

# Ash Tree Court

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 26 and 27 April 2016. We also carried out an unannounced inspection on 5 May 2016. We carried out this comprehensive inspection at Primary Integrated Community Services Ltd as part of our comprehensive inspection programme. However, we do not currently have a legal duty to rate community independent health services but we highlight good practice and issues that service providers need to improve.

This organisation has one location:

Ash Tree Court served as the administrative location for Primary Integrated Community Services Ltd comprising of community end of life and community adult nursing services.

Primary Integrated Community Services Ltd (known as PICS) are based at Ash Tree Court in Nottingham was formed in 2008 and incorporated in 2013. The organisation is a general practitioner (GP) owned company with 160 GP shareholders and three consultant shareholders. The service was established originally to bridge the gap between primary, secondary and community care. The organisation provides the following services across five clinical commissioning group areas in Nottinghamshire: Non-malignant palliative care services, respiratory care, care co-ordination, heart failure and atrial fibrillation services and community gynaecology. The organisation also subcontracted the provision of a carpal tunnel clinic and pain management service to a third party provider. We did not inspect the subcontracted services. The organisation employs 35 staff in total including clinical, administrative and managerial staff.

There had been no previous inspection of this organisation.

Our key findings were as follows:

- The organisation had incident reporting systems in place and we saw evidence of robust investigations and learning from incidents. We saw evidence managers applied the Duty of Candour at all stages of the investigation process.
- There was enough staff to meet demand and manage caseloads. Staff spent as long as they needed with patients on each home visit.
- Staff adhered to infection control policies and cleaned their hands after every patient contact. Equipment was clean and staff used personal protective equipment when required.
- Staff undertook comprehensive risk assessments of their patients and followed care plans that managed the risks. Staff understood their responsibilities to safeguard people from avoidable harm.
- The organisation had a safeguarding vulnerable adult's policy and had developed a reporting and recording system. Staff had a good understanding of their responsibilities to protect people from abuse and avoidable harm.
- Medicines were stored and managed in line with good practice.
- All staff were up to date with their mandatory training.
- Staff used electronic patient records which allowed them to share and review information quickly and securely. Staff locked paper records in filing cabinets at the administrative base, Ash Tree Court.
- Patients received evidenced based care and we saw policies based on national guidance. Managers mapped services against national guidelines and frameworks.
- Staff had advanced care-planning discussions with their patients, which included asking the patient where they would prefer to be cared for in their last days of life.
- All clinical staff within had regular clinical supervisions and meaningful appraisals with clear objectives. There was evidence of continuing professional development.
- There was very good multi-disciplinary working and collaborative working with other health professionals.
- There was positive use of smartphone technology with selected heart failure patients inputting daily information to support their treatment plan.

# Summary of findings

- Staff and patients made decisions about DNACPR in partnership and were completed and shared appropriately.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care, which was kind and promoted people's dignity. Without exception, the patients and relative we spoke with told us staff were exceptionally kind and caring.
- Patients and relatives we spoke with were, without exception, positive about the way staff treated them. People considered the care they received exceeded their expectations.
- Staff gave all patients within the palliative care service the opportunity to create an advance care plan and staff discussed DNACPR decisions with patients and their relatives. We observed staff reflecting patient's individual preferences and needs in how staff delivered care.
- Relationships between people who used the service, those close to them and staff were strong, caring and supportive.
- People's emotional and social needs were highly valued by staff and staff had embedded these patient's care and treatment.
- There was a long-term commitment to supporting patients and their carers, developing trusting and committed relationships. This empowered and enabled patients to remain in their own homes for as long as possible.
- Staff ensured patients were involved in their care and treatment by making sure patients understood what staff told them. Staff allowed patients and carers time to ask questions and home visits were never rushed.
- Staff took part in fundraising activities in their own time to support groups their patients attended.
- There was regular engagement with commissioners to ensure the service met people's needs. Service reviews demonstrated the number of patients who died in their preferred place of care was above 80%.
- Patient's needs and wishes were at the centre of the service. Staff saw patients at their home, assessed their needs based on the patient's own priorities and devised a plan of care, with the understanding, involvement and agreement of the patient. Patients had individualised plans of care, which took into account people's personal, cultural social and religious needs.
- Palliative care nurses ensured their patients were able to contact them during working hours and were able to make urgent non-planned visits if the patient needed it.
- Nursing staff worked flexibly when required to meet the needs of their patients. They made bereavement visits to the families of their patients and attended funerals whenever possible.
- Staff assisted and signposted patients to enable them to access other services, therefore giving them choices in how they were supported.
- The organisation tailored services to meet the needs of patients and patient's needs and personal preferences were central to the planning and delivery of individualised care.
- Patients knew how to make a complaint if they needed to. The organisation had a clear complaints policy and was open and transparent when investigating complaints. Both the patient and staff received feedback, actions and learning from complaints.
- The organisation had clear short term and long-term strategies. Managers involved staff at all levels to develop the strategy for the organisation and their individual services.
- The organisation had clear vision and values, which were developed with all staff. All staff spoken with, knew and were signed up to the organisational values.
- At the time of our inspection, the organisation was in a state of transition and moving towards becoming a larger organisation. We saw leaders managed this effectively with a clear governance structure in place to manage performance and risk.
- Staff morale was high and there was a high level of staff satisfaction across the organisation. There was a commitment and culture of putting patients first.
- Staff we spoke with spoke positively about the service leads. We were told both the managing director and clinical director were approachable, visible, motivated staff and cared about staff members as individuals
- Managers encouraged and supported staff to innovate. For example, managers were supporting one member of staff to develop a business plan regarding training in care homes.

# Summary of findings

- We saw examples of where managers had changed the way the organisation worked in response to staff feedback.
- Staff attended voluntary groups for patients with long-term conditions. Nurses talked to patients and provided information about other services and support groups. Staff also gave talks about managing conditions and palliative care services.
- Despite the organisation having limited patient engagement networks, the organisation used existing networks and acted on patient feedback.

However we also found:

- Not all staff knew of or understood the Duty of Candour.
- Enhanced safeguarding training had not been provided for the nursing safeguarding lead, which does not follow best practice.
- The organisation did not meet some of the requirements of the Fit and Proper Person Requirement (FPPR). There were gaps in evidence collected regarding board members meeting the FPPR requirement. Therefore the organisation could not assure board members were fit to undertake their role.

We saw several areas of outstanding practice including:

- Staff provided exceptional, individualised person centred care to adults with long-term conditions who were coming to the end of their lives.
- Palliative care nurse input contributed to a high proportion of patients making advance care decisions and dying in their preferred place of care.
- Staff went the extra mile and worked flexibly within, and sometimes outside of these hours, to provide care and support to patients and relatives at a time of greatest need. Patients spoke highly about the services they received.
- Staff were kind, compassionate and we saw numerous examples across end of life and community adult services of positive interactions and involvement of care between staff and patients.
- Staff supported patients to continue as normal a life as possible. For example, staff referred patients who were smokers and prescribed oxygen at home to the Fire Safety Officer for a comprehensive risk assessment. Staff mitigated risks where possible but nursing staff acknowledged it was patient choice.
- Staff went out of their way to respond to patient's needs. Nurses took prescriptions to pharmacies and made arrangements for a patient who was travelling abroad for a long awaited holiday to call them if they were concerned in any way about their condition or medication whilst out of the country.
- There was positive use of smartphone technology with selected heart failure patients inputting daily information to support their treatment plan. Staff had an application on their mobile phone, which allowed them to access and monitor effectiveness of treatment.
- We saw numerous examples of staff involvement in developing organisation values, vision, and strategy. All staff said they felt they could influence change and managers worked collaboratively with staff to help them feel connected.
- Leaders were visible and supportive of staff both personally and professionally. We saw an example of managers encouraging and supporting a member of staff to write a business plan to introduce training into care homes.
- There was a highly motivated patient centred and supportive culture within the organisation. Staff put each other and patients first. All staff we spoke with liked working at the organisation and morale was high across all staff groups.
- Staff raised money in their own time for support groups that their patients attended.

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

- The provider should ensure staff know about the Duty of Candour and how it applies to them in their roles.
- The provider should ensure staff receive the appropriate level of safeguarding training so they can identify when patients are at risk of abuse and harm.

Importantly, the provider must:

# Summary of findings

- The provider must ensure Fit and Proper Person Requirements for board members are evidenced and available to assure themselves that directors have the capacity and capabilities to undertake the roles.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

## Overall summary

We do not currently have a legal duty to rate community independent health services but we highlight good practice and issues that service providers need to improve. We found:

Staff treated patients with compassion, dignity and respect. Patients were positive about their care and we saw that they were involved in their care and treatment.

Staff undertook comprehensive risk assessments of their patients and followed care plans that managed the risks. Staff understood their responsibilities to safeguard people from avoidable harm.

Patients received evidenced based care and we saw policies based on national guidance.

The organisation provided staff with appropriate training, regular supervisions and annual appraisals.

Patient's needs and wishes were at the centre of the service. Patients were all seen at home, their needs were

assessed based on the patient's own priorities and a plan of care was devised, with the understanding, involvement and agreement of the patient. Patients had individualised plans of care, which considered personal, cultural social and religious needs.

Patients were involved in advance care planning and do not attempt cardio pulmonary resuscitation (DNACPR) decisions which were shared appropriately with other providers involved in the care.

The organisation had a clear vision, strategy and purpose, which was shared by all staff. Leadership was visible at all levels of the service. Leaders were aware of issues affecting service delivery and passionate about their staff.

Staff felt supported and there was an open, honest patient centred culture. Staff were consistently positive about working for PICS telling us they were proud of the organisation and felt valued and respected.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Community health services for adults

### Rating Summary of each main service

We do not currently have a legal duty to rate independent community health services but we highlight good practice and issues that service providers need to improve.  
During our inspection we found:

There was a positive incident reporting culture with examples of sharing and learning from past incidents.

There was clear evidence of an open and honest culture with the patient being central in the planning of care provision by all of the community adult services provided. Staff were appropriately trained with regular supervision and annual appraisals. Staff provided evidence based care and treatment and we saw positive use of information technology to support the treatment and care of patients. Care was found to be individualised, flexible and highly regarded by both patients and carers. Patient feedback was positive and we saw positive interactions between staff and patients. We saw examples of staff going the extra mile for patients. The organisation responded to identified community need and had worked with primary and secondary care to establish an innovative community gynaecology service. Staff were consistently positive about working for the organisation telling us they were proud of the organisation and felt valued and respected. However we also found:  
Not all staff knew about the duty of candour and how it impacted on their roles.  
The nominated safeguarding nurse had not received safeguarding training to level three as per best practice. However at our unannounced visit they had commenced a level three course.  
The organisation could not assure themselves they were meeting the regulatory requirements set down by the Fit and Proper Person Requirement (FPPR).

# Summary of findings

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# Ash Tree Court

**Services we looked at**

Community health services for adults including palliative care.



# Summary of this inspection

## Background to Ash Tree Court

Primary Integrated Community Services Ltd (known as PICS) are based at Ash Tree Court in Nottingham was established in 2008 and incorporated in 2013. PICS is a general practitioner (GP) owned company with 160 GP shareholders and three consultant shareholders. The service was originally established to bridge the gap between primary, secondary and community care. The organisations aim is to manage patient's conditions in the community, prevent admissions to hospital through patient and carer support, medical advice, rehabilitation and follow-up.

The organisation provides the following services across five clinical commissioning group areas across Nottinghamshire: Non-malignant palliative care services, respiratory care, care co-ordination, heart failure and atrial fibrillation services, and community gynaecology. The organisation also subcontracted the provision of a carpal tunnel clinic and pain management service to a third party provider. We did not inspect the subcontracted services. Care is provided in patient's own homes, nursing homes, hospices or GP surgeries.

The organisation employs 35 staff in total including managers, administrative staff and 20 nursing staff. Of the nursing staff, 11 provide the community care and nine provide the palliative care. The service contracts some

services to local GPs and secondary care consultants but these medical staff are not directly employed by the organisation. The medical director oversees and supports the services provided by the organisation.

Patients are referred into the service by general practitioners (GPs) specialist nurses based in hospitals, district nursing teams, hospital discharge teams and specialist consultants within secondary care (hospital). Services provided by the community nursing team include respiratory care and heart failure, atrial fibrillation care and care co-ordination. Care co-ordination aims to support patients aged 75 or over or with complex needs to live independently for longer and avoid hospital admissions. In addition there is also a pain management service, a carpal tunnel clinic [carpal tunnel syndrome includes chronic pain, numbness, or tingling in the hand, caused by compression of a nerve in the wrist] and a community gynaecology service.

Patients in three CCG areas; Nottingham West, Nottingham City and Mansfield and Ashfield with a diagnosis of heart failure, chronic obstructive pulmonary disease(COPD) or renal conditions, and who are assessed to be in the last 12 months of life, are referred to the PICS palliative care nurses.

Care is provided in patient's own homes, nursing homes, hospices or GP surgeries.

## Our inspection team

Our inspection team was led by: Jason Bennett, Inspector Care Quality Commission.

Our inspection team included CQC inspectors and specialist community and end of life nurses.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive pilot of independent community health services inspection programme. However, We do not

currently have a legal duty to rate community independent health services but we highlight good practice and issues that service providers need to improve.

# Summary of this inspection

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the organisation and asked other organisations to share what they knew. We carried out an announced visit on 26 and 27 April 2016. During the visit we held focus groups with administrative and nursing staff who worked within the service.

During the inspection we visited the organisations business base at Ash Tree Court where we spoke with managers, clinicians, specialist nurses and administrative staff individually or in groups.

Within the community health services for adults we accompanied five nurses from heart failure, respiratory and care co-ordination services on home visits, spoke with 11 patients and nine carers and relatives. Additionally we telephoned six patients who had agreed in advance to take calls, one specialist pain consultant and a specialist pain nurse. We looked at nine staff records.

We reviewed the electronic records of eight patients visited and nine sets of written notes.

## What people who use the service say

The organisation compiled a patient satisfaction survey report for January to December 2015. A total of 79 questionnaires were sent to patients within the Nottingham West and Nottingham City palliative care teams with a combined response rate of 60%. The survey results showed 100% of patients within the Nottingham City team and 93% of patients within the Nottingham West team felt that they had been treated with dignity and respect and the service addressed their needs and priorities.

All patients and carers spoken with during our inspection were exceptionally positive about the service they received from staff.

Statements included:-

- "They have changed our lives".
- "I would not be here now without my PICS nurse".
- "There isn't anything they won't do to help".
- "They are there for you whenever you need them".
- "If the PICS nurse hadn't come into our lives, I wouldn't be here now!"
- "The care was exactly what I wanted for my husband".
- "They are fantastic, absolutely marvellous".

Patients said they were treated with dignity, respect and were involved in their care and treatment.

# Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Are community health services for adults safe?

We did not rate safe for community health services for adults because we do not currently have a legal duty to rate independent community health services. We found:

- There was a positive incident reporting culture with examples of sharing and learning from past incidents.
- The service had a safeguarding vulnerable adult's policy, had developed a reporting and recording system and staff had a good understanding of their responsibilities to protect people from avoidable harms.
- Medicines were stored appropriately and non-medical prescribers were aware of their responsibilities.
- Infection control and prevention practices were followed by staff and equipment cleaned after each use.
- Staff had completed all required mandatory training.
- There was evidence of collaborative working with patients and carers to maintain safety and avoid any risk of harm to patients in the home.

However we also found:

- The nominated safeguarding nurse had not received safeguarding training to level three, which did not follow good practice. However, at our unannounced visit they had sourced and commenced a level three safeguarding course.
- Staff were open and transparent however, they did not know about the duty of candour and how it applied to them in their roles.

### Safety performance

- Primary Integrated Community Services Ltd (PICS) were not commissioned to report on the NHS Safety Thermometer. The safety thermometer measures harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a

catheter) and venous thromboembolism (blood clots). However, we observed nurses discussing these safety issues with patients and recording any identified concerns or actions taken.

### Incident reporting, learning and improvement

- Data provided by PICS in advance of the inspection indicated there had been no never events reported by the adult community care service. 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.
- The Primary Integrated Community Services Ltd (PICS) used the term "significant event" to describe "incidents" as this reflected the reporting system used and a comprehensive protocol was in place. Staff reported significant events using a significant event analysis form. Staff sent forms to the medical director and the managing director. All staff we spoke with understood their responsibilities to raise concerns and report incidents.
- There had been 15 significant events recorded, as per local policy, during 2015/2016, three for community health services for adults and twelve for the end of life service. We reviewed eight significant events (for the period September 2015 and April 2016) in detail and saw managers investigated them in accordance with organisational policy. The medical director conducted reviews and investigations for clinical significant events and the managing director reviewed non-clinical events. Managers discussed significant events at clinical governance meetings with learning and actions identified. We saw evidence of communication with other providers as part of investigations. We saw evidence of staff following up and reviewing actions. There were no overdue actions for either service.

# Community health services for adults

- Managers provided feedback and learning through monthly clinical team and bi-monthly multi-disciplinary team (MDT) meetings and we saw this evidenced in meeting minutes. All staff we spoke with said managers provided feedback from significant events and gave examples shared learning. For example, there was shared learning regarding the administration of Sodium Citrate. Additionally we saw team meeting minutes, which gave examples of feedback, and learning from incidents. This included improving processes for referring patients into emergency respite care.
- The organisation had an up to date incident reporting policy and a significant event protocol and procedure document. These documents were readily available to all staff both on line and on file at the main business base (Ash Tree Court). A staff survey in March 2016 had identified some confusion amongst staff regarding the terminology 'incident' and 'significant event', a communication plan was in place to address this and we saw evidence within multi-disciplinary meeting notes for April 2016 were this had been discussed.
- Staff spoken with understood their responsibility to report incidents and knew how to submit an incident using the electronic reporting system. Staff told us they had minimal experience of submitting incidents although they could give an example of an incident, which had resulted in a change of practice. This involved secure storage of completed prescription forms following temporary loss of a completed form within a surgery waiting room. Secure storage and information governance responsibilities had been highlighted to staff transporting completed prescription forms with an action to ensure all forms are placed in a zipped compartment of their workbag for transit. We saw evidence within incident investigation of staff and managers applying duty of candour both at the time of the incident as well as involving patients and their relatives in any investigation outcome.

## Duty Of Candour

- Some staff we spoke with were unfamiliar with the term duty of candour but understood the requirement to be open and honest when anything went wrong. We were told of a recent apology made to a patient following a breach of confidentiality. Duty of candour is a regulatory duty that requires providers of health and social care

services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.

## Safeguarding

- All medical, nursing and administrative staff had completed level one e-learning entitled "An introduction to adult safeguarding". Senior staff told us the clinical commissioning groups (CCGs) organised face to face safeguarding training at level two for which staff could attend. Safeguarding has three levels of training; level one for non-clinical staff, level two for clinical staff and level three for staff working directly with children and young people.
- The organisation had a Safeguarding Adults Policy with a reporting and recording system. We reviewed incidents where the safeguarding policy was followed and all actions appropriately recorded. These had been referred to the local safeguarding authority as per policy.
- We reviewed significant event records where the safeguarding policy had been followed and concerns had been appropriately recorded and referred to the local safeguarding authority.
- Staff we spoke with understood their responsibilities to protect patients from avoidable harm. Staff gave examples of when they would raise a safeguarding concern ranging from physical, mental and financial abuse. The Medical Director was the clinical lead for safeguarding and there was a nominated safeguarding nurse. All staff we spoke with said they knew who the safeguarding lead was.
- At the time of our visit, the nominated nurse for safeguarding had not received any enhanced safeguarding training, which does not reflect recognised good practice. Nursing staff had received level one safeguarding adults training. We escalated our concerns to managers about the lack of enhanced training. By the end of our announced inspection, managers had added the issue to the risk register and additional training had been identified. During our unannounced visit, we saw the lead nurse had started a level three safeguarding adult's module. Further level two and three courses had been identified for June 2016.

## Medicines

# Community health services for adults

- The organisation held a small stock of medicines for example, chirocaine (local anaesthetic) and nexplanon (birth control), which was used by GPs or consultants in clinics the service provided. The organisation did not keep any controlled drugs. Community adult care nurses carried salbutamol (used to treat asthma or conditions associated with lung disease) when requested by the patient to collect from a pharmacy. Palliative care nurses carried medicines on rare occasions including an anaphylactic 'Shock Box' as and when required for flu injections.
- We observed all medicines were stored in a locked cupboard within a storeroom with restricted named access to keys. There was a system of signing stock in and out as a method of audit and stock control and we saw evidence that expired medicines were taken to a local pharmacy for destruction.
- Community adult and palliative care nurses did not directly administer medications apart from flu vaccinations. Their role was to educate and support patients to take prescribed medications safely. The specialist nurses reviewed all medications being taken, at each visit and discussed effectiveness with patients. We observed this in practice when a patient with oedema (excess fluid in the tissues causing swelling, particularly to the lower limbs) was experiencing uncomfortable symptoms. Medication dosage was discussed, advice given and a plan to call the patient made to assess the effectiveness of the dosage change agreed. This was clearly documented and the patients GP informed.
- Some nursing staff had completed or were studying to become nurse prescribers. (Non-medical prescribing is undertaken by a health professional who is not a doctor and who had undergone additional training). This qualification enabled community adult nurses to prescribe medication and titrate (adjust) drug doses to maximise clinical effectiveness and improve the quality of life for the patients within their caseload.
- Palliative care nurses were able to prescribe medicines in addition to those prescribed by GPs such as antibiotics and steroids and anticipatory medicines. Prescribing anticipatory, 'just in case' medicines (before the patient experiences symptoms) allows patients to receive effective symptom control in a timely way.

However nursing staff told us nurse prescribers mostly prescribed rescue antibiotics (antibiotics provided to patients during early symptoms of infection), this prevented delays in obtaining a prescription from GPs.

- All medication advice or alteration was recorded on the electronic patient records system and emailed to the relevant general practitioner (GP) for information. Patients were encouraged to contact the nurse to report the effects of agreed changes or discuss any concerns.
- Non-medical prescribers we spoke with had a good understanding of the need to follow current evidence and best practice for prescribing using NICE guidance for palliative care medicines and by attending the Nottingham City Care Non-Medical Prescribers Forum.
- British National Formulary (BNF) books were issued to all non-medical prescribers.
- Prescription (FP10) forms were managed and stored securely in accordance with NHS guidance 2013.

## Environment and equipment

- The organisation's business base was in Ash Tree Court, Nottingham Business Park. The premises were an administration centre only. Patients were seen in their own home, nursing or residential homes and at other clinical establishments, for example GP surgeries.
- The service ensured the health and safety of its employees. The office premises were well maintained and visibly clean. Fire extinguishers were in prominent places and regularly serviced, we observed security arrangements that protected the staff and premises.
- There was a small amount of equipment and consumables stored in a cupboard at the business base. This included items such as sterile dressings, gloves, aprons, unused sharps bins and venepuncture (blood taking) equipment. All disposable items were appropriately stored and within the expiry date. Electronic equipment was labelled as safety tested and calibrated. There was an equipment service log.
- Staff carried a small amount of equipment required to undertake clinical assessments. This included sphygmomanometer (for recording blood pressure), stethoscope, digital temperature recorder and a digital oxygen saturation recorder (to record blood oxygen levels). These items were stored in each nurses visit bag.

# Community health services for adults

- Syringe drivers for palliative care patients were requested through the district nurse team for patients at home who required continuous infusion of medication to control their symptoms. The district nurses were responsible for the equipment and the medication.

## Quality of records

- Patient records were stored using a computerised electronic system, commonly used within primary care (community care and General Practitioners'). The electronic system allowed nursing staff to record, share information and make referrals to other health care professionals.
- Staff printed off a summary sheet for each patient prior to a visit and used these to document actions and discussions, which had taken place. These notes were transcribed onto the electronic system on return to Ash Tree Court. The summary sheets were then disposed of in the confidential waste bin for shredding. Service leads told us they were in the process of trialling a mobile working system, which would be paperless.
- We looked at the electronic records of patients visited during the inspection. These were an accurate reflection of the visit with clear patient outcomes and agreed care plan changes.
- GPs were communicated with through the 'task' facility, of the electronic patient system (similar to email), of medication changes, identified patient concerns and requests for additional input required, for example appointments or blood tests.
- There were some historic paper documents relating to patients who had not yet been transferred to the electronic system. These were stored safely in locked filing cabinets.
- Documentation audits had been completed with patient records being scored against a checklist for quality and completeness, a percentage score was awarded. We saw copies of these audits from February 2015, which showed 80% to 100% compliance in both electronic and paper records. Actions and repeat audit dates were included. An action example was to check the emergency contact information provided. We observed this check being carried out when accompanying nurses visiting patients.

## Cleanliness, infection control and hygiene

- Staff followed good infection prevention and control principles. They were bare below the elbow when attending patients wore no jewellery, except a wedding ring, and long hair was tied back.
- We observed staff washing their hands and using hand cleansing gel prior to, and after patient contact. We were offered the use of hand cleansing gel prior to entering and on leaving patients' homes, however the service did not audit infection control practices.
- We saw all equipment was appropriately cleaned after use. This reduced risks of passing infections between patients.
- We observed nursing staff using personal protective equipment (PPE) including aprons and gloves, for direct patient care. These items were disposed of in the patient's own waste bins.
- Nursing staff were provided with bins for the disposal of sharps and the organisation arranged for their safe disposal with a specialist contractor.
- Data provided by PICS told us all clinical staff had received mandatory infection control training within the past two years

## Mandatory training

- The majority of mandatory training was provided through e learning and completed during induction. Staff told us they were given time to complete e learning during their initial supernumerary period of employment with the company. Training included safeguarding adults, infection control, anaphylaxis, moving and handling, information governance, records management, conflict resolution, customer care and whistleblowing.
- Staff were required to complete updates at one, two or three yearly intervals, dependant on the nature of the training. Data provided by the organisation showed 100% of PICS nursing staff were up to date with all required mandatory training.
- Data provided by PICS indicated all staff had received mandatory training on information governance, records management and consent. This meant all staff had training, which gave them an understanding of patient confidentiality and gaining consent to treatment. Mandatory and other training requirements were discussed at annual staff appraisals.



# Community health services for adults

- Service leads informed us of additional face-to-face training planned for 2016/17, which included safeguarding, manual handling, basic life support, Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS).

## Assessing and responding to patient risk

- Staff working within the PICS service assessed each patient during home visits using their specialised clinical experience and knowledge to establish their level of risk. Nurses had additional training and practical experience within their speciality. They received specialist clinical supervision by the medical director and from hospital based consultants to monitor and develop their expertise.
- Nursing staff told us an initial assessment was carried out for each patient at the first visit. Safety of patients visited in their own homes was included within initial assessments and during subsequent visits. This included falls prevention through discussions about the use of mobility aids such as walking sticks or frames. Nurses worked collaboratively with patients and their carers to prevent harm occurring. We observed this in practice whilst accompanying nurses visiting patients. On one occasion, the nurse pointed out a rug, which could be a trip hazard.
- We were shown care plans for the initial assessments, which were comprehensive and covered all aspects of patient's wellbeing, including physical, social and psychological. Assessments included the risk of patients developing venous thromboembolism (VTE) which are blood clots in the deep veins of the leg, nutrition and hydration and the risk of patients developing pressure sores. We observed nurses asking patients about all of these issues during our visits to patient's homes.
- Skin integrity was checked, documented and advice given about pressure area awareness. Patients at high risk of developing pressure sores were assessed using the malnutrition universal screening tool (MUST) - a five-step tool used to identify adults who are malnourished, at risk of malnutrition or obese. Nurses visiting patients told us they could make direct referrals to a dietitian if necessary.
- Patients' clinical condition was assessed and improvements or deteriorations discussed directly with patients and their carers. The emphasis was on patient self-management with support through clinical advice.
- Staff told us they assessed each patient individually, discussed their condition with them and where appropriate with their carers. Risks were identified and options for action discussed. We observed these discussions taking place with clear instruction provided for action should the patient deteriorate. This ranged from medication changes, calls to the nurse for an additional visit or if necessary when to dial 999 for emergency assistance.
- Patients who were prescribed oxygen at home were referred to the Fire Safety Officer for a comprehensive risk assessment. Staff told us they would try to mitigate any risks where possible. For example, we heard of patients who were prescribed oxygen who wished to continue to smoke. Fire retardant blankets would be given and nursing staff would try to educate patients of the associated risks of smoking whilst on oxygen. One of the patients we visited with the nursing team confirmed a fire assessment had been completed.
- Nurses had direct access to the patients GP or specialist consultant if additional and urgent clinical advice was required. Staff worked Monday to Friday 9am to 5pm with the exception of the care coordination team who worked between 9am and 6pm weekdays. We observed nursing staff checking patients and relatives had out of hours and emergency contact numbers to use if the patient was deteriorating.

## Staffing levels and caseload

- The palliative care service was split into three teams to mirror the CCGs that had commissioned them. The Mansfield and Ashfield team had 2.4 whole time equivalent (WTE) band seven nursing staff. They had also recruited a 0.6WTE band seven role but they had not started at the time of inspection. Nottingham City team had 2.6 WTE with one band seven nurse and 1.6 WTE band six staff nurse. Nottingham West team had three WTE band seven nursing staff and had recently recruited two staff nurses (one 0.6 WTE and one 0.4 WTE) who were not yet in post.
- Each community nurse specialist had a caseload of active patients, those receiving visits, and previous patients with open access to the service if their condition deteriorated. Patients with long-term conditions remained registered with the service. We observed nurses managing their own caseload diary.
- Staff told us they had time to support patients on their caseload and provided cover for each other during leave

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or sickness. However, a staff survey from March 2016, showed staff thought there should be a process to assess and monitor the numbers on each staff member's caseload. In a "You said, we did" response to the survey, service leads stated that they would use the clinical governance committee to benchmark caseloads internally and externally with other community health providers and review the minimum and maximum number. Service leads told us that they had added this issue to the organisation's risk register and were monitoring caseloads closely.

- The nursing teams planned home visits in accordance with demand. This meant there were no fixed numbers of visits per day or time spent with the patient. Staff told us this gave them flexibility and time to attend multi-disciplinary team (MDT) meetings and be available for urgent non-planned visits if a patient requested one.
- There were systems in place for staff to cover each other in the event of sickness and appointments agreed, with patients, taking into consideration booked annual leave. The organisation reorganised appointments, by telephone, in the event of staff being unable to make a visit due to sickness.
- The organisation did not use agency staff.

## Managing anticipated risks

- The organisation had a lone working policy, which we reviewed. Included was risk assessment of patient's homes, numbers of staffing required to attend, a system to record that staff were safe, and a procedure for raising the alarm if staff had concerns about themselves or colleagues.
- Staff we spoke with knew the lone working policy and could explain how they would use it. They stated the telephone number to call and the phrase to trigger assistance in an emergency. However, none of the staff spoken with had been in a position where they had needed to use the alert. Staff told us they knew their patients well but would follow the lone working policy if they had any concerns. We observed staff logging in and out of work to make sure they were safe.
- The organisation had a Business Interruption Plan of which staff were aware. Information technology systems were in place to enable staff to work from home or GP

surgeries, maintaining their home visiting service. In the event of adverse weather, staff contacted patients and rearranged appointments. Patients who required urgent visits would be referred to the GP.

## Are community health services for adults effective?

(for example, treatment is effective)

We did not rate effective for community health services for adults because we do not currently have a legal duty to rate independent community health services.

We found:-

- Primary Integrated Community Services (PICS) Ltd applied evidence based best practice to the community health services and end of life care for adults. The organisation mapped treatment and care to National Institute for Health and Care Excellence (NICE) and Gold Standard Framework guidance.
- The organisation worked in partnership with local NHS trusts to provide seamless care between primary and secondary care.
- Patient outcomes were consistently positive within adult community services and end of life care.
- Staff were fully competent to do their job effectively, encouraged to undertake professional development and were up to date with annual appraisals.
- There was strong evidence of multidisciplinary working both internally within PICS and with other health professionals outside of the organisation.
- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were made in partnership with patients and were completed and shared appropriately.
- There was positive use of smartphone technology with selected heart failure patients inputting daily information to support their individual treatment plan.
- There was a good overall understanding by staff of their responsibilities in relation to safeguarding, mental capacity act (MCA) and the Deprivation of Liberty Safeguards (DOLS).

## Evidence based care and treatment

- The organisation mapped all services provided to NICE guidelines meaning treatment and care pathways reflected best practice. Treatment was integrated with local quality markers. An example was the integrated



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care pathway for heart failure developed by Nottinghamshire coronary heart disease network, based on clinical evidence (NICE 2010), where a traffic light system was used to identify the different stages of a patient's journey. This enabled a seamless process between primary and secondary care. Additionally the community service incorporated chronic obstructive pulmonary disease in over 16 year olds (NICE guidelines CG101), chronic heart failure in adults (NICE guidelines CG108) and atrial fibrillation (NICE quality standard QS93) into their daily practice.

- The organisation used National Institute of Health and Care Excellence (NICE) guidelines "Care of dying adult in the last days of life" to support the care and treatment provided for patients.
- Staff working within end of life applied the standards advocated by the Gold Standards Framework Centre for End of Life Care (GSF), this supported advance care planning when attending multi-disciplinary meetings (MDT). We observed staff referring to NICE "End of life care for adults" guidance as part of their MDT discussions.
- Staff told us they used guidelines when planning care for each patient and gave verbal examples of how they ensured each patient received treatment based on current best practice. We saw evidence of how staff adjusted treatment in accordance with the guidelines to improve a patient's clinical condition. For example adjusting nebuliser (respiratory medication) schedules to improve respiratory function and reduce breathlessness.
- The organisation had a holistic approach to assessing, planning and delivering patient centred care and treatment to patients.
- Staff had access to guidelines on line and at the PICS base.

## Pain relief

- Patients and relatives we spoke with told us their pain was well managed and the nursing team organised all necessary prescriptions.
- The organisation commissioned a third party provider to deliver consultant led pain management services. Therefore, patients had access to pain management pathways. We saw staff had referred patients to individualised pain management pathways. For example, patients with back pain had early scans to establish a definitive diagnosis; this reduced the

percentage of patients requiring referral to hospital for assessment. One in twenty patients were referred to hospital; this reduced the demand on acute hospital pain services and promoted care closer to home.

- Community nurses discussed pain with the patients they visited and provided advice if necessary. If patients had pain, not related to the specialism for which they were being visited, the nurses would help the patient to make an appointment to see their General Practitioner and include information in the communication update post visit.
- In the pain clinics, analgesia was prescribed by the consultant or general practitioner. The nurses were a point of advice and support.
- Nurse prescribers within the palliative care team prescribed steroids and anticipatory (just in case) medications such as opioids (painkillers). However, we were told in the majority of cases staff would ask the general practitioner (GP) to review and prescribe medication and would ensure this was done in a timely way. We looked at patient records on the electronic recording system and observed that GPs were being asked to review pain relief and other medication.

## Nutrition and hydration

- Nutrition and hydration discussions took place with patients during home visits and advice provided which was relevant to each patient's clinical condition. For example, staff advised patients taking diuretic medication, which increases urine output, not to restrict their fluid intake and the nurses checked or requested blood tests to monitor kidney function.
- We saw evidence in the electronic and paper notes demonstrating initial assessments of patients using the malnutrition universal screening tool (MUST), there was no required onward referrals from the assessments we reviewed. However, nurses were able to describe the referral process using the task facility on the electronic records system.
- Community nurses told us they could refer patients to a dietician if required.
- We accompanied nurses on home visits to patients receiving palliative care. We observed staff asking patients about nutrition and hydration, they gave information to patients and made suggestions for

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dietary changes. Patients who were assessed to be at high risk of developing pressure sores were also assessed using the malnutrition universal screening tool (MUST).

- We observed staff's concern about one patient who was having difficulty swallowing. We checked the patient's record and saw a referral had been made to the speech and language therapy (SALT) team for an assessment.

## Technology and telemedicine

- Staff used an electronic system for recording patient information, referring to other services or requesting investigations.
- The electronic system had a 'task' facility, which enabled rapid and effective communication with general practitioners (GPs). This was fully utilised with information relating to patients recorded and if required sent to the patients GP at the end of each working day. The facility enabled timely co-ordination of tests or requests for non-urgent GP intervention.
- Smartphone technology was in use for 44 patients with heart failure who were willing and able to use a smartphone. They had an application (App) on their mobile phone, which allowed them to input data such as daily weight, which the nurses could access to monitor the effectiveness of treatment. Patients could also access information about their condition through the system.
- There are plans to introduce a portable electronic tablet for recording patient information and outcomes of visits. Staff downloaded information from the tablet to the main server on return to the business base, working towards a paper free environment.

## Patient outcomes

- The organisation provided evidence of consistently positive outcomes for patients referred into their service. For example, patients with chronic obstructive pulmonary disease (COPD) in Nottingham West clinical commissioning group (CCG) had a hospital admission rate of 7.4% per 100 patients; this is 33% lower than the national average of 11%. Hospital readmission rate, for the same patient group, following discharge (per 100 patients) was 12%, which was 20% lower than the national average of 15%.

- The diabetes team working with newly diagnosed patients had identified an 8% increase in medication compliance, improving diabetes management in the community.
- The care co-ordination teamwork to prevent hospitalisation of patients identified on GP registers as in the top 2% of risk due to complex medical and care needs. Staff and patients gave examples of where intervention had been successful (case studies) where comprehensive assessment and appropriate referral by nurses to support groups had enabled patients to remain within their own homes.
- The long term conditions (LTC), non-malignant palliative care service was a unique service not provided by other providers and therefore service leads told us they found it difficult to benchmark their service.
- A local university was commissioned to undertake a service evaluation of the newly commissioned end of life LTC service. The study ran for six months from August 2015 to January 2016. The evaluation had several objectives including the effectiveness and success of the pilot scheme, patient, staff and provider experience. The authors of the report found "the service was highly valued by patients, their spouses and the majority of key stakeholders, however there have been problems integrating the pilot within existing services". Service leads told us they had responded by educating other services about their role and remit and by building relationships with other local providers. For example, staff attended the local community matrons' forum.
- Service leads told us joint pathways were being developed between providers within the South Nottinghamshire Provider Alliance. One aspect of this would be the implementation of the End of Life Care Quality Assessment Tool (ELCQuA) or other similar tool.

## Competent staff

- All staff were required to complete induction on joining the organisation. We spoke with a new member of staff who described a three-week induction period and told us it had been very useful. This had included mandatory training and spending time with other community health teams, for example, GP practices and district nurses. We saw evidence in staff files of completed induction checklists, which managers had signed off. The induction included mandatory training checklist as well as familiarisation with organisational policies and procedures.

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- Data provided by PICS indicated all staff, except new starters, had received appraisals within the past 12 months. We looked at appraisal records and saw each one included clear objectives. The organisation viewed the appraisal process as a joint venture between managers and staff. Managers set goals for staff and staff could set goals for themselves. We looked at three completed appraisal forms and saw staff undertook a variety of personal development activities including shadowing, mentoring and additional training. Staff we spoke with told us they had received meaningful appraisals within the last 12 months, had agreed, and understood their personal objectives.
  - Managers typed up appraisals onto electronic documents. Therefore, there was no evidence of staff signing off or agreeing to the appraisal objectives on the typed document. In response to this, managers said the procedure was that staff agreed their appraisal objectives with the appraiser and the agreed objectives forwarded to the human resources lead to file electronically. As such the staff member email is evidence of signing off their objectives. Managers we spoke with said and were working to change the format of appraisals to include staff signatures.
  - The organisation recruited staff with expertise in palliative care. Staff told us additional training would be provided if highlighted during the appraisal process or if staff felt uncomfortable, for example, with breaking bad news and having difficult conversations. Staff also told us they could access study days held at a local hospice.
  - End of life nurses had monthly clinical supervision provided by staff at a local hospice, which focused on psychological skills, issues and psychological wellbeing of patients, and staff. We saw a formal framework and template had recently been developed to record the details of meetings and where further training was identified.
  - Some end of life nurses had additional qualifications as verifiers of death. Staff we spoke with told us this was an important part of the holistic care they provided. One member of staff told us “they may have stopped breathing but they’re still my patients, and I want to do the very best I can for them and their families”.
  - Staff took part in a variety of development activities. The service encouraged staff to participate in protected learning time events held by another local NHS provider. Service leads told us they tried to release as many staff as possible to attend learning sessions and encouraged sharing and learning through mentoring, group and peer meetings. The organisation released staff to shadow other staff, attend seminars and conferences relating to their clinical speciality and personal development plan. We saw evidence of continuing professional development in staff files.
  - We checked nine staff employment records. All staff, where applicable had proof of identity and evidence of professional registration and qualifications. Managers recorded and monitored dates for revalidation on a monthly basis; there was a system in place for ensuring the continued competencies and registrations of their staff.
  - All staff had an up to date disclosure and barring service (DBS) checks. The organisation kept details of certificate numbers and review dates. Managers reviewed them on a monthly basis so staff were always up to date with renewing them. Staff renewed their DBS checks every three years.
  - The organisation commissioned a staff survey in March 2016. One issue highlighted was some staff needed additional training on the electronic patient record system. Service leads told us they had provided further training in response to this concern.
  - The organisation encouraged staff to participate in protected learning time (PLT) events held by another NHS provider. Service leads told us they tried to release as many staff as possible to attend and learning was shared through group or peer meetings for those who were unable to attend. We saw evidence of continuing professional development in staff files. Respiratory nurses were members of the British Lung Foundation providing them with access to up to date information and courses related to their speciality.
  - Third year student nurses were accepted on a four week placements within all the service specialities. Staff told us students were fully supported and supernumerary.
  - There was a structured induction programme for new staff. We saw evidence in staff files of completed induction checklists, which were signed by a manager. The induction included mandatory training checklist as well as familiarisation with organisational policies and procedures.
- Multi-disciplinary working and coordinated care pathways**
- The community adult service was a collaborative consultant led team with specialist nurses who also had

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established professional relationships with hospital based specialist consultants and access to allied professionals as required. The management and administrative staff worked closely with the clinical teams.

- Staff within the community adult services told us they worked collaboratively as a multidisciplinary team (MDT). Specialist nurses had their own caseload and could see and make clinical decisions relating to each individual patient's care, based on NICE guidelines. However, they had access to specialist consultants and GPs for advice or discussion whenever required. This worked well for patients and staff. One consultant said 'I have a fantastic relationship with the PICS nurses, we learn from each other and have the patient at the centre of all of our discussions'.
- The organisation had staff MDT meetings every eight weeks to discuss organisational issues. All services within PICS had clinical MDT team meetings monthly. We saw comprehensive documentary evidence of these meetings during our visit, through access to the organisation's intranet.
- Patient centred MDT meetings took place at GP practices, attended by PICS nurses. This included risk of admission meetings, which were attended by the care co-ordination team.
- We attended a GSF (Gold Standard Framework) meeting with staff from the palliative care team. It was held at a local GP surgery and we observed very good collaborative working with the GP, district nurse, community matron, social workers and community nurse specialist. Each patient was discussed individually. Staff told us each GP within the commissioned area held GSF meetings and every effort was made to attend as many of these as possible.
- Nurses worked collaboratively with charities such as the Red Cross and Marie Curie and other local care providers such as nursing homes and hospices.
- Staff described good collaborative working and communication with the GP and told us they could contact any GP to discuss concerns about one of their patients.
- Staff made referrals for other community services such as podiatry, phlebotomy and language translation services through another local NHS community provider's single point of access (SPA) system.

- End of life nurses told us that they attended the Nottinghamshire Strategic End of Life meetings on a rotation basis.
- Patients told us they thought the end of life team worked very well with the GPs and District nurses to provide a seamless service.

## **Referral, transfer, discharge and transition**

- Hospitals or GPs referred patients to the adult community health service. The organisation received referrals by secure fax. Staff made contact with the patient and agreed arrangements for the first appointment as soon as possible.
- Staff did not discharge patients from the community care service as the nature of their condition meant there was a need for long-term support. However, patients under the care of the service were not all active, meaning they were not receiving visits but could reactivate visits as required.
- Specialist nurses initiated direct hospital admission, in consultation with their patient's clinicians, if considered necessary.
- Nurses worked Monday to Friday from 9am to 5pm or 9am to 6pm. Staff gave patients information cards with contact details of their named nurse. Staff provided patients with telephone numbers of services outside of working hours, the nurses made sure patients, and carers knew whom to contact in an emergency.
- Community care staff could refer patients to other services provided by the organisation. For example, staff transferred patients reaching the end stages of their condition and requiring end of life (EOL) care to the EOL team.
- Referrals into the EOL service could be made by GP or secondary care services and we saw clear referral pathways for all three of the separate CCG areas. Staff we spoke with said the majority of patients knew about the referral and were happy for staff to make a referral.
- The organisation received referrals for EOL care by secure fax. There were no time targets set for referral to first visit; staff told us they would arrange the first appointment as soon as possible. The average number of days from referral to initial assessment was 18 days for Nottingham west clinical commissioning group (NWCCG) team, 11 days for the Mansfield team and 27 days for the Nottingham central team.

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- The organisation provided service reviews for all three of the CCGs. This data included numbers of referrals by GP, whether they were appropriate, sex of the patients and outcomes. It also included an estimate of the number of avoided hospital admissions for each service.
  - There were 114 referrals into the palliative care team from the NWCCG area January 2014 to September 2015, an average of 5.4 per month.
  - There were 134 referrals into the palliative care team from the Nottingham City clinical commissioning group (NCCCG) area March 2014 to November 2015 an average of 6.4 per month.
  - There were 165 referrals into the palliative care team from MACCG from June 2013 to April 2015, an average of 7.2 per month.
  - Data provided by the organisation showed palliative care nurses in the NWCCG area had seen 114 new patients and made 972 home visits from Jan 2014 to September 2015. During this period, they made 78 bereavement visits to relatives of their patients. Palliative care nurses in the NCCCG saw 109 new patients, made 1688 follow-up visits and 26 bereavement visits from March 2014 to November 2015. Palliative care nurses in the MACCG area saw 136 new patients, made 1714 follow up visits and 51 bereavement visits from June 2013 to April 2015.
  - Staff said they never fully discharged patients from the service. If a patient no longer wished staff to visit, staff would give an open appointment, so the patient could self-refer back in at any time. A data review of the NWCCG service undertaken from January 2011 to September 2015 showed, out of 301 referrals into the service, one patient had declined the service and two patients had open appointments. The NCCCG had one patient who had declined the service from March 2014 to November 2015 and the MACCG team had two patients who had declined the service and three patients with open appointments.
- within the palliative care team made additional phone calls, emails and safe haven faxes to contact GPs, to share information such as referrals and review of medications.
- The organisation provided staff with laptops so they could work from home and have access to information. Staff told us they occasionally use laptops in a patient's home to enter contemporaneous notes but this was not always appropriate.
  - Staff had password protected mobile smart phones so they could access information whilst in patient homes or travelling around if necessary.
  - Staff could access the organisation's intranet from their own homes. However all staff we spoke with chose to update patient records at the end of each working shift, at Ash Tree Court.
  - Staff had mobile smart phones so they could access information whilst in patients' homes or travelling around if necessary. The phones were password protected so staff could keep information secure. Do not attempt Cardio Pulmonary Resuscitation (DNACPR) decision forms were not uploaded to the electronic patient system because not all of the GPs were using the same system. Staff sent a copy to the GP, who was responsible for ensuring it was scanned onto EPaCCS.
  - One of the results of a staff survey undertaken in March 2016 indicated 76% of staff rated their ability to find policies and procedures as good. Service leads told us they had already responded to this result by putting shortcuts on computer desktops to make it easier for staff to locate policies and procedures.
  - Service leads told us they were planning to pilot a system of mobile working this year, which would include a system of docking stations to make access to information easier and more efficient and would lead to a fully paperless environment.

## Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed community care nurses asking for consent before undertaking any personal care or examination. For example, we observed verbal consent prior to lifting a patients clothing to enable physical examination or to take observations such as blood pressure or temperature.
- All staff we spoke with told us they had received Mental Capacity Act (MCA) 2005 training and could describe the procedures. They told us they would contact the

## Access to information

- Staff within community and palliative care used an electronic patient record system to document all patient contact. The majority of GPs within the three CCG areas used the same electronic patient system. This meant staff could share information with GPs and vice versa. Staff maintained paper records for patients whose GP practices were not using the electronic system. Staff



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patient's GP if they had any concerns. We saw "test of capacity" forms within patient records demonstrating an awareness of the MCA and documentary evidence of discussions with carers and GP's.

- Staff supported patients in their right to choose regarding all aspects of their treatment. For example, we observed a patient given detailed information about the risks and benefits of medication changes to enable them to manage their own condition effectively.
- Staff told us they had received Deprivation of Liberty Safeguards training (DoLS) as part of their mandatory training and staff training records confirmed this.
- Staff said they discussed DNACPR (do not attempt cardio pulmonary resuscitation) decisions with patients and relatives as part of advanced care planning discussions. However, staff would only discuss when a patient was ready to have those conversations. We spoke to a relative of a patient who had recently died; they confirmed there had been a sensitive conversation about a DNACPR in the last weeks of the patient's life.
- Staff from the palliative care teams told us they would always discuss DNACPR with the patient's GP and then complete the forms. Staff left original copies of the DNACPR forms with the patient at their home, nursing home or hospice. Staff kept a copy for the organisation file and sent a copy to the GP. We looked at four DNACPR forms and found they had been completed correctly. The organisation monitored the number of DNACPR forms completed as part of the service reviews but did not audit them.

## Are community health services for adults caring?

We did not rate caring for community health services for adults because we do not currently have a legal duty to rate independent community health services.

We found

- There was a strong patient-centred culture. Staff were highly motivated and provided individualised and compassionate care. Patients and relative we spoke with told us staff were exceptionally kind and caring.
- Without exception, patients and relatives told us staff were exceptionally kind, caring and had exceeded their expectations.

- Community care staff went the extra mile to help patients and carers maintain their independence. For example, staff helped with shopping when a relative was not able to and offered to be a contact point for advice when a patient was away on holiday.
- Palliative care staff gave all patients within the palliative care service the opportunity to create an advance care plan and staff discussed DNACPR decisions with patients and their relatives. We observed people's individual preference and needs were always reflected in how staff delivered care.
- Staff took part in fundraising activities in their own time to support groups their patients attended.
- Staff showed a high level of understanding and empathy in providing emotional support to patients and their carers. We saw staff reassure patients and numerous positive interactions between staff and patients.
- There was a long term commitment to supporting patients and their carers, developing trusting and committed relationships. This empowered and enabled patients to remain in their own homes for as long as possible.
- Staff ensured patients were involved in their care and treatment by making sure patients understood what they were being told. Staff allowed patients and carers time to ask questions and home visits were never rushed.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

## Compassionate care

- Feedback from people who used the service and those close to them was consistently positive about the way staff treated them. We spoke with patients and carers who said the care, treatment and compassion had changed their lives. We reviewed written patient feedback of community adult nursing services. Without exception, feedback was positive with patients thanking and praising staff. We accompanied specialist community nurses visiting patients in their homes. Their approach demonstrated a high level of individualised patient care, supporting them to understand and manage their own conditions effectively. We observed nurses providing additional support to one patient who was going abroad on holiday, the nurse explained to the

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patient how a health clinic abroad could contact her if the patient became ill or they needed advice on his condition. An offer to speak to the travelling companion in advance of travel was offered.

- Staff went the extra mile to help patients and carers maintain their independence. For example, staff helped with simple shopping when a relative was not able and a nurse brought a patient's washing in off the line when it was raining to assist the patient who had limited mobility. Staff provided patients and carers with ample time to discuss any element of their clinical condition or issues affecting their quality of life. Staff did not rush patients and allowed them to talk and express their concerns. Staff reassured patients through verbal communication and physical gestures such as handholding.
- Staff were fully committed to working in partnership with their patients to make improvements a reality. However, they knew the long-term effects of patient's chronic conditions and sensitively approached the management of deterioration and end of life care.
- Staff respected patient privacy and dignity at all times during the home visits. Staff closed curtains and doors when appropriate and always sought consent for our inspection team to be present.
- We observed nursing staff understood their patients' religious needs, for example we heard a nurse ask a Muslim patient if the appointment time would be convenient and not clash with their prayer time. Despite staff transferring patients to different teams within the provider (from adult nursing to end of life), community nurses told us they often chose to remain in contact with patients. This was because nurses got to know them and their families whilst in their care and had developed strong relationships.
- Staff took part in fundraising activities in their own time to support groups their patients attended. For example, staff posed for a calendar to raise money for a group that supported their respiratory patients.
- The organisation compiled a patient satisfaction report for January 2015 to December 2015. A total of 79 questionnaires were sent to patients within the Nottingham West and Nottingham City palliative care teams with a combined response rate of 60%. The survey results showed 100% of patients within the

Nottingham City team and 93% of patients within the Nottingham West team felt that they had been treated with dignity and respect and the service addressed their needs and priorities.

## **Understanding and involvement of patients and those close to them**

- We saw in records and through observations, patients and their carers were involved in every aspect of treatment and care planning. We observed staff discussing care with patients and relatives, ensuring they understood their treatment and condition. Patients and those important to them we spoke with told us staff gave them enough information about their care and treatment.
- Some patients we visited were dependant on their carer or partner for many aspects of their daily care. Staff were respectful of these relationships and ensured they understood the patient's condition and the treatment decisions made. For example, a patient needed their medication altering according to their daily weight. Staff explained this carefully to both patient and carer with instructions to inform the nurse by telephone of any changes made.
- Staff had eye contact with patients when asking questions, and used prompts to communicate and ensure patients understood their treatment and care. Staff allowed patients and their carers to ask questions in order to clarify anything they did not understand.
- We spoke with carers during visits who were actively involved in all aspects of care provision. They told us they were only able to do this because of the 'fantastic' support provided by the specialist nurses.
- One carer told us a nurse had recognised symptoms and helped them to access treatment for their own medical condition. The carer said they could not have managed if the nurse had not helped "sort me out".
- Staff gave patients within the palliative care service the opportunity to create an advance care plan and staff consulted patients about "do not attempt cardio pulmonary resuscitation" (DNAPCR) options. Staff discussed decisions with patients and their relatives. We observed staff always delivered care in a way that reflected people's individual preference and needs. For example, staff told us they would carefully time these difficult conversations with relatives and their carers so as not to cause unnecessary distress.

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- We witnessed a conversation between a nurse and her patient. The patient was asking the nurse how long they had to live and the nurse spoke with the patient in a sensitive and caring way, whilst at the same time giving the information the patient wanted.
- Staff told us they developed close relationships with their patients and relatives and obtained information such as social history, care preferences and special memories or anniversaries. This supported the provision of person-centred care.
- A relative of a patient who had recently died told us “they made a world of difference to me, they always listened to me and took the stress off my shoulders”.
- The organisation compiled a patient satisfaction report which was compiled for the period January to December 2015. Staff sent 79 questionnaires to patients within the Nottingham West and Nottingham City palliative care teams with a response rate of 60%. The survey results were that 100% of patients in the Nottingham City team and 93% in the Nottingham West team felt involved in their care and felt staff answered their questions and those of their relatives in a way they understood.
- Community care staff involved family members and carers with patient’s permission in care planning, offering support and advice to enable them to become involved in all aspects of the patient’s care. Carers spoken with during home visits were very positive about the support provided by the nurses. Saying ‘they understand our needs and offer great advice’ one carer said they would be unable to cope without the friendship offered by the nurses.
- Patients and carers said staff kept them up to date about latest treatments for their condition and were confident they were receiving the ‘best available’ care.

## Emotional support

- Relationships between people who used the service, those close to them and staff was strong, caring and supportive. We observed nurses make small caring gestures to the patients and relatives, such as a hug or holding their hand, and the patients seemed to appreciate these gestures and reciprocated.
- People’s emotional and social needs were highly valued by staff and were embedded in their care and treatment. We observed all staff asking patients about their social life and making suggestions to help them maintain their social contacts for example attending a social club.

- Patients’ relatives told us staff encouraged them to make contact whenever they needed additional support, which gave them peace of mind.
- Staff demonstrated a clear understanding of the impact of complex medical conditions on their patients, carers and family. Staff demonstrated empathy and discussed issues with patients and carers, often providing emotional support by allowing them to talk or answering their questions.
- Patients and carers openly discussed their need for the nurses’ support in managing their condition, saying they would not know what to do without them.

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

We did not rate responsive for community health and services for adults because we do not currently have a legal duty to rate independent community health services.

We found:

- Services were tailored to meet patient’s needs, personal preferences and they were central to the planning and delivery of individualised care.
- There was regular engagement with commissioners and stakeholders to ensure the service met people’s needs and service reviews used to demonstrate successful outcomes. For example, the number of patients who died in their preferred place of care was above 80% for all three of the clinical commissioning group (CCG) areas. Patient’s needs and wishes were at the centre of the service. Staff saw patients at their home, assessed their needs based on the patient’s own priorities and devised a plan of care, with the understanding, involvement and agreement of the patient. Patients had individualised plans of care, which took into account people’s personal, cultural, social and religious needs.
- Staff were flexible and responded to patients changing circumstances.
- Staff assisted and signposted patients to enable them to access other services, therefore giving them choices in how they were supported.
- The organisation had a complaints policy with clear timescales for responses however there had been no complaints made about the service.



# Community health services for adults

## Planning and delivering services which meet people's needs

- Primary Integrated Community Services Ltd (PICS) delivered services across four clinical commissioning group (CCG) areas. Services included respiratory, gynaecology, and heart failure services. The organisation also subcontracted a pain management service to a third party provider to provide support and pain management pathways for patients in a fifth CCG area.
- Service leads met with the CCGs quarterly to review service provision and consider future developments; we reviewed minutes of one of these meetings and saw that provision of services against patient needs were discussed.
- The organisation worked in partnership with local providers to support patients with long term conditions particularly around anxiety and depression. In addition, managers attended meetings and events to contribute to the end of life strategy for Nottinghamshire. The end of life strategy influenced the provision of services across the county for patients with mental health conditions.
- Some of the staff within the palliative care teams could verify death, which meant deceased families did not have to wait for a GP to attend. This meant families could start to make funeral arrangements. Staff told us that it was less stressful for the families than having to wait several hours for a GP to call.
- Nurses from the palliative care team wore a non-clinical uniform of blouses with skirts or trousers, which the service believes, promoted the supportive nature of the service rather than the clinical care that others such as district nurses provided.
- A member of staff we spoke with told us they were one of ten members of staff who had signed up to become a Dignity Champion (individuals or organisations who work to put dignity and respect at the heart of care services).
- Palliative care nurses were able to signpost other services for patients and carers including hospice day services, befriending, voluntary agencies and carer breaks and we saw this reflected in patient records.
- Local learning disability nurses provided a range of written information to support the community services including leaflets and visual aids.

## Equality and diversity

- The organisation had completed a Provider Equality Impact Assessment (EIA) for each of the four CCGs to ensure services did not exclude or have any negative impact on equality groups.
- There were no barriers for disabled people to access the service. Staff saw patients in a convenient place to enable free access. Patients visited by staff in their own homes who were unable to open the door had agreed arrangements for safe access. For example, we observed the use of a key safe to access one patients home.
- All staff had received equality and diversity training as part of their mandatory or induction training.
- Staff could access interpretation and translation services if required.

## Meeting the needs of people in vulnerable circumstances

- Staff explained to us, all patients visited in their own home were vulnerable due to the nature of the conditions they were living with. We observed staff being open to changing circumstances when visiting patients, this included suggesting other support services if a patient's care needs were changing or a carer needed additional support. Staff gave patients advice on small changes in daily activity or treatment to improve symptoms and have a positive effect.
- Staff worked with a range of voluntary organisations and local support groups, which they could direct people to if required. Nurses talked to patients about voluntary agencies that could help them by providing transport to support groups or offer a sitting service so the carer could go out without worry. Nurses also attended support groups to help signpost patients to other services and address low level symptoms of their conditions. This helped patients to deal with small problems before they escalated.
- A representative of a support group said, "the nurses are accommodating and will always adapt" to different situations according to patient need.
- We looked at records of palliative care patients and observed patients had individualised plans of care, which into account took peoples personal, cultural social and religious needs. Staff told us they recognised and respected the totality of people's needs and they tailored the frequency of visits to the individual's needs. Staff made extra visits if patients and carers wanted, in the last days of life for symptom control or additional support.

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- We looked at patients records and observed patients social and spiritual activities were recorded on the care plans, for example on one person's care plan we saw details of a sports club the patient attended had been recorded, in another we saw a significant anniversary had been identified.
- We saw staff give leaflets to patients and their relatives, which included information about the Primary Integrated Community Services (PICS) long-term conditions (LTC) palliative care service, DNACPR decisions, preventing pressure ulcers and local hospice day therapy.
- Nurses worked flexibly when it was required, for example, a nurse who received a call to attend a dying patient in the afternoon of New Year's Eve and had worked late to support the patient and the family in their last hours.
- Staff told us of the sensitive conversations they held with patients around do not attempt cardio-pulmonary resuscitation (DNACPR) decisions and the education and advice provided for their carers to try to avoid unnecessary calls to the ambulance service in the last hours of life, in order for patients to have a calm and dignified death.
- Nursing staff often made bereavement visits to offer support to relatives and made every effort to attend their patients' funerals.
- Palliative care team nurses issued DS1500 forms to patients that needed help to look after themselves, which allowed them to claim Disability Living Allowance from the Department of Work and Pensions.
- Staff told us they could access interpreters through another local NHS community provider's single point of access (SPA) for patients who did not speak English.
- There was access to learning disability specialist nurses working within Nottinghamshire community services. Staff attended training sessions facilitated by these nurses. We were informed of joint visits made to support the care co-ordination team when assessing patients with learning disabilities.
- Staff within the palliative care teams could access support from another local provider to assist with the care of patients with learning disabilities. Staff gave examples of joint working and visits with specialist nurses from a provider who also had leaflets and visual aids.

- Patients with a primary diagnosis of dementia did not fit the referral criteria for this service. However, the service would continue to treat patients living with deteriorating dementia and access other specialist teams so that patients could have continuity of care.
- Staff were able to signpost patients to voluntary organisations and local support groups if required

## **Access to the right care at the right time**

- Services provided by community adult nursing were through health professional referral only. There is no national referral to treatment time measure for these services. However, staff applied consideration of prioritisation to urgent referrals. The service did not provide emergency care.
- Data provided by the organisation showed referral to initial treatment times for community health services for adults were - heart failure 19 - 24 days, atrial fibrillation 18 days, care co-ordination 14 days, respiratory care 14 days and pain management 21 days. Gynaecology was a new service (two months) and therefore referral to treatment data was not yet available. No targets had been set concerning referral to treatment times.
- Staff visited patients in their own home, care/residential home or clinic. This was organised by the administration team who applied flexibility to meet individual needs and preferences. One clinician told us 'the support from the clerical team is excellent and super-efficient. There were very rarely vacant slots and the team went out of their way to contact patients in order to fill slots resulting from cancellation. On one occasion an urgent appointment was arranged for a patient for the next working day, this was communicated with the clinician by text and all arrangements made despite the request being made outside of working hours (after 5pm).
- Staff agreed appointments with patients and a letter of confirmation sent one week prior to the appointment. We viewed a sample letter and found it to be clear and informative with a contact number for advice, cancellation or reorganisation.
- Patients were encouraged to ring at any time during working hours if they had a concern or felt they needed someone to visit. Patients told us they felt comfortable to ring and staff would always respond to them as soon as possible.

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- Staff gave patients a choice of appointment times wherever possible. Staff provided patients with names and contact numbers to book, alter appointments or to ask a question relating to their treatment.
- Palliative care nurses followed the Gold Standard Framework (GSF) and had advanced care planning discussions with their patients. One part of this process was to ask the patient where they would prefer to be cared for in their last days of life. Data provided by PICS showed the number of patients who died in their preferred place of care; for the NWCCG area from January 2015 to September 2015 was 81.3%, for NCCCG from March 2014 to November 2015 was 80% and, for MACCG from June 2013 to April 2015 was 95%. This compares to a national average of 45-50%.
- Staff gave patients cards with the contact numbers of staff members within the teams. Patients told us they knew the working hours of the service and were encouraged to ring at any time during working hours if they had a concern or felt they needed someone to visit.
- Staff provided patients with contact numbers for out of hour's services so they knew whom to contact in an emergency. We accompanied a palliative care nurse to a patient's home and observed the nurse make sure the patient understood there was a bank holiday the following week and had all the emergency numbers to hand.
- Staff told us they had access to a phlebotomy service for their patients, but they would often take any bloods required during their home visit so patients did not have to make or wait for further appointments. Similarly staff and service leads told us palliative care nurses would administer the flu jab to their patients during the home visit if the patient wanted it.
- We observed staff from the palliative care teams made the next appointment for their patient whilst at the home and ensured the patient understood they could rearrange the appointment if it was not convenient.

## Learning from complaints and concerns

- The service received one complaint for the period April 2015 and March 2016. The complaint was about the organisation sending a confidential letter to the wrong address and therefore breaching patient confidentiality. We reviewed the complaint investigation and saw the complaint investigation was robust, with identified

learning and actions. We saw managers informed the complainant of progress against the complaint at each point including when the investigating did not meet timescales set out in the trust policy.

- We saw the organisation informed the patient and recipient of the letter of the error. The patient was offered a full apology in the complaint outcome letter. The organisation had been open and transparent throughout the complaints process.
- Managers shared learning from the complaint with all staff across the organisation through staff meetings. All staff we spoke with knew about the complaint received and could describe the lessons learnt as a result.
- Staff told us they gave a complaint information leaflet to all patients at the first visit with details of who to contact to make a complaint. A patient we spoke with confirmed they had received such leaflet. The leaflet gave details of how to raise a concern and which organisations existed to support them if they were dissatisfied with the response provided.

## Are community health services for adults well-led?

We did not rate well-led for community health services for adults because we do not currently have a legal duty to rate independent community health services.

We found:

- The organisation had a clear strategy for the service and this was evidenced in both strategic and operational meetings. We saw evidence that staff had contributed towards the strategy.
- The organisation had clear vision and values. Managers developed vision and values in consultation with staff through a series of workshops and events. All staff we spoke with knew about and demonstrated enthusiasm for the vision and values.
- There was a common focus within the organisation on improving the quality of care and people's experiences. The service celebrated staff innovation and managers encouraged staff to suggest and implement improvements and innovations.

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- There was an effective clinical governance structure in place and service leads demonstrated they understood and were managing the risks to their organisation. The organisation worked collaboratively to improve services and care outcomes.
- Staff we spoke with spoke positively about managers. We were told both the managing director and medical director were approachable, visible, and cared about staff members as individuals
- We found there were high levels of staff satisfaction and engagement across all staff groups. Staff were proud to work for the organisation and spoke highly of the culture. We saw examples of where managers made changes as a result of staff feedback.

However we also found:

- The organisation did not meet regulatory requirements regarding the Fit and Proper Person Requirement (FPPR). The organisation did not have documentation in place to assure board members were fit to undertake their role.

## **Governance, risk management and quality measurement**

- The organisation had recently been through a restructure and was in a period of transition. Managers were working towards the new board structure to be in place by September 2016 and there was an action plan to support this work. The organisation was to recruit a non-executive chair and non-executive directors to the board and expand the board membership. The new structure would help to increase accountability for the managing and medical director to perform against the new five-year strategy.
- Service leads had a long-term strategy working towards becoming a Multi Specialist Community Provider (MCP) as detailed in the NHS England five year forward view. This was a new model of care using community health services and hospital specialists in a shift towards community rather than hospital based outpatient consultations.
- We found there was a clear strategy and vision for the community adult nursing service. The vision was ‘to provide local, integrated community and primary care services that are clinically led, sustainable, innovative and create individualised patient care of the highest quality’. We saw a draft five-year plan and managers were due to present it to the board in May 2016. Staff

told us some parts of the plan had come from the multi-disciplinary (MDT) meetings and staff had been included in the formulation of the plan. We saw in minutes of meetings evidence of managers and staff discussing plans. A strategic objective was ‘to invest in our staff and provide a great place to work’.

- Service leads told us they were developing joint pathways with providers within south Nottinghamshire to expand community services provided by the organisation as part of the ongoing strategy.
- The vision and values for the service centred on “PICS Cares”. Managers had developed PICS cares in consultation with staff through a series of workshops and events. The vision and values represented the organisations commitment to putting patients first. All staff we spoke with knew about and demonstrated enthusiasm for the vision and values.
- The service had a business development manager responsible for developing business opportunities and plans against the strategy. The business development manager presented organisational business plans to commissioners supporting the development of the organisational strategy.
- The service celebrated staff innovation and managers encouraged staff to suggest improvements and innovations. For example, we spoke with a nurse who had identified issues with the use of syringe drivers for symptom control within some nursing homes and who had wanted to deliver some teaching and training to the nursing home staff. They had been encouraged by service leads to discuss the issue with the CCG and been supported to write a business plan which would improve the care and experience of patients.
- We looked at minutes of MDT meetings and saw evidence of staff making suggestions for service improvement. One example was to explore the use of social media to provide patients with information on a range of topics.
- All staff were actively involved in activities to monitor and improve quality and outcomes. This was recognised by a commissioning group who nominated the team to the NHS Alliance for a clinical leadership award, for which they were successful.
- The organisation had been commissioned to provide a unique community gynaecology service. This enabled patients to see a GP with a special interest at one of two GP practices, avoiding the need for a hospital visit. All non-surgical gynaecological conditions could be seen in

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the clinic. Full support for this service was being provided by a consultant gynaecologist and diploma level training provided for the identified GPs with a special interest.

- The organisation worked collaboratively with other providers to form the South Nottinghamshire Provider Alliance. Service leads told us being part of this alliance allowed PICS to bid for services which otherwise would be too large for them to manage as an individual organisation.
- The medical director was the respiratory clinical lead across the wider health community. He had presented at the East Midlands Strategic Clinical Network chronic obstructive pulmonary disease (COPD) event in November 2015.
- The respiratory service had taken part in a regional breathe easy conference (March 2015) giving a presentation on their purpose of supporting patients and their carer to manage chronic respiratory disease in the community and prevent hospitalisation.
- Palliative care nurses from PICS have been working with Nottingham West CCG, the British Lung foundation and Breathe Easy Nottingham West in the government funded NESTA Project. The project aimed to boost respiratory support for patients and the results were due to be published later in 2016.
- Staff and managers worked towards educating other providers as to their role and remit, and by building relationships with other local providers, for example, staff were attending the local Community Matrons Forum. This was in response to recommendations from a commissioner regarding integrating their services with other providers in the area.
- Service leads told us the planned pilot to use electronic tablets and docking stations for remote working. This would make access to information easier and more efficient for example securely and remotely accessing case notes. This was planned for the next 12 months.
- Managers engaged with staff about most areas of the running of the organisation. Staff said they felt involved and could contribute to the way their services and the organisation was run. Managers engaged staff through team meetings, emails, and face to face contact.
- The service held regular staff meetings where everyone was invited and all contributions welcomed. Managers engaged with staff about most areas of the running of the organisation. Staff said they felt involved and could contribute to the management and running of services within the organisation.
- Data from a staff survey commissioned in March 2016 indicated; 82% of staff felt they had job satisfaction, 83% felt supported by their colleagues and managers, 85% felt they had good inter-staff relationships and 83% described communication as good. Managers had responded to the staff survey, by producing a “you said – we did” poster and had worked with staff to plan whole team weekend leisure activities. Managers had also recently introduced a quarterly newsletter in response to staff feedback.
- The organisation had limited public engagement pathways. Managers said they used other engagement networks through voluntary organisations, GP patient participation groups, and CCGs. In addition managers used patient feedback via their own patient satisfaction surveys and complaints procedure. Managers were working towards setting up their own engagement groups and this had been identified as a priority going forward.
- The service conducted patient surveys for commissioners and a patient representative from Healthwatch attended the 2015 Nottingham West Service Review. Staff name badges and titles were reviewed as a result of stakeholder feedback from the external review.
- The palliative care nurses attended Breathe Easy support groups which are organised by the British Lung Foundation and which support patients living with a lung condition. The service was planning similar engagement meetings with heart failure patients. Staff attended voluntary groups for patients with long-term conditions. Nurses talked to patients and provided information about the service to prepare them for discussions around dying.
- The medical director and nursing staff worked closely with voluntary groups for patients with long-term conditions. They attended meetings and gave talks on managing conditions and answered any patient questions. A representative from one group said nurses improved the speed of patients’ access to oxygen after feedback from members of the group.
- Service user and stakeholder engagement was included in the Contract and Service review for Mansfield and Ashfield CCG.



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- The service provided the inspection team with a list of patients and carers who were willing to receive telephone calls from a care quality commission inspector. We spoke with three patients and two relatives of patients who were all very positive about the service provided.
- The medical director and nursing staff worked closely with voluntary groups for patients with long-term conditions. They attended meetings and gave talks on managing conditions and answered any patient questions. A representative from one group said nurses improved the speed of patients' access to oxygen after feedback from members of the group.
- Staff attended the Strategic End of Life Steering Group meetings for South and Mid Nottinghamshire and have presented at the Dying Matters event.
- There was a common focus within the organisation to continually improve the quality of care and people's experiences. Staff innovation was celebrated and suggestions for improvements encouraged. One member of staff told us "Patients are at the centre of everything we do". Patients we spoke with confirmed they felt in control of their own care and fully involved in all of the decision-making.
- We found there were high levels of morale and staff satisfaction across all speciality groups. Staff were very proud of the organisation, the way the service had developed and in particular, the personalised service they provided for patients.
- All staff spoken with told us of a positive open culture within the organisation. Staff described not wanting to work anywhere else. One member of staff told us "this is the best organisation I have worked for in my 30 years".
- Staff said they were treated with respect and their opinions were valued. Staff regularly had conversations about the service in an open environment and the managing director has an "open door". We observed staff from all levels of the organisation talked to each other professionally, respectfully and at an equal level.
- The managing director had an "open door" policy and was actively involved in the staff appraisal process and clinical supervision. Staff respected and liked the managing director for their hands on approach and this approach set the tone and culture of the organisation.
- There was a clear structure of leadership within the organisation, overseen by a board of directors. The medical director had overall clinical responsibility and worked closely with the clinical service teams. The managing director, supported by the operations manager oversaw the financial and business development of the company.
- The managing director had an external mentor, who supported them to improve the leadership skills needed to manage the transition phase of the organisation. The managing director provided open and visible leadership throughout the transitional period, which staff said helped them feel comfortable and happy through the change.
- An operations manager had recently been appointed following recognition of an over reliance on a small number of key personnel, including the managing director. The operations manager had been recruited from within the organisation and therefore had a good understanding of the service.
- All staff, without exception, were positive about the leaders and told us they were supported and respected in every element of their work. Staff said both the managing director and clinical director were approachable and visible, motivated staff and cared about staff members as individuals. Leaders had an open door policy and staff could approach them at any time. We saw many positive interactions between staff and their leaders. One member of staff said, "the managers are great, they are the reason I would not want to work anywhere else". We heard and saw examples in staff files of managers supporting staff.
- The Fit and Proper Person Requirement (FPPR) places a requirement on providers to ensure directors and board members are fit and proper to carry out these roles. The organisation had a FPPR policy, which contained the criteria and processes for checking whether current and newly recruited board members were fit for their role. This included a checklist of evidence required and a self-declaration form.
- We checked the employment files for four directors, including the managing director. We saw the organisation had not collected all the evidence in order to assess the fitness of staff to undertake the role. One out four directors did not have a recorded DBS check. None of the files had capacity, capability or occupation health checks. Therefore, there was no assurance of director's capability, health status or capacity to undertake the role. One file did not have photo identification.

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- A remuneration committee was due to start in May 2016 to oversee recruitment of board members, including responsibility for ensuring board met FPPR requirements. The committee had a term of reference and a clear role. The organisation had developed induction packs for new board members in anticipation of recruitment. After the inspection the organisation confirmed they had sought further assurance on the relevant director's competency to hold a senior position. The organisation also said, "We have reviewed our policy to state that any self-declaration subject is subject by occupational health in order to make reasonable adjustments as required".
  - There was positivity from all leaders about the future development of the organisation and its sustainability. Leaders understood challenges presented to staff and where possible supported them to overcome challenges and difficulties.
  - Service leads contributed positively to the inspection process by identifying patients who were willing to allow us to accompany nurses on home visits and by providing a list of patients who were happy for us to telephone them to discuss their experience of the service. This meant we could talk to more patients and relatives and get a wider range of feedback about the service.
  - Service leads told us they measured the quality of the service in a variety of ways. The CCGs had set objectives, which included patient experience, financial effectiveness and activity levels, and these were included in the service reviews. They also said, as this was a non-profit making organisation, the shareholders were concerned with patient outcomes. One member of staff we spoke with told us "quality has always been more important than numbers".
  - This service had not benchmarked their outcomes as this was a unique service and there were no comparable services.
  - The organisation had a clinical risk register, which included the community adult nursing service, and we looked at the action plan for the risks recorded. We found the service managed risks appropriately; staff took ownership of actions and recorded target dates for completion of actions. Staff and managers knew of the key risks to the service. This included capacity management.
  - The service leads demonstrated they had a clear understanding of the external risks to their organisation.
- They also told us they knew the risk of getting too big too quickly, which could impact on their ability to maintain current levels of service, and the need to develop services were financially viable.
- The organisation had a conflict of interest policy and systems to ensure there were no conflicts of interests with commissioners. This was because the organisation was owned and managed by GPs and many GPs were also involved in commissioning services. Any CCG board members could not be shareholders in the organisation. We spoke with commissioners who were assured there were no conflicts of interest.
  - The organisation subcontracted a carpal tunnel and pain management service to third party providers. We reviewed the contract arrangements and saw systems in place to manage and monitor the contracts. Where necessary the organisation had requested details about finance and suitability of staff delivering the services. We spoke with commissioners who said they had no concerns regarding these contract arrangements.
  - Staff and managers worked with GPs and other providers to improve care and outcomes for patients. However, they had not benchmarked their outcomes as this was a unique service and there were no comparable services.
  - There were ongoing changes in the governance structure due to organisation increasing in size. The organisation was to recruit a non-executive chair and non-executive directors to the board. The non-executive directors would oversee and take responsibility for different areas of the organisation including Clinical Governance.
  - The organisation had a range of strategic and operational meetings to manage risk, performance and quality. We saw clear lines of communication up and down the organisation and evidence of discussion of key issues. Discussion at operational level reflected discussions at strategic level.
  - The organisation had introduced a new clinical governance framework in January 2016, which included the formation of new monthly clinical governance and risk meeting. The clinical governance meeting had held four meetings to date at the time of inspection. Minutes of the meetings were brief but we saw it reviewed significant events, risks and safeguarding concerns. The meeting identified actions and learning which also included dissemination of learning.

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- The organisation held executive and management meetings monthly and board meetings held bi-monthly. This meant there was regular oversight of strategy, risks, and performance. Minutes of board meetings showed they discussed strategy, performance in each clinical commissioning group area, and staff feedback. In addition, the board discussed new local and national models of care for example, seven day working for GPs and the impacts on the service. This meant the board had a clear direction of strategic travel using performance and staff feedback.
- Staff held monthly team meetings and bi-monthly multi-disciplinary team (MDT) meetings. We reviewed the minutes of a clinical team meeting from 2nd March 2016, which was attended by the medical director, operations manager and nursing staff. Managers discussed quality issues, referrals, review of incidents, risk and plans with staff.



# Outstanding practice and areas for improvement

## Outstanding practice

- Primary integrated community services Ltd (PICS) provided exceptional, individualised person centred care to adults with long term conditions including chronic obstructive pulmonary disease, heart failure and atrial fibrillation. Staff were highly trained and were able to practice as independent practitioners supporting patients to manage their own conditions and avoid hospitalisation.
- Palliative care nurse input contributed to a high proportion of patients making advance care decisions and dying in their preferred place of care. Service reviews demonstrated the number of patients who died in their preferred place of care was above 80% for all three of the clinical commissioning group (CCG) teams.
- Staff were kind, compassionate and we saw numerous examples across services of positive interactions and involvement of care between staff and patients.
- Palliative care nurses worked 9am to 5pm Monday to Friday but would work flexibly within, and sometimes outside of these hours, provide care and support to patients and relatives at a time of greatest need.
- Staff went out of their way to support their patients. Nurses took prescriptions to pharmacies and made arrangements for a patient who was travelling abroad for a long awaited holiday to call them if they were concerned in any way about their condition or medication whilst out of the country
- Staff referred patients who were prescribed oxygen at home to the Fire Safety Officer for a comprehensive risk assessment. Staff mitigated risks where possible for example, staff told us about patients who were prescribed oxygen who wished to smoking. Patients were given fire retardant blankets and nursing staff would educate patients of the associated risks of smoking whilst on oxygen.
- There was positive use of smartphone technology with selected heart failure patients inputting daily information to support their treatment plan. Staff had an application on their mobile phone, which allowed them to input data such as daily weight, which the nurses could access to monitor the effectiveness of treatment. Patients could also access information about their condition through the system.
- We saw numerous examples of staff involvement in developing organisation values, vision, and strategy. All staff said they felt they could influence change and managers worked collaboratively with staff to help them feel connected.
- Leaders were visible and supportive of staff both personally and professionally. We saw an example of managers encouraging and supporting a member of staff to write a business plan to introduce training into care homes.
- There was a highly motivated patient centred and supportive culture within the organisation. Staff put each other and patients first. All staff we spoke with liked working at the organisation and morale was high across all staff groups.
- Staff raised money in their own time for support groups that their patients attended.

## Areas for improvement

### Action the provider **MUST** take to improve

The provider must ensure Fit and Proper Person Requirements for board members are evidenced and available to assure themselves that directors have the capacity and capabilities to undertake the roles.

### Action the provider **SHOULD** take to improve

- The provider should ensure staff know about the Duty of Candour and how it applies to them in their roles
- The provider should ensure staff receive the appropriate level of safeguarding training so they can identify when patients are at risk of abuse and harm.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors</p> <p>(5)The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or (b)—</p> <p>(a) the information specified in Schedule 3</p> <p>How the regulation was not being met:</p> <p>The provider did not have all the information for directors relating to schedule 3 of the regulations available to the commission on inspection</p>