the quality of the investigation and the way the lessons were learnt was inconsistent at times. Some co-owners we talked with during the inspection were unable to provide examples of improvements to the services and learning arising from these complaints.
- This suggested that opportunities to fully learn and improve services after investigation might have been missed.

Are community health services for adults well-led?

Good 

We have rated this service as good.

- We saw good local leadership with an open and transparent culture. There was a clear vision and focus on the delivery of excellent quality care. Co-owners were

Community health services for adults

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

- The governance framework ensured co-owner responsibilities were clear and that quality, performance and risks were all understood.
- In addition to features of the organisation such as a co-owner council, the senior management team were visible and regularly engaged with co-owners and patients.

However,

- While we saw governance and risk management systems in place, there was some variation in the understanding of co-owners about learning from incidents or complaints. The quality of incident investigations and root cause analysis varied. We acknowledge that CSH were addressing this.

Service vision and strategy

- We saw that CSH had developed a “house of quality” strategy model based on the principles of patient experience, clinical effectiveness and patient safety. We saw posters summarising the model on display in clinic offices and team meeting rooms.
- Managers and co-owners we spoke with had a clear focus on the fundamentals of quality care and co-owners at all levels expressed strong commitment to the vision and strategy for the service.
- Through the voice programme, co-owners told us they had felt engaged and consulted at all key stages of the organisation's strategy development and implementation.

Governance, risk management and quality measurement

- CSH operated an ‘integrated governance committee’ (IGC) that functioned at board level. According to senior managers, the IGC met monthly and examined risk and risk reduction measures as well as progress against strategic objectives. The IGC also monitored quality standards, services and indicators and worked with sub-committees such as a learning and development steering group, patient experience forum, infection prevention and control group, information governance and medicines management committee.

- CSH had departmental and central risk registers to help identify and monitor the risk in each service. We saw examples of registers that contained a description of the problem, the risks posed and the underlying cause. These were updated regularly and recently.
- The ‘Voice’ was an additional feature of CSH organisation that contributed to governance by enhancing communications between the board and CSH co-owners. The Voice operated in a similar way to an employee council, with elected representatives who ensured co-owners’ voices were heard at board level.
- CSH used a system of briefs designed to disseminate information to co-owners. A core brief was produced monthly which was then supported by team or departmental briefings and emails.
- Although we saw governance and risk management systems in place, some co-owners we spoke with were unable to provide examples of learning from incidents or complaints.
- We also noted that quality of incident investigations and root cause analysis varied and we saw that CSH were addressing this.

Leadership of this service

- CSH was owned by its employees, although in this case the co-owners did not receive any dividends. The nature of the co-ownership model was a source of pride to co-owners we spoke to and illustrated a strong personal commitment, at all levels, to the delivery of higher quality healthcare.
- We saw staff survey results from 2016 that showed 92% of co-owners knew the CSH strategy, 94% felt they understood the vision and 97% agreed that they had a good understanding of the principles and values of CSH. According to the data provided, these creditable figures had improved since 2015 and indicated that CSH was effective in communicating with and gaining support from its workforce.
- One aspect of the leadership of this service was the Voice, the employee council. We were told that their role was to challenge and question CSH Surrey's strategy and performance on behalf of all stakeholders, helping to ensure the board operated in the best interests of patients, co-owners and the organisation. Co-owners gave a practical example of the Voice's work in this regard: the committee would undertake interviews and play a central role in the appointment of the new Chief Executive Officer.

Community health services for adults

- Co-owners we spoke to expressed confidence in the senior leadership of the organisation. Most were aware of the resignation of the chief executive and members of the Voice told us that they would be involved in the selection of a new chief executive, which was consistent with the rules of the company.
- Co-owners said that managers and members of the board were visible and approachable and this was an important positive part of working for CSH. They felt valued and well supported by peers and line managers, although some expressed concern about staffing and activity levels.

Culture within this service

- Co-owners we spoke to were candid and transparent about the challenges they faced and expressed a strong willingness to engage with change.
- They were positive about the organisation and felt they were listened to, valued and could influence the delivery of care.
- 91% of co-owners said that “valued working for a co-owned organisation such as CSH” in the last staff survey and those we spoke to at all levels of the organisation were clearly committed to patient-centred and high quality care.
- Co-owners reported taking pride in supporting each other and this was supported by the results of the staff survey when 96% said they enjoyed the work they did for CSH
- We saw core values displayed on posters and leaflets that aligned to the same domains used by the CQC. Managers stated this was a deliberate policy to enhance understanding of the values and illustrate ways they should be incorporated into practice. For instance, the values had been incorporated into the annual appraisal process for all co-owners.

Public engagement

- Overall, there were effective systems in place for stakeholders and members of the public to provide feedback to CSH. We saw posters encouraging feedback on display at clinic locations as well as the CSH website.
- The CSH website included prominently marked sections where members of the public or service users could lodge complaints or provide feedback electronically. Each section had clear explanations of the process.
- We saw examples on display of co-owners participating in local charity events and we were told that CSH had worked with the CCG and charities in the region to provide support for people in need.
- Managers stated that CSH also facilitated health promotion events in the local community and co-owners working in areas such as heart failure and domiciliary physiotherapy gave us examples of initiatives undertaken.

Co-owners engagement






- Overall, co-owner engagement was a strong feature of CSH and this was supported by information published by the organisation. For example, 81% of co-owners would recommend CSH as the provider of choice, comparing with 69 % among NHS staff.
- CSH fostered engagement through an active employee recognition process, health promotion events and the use of forums such as the Voice.
- For example, Voice members were given protected time each week to visit and meet with colleagues in the clinics and locations in their area. This amounted to half a day per week, which we were told for practical reasons, was usually taken as one full day a fortnight.

Innovation, improvement and sustainability

- Managers stated that CSH had been awarded a contract in an adjoining region, which was due to start in April. The other service already used mobile electronic reporting and CSH had established a transition team whose role included the management of merging the two systems.

Community health services for children, young people and families

Requires improvement 

Safe	Requires improvement 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Requires improvement 

Information about the service

Central Surrey Health was a profit for social purpose enterprise commissioned to provide a range of health services to a population of around 290,000 in mid Surrey. The services provided for children and young people (CYP) included health visiting, school nursing, and services for looked after children (LAC), speech and language, physiotherapy and occupational therapy.

We visited a range of services including community health centres, a school for children with complex needs, and we accompanied staff on home visits, and observed safeguarding in action sessions. We spoke with 53 co-owners across the service including speech and language therapists, physiotherapists, health visitors, school nurses, community children's nursing and continuing health care team, admin staff, students, clinical service managers and twenty parents and six children who used the service.

During the inspection, we held focus groups with co-owners. We visited teams either at their place of work, or within the community setting. During our inspection, we spoke with 20 parents and children and reviewed 20 CQC feedback cards. We looked at a random sample of clinical settings across trust locations where we reviewed individual care plans for children, risk assessments, and a variety of team specific and service based documents and plans. We also sought feedback from external partner organisations, and reviewed online feedback.

Summary of findings

We have rated this service as requires improvement, because:

- We identified incidents were under reported in the Children and Young People (CYP) service. We found the quality of incident investigation was varied, and there was a lack of senior management and governance oversight of the quality of incident handling. This meant that that the organisation's ability to learn, improve, and prevent future recurrence was affected. The governance structure was not well understood by some co-owners and the flow of information was not effective.
- We identified concerns about senior manager oversight of the special school service. This related to a lack of timely, proactive service planning to ensure the special school nurse team (SSNT) could meet the complex needs of those who used the service.
- Data demonstrated very low levels of complaints in the service. However, the complaints we reviewed showed the quality of the investigations, response tone and learning from these was inconsistent.
- Co-owners in the service were found to be stretched across the service. Whilst we recognise an active recruitment drive was in progress, there were high vacancy and workforce turnover rates. Data from the recent co-owner survey suggested low satisfaction levels in response to the question 'do you feel there are enough co-owners in your area of work to get everything done'.
- Appraisals rates reported in the performance report 2016, showed that the appraisals rates for co-owners

Community health services for children, young people and families

Requires improvement



was low. This meant that some co-owners did not have an annual appraisal. The reason given for this performance was current workload, managing vacancies, and long-term sickness.

- The records we viewed demonstrated that co-owners had achieved a compliance rate of 89% which was not meeting the provider's benchmark of 95%.
- Areas we visited were visibly clean and tidy, and local cleaning records were available. However, we asked the provider for evidence of departmental oversight of hand hygiene and environmental cleaning audits. We were not provided with meaningful data that demonstrated departmental oversight of compliance or evidence of trend and theme monitoring.
- There were significant delays in accessing the tongue-tie service. Tongue-tie can be defined as a condition present at birth that restricts the tongue's range of motion. With tongue-tie, an unusually short, thick or tight band of tissue (lingual frenulum) tethers the bottom of the tongue's tip to the floor of the mouth. This meant the service was not managing to meet the needs of local people. However, senior managers had an action plan in place to address the delays.

However:

- Duty of candour was well understood and co-owners understood their role to ensure compliance with this regulation.
- Medications were safely handled, managed, and stored appropriately. However, we requested evidence of medicines audits which was not received.
- CYP were protected from the risk of foreseeable emergencies because suitable equipment and competent co-owners were made available.
- There were appropriate systems and processes to ensure major incidents and foreseeable events were managed effectively.
- The care delivered reflected national guidance and data showed that patient outcomes were favourable when compared to national averages.
- Children and young people were protected from the risk of abuse because there were systems in place to

ensure risks were identified and appropriately managed. The service had embedded multidisciplinary working to ensure that service users received the best and most effective care available.

- Children and young people had their individual healthcare needs assessed and were involved where possible in planning their care.
- Records were contemporaneous, fit for purpose and available to all members of the MDT which aided care continuity. Where paper records were used, files were held securely and kept confidential.
- Co-owners were observed providing professional, kind and compassionate care that reflected people's wishes and diverse needs.
- Working relationships between co-owners was strong, and had a strong focus on integrity, as well as compassion and support for each other, as well as the children and families they came into contact with.
- Feedback received from children and young people was entirely positive. CQC did not receive any complaints about this service during the inspection time frame.
- Co-owners clearly understood and were completely committed to the organisation's values, beliefs, vision and strategy. Morale was found to be very high. There was evidence that staff engagement was meaningful and much valued.
- There were systems to ensure the views of the public could be sought.

Community health services for children, young people and families

Requires improvement 

Are community health services for children, young people and families safe?

Requires improvement 

We have rated safety of the service as requires improvement.

- Children and young people (CYP) were not protected from the risk of inappropriate or unsafe care because incidents were under reported. There was a lack of senior oversight of the local investigation quality and learning from these. This affected the organisation's ability to learn from incidents and prevent future recurrence.
- The workforce was affected by a high number of vacancies. While we recognise the organisation was actively recruiting, the vacancy levels meant that teams were fragile in circumstances of unforeseen sickness. Data from the recent co-owner survey suggested low satisfaction levels in response to the question 'do you felt there were enough co-owners in their areas of work to get everything done'.
- Training and mandatory training rates were not meeting the targets set by the organisation.
- We asked the provider for evidence of departmental oversight of hand hygiene and environmental cleaning audits. We were not provided with meaningful data that demonstrated departmental oversight of compliance or evidence of trend and theme monitoring.
- We requested evidence of medicine audits but did not receive these.

However:

- There were systems to ensure children and young people were protected from the risk of health-acquired infections. Areas we visited were visibly clean and tidy, and local cleaning records were available.
- The provider ensured medications were stored and handled appropriately in line with national guidance.
- Patients were protected from the risk of foreseeable emergencies because suitable equipment and competent co-owners were made available. A range of risk assessments were utilised by the various clinical teams to assess and manage risk.
- There were systems to safeguard children and young people who may be identified as at risk of abuse.

- Co-owners we talked with had a comprehensive understanding of their role under the duty of candour (DOC) regulations. We viewed evidence that demonstrated DOC was regularly applied in practice.
- The records we viewed were generally found to be accurate, fit for purpose, and where paper records were used, they were kept confidential and stored securely. Records were signed, dated, legible, complete, and contemporaneous.
- CSH had appropriate systems and processes to ensure major incidents and foreseeable events were managed effectively.

Safety performance

Incident reporting, learning and improvement

- Children and young people (CYP) were not protected from the risk of inappropriate or unsafe care because incidents were under reported. There was a lack of senior oversight of the local investigation quality and learning outcomes. This affected the organisation's ability to learn from incidents and prevent future recurrence.
- The co-owners we spoke with did not have a consistent approach to reporting incidents. The reasons given ranged from "not being sure" what should be reported, "not having the time" to report, and being told 'not to' report certain incidents particularly, co-owner and workload constraints.
- We asked co-owners if they routinely reported work force shortages on the electronic system. We received mixed feedback. It ranged from actively reporting, to a perception that the senior managers did not want the continuous reporting of a shortage that was already identified.
- We were informed of an incident that had occurred involving a lone worker just before the inspection. This incident was not reported by the co-owner involved. It was formally reported as an incident when a verbal account of the event was given to a senior manager.
- There was an electronic reporting system in place that was easily accessed. A number of co-owners had been identified as incident handlers on the electronic system. This meant they were responsible for reviewing and investigating incidents at a local level. We were told that senior management were able to view all the incidents, their investigations and actions logged for the CYP service.

Community health services for children, young people and families

Requires improvement 

- However, it was clear from the records we viewed and the interviews we undertook that senior management and governance oversight was not robust enough to meet the standard of incident management.
- We reviewed the electronic log, investigation and actions taken records whilst on site. The data presented to us highlighted a variance in the investigation quality.
- Co-owners told us they had not received any formal investigation training. This may have had an impact on the variance in investigation quality, actions taken, risk categorisation and subsequent learning. CSH told us investigation training was delivered by the patient safety and risk lead. However there was no formal way to evidence or monitor attendance or compliance. We were told this training was only recorded through a diary and email correspondence.
- This meant the organisation was missing an opportunity to improve practice, safety and strengthen organisational learning.
- Whilst the organisation had started Root Cause Analysis (RCA) training in November 2016, only a small number of co-owners had attended. We were told that more training would be provided in the New Year.
- We were provided with a copy of the CSH 'Core Brief' for November 2016 which documented the trends and themes and two examples of recent incidents. We were also told about a process where co-owners shared learning from incidents at team meetings. We reviewed meeting minutes and saw that incidents were discussed. Whilst this provided some evidence that incidents were being reviewed at both senior and local levels, the co-owners we talked with were not consistently able to provide inspectors with robust examples of learning from incidents. This meant that the systems and processes in place to learn from incidents were not working in practice.
- There were no 'Never Events' reported for the inspection time frame of January 2016 to January 2017. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Duty of Candour

- Duty of candour guidance was available for co-owners to follow.

- Co-owners we talked with had a comprehensive understanding of their role under the duty of candour regulations. They told us they received the necessary training and records we viewed evidenced this. Other documentation we viewed (for example: complaints responses) evidenced that duty of candour was being appropriately applied by CSH.

Safeguarding

- There were systems to safeguard children and young people who may be identified as at risk of abuse.
- Five safeguarding concerns for Central Surrey Health were raised between 6 December 2015 and 5 December 2016. As at 5 December 2016, all of the safeguarding alerts had the status 'Closed'.
- Safeguarding policies and procedures reflected national guidance, was easily available and well understood by co-owners.
- The safeguarding competency framework was in line with the 'Working together to safeguard children 2015' guidance.
- Level one safeguarding training was delivered as part of the mandatory training programme and embedded into all co-owners' induction programme. Level 3 training was provided to appropriate co-owners. Data provided demonstrated compliance as 91% across the service. The service compliance rate was set at 90%.
- There was a safeguarding lead nurse, two safeguarding advisors and local advisors from speciality teams. This meant that co-owners were provided with the appropriate safeguarding support to ensure they could undertake their roles.
- Co-owners were able to tell us how to recognise a safeguarding concern and how to report it. They were also able to provide examples of reporting concerns.
- This included the identification and reporting of CYP who may have been subjected to female genital mutilation (FGM). This meant that co-owners had the knowledge necessary to safeguard children and young people in vulnerable circumstances.
- There was senior oversight of safeguarding reports. For example, a safeguarding was raised for an incident involving a vulnerable adult from adult services. The report was reviewed by a senior member of the safeguarding team who identified there was also a vulnerable child involved in the situation that had not

Community health services for children, young people and families

Requires improvement 

been identified. A safeguarding alert was then raised for that child. The learning from this was shared across the organisation. The scenario was also used as a teaching aid by safeguarding trainers.

- We saw evidence that safeguarding alerts were investigated and learned from and there was a dedicated multidisciplinary, multi-agency approach to safeguarding across the organisation. The organisation-wide clinical governance group ensured, and assured, all quality issues and undertook detailed reviews in key areas of harm prevention in relation to safeguarding.
- We found processes in place for following children who repeatedly missed outpatient appointments. This ensured children that may be at risk of harm were quickly identified and had contact with clinicians. These systems had been reviewed after a recent multi agency report of a vulnerable child who missed an appointment and suffered harm.
- There were very good networks of support in place for Looked After Children (LAC). Co-owners worked closely with young people and built up close working relationships with them. Co-owners were dedicated to supporting looked after children and even when children moved out of the area, still worked hard to maintain contact and continue to deliver support.
- We saw evidence of continuous learning from serious incidents and serious cases reviews. The safeguarding team held workshops and lunch and learn sessions as well as facilitated supervision to ensure the learning was embedded in the service.
- The CSH website provided easy access for members of the public to raise a safeguarding concern.

Medicines

- The provider ensured medicines were stored and handled appropriately in line with national guidance.
- Patient group directions (PGDs) were used by co-owners to enable them to give children immunisations and vaccinations. The PGDs used had been reviewed regularly and were up to date.
- The temperature of fridges where medicines were stored was recorded daily, in line with best practice. This provided assurance the unit stored refrigerated medicines within the correct temperature range to maintain their function and safety.
- Special school nurse team (SSNT) had effective systems in place to minimise the risk of drug errors to children.

This included having a picture of a child in the medication tray to aid the identification process. Care plans also had allergies noted and the SSNT had a very good knowledge of children's individual allergies, sensitivities, and parental medical preferences.

- We were told by co-owners that medication audits had been undertaken. The special school nurse team told us they received a 'silver' which was a very good outcome for medicines management. We requested evidence of medicines audits from the provider. However, they were not received. We acknowledge receipt of a seizure protocol for a child in the SSNT service.

Environment and equipment

- Patients were protected from the risk of foreseeable emergencies because suitable equipment and competent co-owners were made available.
- Resuscitation equipment and first aid kits were available in the areas we visited. Records demonstrated this equipment was easily accessible and regularly checked in line with best practice guidance. Each centre had a delegated individual whose job it was to check the first aid kits and defibrillator checks were undertaken by an external company.
- Records we viewed demonstrated medical devices like weighing scales were calibrated and serviced.
- We found there were appropriate Service Level Agreements (SLA's) for the maintenance of equipment and clinical waste management.
- However, we noted that Bournhall clinic had two lifts. One was out of order for approximately one year. Whilst the risk to service users was minimised as the second lift worked, the period for repairs exceeded a desirable timeframe. Lift repairs were the responsibility of an external organisation.

Quality of records

- CYP predominantly used an electronic records system with the exception of a few satellite services that continued to use paper. This meant that records were mostly available and accessible to all co-owners in the Multi-Disciplinary Team (MDT).
- The records we viewed were generally found to be accurate, fit for purpose, and where paper records were used, they were kept confidential and stored securely.
- Records were signed, dated, legible, complete, and contemporaneous.

Community health services for children, young people and families

Requires improvement 

- We were told that records were routinely audited and identified areas of non-compliance were addressed. We were provided with the action plan from the 2016 audit which suggest the audit outcome as 'general improvement in record keeping practices'. We were also provided with a detailed action plan as a result of the audit which identified nine themes and actions. Each action was given an amber RAG rating. Examples of the recorded actions included: Review process for recording ethnicity by practitioners and admin; implement revised process : Review process of linking parents to children on electronic records system: Provide assurance of CYP and parental involvement in care planning.

Cleanliness, infection control and hygiene

- There were systems to ensure children and young people were protected from the risk of healthcare-acquired infections. There were appropriate policies and guidance in place that reflected national guidance. Co-owners were aware of the contents of these policies and able to apply them in practice.
- We saw local evidence of audit processes to monitor the standard of cleanliness across the various clinics. This included environmental and handwashing audits.
- However, we asked the provider for evidence of departmental oversight of hand hygiene and environmental cleaning audits. We were only provided with two documents. One was a list that suggested hand hygiene audits were undertaken and the other was a blank audit tool. We were not provided with meaningful data that demonstrated departmental oversight of compliance or evidence of trend and theme monitoring.
- We observed clinical waste was handled, stored, and removed in line with national guidance, HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. However, in Banstead clinic we identified three refuse bins were not stored in secure areas and one bin was unlocked. This was a potential fire hazard. This had also been identified in the recent fire safety audit. We brought this to the attention of clinical co-owners who took immediate action.
- Co-owners had access to an ample supply of personal protective equipment (PPE). We observed the PPE being used effectively during the patient contacts we observed.

- The clinical areas we viewed appeared clean. We looked at individual cleaning logs for furnishings and toys and found them to be satisfactory.
- This meant that CYP were protected from the risk of healthcare acquired infections.

Mandatory training

- Children and young people (CYP) who used services were cared for by co-owners who had received an appropriate level of training to undertake their roles.
- Mandatory training modules included incident reporting, fire safety, health, safety and welfare, safeguarding, infection control, conflict resolution and equality and diversity. Mandatory training was provided through online or face to face teaching sessions and initially, as a part of a two day induction for new starters.
- CSH target for mandatory training compliance was 95%. The records we viewed demonstrated that co-owners had achieved a compliance rate of 89%. The compliance rate has been recently affected by staffing levels in the school nurse and health visiting teams that have a high vacancy rate.
- Training records were held centrally by the Human Resources, (HR) team. We found good local oversight in the clinical areas and saw evidence that training compliance was continually monitored. Area leads were provided with regular reports and reminders to ensure co owners training was up to date. The provider had an ongoing plan in place to increase compliance with training rates.
- The co-owners we talked with told us they received ample training to be able to undertake their roles. Co-owners felt supported to access additional training to meet the needs of the CYP they cared for. However, it is worth noting that we were told frequently during the inspection that workforce shortages had a direct impact on co-owners being able to access training.

Assessing and responding to patient risk

- A range of risk assessments were utilised by the various clinical teams to assess and manage risk. Examples included risk assessments for children who were at risk of developing pressure ulcers, manual handling risk assessments, and those children who were subject to a child protection plan.
- Where risks were identified, co-owners had access to support, guidance and equipment to help manage these risks.

Community health services for children, young people and families

Requires improvement 

- We were told that whilst there were systems in place to source specialist equipment, they occasionally experienced delays predominantly associated with securing funding from third party commissioners.
- Multi-agency care planning meetings took place for children who were scheduled to attend the SSNT service. Meetings were attended by parents and / or carers, key workers and a range of health care professionals to ensure that appropriate care plans and risk assessments were implemented.

Staffing levels and caseload

- Staffing levels and caseloads in the CYP service were stretched.
- Whilst we recognise the associated risks were monitored, we had significant concerns about the service being heavily reliant on the good will of the co-owners, and its fragility to unforeseen sickness. This was apparent across all specialities.
- Bank and agency workers were used as much as possible to backfill the posts, however, co-owners told us it was not always possible to find co-owners to provide cover.
- Staffing data presented to CQC showed a substantive Health Visiting (HV) team of 60.5 with 14 co-owners recorded as a 'leaver' between October 2015 and October 2016. HV vacancies had been reviewed and amended following a national review. The establishment number was reduced from 42.7 WTE to 37.92 WTE, as part of a Commissioner led skill mix diversity initiative. However, data suggested a vacancy rate of 13.8% and a sickness rate of 3.7%. There was an annual co-owner turnover of 25.3% in this group.
- The HV team cared for an average of 136 children a month on a protection plan, an average of 237 children a month who were identified as vulnerable, and an average of 86 children a month who were identified as a Looked After Child (LAC).
- The family nurse partnership reported a workforce of 6 substantive staff with a vacancy rate of 10%. There was no sickness rate recorded for this group.
- The therapists' group was recorded as having 58 substantive staff with an annual turnover of 12% and a vacancy rate of 8%. The sickness rate for this group was recorded as 3.4%.
- The data for school nurses reported a substantive staff numbers of 34 with a vacancy rate of 13.8% and a turnover of 7%. Between January and October 2016, the school nurses on average had 177 referrals for individual intervention and immunised an average of 890 children a month.
- We recognised the SSNT team worked tirelessly, cohesively and flexibly to ensure children's needs were safely met. However, the team was small and fragile to unforeseen sickness or absence, due to the highly specialised skill set required to undertake this role.
- There was a lack of an experienced temporary work force for the SSNT service. Whilst there were three SSNT nurses registered on the co-owner bank, at the time of the inspection, only one of them was able to provide very limited cover. This meant that the slightest variation in co-owner numbers affected the specialist skill mix which may compromise the safety of the service. This could affect various aspects of the SSNTcare delivery, but in particular, the provision of tracheostomy care. A tracheostomy can be defined as an incision in the windpipe made to relieve an obstruction to breathing. This meant that the risk to children with complex care needs who used the service was not always effectively managed from a senior management perspective. It is important to note that the care we observed being delivered by the nursing team during the inspection was safe.
- The therapists reported a workforce turnover of 3%. Between April and October 2016, the paediatric Occupational Therapy service had an average monthly caseload of 329 children. In the same time period the Physiotherapy team reported an average monthly case load of 240 and Speech and Language therapists an average of 1772. Paediatric Dietetics Service reported an average monthly caseload of 485.
- We were told about the proactive steps being taken to address the vacancy rates. This included a Surrey wide radio campaign. There were also plans to undertake a 'bus stop advertisement campaign as well as employment stands at local supermarkets. Co-owners worked as flexibly as possible to ensure they could meet the needs of the service.

Managing anticipated risks

- CSH had a risk register that was used to monitor risk in the service.
- Each risk entry contained a description of the problem, the risks posed and the underlying cause. We found that each risk was scored according to a nationally

Community health services for children, young people and families

Requires improvement



recognised risk scoring system, and then subsequently RAG rated. Red, Amber, Green (RAG) rating can be defined as a common management method of rating for risks, based on Red, Amber (yellow), and Green colours used in a traffic light rating system. Key Controls were listed to assist co-owners with managing the risk, and summaries of action plans were included to demonstrate how the risk would be resolved. Each risk was assigned a Red, Amber, Green (T+RAG) rating and had a "Risk Owner". Review dates were documented.

- We found a lone working policy in place and co-owners were aware of its content.
- Co-owners told us about the protocols for arranging, and carrying out home visits.
- The community children's co-owners operated a "Checking in" system whereby co-owners texted or rang the office based nurse to notify them of their location. There was a process for escalating issues if a co-owner failed to check in.
- Support and guidance was provided to co-owners by way of managers who operated on-call rotas.
- However, we were aware of two incidents that had occurred in short succession that meant that co-owners found themselves in unsafe situations. One was reported in December 2016 and the other was identified during the inspection. This meant that on both occasions co-owners found themselves in a compromising situation. One of the measures taken after the first incident included reviewing the lone working policy.

Major incident awareness and training

- CSH had appropriate systems and processes to ensure major incidents and foreseeable events were managed effectively.
- We saw documentary evidence of annual fire assessment and environmental audits to ensure compliance with Health and Safety requirements.
- We saw firefighting equipment and designated fire assembly points. Documents we viewed showed that equipment was regularly tested and serviced.
- CSH had an up to date major incident and unforeseen adverse weather policy in place.
- Co-owners were able to tell us what was expected of them in each circumstance.
- One clinic we visited was able to provide a recent example of having to evacuate the building because of a

suspected fire. The evacuation tested the local policy, which we were told, worked well in practice. The team was also supported by the estates team who responded within the expected timeframe.

- The service experienced recent IT connectivity and printing difficulties which resulted in implementing the Business Continuity Plans for two days. This was reported as a success which meant the plan had been tested and was fit for purpose.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Good



We have rated the children and young people services as good.

- Policies and procedures reflected best practice, such as National Institute of Clinical Excellence (NICE) and other guidelines. The care delivered was evidence based and there was participation in national audit programmes. However, we found the range of audits undertaken to be very restricted.
- Data demonstrated good breast feeding rates. The service was achieving 78% against a target of 63%.
- The service was managing to deliver the percentage of new birth visits undertaken by 14 days of age. The benchmark had been set at 90% and the service was achieving an average of 93%.
- Children's pain, nutrition, and hydration needs were assessed and addressed in line with best practice guidance. There was also evidence of strong inter-professional, cross discipline and multi-agency working in the service.
- CYP received care from clinicians who were competent. We were told co-owners received an induction to the organisation and to services as well as regular safeguarding supervision and annual appraisals. Clinical supervision was firmly embedded in practice and was well documented. New and newly qualified co-owners were offered preceptorship by the organisation. However, compliance rates were low which meant that some co-owners did not undertake an annual appraisal.

Community health services for children, young people and families

Requires improvement 

- The organisation had policies and procedures to ensure multidisciplinary and multi-agency work took place. Additionally, there were arrangements to support young people who were transitioning to adult services.
- Records were predominantly electronic and co-owners had been provided with laptops to promote mobile working and improve accessibility. The records we viewed were contemporaneous and fit for purpose.
- Co-owners had a good understanding of how to obtain consent. Fraser guidelines were followed to ensure that people who used the services were appropriately. Fraser competency is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Co-owners were supported to undertake training and annual appraisals, compliance rates for both were below the organisational benchmarks. Compliance with statutory and mandatory training across the specialities in the service was reported at 91%. Appraisals rates reported in the performance report 2016, showed that the appraisals rates for school nurses ranged between 31% and 67%.

However:

- Co-owner appraisal rates were low.
- At the time of the inspection, the SSNT had only one trained nurse who was competent in the care of tracheostomy patients, despite the service having two children with this healthcare requirement.

Evidence based care and treatment

- CYP were receiving care and treatment that reflected best practice and national guidance. For example, immunisation of young children, Looked after children (LGB19).
- The policies listed promoted the social and emotional wellbeing of children and young people and provided guidance for co-owners to meet objectives outlined in the public health outcomes framework for England, 2013–2016.
- Health visitors and their teams delivered the Healthy Child Programme (HCP) to all children and families during pregnancy until five years of age. The Healthy Child Programme for the early life stages focused on a

universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

- Looked after Children (LAC) teams supported 'looked after' children, to improve their health and life chances; provide holistic and health educational approach to health assessments; and contribute to strategic planning to raise the profile of children and young people within the care system.
- The service was awaiting the second part of the Unicef baby friendly accreditation. An action plan was in place and the service hoped to achieve re-accreditation by April 2017. Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services.
- Health visitor teams were using a maternal mood assessment in line with NICE guidance. (NICE postnatal care quality statement 10 'Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems').
- Health visitors used a family health assessment tool (new birth) which was family/parent led. We saw it was signed and dated by the parents. This was an evidence based tool, developed with a view to increase parents' involvement and encourage active participation.
- A Safeguarding supervision audit was undertaken in March 2016. Recommendations included an improved data base to monitor supervisions, improved completion and review of supervision agreements and improve transition for families moving out of area. Plans were in place to re-audit the progress and effectiveness of the recommendations in 2017.
- We requested evidence of a formal audit plan for the service however, we did not receive this. We were provided with examples of audit activity but not an annual plan.
- We did receive a sample of audits that demonstrated local level audit activity. For example a document audit called 'How we all are doing with the forms and the process' and a Parents' perspectives of using a Therapeutic Listening Programme with their children with sensory processing difficulties and Auditory intervention used to treat sensory processing difficulties to improve participation in activities of daily living.
- CSH had embraced the new national campaign to promote language development and improve children's

Community health services for children, young people and families

Requires improvement 

life chances. We saw posters and information for parents and carers in all the areas we visited. These encouraged parents to switch off technology and talk to their child. This was an example of the service delivering a national driven health promotion campaign.

- There was an enuresis service provided at CSH, which received between 6 and 11 referrals a month. Enuresis can be defined as a repeated inability to control urination. We were presented with data that demonstrated the service was fit for purpose and meeting the needs of the service users. However, it was outside of the reporting time frame and could not be included in this report.

Pain relief

- We found a recognised pain assessment tool in use, which reflected national guidance.
- Children's pain levels were appropriately assessed according to the age of the child and their individual needs.
- The SSNT provided care to children with complex health needs. We saw them use different pain assessment methods such as pictures and assessment of facial and body language, where verbal communication was not possible.
- Children's pain scores were documented and acted upon.
- Parental permission and preferences was obtained and recorded for those who required pain relief.
- This meant that children had their pain needs assessed and addressed.

Nutrition and hydration

- The SSNT ensured that children had nutritional and hydration plans in place which reflected national guidance and demonstrated a multidisciplinary approach to meeting children's dietary needs.
- We saw co-owners following the feeding regime as prescribed, for those where were receiving enteral feeding.
- Children who were at risk of obesity had access to a weight clinic to monitor their progress.
- The child and their parents had access to a dietitian who provided a regular review of their dietary requirement and provided dietary support for parents.
- Breastfeeding and Infant Feeding teams supported well established peer supporters and health visiting teams to deliver breastfeeding drop-in sessions.

Technology and telemedicine

- The service predominantly used an electronic record system to record and store confidential information.
- This promoted a multidisciplinary team approach to care and improved continuity. It also alerted Co-owners when vulnerable children missed appointments.
- However, it was noted some satellite services still relied on paper records.
- A health visitor helpline was in operation. It provided advice, support and signposting for parents. This meant that parents had easy access to speciality information.
- This service prevented people accessing services unnecessarily for advice that could be provided over the phone, leaving more capacity for face to face consultation for those who required the support.
- The data presented to CQC to measure the outcomes and efficiency from this service was unfortunately outside of the reporting timeframe and therefore not included in this report.

Patient outcomes

- Data for the reporting period January 2016 to October 2016 demonstrated that the service was predominately managing to deliver the percentage of new birth visits undertaken by 14 days of age. The benchmark had been set at 90% and the service was achieving an average of 93%. This meant that the national benchmark for these visits was being achieved.
- The percentage of new birth visits undertaken by and after 14 days of age was meeting the recommended national benchmarks.
- The percentage of maternal mood reviews with a benchmark of 83% was continuously achieved over the reporting period.
- Data showed the prevalence of breastfeeding at six to eight weeks had exceeded the set target of 63% by achieving 78% in October 2016.
- The performance report for October 2016 acknowledged that breastfeeding rates had improved by 18 %.
- Targets for 12 month reviews set at 78% had been continuously achieved and was recorded as 82% as of October 2016.
- The percentage of 27 month reviews undertaken exceeded the set target of 79% in October 2016,

Community health services for children, young people and families

Requires improvement



compliance was recorded as 81%. However, it is worth noting in the ten month period between January 2016 and October 2016 this was the only occasion where the target was achieved.

Competent Co-owners

- CYP were cared for by co-owners with the right knowledge, experience, and qualifications to support their needs. Co-owners were encouraged to acquire additional skills and qualifications relevant to their positions.
- We were told that co-owners' competence was continuously reviewed through annual appraisal, supervisions and one to one sessions.
- Data showed the average appraisal rate of 65%, and 67% of school nurses had an annual appraisal. The reason given for this performance was current workload, managing vacancies, and long-term sickness. The compliance target for the organisation had been set at 100%. The service was continuously working towards meeting the benchmark.
- We were told that temporary workers were provided with an induction when they commenced work for the first time. We saw comprehensive documentation used to record details of the formal induction. However, we did not see any completed induction records during the inspection. After the inspection, the provider sent CQC evidence of one induction for a member of the administration team dated August 2016.
- Co-owners from the administration group we talked with were able to demonstrate good compliance rates with training.
- CSH provided two days mandatory training for new co-owners. The induction included a wide range of training for example, basic life support, health and safety, fire training, conflict resolution, moving and handling, and all staff received level one safeguarding training. Level three training was also provided to relevant staff.
- We received combined data for vacancies, appraisals and mandatory training for the therapies co-owners. Rates reported a 67% compliance with appraisals and mandatory training as 91%, both were below the set targets.
- At the time of the inspection, the SSNT had only one trained nurse who was competent to in the care of

tracheostomy patients despite the service having two children with this healthcare requirement. We were told that training was going to be provided to other members of the team.

Multi-disciplinary working and coordinated care pathways

- Co-owners had multidisciplinary and multi-agency working within the organisation.
- They provided many examples of how they worked with other members of the multidisciplinary team to be able to meet the needs of children and their families
- We were told by co-owners that they had good working relationships with GPs, school co-owners, social services and the police. This meant that information was shared readily and cross agency working ensured that where there were concerns about vulnerable children, these were shared and managed.
- There was good attendance at multi-agency safeguarding hub meetings. We were told that attendance at meetings was given priority over other work.
- Co-owners had an awareness of the services that were available to children in the area they worked and were able to contact other teams for advice and make referrals when necessary.
- We visited a school which looked after children and young people with special needs. We looked at the records held and found that they contained entries from a number of different co-owners including nurses and therapists.
- We also reviewed a sample of electronic records that demonstrated good multidisciplinary working.

Referral, transfer, discharge and transition

- There were procedures in place to ensure that young people made the transition to adult services.
- The organisation used a continuum of need assessment tool. This made sure that each person involved in a patient's care was aware of the level of need and support of the patient.
- There were policies and procedures in place to make sure that as children transferred from health visiting to school nursing, relevant and important information was passed to the receiving clinician.

Community health services for children, young people and families

Requires improvement 

- Both health visitors and school nurses told us that they worked closely with each other to make sure that vulnerable children and their families were discussed and important information relayed.

Access to information

- Co-owners were able to access electronic records about children and young people who were transferring between services, such as from health visiting to school nursing, or to adult services. With the implementation of an electronic records system all members of the multidisciplinary team had access to patient records.
- Co-owners could access current guidelines, policies, procedures via the intranet.
- This meant that co-owners could access advice and up to date guidance easily.

Consent

- There were systems in place to gain and review consent from children and their parents or guardians.
- Co-owners used 'Fraser competencies' to determine whether a child was mature enough to make their own decisions and give consent.
- Therapy and nursing teams were seen to involve parents in planning children's care, including consent, and they followed national guidance on consent for children assessed as competent.
- We observed consent being obtained during the inspection. We noted the interactions as competent and professional.
- Records we viewed demonstrated consent was always obtained and recorded.
- We also reviewed data that showed co-owners received consent and Mental Capacity Training (MCA) and Deprivation of liberty (DoLs) training. This meant that staff had the training necessary to obtain consent and understood their roles to ensure compliance with the Mental Capacity Act 2005.

Are community health services for children, young people and families caring?

Outstanding



We have rated the care delivered in the CYP service as outstanding.

- Service users were truly respected and valued as individuals and empowered as partners in their care.
- Feedback from the children and young people who used the service and those close to them was consistently positive about the way they were treated by co-owners.
- The feedback received by CQC demonstrated that co-owners in all specialities went that extra mile to ensure children were cared for and the service was delivered regardless of constraints.
- We found evidence of a strong culture and commitment to the "patient first" ethos. This was firmly incorporated into the care philosophy and the work culture of the co-owners. The care delivered was individualised, holistic and met the needs of the children and their families.
- Examples of co-owners providing exemplary care included the SSNT providing end of life care support for a child and their family. When the child was admitted to a hospice, members of the nursing team visited the child continuously in their own time. This was to ensure relationship continuity for the child, as well as providing emotional support for the child's sibling and parents. The team provided a much needed and appreciated break for the parents most evenings during a very emotionally challenging time. The school nurses ensured a referral for the sibling was made to external organisations to help them with the anticipated bereavement.
- There was another example of assisting a family through a difficult time when a parent had an unexpected accident. This meant the parent was unable to work in the run up to the Christmas period. A member of team recognised the distress and signposted the family to an external organisation to get financial help. The nurse also provided support and oversight of the complex administration process that was overwhelming for the family. The application was successful and the hardship fund was granted.
- There was a strong, visible, person-centered culture present in the CYP service. Co-owners were highly motivated and inspired to offer care that was kind, promoted dignity, respect and person centered care. We witnessed co-owners address sensitive issues with tact, diplomacy and in a caring yet professional way. Their interactions demonstrated positive and resilient relationships between CYP and those close to them.

Community health services for children, young people and families

Requires improvement 

- Working relationships between co-owners was strong, and had a noticeable focus on integrity, as well as compassion and support for each other, as well as the children and families they came into contact with. The resolute commitment of the co-owners was not just valued by services users and their families, but also by the senior leadership team.
- Co-owners recognised and respected people's personal, cultural, social and religious needs into account.
- Children's individual preferences were well documented and reflected in the care plans we viewed. As was the views and preferences of their parents and guardians.

Detailed findings

Compassionate care

- Co-owners were highly motivated to deliver care that was kind and compassionate to the CYP and their families. There was a focus on providing individualised and holistic care and the records we viewed evidenced this.
- The service had a strong, tangible person centred culture. Co-owners placed a high value on building relationships with CYP and supported them in a way that ensured they felt understood and valued.
- We undertook a number of visits with the nurses and therapists during the inspection. All the interactions we observed between the co-owners were professional, compassionate, individualised and child centred.
- We observed one co-owner undertake a home visit in challenging circumstances. The situation was handled professionally, with tact and diplomacy. It demonstrated good conflict resolution and communication skills.
- All co-owners wore name badges and introduced themselves by name. We noted CYP were routinely asked how they would like to be addressed. There was an important emphasis put on initial introductions that supported positive communication between the co-owners and the service users.
- Friends and family data suggested that 100% of the people surveyed were happy with the service they received. However, it is worth noting the response rate was low (twenty three responses).
- CQC received 20 written feedback forms during the inspection, all of which were overwhelmingly positive.
- An example of the comments received included,
- "The SSNT are amazing. They are incredibly caring and always listen to the school, co-owners and children.

They are professional and always treat the children with dignity and respect. No matter how small the issue, they are always willing to help. We would be lost without our incredible nurses"

- "Excellent health visiting team. Very friendly and professional, able to offer lots of advice to us as first time parents. Very good at answering ad hoc questions and showing what services are available."
- "We received a very good quality of care and support from all the teams. All the nurses and therapists are kind, caring, and approachable. They build up good relationships with the children and treat them with dignity and respect for all procedures".

Understanding and involvement of patients and those close to them

- Co-owners told us they empowered people to be involved in the planning of their care as much as reasonably possible. The people we talked with during the inspection told us they felt involved in planning their care. We observed this positive approach during the inspection across the range of services we visited.
- Parents and carers of children told us that co- owners focused on their needs and the needs of their children.
- Parents also told us they felt involved in discussions about care and treatment options, and felt confident to ask questions about the care and treatment they were receiving and make decisions based on the information they received.
- Co-owners told us that whenever possible they supported children and their parents and carers to manage their own treatment needs.
- SSNT pupils participated in the Sports Relief mile in March 2016. They ran for 15 minutes every day for a term. The SSNT was able to evidence a measureable impact on pupils' health and wellbeing and Body Mass Index's (BMI). The team was excited about continuing this initiative in 2017 as a way of continuously improving the children's health through regular exercise, having fun and raising money for charity.
- The examples provided and the and comments received were evidence that co-owners went above and beyond their role to ensure that the children, their parents, guardians and siblings were provided with care that took all their needs into account.

Emotional support

Community health services for children, young people and families

Requires improvement 

- There were systems that provided emotional support to the children and young people who used the service.
- In the first instance, emotional support was provided by the nurses, therapists, and ancillary co-owners.
- Co-owners provided many examples of how they supported the CYP that used the service. We also observed this during the home visits we undertook. There was also evidence of good emotional support in the feedback we received from those who used the service.
- Should further more specialised support be needed, co-owners were able to make referrals to other services such as child and adolescent mental health services (CAMHS), psychologists, GPs and counselling services. Data recorded on the quarter three PIMHS data (October 2016 to December 2016) provided to CQC showed no referrals to CAMHS. However, data did suggest sixty one referrals were made to Perinatal and Infant Mental Health (PIMH). Sixty-one referrals were also made to local GP's.
- We also noted various information posters displayed in clinical areas offering emotional support to parents and young people.
- This meant that CYP, parents and guardians, had their emotional needs appropriately met by the service.
- CSH was meeting the national referral to treatment targets for the services it provided. This meant that CYP had timely access to the care and treatment they needed. However, long waits to access the Tongue Tie service were noted. Senior managers had put an action plan in place to address the delays.
- School nurses offered regular drop-in sessions for pupils to attend and discuss concerns or questions they had about sexual health, smoking, alcohol consumption, drugs or general health.
- We found the care delivered by the SSNT to be an excellent example of individual, holistic, and responsive care.
- Numbers of complaints to the service were noted as low. A total of six were reported between July 2016 and October 2016. Whilst there was a system to monitor and respond to complaints, co-owners were not able to provide consistent examples of service changes or learning because of comments or complaints.

However:

- There was no designated or lead health visitor who specialised in meeting the needs of minority groups.
- We identified concerns about senior managers' oversight of the SSNT service. This related to a lack of timely, proactive service planning to ensure the SSNT could meet the complex needs of those who used the service.
- We found the responses to the complaints varied in quality. This meant the organisation was missing an opportunity to use comments and complaints to improve the services it delivered.
- Written information in different languages was not readily available.

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

Good 

We have rated the CYP service as good.

- Services were tailored to the needs of local populations and co-owners were able to access training specific to the needs of the populations they supported. There was access to interpreters.
- There was sufficient equipment to ensure that people with disabilities were able to access services and buildings complied with the Disability Discrimination Act 1995.
- The service addressed the care needs of hard to reach groups, for example, travellers, refugees, asylum seekers and black and minority ethnic groups.

Planning and delivering services which meet people's needs

- CSH adapted its services to meet the needs of its demographics, because local healthcare needs were continuously assessed and reviewed.
- Engagement with local stakeholders and service commissioners made sure the service delivered was aligned with need.
- When a need was identified, the necessary steps were taken to address these needs. For example, extending clinic times to ensure those who were unable to attend appointments in working hours could access care.

Community health services for children, young people and families

Requires improvement



- We saw evidence of the service responding immediately to an immunisation call from Public Health England. All the children received their meningitis vaccination within 5 days of receiving the request.

Equality and diversity

- The service addressed the care needs of hard to reach groups, for example, travellers, refugees, asylum seekers and black and minority ethnic groups.
- However, there was no designated or lead health visitor who specialised in meeting the needs of minority groups.
- Social networking groups were used to communicate with local travellers.
- We noted a lack of information in different languages for ethnic minority groups.
- Co-owners told us that accessing written information in different languages was not always possible.
- Co-owners were able to demonstrate that translator services were available and being used.
- Buildings were easily accessible and adhered to the Disability Discrimination Act 1995.
- School nurses worked closely with pupils to help them to understand cultural differences, such as forced marriage and female genital mutilation.

Meeting the needs of people in vulnerable circumstances

- There were systems to ensure the service could meet the needs of CYP in vulnerable circumstances.
- Services were tailored to the needs of local populations and most co-owners were able to access training specific to the needs of those supported.
- CSH provided post-natal depression support groups, breastfeeding and baby massage groups.
- CYP was delivering a national campaign to promote language development and improve children's life chances. This meant that parents were provided with information about the importance of continuous communication and interaction with their children. It also encouraged parents to switch off technology each day to encourage the interactions.
- There was an electronic system in place to alert co-owners when children on a protection plan missed an appointment. This meant that children in vulnerable circumstances were protected.
- During the inspection, we were taken on an emergency visit to a primary school to review a child on a

protection plan. The MDT (Occupational therapist and Physiotherapist) realised that the child had missed an appointment. Within less than 24 hours of the missed appointment, a decision was made to take the service to the child at their school. This was a responsive measure to ensure care continuity and appropriate welfare checks were carried out.

- We found appropriate handover arrangements in place for those children and young people moving between services and transitioning to adult services. This meant that there were systems to ensure the safe transfer and care continuity between services.
- The service provided various information leaflets to help provide understanding of particular conditions and the services available. Examples of this included, information on smoking cessation, 'be the boss of your bladder' enuresis leaflet, domestic abuse, dignity in care.

Access to the right care at the right time

- We were aware that there were long waits for the tongue-tie service. The service was without a lead nurse at the time of the inspection. Children who required this service were unable to access it in a timely manner. Senior managers had put an action plan in place to address the delays.
- The paediatric dietetics service received between four and 41 referrals a month and appointments were offered within five to six weeks of the initial referral. This meant that the service was meeting the national eight week target.
- Paediatric OT Service received between 53 and 76 referrals a month. Data reported in October 2016 performance report demonstrated initial appointments being provided within one to two weeks. This meant that this service was exceeding the national referral targets.
- Paediatric Physiotherapy Service received between 28 and 41 referrals a month. The waiting times for this service were reported as one to two weeks. This meant that the service was meeting its waiting targets.
- Speech and Language Therapy Service (SALT) was receiving between 95 and 131 referrals a month. Data showed us that the average waiting time for an initial referral was eight weeks. This was under the national requirement of 18 weeks, which meant CYP had access to the service in a timely manner.

Community health services for children, young people and families

Requires improvement 

- The paediatric physiotherapy service received between 35 and 62 referrals a month. The average waiting time was reported as two weeks which was well within the national target of 18 weeks. However, data demonstrated a high 'Did Not Attend' (DNA) rate which was under investigation by the provider.
- CSH was planning to roll out an appointment text messaging reminder service, following a successful pilot to further positively impact the reduction of DNA rates within clinical services.
- CYP who used the service generally had access to the right care at the right time.
- The co-owners had ensured that it had built good relationships with neighbouring organisations and commissioners to ensure continuity of care and good communication for the children who used the service. Examples of this were the CAMHS team and psychologists.
- School nurses offered regular drop-in sessions for pupils to attend and discuss concerns or questions they had about sexual health, smoking, alcohol consumption, drugs or general health.
- School nurses delivered health promotion in schools, usually at school assemblies. These focused on topics such as smoking, alcohol and drug taking, sexual health, information about immunisation and vaccinations, forced marriage and female genital mutilation.
- There were many examples where children identified as vulnerable had missed appointments and had the service taken directly to them. This ensured they were getting the care and treatment they needed and had a welfare check at the same time.
- We identified concerns about senior managers' oversight of the SSNT service. This related to a lack of timely, proactive service planning to ensure the SSNT could meet the complex needs of those who used the service. We recognise that the risk to a small number of children was mitigated with the help of an external provider. However, documentary evidence provided to CQC evidenced a long delay between receiving notice of the children's complex care needs in February 2016, and the service being configured to meet these needs. Emails showed that despite the children formally entering the service in September and October 2016, clarification about the actual service specification was still being sought from commissioners in December 2016.
- One nurse had received the relevant training to meet the care needs of these children and provide teaching to others employed by the school who would then provide one to one care. This SSNT was assessed as competent in December 2016, nearly four months after the first child started using the service. Training was provided by an external provider free of charge to assist the service to meet the needs of these children.
- However, this meant that the service did not act in a responsive way to meet the needs of these children. With a national increase in the number of children with complex health needs, there was an important emphasis to ensure services provided safe care with a competent workforce.

Learning from complaints and concerns

- There was a system in place to monitor and learn from complaints.
- Data demonstrated very low levels of complaints in the service. According to the minutes from the October 2016 performance report a total of six complaints were received between July and October 2017.
- We reviewed a sample of complaints during the inspection. The quality of the investigations, response tone and learning was inconsistent.
- Some were well documented and appropriately handled and responded to, and others were not.
- We saw an example where the service responded poorly to a mother in a distressed state. The complaint was related to a request for additional continence supplies for a child. This included a very detailed description of how the lack of these resources was having a negative impact on the child. The service was funded to provide to supply four incontinence pads. After a funding review initiated by the mother additional resources was made available. Despite this, we viewed additional correspondence from within the CYP service that suggested the resources should be withheld. The document trail we reviewed did not demonstrate a compassionate or fair response to the complaint. Nor did it reflect CSH values of putting the patient first.
- We recognise examples of learning from comments and complaints was provided to co-owners in the regular core briefings. The co-owners we talked with during the inspection were unable to provide consistent examples of improvements to the services and learning arising from complaints.

Community health services for children, young people and families

Requires improvement 

- This meant that CSH was missing an opportunity to actively learn and improve its services.
- Service users we spoke with told us they never had to complain. They felt confident their concerns would be treated with respect, and dealt with in a transparent manner by CSH.
- Co-owners told us they knew how to handle complaints and when to escalate a complaint to a manager.

Are community health services for children, young people and families well-led?

Requires improvement 

Summary

We have rated this service as requires improvement.

- There was a governance and risk management structure in the service. We reviewed how incidents were handled, investigated, and learned from, it was evident that investigations lacked consistency, quality and governance oversight. There was a lack of productive organisational learning to prevent incidents recurring and co-owners did not have a clear understanding of the governance structure or processes. They lacked clarity about how information from the various boards and committees flowed in the service. Senior managers and board members were aware that incidents were under reported. This was evident from the interviews we undertook during the inspection and the meeting minutes we reviewed.
- Risk registers were kept at service and organisational levels. Evidence provided to CQC showed these risks were reviewed, there was a Red, Amber, Green (RAG) rating, and action plans documented. Co-owners were not consistently able to tell inspectors what the top three risks for their areas, action plans and proposed resolution time frames were.
- We found a commendable cohesive group of co-owners, who were dedicated and loyal to the services they delivered, and the organisation and future vision.
- The majority of co-owners we talked with told us they felt well supported by local, senior and board management. They described feeling valued, appreciated and genuinely having an ability to influence

how the service was run as a co-owner. There was a unanimous understanding of the service vision and strategy, that co-owners felt actively involved in, and totally committed to its success.

- Morale was positive and CSH was consistently described as a 'very good place to work'. Co-owner engagement was meaningful, productive and frequently had an emphasis on the health and wellbeing of the co-owners. The organisation values were actively lived and firmly embedded in practice, and into the appraisal system.
- The co-owners' survey reported high engagement scores. It also suggested that co-owners were likely to recommend the service to their friends and family.
- There were appropriate processes for members of the public to express their views on the service. We saw posters encouraging people to provide feedback as well as ample feedback questionnaires being made available in clinical areas.

However:

- We were not confident that service risks were being identified and resolved in a responsive way.
- There was under reporting of incidents and a lack of consistency and governance oversight of how incidents and complaints were handled, learned from and resolved.

Service vision and strategy

- There was a clear vision and strategy for the service which was widely understood and supported.
- Co-owners at all levels felt very much involved in its design and were committed to its successful implementation.
- Co-owners welcomed the future changes proposed for the service. They told us they positively embraced change and were excited about the prospect of improved resources for children and young people who used services.

Governance, risk management and quality measurement

- The governance structure comprised a number of sub groups and forums. This included the SSNT, privacy and dignity group, medical devices group, professional congress, learning and development steering group, patient experience forum, Infection prevention and control, information governance, safeguarding of

Community health services for children, young people and families

Requires improvement 

children and young people committee, medicines management committee. All of these committees and forums sent information upwards to the bi-monthly quality and clinical governance committee. This committee then escalated information to the board and the CSH Voice. (The Voice can be defined as an independently elected collective selected by co-owners to represent their values and hold the board to account). The same route was used in reverse to disseminate information from these boards to co-owners.

- Whilst there was a governance and risk management system in place, it was poorly understood by co-owners.
- Co-owners were not always able to provide examples from learning from incidents, complaints, or cross departmental learning when we asked.
- The 'core brief' was the main source of information dissemination in CYP. This method was supported by emails and face to face conversations. However, it was clear from our inspection that information did not flow as well as it should. Co-owners told us they attended a core brief regularly but were not always able to relay the information the brief contained when questioned.
- The quality of the incident investigations and root cause analysis we reviewed lacked the level of scrutiny required to facilitate learning, appropriate risk management and quality learning. The majority of co-owners who were involved in the investigation process did not have investigation training. This may have had an adverse impact on the quality of investigation, action plans, and organisational learning.
- We recognise the service has had an increase in the number of incidents reported when compared to the previous 12 month reporting period. However, we remain concerned that incidents are under reported.
- However, it is worth noting that the October 2016 board minutes we viewed suggested that the Quality and Governance report format was going to be reviewed to improve information relating to themes and learning.
- Risk registers were in operation and contained appropriate risks with RAG ratings.
- However, we noted the two risks identified in the SSNT service dated 25/11/2016 and set to 15, with 25 as the highest level. The date on the entry relating to tracheostomy training for co-owners did not accurately

reflect the timescales of the risk when compared to the timescales of the additional data provided to CQC. This may suggest undue delays in identifying and, or, escalating the risk.

- Co-owners we talked with were not consistently able to identify the risks in their services. This may suggest that the methods of communicating risk may not be effective.
- There were systems and processes for dealing with complaints, but there was an inconsistent approach to the quality of investigation, responses and learning from these.
- There was a concern with the way performance data was managed and presented to CQC. It was difficult to obtain meaningful data, presented in a way that reflected the quality of the service, in a timely manner.

Leadership of this service

- The majority of co-owners we spoke with expressed confidence in the leadership of the organisation.
- Teams told us they felt valued and supported. They also told us that members of the board were very visible, approachable and made them feel an important part of the organisation.
- However, we did receive some comments that suggested that senior managers may not always be responsive to co-owners' concerns about service needs.
- Feedback received about local leadership was unanimously complimentary.
- Most co-owners felt that the organisation was functioning well but were concerned about the high vacancy rates.
- All the co-owners we talked with were adamant that being a co-owner meant that they were a significant part of the organisation.
- They also felt strongly that they had a valuable voice that could influence change. They felt their opinions would be respected and listened to by members of the board who also lived the values and beliefs of the organisation.
- We were provided with three examples of 'patient stories' from the CYP service that were presented to the board in the last year.

Culture within this service

- There was a healthy and positive culture in CYP service.
- We asked co-owners what it meant to be a co-owner rather than an employee of an organisation. The

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response was the same across the service. Co-owners felt they were part of the bigger picture and had a voice in the organisation that would be genuinely listened to. They felt they could influence change if needed.

- The most prominent elements expressed by the co-owners we talked with were feeling valued, and living the organisation's values. There was a consistent sense of feeling valued by service users, and by each other, line and senior managers and at board level.
- There was a strong commitment to the organisation's values that was lived out in daily practice.
- The core values were linked to the 1:1 and PDR processes and firmly embedded across the service.
- Co-owners expressed a great sense of pride in the organisation, its leaders, and the service it delivered.
- There was also a very positive attitude toward embracing change and the challenges that change brings.
- We found a commendable cohesive group of co-owners, who were dedicated and loyal to the services they delivered, and the organisation and future vision.

Public engagement

- There were appropriate systems for members of the public to express their views on the service. We saw posters encouraging people to provide feedback.
- Ample feedback questionnaires were made available in clinical areas.
- CSH also conducted a 'User View' audit.
- The organisation website had a page which provided links for the public to be able to provide their feedback electronically to CSH.
- This page also provided the contact details of other external independent organisations that welcomed public feedback.
- CSH Surrey worked with a local CCG and five charities to help those in need over the winter period to get food, warm clothing and Christmas presents and books out to families in the local area.
- Co-owners, their friends, families and general public had participated in fundraisers for local charities.
- The service also engaged with various young carers' associations and youth groups in the locality.
- The health visiting team provided 'Safe sleeping' health promotion activity in local supermarkets.

Co-owners engagement

- Co-owners were very engaged with management, the vision and strategy and the organisational values and beliefs.
- The co-owners' survey results were present in specialities. Groups presented were health visitors (HV), school nurses (SN) and therapies. All three groups had a score that reflected an improvement on the previous year's engagement score. The 2016 data suggested engagement scores of between 85% and 96%.
- Co-owners were extremely likely to recommend the service to their friends and family. Scores ranged between 75% and 100% for the three groups.
- When asked if co-owners would recommend the services as a place to work, the results varied between 45% in the health visiting group and 76% in the school nurse group.
- However, it was clear co-owners in all three groups reported they did not have enough co-owners in their area of work to get everything done.
- There was an active award recognition process. Co-owners proudly displayed their achievements to inspectors throughout the visit. We saw examples of a physiotherapist who won the 'Outstanding therapist of the year' award and a nurse in the acute school nurse service who received an outstanding school nurse award. We also saw the administration teams were equally recognised through the awards programme.
- A practice development Lead in the children and families service received the prestigious title of Queen's Nurse (QN).
- There were various forums co-owners could use to make their voice heard. This included the 'Voice'. This was a group selected by co-owners to be their voice at board level.
- Electronic forums were available for co-owners to come together.
- CSH had provided blood pressure and heart checks for co-owners for a 'Healthy Hearts' health promotion event.
- The board provided fruit baskets to co-owners before Christmas as a "thank you" for their hard work and commitment.
- A school nurse forum was in operation. Co-owners were given protected time to network, share ideas, promote evidence based practice and ensure consistent school nurse practice across the localities. However, the SSNT found this forum difficult to engage with for capacity reasons.

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Innovation, improvement and sustainability

- SSNT pupils participated in the Sports Relief mile in March 2016. They ran for 15 minutes every day for a term. The SSNT were able to evidence a measurable impact on pupils' health and wellbeing and Body Mass Index's (BMI). The SSNT were excited about continuing this initiative in 2017 as a way of continuously improving the children's health through regular exercise and fun.
- There was a very strong emphasis on improving the health and wellbeing of the co-owners at CSH. Activities included the 'Create a Cocktail' competition for alcohol-free 'Dry January', fruit baskets at Christmas instead of high fat alternatives, Yoga, and blood pressure checks.
- Therapists worked closely with local specialist schools and centres to embed occupational therapy within the curriculum. The service was frequently approached by the LEA and local schools to deliver training.

Outstanding practice and areas for improvement

Outstanding practice

The SEND team went beyond their roles to ensure that the children in their care, their families, and siblings received a consistent, high quality holistic service.

We saw that there was an imaginative approach on managing the risk of patient falls at Dorking Community Hospital with the desktop mapping of the ward using Lego enabling co-owners to identify where falls had occur and where there might be increased risk for the patients. This heightened the awareness of all the co-owners to patient falls and not only enhanced the safety of the patients, it was a learning tool for staff that had a good practical application.

In community hospitals, the introduction of the 'blue moon' project enabled staff to identify patients with cognitive impairment such as dementia. This meant that co-owners could easily identify that certain patients needed additional support to be safe in their surroundings because they were wearing a blue wristband. We saw this as enhancing safety for particularly vulnerable patients.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure the tongue tie service can meet the needs of the local population in a timely manner.

The provider should improve management over sight of the SEND service and effectively manage any risks in the service in a responsive way.

The provider should improve its staffing levels across the entire service.

The provider should improve the appraisal rates across all staff groups in the service.

The provider should review its current local and national audit activity with a view to strengthening the service and empowering co-owners to embrace a positive audit culture.

The provider should review its governance oversight of incident handling and complaints management to ensure quality.

The provider should review the way it manages data in the organisation to ensure it can demonstrate quality outcomes for all its services.