Central Essex Community Services C.I.C.

Quality Report

St Peter's Hospital
Admin Block
32a Spital Road
Maldon
Essex
CM9 6EG
Tel: 01621 727325
Website: www.provide.org.uk

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

Summary of findings

Contents

Summary of findings

Overall summary

Central Essex Community Services C.I.C. is a provider of integrated health and social care and provides a broad range of community services to more than 1.9 million people in Essex, Cambridgeshire, Peterborough, and the London boroughs of Waltham Forest and Redbridge.

Whilst the provider HQ is based at St Peter's Hospital in Maldon, Essex, it provides over 50 services to children, families and adults within a wide range of community settings. This includes a community ward in each of three hospitals (St Peter's in Maldon, Braintree Community Hospital and Halstead Community Hospital), community clinics, schools, nursing homes and primary care settings, as well as within peoples own homes.

We chose to inspect Central Essex Community Services C.I.C. as part of the first pilot phase of the new inspection process we are introducing for community health services

We found that Central Essex Community Services C.I.C. was providing safe care and saw some good examples of caring and compassionate care. Staff spoke with passion about their work, felt proud and understood the values of the organisation.

Front line staff work hard to ensure individualised and person centred care, tailored to best meet the needs of patients, families and carers. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time. However, strategic planning and development of some services lacks the direct consultation with and feedback from patients, families and carers.

The Board and senior managers had oversight of the reported risks and had measures in place to manage reported risks. However, the risk management systems are immature and pose a risk to the Board's ability to have a clear oversight of risks to quality in the organisation. Action is required to enhance staff ability and awareness to identify and consider serious incidents, incidents, near miss incidents and risks and what they should do with that information.

We found some good examples of innovative practice not least the care given to patients by the children's speech and language therapists. The service had won a national innovation award for contribution to their profession.

In 2012/13, the provider surveyed people using each of its services with the results reported to be generally favourable. However, as the survey was for Central Essex Community Services C.I.C. only, it is not possible to benchmark the results against other similar organisations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Services are generally safe. There were arrangements in place to minimise risks to patients including measures to prevent falls and pressure ulcers. Staffing levels were generally safe in the majority of services although there is currently under resource issues for qualified school nurses and an inadequate staff skill mix, including the ratio between substantive and agency staff, at Braintree Community Hospital ward.

We were concerned about the inconsistency in reporting practice. There was varying ability and awareness amongst staff to identify and consider serious incidents, incidents, near miss incidents and risks and what to then do with that information. We were also concerned at the inconsistency in practice in regards to learning from incidents and sharing of that learning both within individual teams and across the organisation.

We also found inconsistency concerning classification and reporting of pressure ulcer incidents.

Are services effective?

Services were generally effective, evidence based and focussed on the needs of the patients. We saw some examples of very good collaborative work and innovative practice. However in palliative care there was limited communication and collaboration with partner agencies or organisations.

The majority of staff were up-to-date with mandatory training but whilst clinical supervision arrangements are in place across the organisation, the quality of such arrangements is variable.

The majority of services' governance arrangements ensured a robust, cyclical process of information sharing between operational services and the Board. However there is weakness in governance arrangements for both the routine monitoring of end of life services and systems to get regular feedback.

Are services caring?

The vast majority of people told us they had positive experiences of care. Patients, families and carers felt well supported and involved with their treatment and staff displayed compassion, kindness and respect at all times.

We found staff to be hard working, caring and committed. Many staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to patients and their representatives and the values of the organisation they worked for.

Are services responsive to people's needs?

We found the provider was responsive to people's needs and people from all communities could access services. Effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time and without avoidable delay. However, strategic planning and development of end of life services lacks the direct consultation with and feedback from patients, families and carers.

We found regular extended waiting times for children and young people attending the diabetic clinics at Broomfield Hospital.

Are services well-led?

The organisation is in general fairly well-led. The Board and senior managers had oversight of the reported risks and had measures in place to manage reported risks. However, the risk management systems were immature and posed a risk to the Board's ability to have a clear oversight of risks to quality in the organisation.

Summary of findings

Action is required to enhance staff ability and awareness to identify and consider serious incidents, incidents, near miss incidents and risks and what they would do with that information.

Summary of findings

What people who use community health services say

Since April 2013, the provider has carried out the NHS Friends and Family Test scores, which asks patients if they would recommend services to people they know. For two of the three inpatient wards (Halstead community hospital ward and St Peter's community hospital ward), the scores were average when compared to the December 2013 score for all NHS and independent sector (where care is provided to NHS patients) inpatient wards. In comparison scores for Braintree community hospital ward (Courtauld Ward) were consistently below the national average between April and September 2013. Since June 2013, the family and friends test has also been undertaken at the Rapid Assessment Unit and the Assessment and Rehabilitation Unit. The scores reported between June and September 2013 for both of these units are well above the national average.

A total of 57 comment cards were collected across 12 locations where Central Essex Community services were provided although there were no comment cards completed for Braintree Community Hospital or Springfield Clinic. The most comments were collected from St Peter's Hospital and Moulsham Grange (36 in total). The overwhelming majority of patients who completed a comment card felt that they had been listened to and cared for with respect and dignity in a clean environment that met their needs. One patient reported that where he had raised concerns he felt he had been listened to.

There were a very small number of negative comments:

- Two comment cards reported there not being enough nurses (both comments card from St Peter's)
- One patient reported an issue with the call system in the day room (St Peter's)
- St Peter's reception is not manned from 8:30am
- Not all staff demonstrated patience and pain relief was not administered on time (Halstead ward)

Areas for improvement

Action the provider MUST take to improve

- Ensure effective arrangements are in place to identify, assess and manage risks across the organisation.
- Ensure sufficient numbers of suitably qualified, skilled and experienced persons are available at all times. (Braintree Community Hospital ward – regulatory action being taken)

Action the provider SHOULD take to improve

- Ensure detailed and up to date care plans are in place for children and young people and that children, young people or families have signed up to their plan of care.
- Ensure action is taken to increase staff awareness regarding formal child protection escalation processes including escalation of alleged abuse that does not reach the local authority's reporting threshold.
- Include dementia training as a component of the mandatory staff training programme.
- Ensure a written plan regarding the development of adult safeguarding practices is developed and implemented.
- Ensure availability of written information concerning vulnerable adult safeguarding reporting processes in all community team offices.
- Ensure all syringe drivers are supplied with tamper proof; lockable covers and that risk assessment are conducted prior to the provision of such equipment.
- Review the availability of guidance to staff concerning equipment access out of hours.
- Ensure collaborative review of the strategy for end of life services and monitor implementation and compliance with national guidance.
- Ensure staff are given the opportunities to receive clinical supervision and processes are in place to monitor these arrangements.
- Review agency staff use to ensure continuity of care.
- Review staff allocation at Braintree Community Hospital Ward to enhance observational oversight of patients.

Action the provider COULD take to improve

- Review use of environment to ensure all areas are used effectively to enhance patient experience.

Summary of findings

- Enhance staff understanding of clinical supervision and ensure processes are in place to monitor clinical supervision received per individual member of staff.

Good practice

- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The positive feedback received from patients across all services regarding the quality of care received; especially in regards to services provided to children and families.
- The care provided was person centred and based on evidence based guidelines
- The effective multidisciplinary team working practices that were person centred and focussed on patient independence.
- The multidisciplinary approach to completion of patient risk assessments at St Peter's Community Hospital ward.

Central Essex Community Services C.I.C.

Detailed findings

Locations we looked at:
Central Essex Community Services C.I.C. HQ; Braintree Community Hospital; Halstead Community Hospital Ward; St Peter's Hospital

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Amanda Musgrave, Care Quality Commission

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

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

Central Essex Community Services C.I.C. is a provider of integrated health and social care and provides a broad range of community services to more than 1.9 million residents of Essex, in Cambridgeshire, Peterborough, and the London boroughs of Waltham Forest and Redbridge.

It became a Community Interest Company (C.I.C.) on 01 April 2011and as a social enterprise, is a business with primarily social objectives. It means that any profits made are reinvested into the local community or back into the business, and do not go to shareholders and owners. Central Essex Community Services C.I.C. is owned by its employees and every employee is given the opportunity to become an owner of the company for just £1. As an owner they have a say in the future direction of the company. They can make suggestions for improvements and influence how any surpluses are reinvested. Owners also elect governors to act as their representatives in the Council of Governors.

The provider changed its name to Provide in September 2013 but continues to trade the name Central Essex

Detailed findings

Community Services. Prior to becoming a community interest company the provider was the provider arm of Mid Essex Primary Care Trust and was required to restructure as part of the Transforming Community Services (TCS) agenda, which separated provider and commissioning bodies in the NHS.

Whilst the provider HQ is based at St Peter's Hospital in Maldon, Essex, it provides over 50 services to children, families and adults within a wide range of community settings. This includes a community ward in each of three hospitals (St Peter's in Maldon, Braintree Community Hospital and Halstead Community Hospital), community clinics, schools, nursing homes and primary care settings, as well as within peoples own homes. The provider has an income of approximately £54 million in 2013/14 and employs over 1,100 people.

The regulated activities that were the reviewed at this inspection were:

- Diagnostic and screening procedures
- Family planning
- Nursing care
- Surgical procedures
- Treatment of disease, disorder or injury

The provider has had five inspections since 2011. Halstead Community Hospital Ward was last inspected in 2013; at that point it was not meeting national standards in respect of assessing and monitoring the quality of service provision.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Where provided the inspection team always looks at the following core service areas at each inspection:

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

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

We carried out an announced visit on 21, 22 and 23 January 2014. During our visit we held focus groups with a range of staff (district nurse team leaders and community matrons, district nurses, health visitors, school nurses, specialist children's nurses, health care support workers, community ward staff, adult allied health professionals and children's allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service. We visited community hospitals, health centres, community clinics and accompanied the provider's staff on patient home visits.

Detailed findings

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

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

Are services safe?

Summary of findings

Services are generally safe. There were arrangements in place to minimise risks to patients including measures to prevent falls and pressure ulcers. Staffing levels were generally safe in the majority of services although there is currently under resource issues for qualified school nurses and an inadequate staff skill mix, including the ratio between substantive and agency staff, at Braintree Community Hospital ward.

We were concerned about the inconsistency in reporting practice. There was varying ability and awareness amongst staff to identify and consider serious incidents, incidents, near miss incidents and risks and what to then do with that information. We were also concerned at the inconsistency in practice in regards to learning from incidents and sharing of that learning both within individual teams and across the organisation.

We also found inconsistency concerning classification and reporting of pressure ulcer incidents.

Our findings

Safety in the past

Overall we found that care had been safe in the past. This was generally supported in all areas we inspected where we found that systems were in place that: protected people from abuse and avoidable harm; supported staff out of hours; and provided guidance in cases of emergency, including individual staff responsibilities.

Exceptions to this were in children and families services where staff were less confident of formal escalation mechanisms where cases of concern are not deemed to meet the thresholds of the local authority and the limited action taken to improve the quality of safeguarding training that could present risk from the non-identification of cases.

Additional detail that supports this can be found in the provider HQ report.

Learning and improvement

In relation to learning and improvement we found that the provider had systems in place, however some issues were identified in cascade of learning within individual teams, between teams and more broadly across the whole organisation. We also found little evidence of analysis and learning from information received from patients around safety of services.

More detail can be found in the provider HQ report and Braintree Community Hospital ward report.

Systems, processes and practices

The provider had policies and processes in place regarding incident reporting and these were available for staff to refer to. However, some issues were identified in the quality of information reported to the Board. Including, the inconsistent application of criteria by which the pressure ulcer incidents are classified and reported as being Central Essex Community Services C.I.C. acquired and avoidable or unavoidable, and the culture of underreporting incidents and risks and self-management of concerns within individual teams.

More detail can be found in the provider HQ report and Community Hospital ward reports.

Monitoring safety and responding to risk

Overall we found that systems were in place to monitor and respond to risk. This was generally supported in all areas we inspected where we found staffing levels and skills mix supported safe practice and risk assessment had been conducted to ensure staff and patient safety. Exceptions to this were the inadequate staffing arrangements at Braintree Community Hospital ward, children and families services where some staff were unclear of the systems in place to monitor and escalate risk, and community nursing teams where patients were not informed of or aware of support systems in place should they wish to report concerns.

There were also ongoing challenges for community nursing teams around lack of connectivity or signal for electronic recording devices when out of office and this impacts on both productivity and lone working systems.

More detail can be found in the provider HQ report and Community Hospital ward reports.

Anticipation and planning

In relation to safety in the future we found that the provider had systems in place to deliver safe care both now and in the future. However, some issues were identified in predictive staffing arrangements within children and families and services for adults requiring community

Are services safe?

inpatient services and the accuracy of quality and safety data presented to the Board. Information that was used to provide Board assurance that good, safe care was provided within all its services, both now and in the future.

More detail can be found in the provider HQ report and Community Hospital ward reports.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

Services were generally effective, evidence based and focussed on the needs of the patients. We saw some examples of very good collaborative work and innovative practice. However in palliative care there was limited communication and collaboration with partner agencies or organisations.

The majority of staff were up-to-date with mandatory training but whilst clinical supervision arrangements are in place across the organisation, the quality of such arrangements is variable.

The majority of services' governance arrangements ensured a robust, cyclical process of information sharing between operational services and the Board. However there are weakness in governance arrangements for both the routine monitoring of end of life services and systems to get regular feedback.

Our findings

Evidence-based guidance

Overall we found that the care provided was evidence based and followed recognisable and approved national guidance. This was generally supported in all areas we inspected where we found staff were clear of their roles in care pathways and worked well with multi-disciplinary colleagues to ensure optimum health and well-being of people and involvement of people in planning their own care, including consent and those people that lacked capacity. The exception to this was end of life services where we observed variation in approaches to care delivery through stages of palliation and an absence of mandatory training in regards to dementia, an omission that could create inconsistencies in practice.

More detail can be found in the provider HQ report.

Monitoring and improvement of outcomes

Overall we found that arrangements were in place to monitor performance and to identify areas in need of improvement. This was generally supported in all areas we inspected where governance arrangements ensured a robust, cyclical process of information sharing between operational services and the Board. Information provided to the Board included: quality and safety reports with performance and delivery against key performance indicators; outcomes of clinical audit activity such as the High Impact Intervention (HII) audits and the NHS Safety Thermometer Programme; and patient experience information, including trends identified following review of such information.

Exceptions to this were end of life services where processes for routine monitoring and systems to ascertain regular feedback were weak.

More detail can be found in the provider HQ report.

Staffing arrangements

Overall we found that there were systems and processes in place to identify and plan for patient safety issues in advance. This was generally supported in all areas we inspected where we found patient dependency assessments being used to determine staffing requirements, comprehensive induction for new starters, effective appraisal processes and good access to and attendance at mandatory training.

Exceptions to this were: inadequate staffing arrangements at Braintree Community Hospital ward; variable use and appropriateness of patient dependency tools used to predict staffing needs for adults requiring community inpatient services; the variable practice across the organisation in regards to the quality of clinical supervision arrangements; and the under resource of qualified school nurses.

More detail can be found in the provider HQ report and Community Hospital ward reports.

Multi-disciplinary working and support

As a provider overall we found good collaborative working within the multi-disciplinary team (MTD). This was supported in all areas we inspected where we found: staff worked well together; effective communication between staff; healthcare professionals valued and respected each other's contribution into the planning and delivery of patient care, including around preferred places of care and death. This work was underpinned by sound implementation of approved care pathways.

Exceptions to this were the lack of detail and updates within paper copies of care plans for people with long term conditions.

More detail can be found in the provider HQ report.

Are Services Effective?

(for example, treatment is effective)

Co-ordination with other providers

In relation to co-ordination with other providers we found that the provider collaborated with other providers to deliver safe and effective services. However, some issues were identified in end of life services where the extent to which the provider collaborated with other providers in the co-ordination of services was limited.

More detail can be found in the provider HQ report.

Effective care delivered close to home

As a provider overall we found that there was a commitment to ensure the care of people was delivered as close to home as possible, minimising disruption to daily life. This was supported in all areas we inspected where we found services provided from clinics held throughout the geographical patch and good multi-professional staff engagement that ensured the delivery of care met patient needs both from a clinical perspective and also close to home.

Are services caring?

Summary of findings

The vast majority of people told us they had positive experiences of care. Patients, families and carers felt well supported and involved with their treatment and staff displayed compassion, kindness and respect at all times.

We found staff to be hard working, caring and committed. Many staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to patients and their representatives and the values of the organisation they worked for.

Our findings

Involvement in care

In relation to involvement in care we found that the provider delivered person centred care within all it's services and that people, their relatives and/or people's representatives were involved in and central to decisions made about the care and support needed.

Trust and respect

As a provider overall we found that patients were treated with dignity and respect within all its services. Each person's culture, beliefs and values had been taken into account in the planning and delivery of care; staff ensured patient confidentiality when attending to care needs; and trusting relationships between staff and patients, focussed on maintenance of or improvement in patient independence.

Patient understanding of their care and treatment

As a provider overall we found that patients had an understanding of their care and treatment. This was generally supported in all areas we inspected where we found good evidence through observation of practice and review of records of action taken by staff to ensure patients understood what was going to happen to them and why, at each stage of their treatment and care. This included adapting style and approach to meet the needs of children and involving relatives and those close to patients where patients lacked capacity.

Emotional support

In relation to emotional support we found that the provider delivered good emotional support within all its services, however some issues were identified in community inpatient services. These are in regards to the limited facilities for group patient interaction at Braintree Community Hospital ward.

More detail to support this can be found in Braintree Community Hospital ward report.

Compassion, dignity and empathy

In relation to the care and treatment of patients we found that the provider delivered care within all it's services that was empathetic, compassionate and that promoted and maintained the dignity of all patients, relatives and patients representatives.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found the provider was responsive to people's needs and people from all communities could access services. Effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time and without avoidable delay. However, strategic planning and development of end of life services lacks the direct consultation with and feedback from patients, families and carers.

We found regular extended waiting times for children and young people attending the diabetic clinics at Broomfield Hospital. This is an issue that had been raised by children and parents in the 'patient reported experience' questionnaire 2013.

Our findings

Meeting people's needs

As a provider overall we found that the provider delivered individualised and person centred care. This was generally supported in all areas where we found multi-disciplinary professionals worked flexibly to ensure joint approaches to care delivery to combine the meeting of identified needs with minimal disruption to family routine; and the majority of staff worked hard to inform commissioners of the local needs.

Exceptions to this were in services for adults with long term conditions where some senior staff told us that they felt excluded from the high level meetings where decisions about services are made; end of life services the draft strategy regarding the delivery of end of life services had been developed without consultation with service users, families or operational professionals; regular extended waiting times for children and young people that attended diabetic clinics at Broomfield Hospital; and the backlog of health assessments for Looked After Children. However, it was noted that the provider was taking actions to address the backlog of health assessments for Looked After Children including engaging with partners to improve service provision.

More detail can be found in the provider HQ report.

Access to services

As a provider overall we found that access to the majority of services was good. This was generally supported in all areas we inspected where we found that services were accessible and tailored by front line professionals to meet patient individual needs, at the times and in the places to best suit their needs. This included those patients that lacked capacity or that presented with hearing or visual complexities.

The exception to this was services provided by the local authority related to children and young people with mental health needs. Additional detail that supports this can be found in the provider HQ report.

Leaving hospital

In relation to leaving hospital we found that the provider delivered good safe care within all its services. This was generally supported in all areas we inspected where we found that discharge arrangements met the needs of patients, including the rapid discharge of those patients who want to end their lives at home; discharge processes included advice around out-of-hours support, with patients and their families being well informed of how to access these systems; and hospital and community multidisciplinary teams members collaborated in both the planning and facilitation of the safe and effective discharge of patients.

Exceptions to this were in services for adults with long term conditions where occasional rapid discharge resulted in absence of information prior to first home visit; children and families services where there no capacity to offer community care for those children and young people presenting with ongoing complexities, out-of-hours; and community inpatient services where changes to discharge arrangements had not been communicated to patients

Additional details can be found in the provider HQ and Community Hospital ward reports.

Support in the community

As a provider overall we found that effective systems were in place to ensure that patients, their relatives and those close to them receive the support they need in the community. This was generally supported in all areas we inspected where we found weekly multidisciplinary team meetings (MDT) were held within the inpatient facility to discuss individual patients' support packages that need to

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

be in place prior to the patient being discharged from hospital; guidance for patients regarding out of hours support; and patients involved in the planning and delivery of care in both hospital and community settings.

Learning from experiences, concerns and complaints

In relation to learning from experiences, concerns and complaints, we found that the provider had systems in place within all it's services and that these systems were generally effective in all areas we inspected.

Exceptions to this were inconsistencies for high level learning in relation to concerns and feedback within services for adults with long term conditions and community hospital wards, and end of life services where staff were unable to identify any instance where patient's views had been utilised to inform service design.

Additional details can be found in the provider HQ and Community Hospital ward reports.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The organisation is in general fairly well-led. The Board and senior managers had oversight of the reported risks and had measures in place to manage reported risks. However, the risk management systems were immature and posed a risk to the Boards ability to have a clear oversight of risks to quality in the organisation.

Action is required to enhance staff ability and awareness to identify and consider serious incidents, incidents, near miss incidents and risks and what they would do with that information.

Our findings

Vision and governance framework

The organisation had a clear organisational structure which was updated following Board restructure in July 2013. There was also a governance and risk management structure.

When the Board restructured the Director of Operations role and Director of Nursing role combined. The clinical and operations executive director also became the sole clinical representative on the Board, as the Medical Advisor, a Board member prior to restructure, now reports to the clinical and operations executive director. These changes to Board structure are of concern given the limited level of clinical challenge to Board debate and decision making, afforded by the new Board structure.

The clinical governance framework is immature. The provider had recognised weaknesses, had taken action and continues to take action to strengthen the systems and processes through which the Board are provided with assurance regarding the quality and safety of services. One action being the Board restructure in July 2013. We found that further action is needed to enhance staff ability and awareness to identify and consider serious incidents, incidents, near miss incidents and risks and what they would do with that information to ensure the Board are fully sighted on the risks within the organisation. Further action was also required to ensure learning and cascade of learning from incidents broadly across the organisation.

The clinical and operations executive director told us that board agendas had recently changed and now began with a patient story. However, it is noted that the patient is not present at the meeting and their story is presented to the board by the clinical and operations executive director. It is further noted that board meetings were held in private and the minutes of these meetings were not published.

The majority of risks on the corporate risk register were focused on contracts, performance and finance. We found that some of the risks we identified during our inspection (such as staffing concerns at Braintree Community Hospital) had already been identified by the provider and were incorporated into its divisional risk register. However, we noted that: in some cases there was a lack of detail to allow the Board to understand and assess the risks recorded; some of the risks recorded on the corporate register had not been reviewed within the last 12 months; and there was a lack of continuity between the risks recorded on the directorate risk registers and those identified on the corporate register. This was particularly noticeable in relation to capacity issues within the individual service areas. It is also noted that minuted notes of board discussions in regards to risks was limited and focussed on those that posed a financial risk.

Staff were clear about the organisation's vision and guiding values, and the majority of staff were aware of the core objectives and performance targets that had been set by the board. When decisions had been made in regards to future service developments there had been good engagement between the board and staff governors.

Patient experience reports are considered by the board monthly. This report includes an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. The report outlines individual complaints and how they were dealt with and the key learnings to be shared.

The extent to which the organisation worked with partners varied, with the strongest partnerships noted within services provided to children and young families and the weakest being end of life care services.

Promoting innovation and learning

The vast majority of staff had completed mandatory training and considered the organisation to be supportive of new initiatives. We found several examples of service led

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

innovation. We noted that the children's speech and language therapists had won a national innovation award for contribution to their profession for creative and committed working.

There are systems for identifying and investigating patient safety incidents and an emphasis in the organisation to reduce harm. However, there were inconsistencies in staff practice regarding the practical application of these systems, resulting in an underreporting of risk across the organisation. Inconsistent practices were also noted in regards to safeguarding practices, including prioritisation of training and awareness of appropriate escalation process for those working alone in the community who may observe safeguarding concerns.

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

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

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

Leadership development

Central Essex Community Services C.I.C. have won a number of national awards in 2013. Not least the Social Enterprise of the Year at the National Business Awards and Cabinet Office public service mutual award.

The Chairman, Chief Executive and Clinical and Operational Director had confidence in the majority of managers in the organisation and action had been taken where leadership was noted to be weak. Some actions remained in progress and this was particularly of note in the lack of leadership we observed at Braintree Community Hospital ward.

Board members regularly visit all parts of the organisation and feedback is presented at board meetings by the deputy chairman. The majority of staff told us that the Board and senior managers were visible and approachable and felt that senior leaders heard, understood and took action when concerns had been raised.

The organisation participates in the Sunday Times Best Companies Survey. In November/December 2012, staff rated the organisation above average in each of the eight key areas. However, the results of the 2013 survey identified a decrease in performance in the leadership category. The question that received the fewest positive responses in relation to leadership was 'Senior managers of this organisation do a lot of telling but not much listening'.

Another category where performance had deteriorated was 'Well-being' (how staff feel about the stress, pressure and the balance between their work and home duties). Questions in this category were rated relatively poorly by respondents and overall the number of positive responses had fallen since 2012. The questions that received less positive responses and had deteriorated since 2012 were: 'Most days I feel exhausted when I come home from work', 'Sometimes I feel like this organisation takes advantage of me' and 'My work deadlines are unrealistic'.

Staff engagement

The majority of staff told us they felt well engaged with the organisation and were communicated with in a variety of ways, for example meetings, newsletters, emails and briefing documents. We saw evidence of this.

Staff were very positive about working for the organisation and told us they felt valued and supported. Staff new to the organisation received a two day induction, which included e-learning, and some were supernumerary to the identified staffing requirements for a period of one month following completion of their two day induction. Some staff who were new to the organisation told us that the induction programme was good, that the chief executive officer was actively involved and had provided a good over view of the organisation and its core values.

Sickness levels for the provider have generally been lower than average and are falling and were noted to have out-performed the average for community trusts January 2012 – June 2013.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Family planning services	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Nursing care	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation

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Compliance actions

Surgical procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

This section is primarily information for the provider

Compliance actions

Regulation 22