

East Coast Community Healthcare C.I.C.

ID 1-286186558

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-534527352	Beccles House	Community team	NR34 9BN
1-295368690	Beccles Hospital	Community team	NR34 9NQ
1-548207916	Gorleston Medical Centre	Community team	NR31 7BU
1-2682497103	Kirkley Mill Surgery	Community team	NR33 0HF
1-199716099	Martham Health Centre	Community team	NR29 4QG
1-295435621	Northgate Hospital	Community team	NR30 1BU
1-2036115722	Sole Bay Health Centre	Community team	IP18 6GY

This report describes our judgement of the quality of care provided within this core service by East Coast Community Healthcare. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by East Coast Community Healthcare and these are brought together to inform our overall judgement of East Coast Community Healthcare

Summary of findings

Ratings

Overall rating for the service		Good	●
Are services safe?		Good	●
Are services effective?		Good	●
Are services caring?		Good	●
Are services responsive?		Good	●
Are services well-led?		Good	●

Summary of findings

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Summary of findings

Overall summary

Overall, we rated East Coast Community Health as good for Adult Community Services because:

- Patients were protected from harm with effective infection prevention and control processes in place and there was evidence of robust investigation of incidents and good dissemination of lessons learned.
- Staff had the appropriate skills and knowledge for their roles and received regular mandatory training and supervision. The organisation actively supported staff to develop and extend their knowledge and competencies, and supported staff with external training and secondments.
- Patient treatment was evidence and national guidelines based and staff met key performance indicators ensuring patients received the right care at the right time.
- There was excellent demonstration of multidisciplinary working within the organisation and with external agencies such as local acute care providers and adult social care.
- Staff treated patients with kindness and compassion and respected patient's dignity at all times. We saw staff involving patients and their families in decision making about their care and providing emotional support with great depth of understanding.
- We saw staff in the hospice at home team completing care visits for patients near the end of their life with kindness, sensitivity and compassion. Staff tailored assessments and treatment to each patient's individual needs and made sure that each patient's wellbeing was their priority.
- The staff covered a diverse geographical area but had a good understanding of the differing needs of the communities they served. They made adjustments and allowances to account for patient preferences.
- The hospice at home service provided visits to patients that were flexible dependent on patients' needs and preferences.
- Complaints were investigated and managed appropriately in a timely manner with learning identified shared with staff.

- Staff were supported with strong local leadership in the community nursing and OOH teams and felt valued by their teams and the organisation.
- The organisation was pro-active in celebrating staff achievements with several members of the adult community teams receiving awards recently.

However:-

- We had concerns regarding patient safety following the temporary suspension of twilight shifts for the community nursing service due to staff shortages. This was being monitored daily. There were six whole time equivalent qualified community nursing vacancies and one band seven post vacant. There was also a high level of sickness which had impacted on workload.
- Individual risks to staff were attached to the patient's electronic record and there was no local risk registers to monitor local risks, therefore we were concerned that there was limited oversight of these risks. There was a lack of oversight of risk assessments relating to individual patients.
- We found three items out of 14 pieces of equipment in use that were not fit for purpose because they had failed or were out of date for maintenance testing.
- There were rural areas where staff did not always have connectivity to the live electronic patient records system and they were unable access or update patient information. Patient risk assessments were not always completed or reviewed appropriately.
- There was a disconnect between the junior staff and the executive team due to poor cascade of information. Junior staff had little or no knowledge of audit or process managed by the executive team, although all the staff we spoke to were aware that they could attend governance meetings, none of them had done so.
- Hospice at home staff were not engaged in interpretation of audit at a local level and there was limited audit of patient outcomes. We did not see evidence of audit being used to drive improvements in the service. However, we acknowledge that the hospice at home service had only recently been set up.

Summary of findings

Background to the service

East Coast Community Healthcare (ECCH) is a registered Community Interest Company (CIC) which is owned by its staff. Prior to the 1st October 2011, they were part of NHS Great Yarmouth and Waveney PCT which was required to divest its community services under Department of Health policy. The population served is around 230,000 people with approximately 70,000 people registered as service users. At the time of inspection, ECCH provided adult community services on behalf of the local NHS commissioning groups and two local county councils.

The community nursing service is the largest proportion of the adult community workforce covering the north and south of the area. The community nurses provide nursing care in people's homes with 44,565 patient contacts made between June 2015 and May 2016. The adult community service also provides a separate out of hospital service (OOH team), again divided into North and Lowestoft teams for admission prevention and those discharged from acute care but still requiring nursing input. The OOH team have access to designated 'beds for care' within local residential homes for patients requiring nursing care or supervision for a period of up to two weeks.

Specialist clinics are provided for continence care, chronic fatigue syndrome/myalgic encephalopathy (CFS/

ME), neurology and chronic respiratory conditions. The service also provides podiatry clinics, leg ulcer clinics, rehabilitation, physiotherapy and occupational therapy. Services and clinics are offered at multiple locations.

The hospice at home service provided end of life care for patients over the age of 18 who were in the last weeks or days of life. These patients were identified through use of the Gold Standards Framework, which is a framework for identifying patients with end of life care needs. From November 2015 to October 2016, there were 118 deaths of patients under the care of the hospice at home team. The service did not record information on whether deaths were related to cancer or other causes.

The hospice at home service offered patients holistic assessment, support with personal care, short respite visits and support with prevention of pressure areas. The service was available seven days a week from 8am to 10pm.

During the inspection, we spoke with 46 members of staff including a deputy director of adult community services, clinical services co-ordinators, community matrons, district nurses, community nurses, healthcare assistants, physiotherapists, occupational therapists and student nurses, and 18 patients and relatives. We observed 12 episodes of care and reviewed 16 patient care records and six medication records.

East Coast Community Healthcare C.I.C.

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There was a positive, no blame culture towards incident reporting with robust mechanisms to investigate and learning from incidents.
- There was good adherence to infection prevention and control policies in patient contact episodes.
- Staff had a clear understanding of their safeguarding responsibilities and there was evidence of good uptake of training, although staff did not always know which level training they had received.
- Mandatory training was reported as 89%, and was well monitored by local leads.
- Medicines were managed safely and staff had the appropriate training to administer medication.

However:

- Some equipment was not always fit for purpose, we found items in use that were either out of date or had no date for maintenance testing.
- Nursing vacancies impacted on the community nursing service ability to provide 24 hour care.

- Patient risk assessments were not always completed or reviewed appropriately.
- Staff told us that they did not receive information concerning harm free care.

Safety performance

- The organisation participated in the patient safety thermometer to monitor harm free care. Staff captured data over the course of one day each month and looked at harm from falls, pressure ulcers, venous thromboembolism, catheter issues and urinary tract infections. Staff received a text message reminder on the set day, to collect the data required. We asked team leads to show us the safety thermometer data and they were unable to provide this.
- The community nursing bases we visited did not display the safety thermometer data and managers did not have access to the safety thermometer data, which was collated centrally and held at the head office. We did not see any evidence that the results of the safety thermometer audits were shared with staff who told us they collected the data on a monthly basis but were unable to tell us about the results.

Are services safe?

- Senior staff in the hospice at home service monitored information on safety outcomes, including pressure ulcers and falls. This was reported in a clinical quality report, which was shared with leaders of the organisation at the Integrated Governance Committee. This meant that leaders of the organisation had regular updates on the safety performance of the service.
- We saw the clinical quality report for September 2016. This showed that from October 2015 to September 2016 there were two patients who acquired pressure ulcers while under the care of the hospice at home team. Senior staff told us that safety outcomes including pressure areas, falls, urinary tract infections related to catheters and venous thromboembolism (VTE) were discussed and analysed at a 'four harms meeting'. This was a monthly meeting attended by community nurses, senior inpatient nurses, the organisation's quality manager and tissue viability specialist nurses. Senior staff in the hospice at home team told us they attended this meeting and shared learning on how to improve safety outcomes with staff. Minutes of the meeting showed these items were discussed.

Incident reporting, learning and improvement

- There were no never events reported during the period September 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The organisation reported 2,306 incidents in total for adult services for the period September 2015-August 2016.
- There were 49 serious incidents requiring investigation during the reporting period, none in the hospice at home service. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in an unexpected or avoidable death of one or more patients, staff, visitors or members of the public, or serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm. We reviewed the root cause analysis of four serious incidents and found them to be thorough, with appropriate recommendations for learning. We reviewed the incident data provided and saw that it recorded a comprehensive range of incidents affecting patients and staff, including pressure ulcers, slips, trips and falls, medication incidents. Pressure sores and decubitus ulcers accounted for 42 of the 49 serious incidents, 1155 of the 1244 moderate incidents and 68 of the 187 low harm incidents reported. Of the 1267 pressure sores reported, 745 had not developed in the providers care leaving 522 that had. The provider undertook analysis of pressure sore incidents to assess whether they were avoidable or not. The results for the reported period showed 64 were avoidable, 1025 were unavoidable and 178 were undetermined from the total of 1267.
- A breakdown of incidents reported in the October 2016 Clinical Quality report demonstrated a robust monitoring and investigation procedure in place.
- Staff reported incidents regarding events that adversely affected patient care or outcomes for patients and staff, and they were open, transparent and honest about reporting incidents.
- There was a positive attitude towards incident reporting and staff were actively encouraged to report incidents.
- Incidents were reported using an electronic system. Once reported, managers reviewed the incidents and, where necessary investigated. All of the staff we spoke to, who were responsible for investigating incidents, told us they had received root cause analysis (RCA) training.
- We spoke to 16 members of staff about incident reporting and all staff reported that they were able to access the electronic reporting system and that they had feedback about incidents and learning in team meetings. One example given was the difficulty in locating advanced directives for end of life patient being cared for at home. A yellow folder is now provided for keeping the documents at patient's homes so that all staff can locate it easily.
- We reviewed minutes for a nursing team meeting for August 2016 and saw that the nursing team's incidents were discussed and learning shared in the meeting. We also reviewed the standardised template for the team meeting minutes, which included incidents reported and learning outcomes as a standing agenda item.

Are services safe?

- We spoke to five of the community nursing team leads, and they told us that staff had access to the incidents on their work laptops. They also told us that staff were reporting incidents appropriately and would discuss any issues regarding incidents.
- Clinical services co-ordinators told us that they had oversight of all incidents raised by staff in the community nursing teams. We spoke to two specialist nurses about incident reporting and both reported that they had oversight of all incidents relating to their specialities and gave example of recent incidents reported relevant to their speciality.
- The tissue viability team had developed a checklist to determine whether a pressure ulcer was avoidable or unavoidable, and carried out a full root cause analysis on all pressure ulcers that were deemed as avoidable and reported as a serious incident. This tool reduced nursing time taken to complete the full root cause analysis for unavoidable pressure ulcers.

Duty of Candour

- Staff knew about their duty of candour responsibilities under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was introduced in November 2014. “The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.”
- The clinical services co-ordinator and the team leads were able to demonstrate the full duty of candour process using scenarios. They also told us that the patient advocacy and liaison service generated patient letters centrally from head office. However, the band five staff nurses and healthcare assistants were not involved in the process of face-to-face apologies or the follow up letter.
- Staff gave examples of when duty of candour had been applied, such as when avoidable pressure areas had developed.
- We reviewed a letter sent to a patient following the development of a grade three pressure ulcer, the letter did not contain the outcome of the root cause analysis. The letter contained contact details for the patient to request the outcome of the root cause analysis.

- We asked three members of the hospice at home staff about duty of candour and all of them were aware of their responsibilities.

Safeguarding

- The provider reported one safeguarding concern during the period September 2015 to August 2016. The safeguarding concern was reported to the local Multi-Agency Safeguarding Hub team and investigated.
- Information supplied by the provider showed that at the time of reporting 92.6% of adult community staff were up to date with safeguarding level two training.
- Staff we spoke with were knowledgeable about the safeguarding policy and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse and all had recently received training to recognise religious radicalisation.
- We spoke to five members of staff in the north community nursing team about safeguarding and all reported that they had completed training in safeguarding adults to level two and also children safeguarding training, however only one member of staff knew what level training they had completed for safeguarding children.
- The community nursing staff we spoke to in the south team all confirmed they had received safeguarding training and were up to date. However none of the staff were able to tell us which level safeguarding training they had received (level two) until they had checked their records.
- The staff members gave us examples of situations where they would raise safeguarding concerns and knew the procedure to follow.
- We saw information about the safeguarding lead and contact details and safeguarding flow charts on notice boards in all of the community nursing bases we visited. The flow chart demonstrated the local safeguarding process for staff to follow in the event of a safeguarding concern.
- One of the community matrons told us that she was a safeguarding champion for her team and felt comfortable with raising safeguarding concerns. She also reported that she supported her colleagues through the process of raising safeguarding concerns.

Medicines

Are services safe?

- The provider had a 'Policy for Safe and Secure Handling of Medicine (Version 5: November 2014)', the policy was within the review date. Areas covered by the policy were transcription of prescribed medicines, transportation, staff role and responsibilities and reporting of errors and near misses.
- We saw that staff had to complete an additional training course and pass an examination to transcribe prescribed medicines. A second nurse who had completed the transcription training checked the transcribed medicines in all cases. We reviewed the staff transcription register and the standard operating procedure for transcription and had no concerns.
- Staff used a red bag for the storage of end of life drugs in a patient's home. The nursing staff sealed the red bags with a security-coded tag; and recorded the tag serial number in the patient record.
- We saw that staff used medicines administration record cards to record all medication given to patients. These cards also recorded any patient allergies and weight, with pages dedicated to regular medication and separate pages for insulin prescriptions.
- We saw that a nurse used a syringe driver prescription and administration record shared with the local NHS trust for end of life patients. The shared charts aimed to increase continuity of care across both services. The record also had guidance for the nurses to give break through pain relief.
- We reviewed two medication charts and in both cases, we saw that the transcriber had recorded the patient's allergies and signed and dated the prescriptions.
- We observed the administration of medication with three patients and found them to be compliant with local policy.
- End of life medicines were prescribed by GPs or by the specialist palliative care team employed by the local acute hospital. Staff told us that palliative care consultants from the local acute hospital could provide specialist support for patients with complex symptom control needs.
- District nursing teams provided day-to-day management of syringe drivers in patients' homes, including re-filling of syringe drivers. There were two registered nurses in the hospice at home service who supported the district nursing teams with management of syringe drivers on an ad-hoc basis. Both nurses in the hospice at home service had completed training on syringe drivers in the last year.

- The syringe drivers used by East Coast Community Healthcare (ECCH) staff in the community hospital and in patients' homes were the same as those used in the local acute hospital. This meant that if patients were discharged with a syringe driver from the acute hospital, staff within ECCH were familiar with this equipment.
- Medicines were delivered to patients by pharmacies or were picked up from pharmacies by patients' carers. This was in line with the organisation's Safe and Secure Handling of Medicines Policy, 2014.

Environment and equipment

- All of the ECCH areas we visited were visibly clean and free of clutter, with several of the areas and offices used being new or recently renovated.
- Staff visited people in their own homes and took equipment needed with them and occasionally left dressings and sharps bins in people's homes for regular use. We checked four sharps bins and they were assembled and dated correctly.
- All equipment and dressings were stored in well-organised storage cupboards in each community nursing base. One of the clinical services co-ordinators told us that administration staff monitored the stock levels and they re-ordered equipment when the stock reached a minimum level.
- The staff at Beccles hospital pre-prepared the following day's equipment and dressings ready for staff to collect and take out on visits. Staff told us that this ensured that the correct dressings were available and reduced the amount of stock that required ordering on a regular basis.
- We reviewed the equipment servicing logs at Shrublands Medical Centre, Sole Bay Health Centre, Northgate and Beccles hospitals community nursing bases. We found up-to-date equipment logs and all equipment booked to staff or patients. However, we found that one syringe driver allocated to a patient was due for electrical safety testing in June 2016. The records showed that this piece of equipment had been not been tested as scheduled.
- Staff in the south community teams were using two manual blood pressure recorders that were either uncalibrated or had failed their most recent calibration test. The staff immediately withdrew the items from service when this was pointed out. The rest of the 14 pieces of equipment we inspected was up-to-date with evidence of electrical safety testing.

Are services safe?

- We looked at a community nurse dressing bag and found one item that had expired in September 2016 out of 22 dressings and dated sundry items.
- We sampled a range of dated disposable items from the community nursing bases and found that all items were stored correctly and within the expiry date.
- We saw grab boxes with syringe driver equipment were available to the nursing staff in all community-nursing bases. The boxes aided the nursing staff to attend end of life patients more quickly with all the required equipment in place so nurses did not have to spend time gathering the equipment before leaving the base.
- Staff delivered inflatable pressure relieving mattresses and cushions to client's homes from a small stock kept at bases. When no longer needed they were returned to the supplier for decontamination and refurbishing. Any other equipment was ordered through a central system and staff told us that it usually arrived within a couple of days.
- Staff ordered equipment from an independent equipment supplies company. Staff told us that equipment could be delivered to patients within 24 hours.
- There was a peripheral store of equipment at Northgate hospital, which staff could access if equipment was needed urgently. We saw this store and found that it was well-organised and had a system in place for monitoring use of equipment.
- We saw the log used to track syringe drivers from October 2015 to November 2016. It was completed showing time and date that a syringe driver was logged out, patient details and the date that it was returned. We checked four syringe drivers that were on site at the time of our visit. All were within date for calibration and electrical safety testing.
- the most up-to-date care and treatment plans and risk assessments for their patients. Four staff told us they frequently had to wait until they got home to update patient records due to connectivity problems.
- We reviewed 12 electronic and four paper (beds for care patients) patient records and we found that staff had recorded accurate information and all records had a timed and dated electronic signature, however we saw that initial assessments including Waterlow pressure ulcer risk scores were not always completed or reviewed despite patients being on a case load for over a year.
- We saw the documentation audit results for September 2015, which showed the community nursing service scored 100% for the correct recording of name, date of birth, NHS number, and address. However, ethnicity, religion, language used and occupational status scored less than 75% and in some cases as low as 24%.
- The documentation audit also showed that the community nursing team scored 100% for time dated staff signatures, chronological order, and contemporaneous record keeping.
- The audit calendar had change prior to our inspection and the completion of documentation audit was due after our inspection.
- Nursing staff used paper records for all drug administration and those records remained in patient's homes.
- Staff used a secure, electronic system to record assessment and treatment of patients. Staff also kept a yellow folder in each patient's home, which contained information on advanced care planning and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation.
- Staff in the hospice at home team did not complete DNACPR documentation. This was completed by GPs or by the specialist palliative care team based at the local acute hospital.
- Palliative patients were identified on the electronic system using a 'pink star.' This meant that any staff treating the patient would be aware that the patient was near the end of their life.
- We reviewed six hospice at home patient care records. All of the records we saw contained holistic assessments of the patient, documentation of the patients' palliative care status and documentation of resuscitation status and preferred place of care.

Quality of records

- Staff used an electronic patient record system, which provided a record of the assessments, care and treatment required by and provided for patients. This was used by the community nursing and out of hospital teams.
- The system could be accessed from office bases or remotely through the use of mobile computers when in the community. However, network connectivity issues in some areas meant staff were unable to access the electronic records. The inability to access the patient's electronic records put staff at risk of not being aware of

Are services safe?

- However, we noted that the holistic assessment was generic, rather than specific to end of life care. Staff told us that they were aiming to develop a specific end of life care template for the hospice at home team to use.

Cleanliness, infection control and hygiene

- Staff adhered to the bare below the elbows policy and wore gloves and aprons when providing care in people's homes and in the leg ulcer clinics to prevent the spread of infection.
- We observed staff washing their hands and using alcohol gel prior to and post procedures in clinics and in client's homes.
- We saw the template for the essential steps to safe, clean care (ESSCC) audit. This audit comprehensively tested the skills and knowledge of individual members of staff and was conducted on a yearly basis. The ESSCC report for the period April 2015 to March 2016 showed that the community adult teams all scored above the required 76% pass mark in the ESSCC test.
- The organisation policy was for teams to complete three monthly uniform and hand hygiene audits. We saw that there were several gaps in the hand hygiene data for the period July to September 2016. Audit data was missing from physiotherapy, the continence team, and the Halesworth/Southwold and Great Yarmouth community nursing teams. In the three months prior to this, the community nursing and continence teams had scored 100% although some of the physiotherapy teams were not shown as submitting any data. The percentage of team staff members audited was between 20% and 100%.
- According to the organisations policy, all clinical staff should also complete the sharps and waste audit tool which goes through safe handling of sharps, sharps injury, body fluid spills, waste, and wearing personal protective equipment (PPE). For the period April 2015 to March 2016, 33% of clinical staff completed the audit.
- In the north community nursing teams, staff removed contaminated waste from patients' homes when patients had bacterial wound infections. The staff carried the waste in their car sealed in a red plastic box and disposed of the waste at a community-nursing base. One of the clinical services co-ordinators told us staff were unhappy with this arrangement at the start but this process was embedded at the time of our inspection.

- We saw labelled clinical waste and domestic waste bins in clinical areas. Nurses had access to hand washing sinks and personal protective equipment within clinic rooms used for patient care. An audit of compliance with hand hygiene procedures in the hospice at home team showed positive results. From 1 April to 30 September, compliance with hand hygiene was 100% and from 1 October to 16 November, compliance was 99%.

Mandatory training

- Mandatory training consisted of manual handling, infection prevention and control, safeguarding, risk awareness, consent, conflict resolution, access to information standards, food hygiene, health and safety, information governance, mental capacity act, record keeping, basic life support, equality and diversity, fire, and preventing radicalisation.
- The organisation mandatory training target was 80%. We saw the latest (November 2016) mandatory training compliance figures provided by the organisation for the community nursing service OOH teams, physiotherapy and occupational therapy teams. The community nursing service was 85%, OOH teams 91%, physiotherapy teams 91% and occupational therapy was 95% confirming good compliance.
- Training was delivered via e-learning and face to face sessions often using scenarios where appropriate. Some staff reported that duty of candour training was included in the consent training but other staff had received separate duty of candour training or could not recall having any duty of candour training.
- The community matrons received an e-mail when their staff were due for mandatory training or refresher session and those matrons that we spoke to were able to check last dates of training and ensure that staff attended.
- The team leads kept training spreadsheets to track the completion of mandatory training for their staff.
- Staff told us that they were no problems accessing mandatory training and they also received a reminder when training was due.
- One of the community nursing team leads told us that the health-coaching module was included in the mandatory training for all clinical staff. She also reported that most of the team had completed the health-coaching module. We saw the training records spreadsheet for the team, which reflected this.

Are services safe?

- Staff also received six monthly leg ulcer update training from the tissue viability nurse and had dementia awareness training from the dementia Friendly Society within the last year and have developed dementia champions.
- We saw records to show that staff compliance with mandatory training in the hospice at home team was 93% in October 2016.

Assessing and responding to patient risk

- The community nurses and matrons had an informal verbal process for daily handovers and formal meetings on Friday and Monday mornings to handover any caseload concerns.
- The OOH teams verbally handed over at every shift change and the 'patient whiteboard' was kept updated at all times and included patient risks.
- Risk assessments were completed on the electronic patient records for patients visited by the community nursing service and the out of hospital teams. Staff were not always able to access to the organisation's electronic record system whilst in rural areas, which meant they were unable to access risk information relating to patients.
- Two team leads told us that all patients had pressure area risk (Waterlow) scores and a malnutrition universal screening tool (MUST) assessment each month or more frequently if there is a change in patient condition.
- We reviewed 16 patient records and found that pressure ulcer risk assessments and MUST had been completed for all of these patients although they were not routinely reviewed monthly as per provider policy.
- The team leads told us that all patients received a full nursing assessment on the first contact appointment. We found two out of the 16 patient records did not have the initial nursing assessments completed.
- The nursing staff were required to complete a moving and handling assessment as well as a falls risk assessment for each new patient. However, on one new patient visit we saw that these assessments were not completed. The patient had recently been discharged from hospital and used a walking frame, which would increase the falls risk for the patient. We also found that three patient records out of the seven we reviewed did not have a completed moving and handling or falls risk assessments.
- All six patient hospice at home records we reviewed contained appropriate risk assessments, including the Waterlow score (for assessing risk of pressure areas), falls history and nutritional assessment.
- Staff used the GP out of hours service for patients who needed urgent medical input for symptom control overnight. Staff told us they had direct telephone access to this service, which meant that medical advice could be accessed quickly.
- Staff had access to telephone advice from the specialist palliative care team based at the local acute hospital until 6pm each day. Staff told us that palliative care consultants from the local acute hospital would come out to visit patients with complex symptom control needs, if required.
- East Coast Community Healthcare had an out of hospital team, which was available 24 hours a day, seven days a week. This team could provide nursing and care input for patients overnight if this was required urgently.
- Staff gave patients a number for the organisation's contact centre, which they could contact 24 hours a day. Patients could call this number out of hours if they had problems with their syringe drivers. Staff told us that the contact centre would request a nurse from the district nursing service or out of hours team to assist patients with management of syringe drivers.
- Staff in the hospice at home team told us that they could access occupational therapy assessments through the out of hospital team for urgent review of equipment within 24 hours. Staff told us they made these referrals directly over the telephone or using the task system on the electronic patient record system.

Staffing levels and caseload

- The OOH north team were fully staffed; there were vacancies in the Lowestoft team for two whole time equivalent (WTE) band six nurses, 0.6 WTE band six physiotherapist, 1.2 WTE band four assistant practitioner and one rehabilitation support worker.
- The community nursing teams were made up of qualified nurses and health care assistants. Total community nursing staff numbers in August 2016 were 103.7 WTE staff. There were 6 WTE trained staff vacancies in total and 1.2 WTE phlebotomy posts vacant. The community nursing staff were sub-divided into teams. Each team had a band six nurse as lead who reported to the clinical co-ordinator for that area.

Are services safe?

- The clinical services co-ordinator for the north area reported that she had two 0.8 WTE and one 0.6 WTE nursing vacancies across the three teams she managed. She also told us that a 0.8 WTE, phlebotomist post was planned for the future.
- The nursing staff held a caseload of approximately 25 patients each to case manage within the north team.
- The teams did not use a staffing tool or capacity workforce tool to assess caseload management and staffing requirements.
- The clinical manager for the south community service had a band seven vacancy, 3.4 WTE band five nurse vacancies with 1.4 WTE due to start in the Lowestoft area, leaving two vacancies. There was also one nurse vacancy at Reydon, a 0.8 WTE nurse vacancy at Halesworth and a 0.4 WTE band two phlebotomy post vacant.
- Staff shortages had impacted on the service as they were unable to provide enough staff to cover 24 hours daily. A short term measure had been introduced, relying on the OOH team to cover the period between six and eight in the evening until the night community nursing staff came on duty.
- The community nursing service did not use agency staff and only occasionally used bank staff.
- There were 2.0 whole time equivalent registered nurses, 2.8 whole time equivalent assistant practitioners and 3.0 whole time equivalent support workers in the hospice at home team.
- The hospice at home team told us that their caseloads were variable, as the service was still being developed, but that their caseloads were manageable at the present time. Information showed they were providing a service to 22 patients at the time of inspection.
- There was a Lone Workers Policy in place dated 01/01/2016 (version 002) and the option of carrying a lone workers device which could relate the wearers location in an emergency or if the worker felt under threat. Most of the staff we spoke to did not use these and there were several 'local' systems in place dependent on the area. Some staff employed a buddy system where they would text or call a nominated colleague when they arrived on duty, when they finished for the day or were concerned regarding entering risky premises. If there was a known risk or concern staff attended in pairs and night duty staff always worked in pairs.
- The OOH team had a standard operational procedure (SOP) to supplement the Lone Working Policy as staff frequently attended premises that had not been risk assessed. This ensured that staff marked "in" and "out" when leaving the building so that the triage team had oversight of all staff whereabouts at all time.
- Staff in the hospice at home team had put in place processes to keep staff safe if they were working alone. This included staff 'checking in' before starting their patient visits and documenting the location of visits on the electronic recording system. Staff also recorded any known risks at different locations on this system. This was in line with the organisation's Lone Working Policy, 2016.

Major incident awareness and training

- We spoke to the clinical service co-ordinators about major incident training for staff. They reported that staff did not have training in major incidents due to the diversity of potential incidents. They also told us that the major incident plan was held and actioned from the head office and staff were contacted with specific instructions. We were given the scenario of the tidal surge in 2014 and how the major incident was managed by head office and had no concerns.
- A band seven nurse was aware of the major incident plan on the provider's intranet site and had yearly mock-up scenarios on mandatory study days. Band six and below staff indicated that although they were aware of plans they had not seen them and would just follow instructions if an incident occurred.

Managing anticipated risks

- Senior staff completed risk assessments for individual risks to staff for example patients with dogs and attached them to the patient's electronic record. We asked the team leads and the clinical services co-ordinators if they held an electronic record of all active risk assessments. They told us that the only record of risk assessments was in the patient's record. Therefore, we were concerned that there was limited oversight of these risks.

Are services effective?

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

We rated effective as good because:

- Staff used up to date policies and best practise evidence and guidelines to inform treatment.
- The community nursing staff worked to key performance indicators (KPIs) for leg ulcer referrals and community matron visits within seven days to complicated long term condition patients.
- The provider took part in local CQUIN goals and had committed to health coaching, staff health and wellbeing and a review of the community nursing service for the period 2016 to 2017.
- The organisation's appraisal rates at the time of inspection for the for the community nursing teams were 75%, this did not meet the organisation targets of 80% and on questioning senior staff confirmed that long term sickness of some staff had impacted on these figures. The OOH team rates were 98%. Staff felt that appraisals were 'meaningful and personal'.
- Staff were encouraged to extend knowledge and the organisation was proactive in providing training.
- Multidisciplinary working was excellent facilitated by open offices and good communication with local GPs. For example, staff attended monthly Gold Standards Framework meetings at GP surgeries where they discussed all patients on the palliative care register.
- Staff discussed pain relief and symptom management with patients. We saw staff making appropriate referrals to make sure that patients' symptoms were controlled.

However:

- Staff did not always have connectivity to the live electronic patient records system and they were unable access or update patient information in rural areas.
- Staff were not engaged in interpretation of audit at a local level and there was limited audit of patient outcomes. We did not see evidence of audit being used to drive improvements in the service.

Evidence based care and treatment

- The community nursing staff provided a range of care packages including palliative care and wound care that were based on current evidence based National Institute for Clinical Excellence (NICE) guidance and best practise standards.
- The provider had a variety of policies and standard operating procedures that all staff had access to through the provider's intranet.
- We reviewed some of the provider's policies including safe and secure handling of medicine and the controlled drugs policy. Both policies referred to relevant legislation and best practice guidance, were up-to-date and had a specified review date.
- The tissue viability and community nursing service had developed a 'leg wound/ulcer pathway' using Royal College of Nursing (RCN) best practice and NICE guidance for ambulatory patients to ensure consistency of treatment.
- Staff could access policies and guidance via the staff intranet. Staff gave us examples of guidance that was relevant to their practice. For example, a nurse in the hospice at home team told us about national guidance they used, such as the National Institute of Health and Care Excellence (NICE) guideline on Care of dying adults in the last days of life, 2015.
- We asked three members of staff how they accessed policies and guidance. All three staff were able to show us relevant policies and guidance on the staff intranet. One nurse told us that E-learning about NICE guidance was available to staff.
- Policies were up to date, version controlled and based on national guidance. For example, staff showed us the DNACPR policy, which was issued in June 2015 and due for review in June 2018. This included recommendations from the resuscitation council.
- Patients approaching the end of life were identified through use of the Gold Standards Framework (GSF). This is a framework for identifying patients with end of life care needs, irrespective of diagnosis. Staff in the hospice at home and district nursing teams told us that

Are services effective?

they attended monthly GSF meetings, at local GP surgeries, where patients on the framework were discussed. This meant that staff had an effective system for identifying patients with end of life care needs.

Pain relief

- We reviewed 16 patient records and saw completed pain scores within each review.
- The community nurses prioritised the visit requests for pain relief, and for palliative care patients. One of the nurses we spoke to had previously worked in palliative care and informally shared her knowledge and experience of pain relief and symptom control with her colleagues.
- The community nurses used a syringe driver administration record in the management of pain for end of life patients. The document contained comprehensive guidance to manage breakthrough pain and dose adjustment anticipatory prescribing for patients dying within hours or day.
- The community nursing service did not have any nurses with extended prescribing qualifications. However, staff discussed patient needs with the patient's GP to ensure the patient had adequate pain relief.
- We observed a procedure in the leg ulcer clinic. This procedure involved a process that may cause some pain in some patients. Staff explained that it was a potentially painful procedure and consent was given verbally by the patient. Throughout the procedure the nurse continually checked if the patient was comfortable and indicated she would stop if the patient was in pain.
- We saw staff discussing pain relief and symptom management with patients. For example, we saw a nurse discussing symptoms such as sickness, pain and breathlessness with a patient.
- Staff made appropriate referrals to make sure that patients' pain was well managed. For example, we saw a nurse discussing a patient's abdominal pain and seeking consent to refer the patient to the GP.
- Staff told us that GPs prescribed anticipatory medicines for patients. This meant that patients were not delayed in receiving pain control.
- The organisation collected information on the number of patients who had pain scores recorded in their records. However, this information was not collected specifically in relation to the hospice at home team.

Nutrition and hydration

- The OOH team provided some assistance with simple meal preparation such as breakfasts and we observed staff checking that clients had eaten, and had food for the day.
- Staff were able to refer to the speech and language teams for those patients who had swallowing difficulties.
- All patients had a malnutrition universal scoring tool (MUST) assessment monthly and staff referred patients with a score of one or more to a dietician. However, one of the team leads told us that there was often a long waiting list for patients to have a dietician review.
- Two of the team leads told us that the nursing staff discussed patient nutritional concerns with GPs in the interim period between dietician referral and review.
- Staff discussed nutrition and hydration with patients. For example, we saw a nurse having a discussion with a patient about their lack of appetite. The nurse asked the patient whether they were taking fortified drinks to support their nutrition and offered to follow up with the GP to make sure that these drinks were delivered in a timely way. The nurse discussed with the patient which flavours of drink they would prefer and gave advice that was tailored to the individual patient. This was in line with the Leadership Alliance for the Care of Dying people: five priorities for care, which states that patients should have "an individual plan of care, which includes food and drink."
- One patient told us they had been given information leaflets about nutrition.
- Six patient records we saw contained information on patients' nutrition and hydration.

Technology and telemedicine

- We saw staff contacting patients on the telephone to check symptoms with them and make recommendations until a nurse could visit them.
- Staff took photographs of wounds using their work smart mobile phone and uploaded these to the electronic patient record. The staff deleted any photographs from their mobile phone once the image uploaded to the electronic patient record.
- The provider had a standard operating procedure in place for the use of work mobile telephone for photographs.

Are services effective?

- We observed the photograph procedure during one home visit and had no concerns.

Patient outcomes

- The clinical co-ordinator for the south reported that the community nursing services were meeting their key performance indicators (KPI). These were; leg ulcer referral to treatment times of four weeks, and patients referred to the community nursing service with complex long-term conditions being seen by a community matron within seven days.
- The OOH teams met KPIs for urgent referrals being assessed within two hours, non-urgent within one working day and care packages in place within 12 hours of referral.
- The organisation participated in two local Commissioning for Quality and Innovation (CQUIN) goals agreed with NHS Great Yarmouth and Waveney CCG for the period April 2015 to March 2016. These were to reduce the number of pressure ulcers and to develop a pathway for early recognition of potential dementia and delirium. The organisation has committed to participate in a further three local CQUINs for the period April 2016 to March 2017. Health coaching for patient self-management, staff health and wellbeing and a review of the community nursing service action plan developed in 2013 focussing on outcomes to improve data entry, analysis and reporting and a caseload analysis to inform commissioning, caseload management and workforce planning.
- The community service ran leg ulcer clinics in each team, the clinical commissioning group had a reported key performance indicator that a nurse reviewed all patients referred to the service within four weeks. However, staff did not measure outcomes for leg ulcer patients at the time of our inspection.
- The neurology lead nurse told us that the neurology service was auditing local outcomes for patient self-management plans. The self-management plans were developed to reduce GP visits and the use of the neurology service for the management of minor illness.
- The provider participated in four district nursing based audits during the period January-May 2016, however the community nurses were not aware of the service participation in any national or local patient outcomes.
- The community nursing service in conjunction with the continence specialist nurse and the infection prevention and control team had audited the use of catheters and catheter washouts performed by the nursing teams. As a result a clinical action plan was developed with patient information and posters with treatment pathways for blocked catheters produced. The plan was to re audit use in November 2016 to assess any changes.
- The service audited the number of patients that died under the care of the hospice at home team and the percentage of these patients who died in their preferred place of care. From November 2015 to October 2016, 118 patients died while under the care of the hospice at home team. In this period, 113 out of 118 patients (96%) died in their preferred place of care.
- Local audits were completed, including records, catheter care, infection control and completion of Waterlow scores (for assessing risk of pressure areas). The hospice at home service did not audit outcomes in relation to pain management or nutrition.
- Leaders told us that they were in the process of developing a 'local voices questionnaire' to gather the views of patients and their relatives in conjunction with GPs and the local acute hospital.
- Staff at a local level (Hospice at Home) were not engaged in interpretation of audit results as this was completed by a separate department in the organisation. Staff told us they would receive notification if audit results showed that improvements were needed and would develop an action plan.
- Staff did not audit implementation of the Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care'.

Competent staff

- The provider target appraisal rate was 80%. Compliance information supplied by the organisation showed that appraisal rates from November 2016 were 75% for the community nursing teams, 98% for the OOH teams, 98% for the physiotherapy teams and 78% for the occupational therapy teams. The overall rate was 82%. The community nursing teams acknowledged that long term sickness had impacted on appraisal rates
- Staff told us that appraisals were 'meaningful and personal' and that goals were set that were achievable and supported, such as mentorship training, non-medical prescribing and district nursing courses.

Are services effective?

- One of the clinical service co-ordinators and two of the team leads told us that four members of staff had completed the district nursing qualification. They also reported that a further two staff members were due to start their district nursing training in January 2017.
- In the OOH team a support worker was being seconded to do their nurse training part time whilst still being employed by the organisation.
- Two of the team leads told us that new staff to the organisation remained supernumerary until they completed their competencies and staff confirmed that they were not expected to attend visits alone until not only had they completed competencies, but that they felt comfortable doing so.
- Newly qualified staff reported they felt well supported by senior staff during their preceptorship period.
- We saw two staff records, which demonstrated that staff received regular clinical supervision. One of the team leads told us that she discussed clinical supervision at one-to-one meetings and appraisals to the individual needs of each staff member. The staff records reflected this in both staff records we reviewed.
- The community matrons met once a month to address concerns and caseloads and also for support and to achieve learning objectives, with outside speakers invited to present. Staff found this to be a valuable learning experience.
- Senior staff told us that all staff in the hospice at home team had attended a three-day palliative care course at the local acute hospital. This course was available three times per year and included clinical assessment skills, advanced communication skills and difficult conversation training.
- Nurses in the hospice at home team completed training on syringe drivers on induction and then at least yearly. Nursing staff in the hospice at home team also completed verification of death training every year. We saw records to show that both nurses in the hospice at home team had completed this training in the last year.
- Staff in the hospice at home team told us they had access to online training accounts through the charity, MacMillan.
- Staff told us that they had clinical supervision every month. We saw records of supervision dated from June 2016 to October 2016 that showed group discussions and training on areas including pressure area care, incident reporting and supporting family members.
- Staff told us that they had appraisals every year. We saw records to show that in October 2016, 100% of staff in the hospice at home team had completed an appraisal in the last 12 months.
- Senior staff told us about innovative ways of training staff on end of life care that they had developed. For example, in one training session staff were given the opportunity to consider what they would put in their yellow folder in terms of their own end of life choices and advanced care plans. This exercise was aimed at improving staff sensitivity and understanding of how this process might feel for a patient.

Multi-disciplinary working and coordinated care pathways

- The OOH team were comprised of trained nurses, assistant practitioners, rehabilitation support workers, occupational therapists, and physiotherapists ensuring a complete multidisciplinary team. They had close ties with the social workers who were located in a nearby office in the Lowestoft team.
- The community nursing teams shared open plan office space with occupational therapy and physiotherapy staff alongside community matrons and visiting specialist nurses.
- We saw open plan office space in all of the community bases we visited and witnessed discussions between the multidisciplinary teams.
- We spoke to four members of staff about multidisciplinary working and all of the staff reported that the shared office space facilitated multidisciplinary discussions regarding shared patients.
- One of the matrons told us that she had regular contact with occupational therapists, physiotherapists and social workers to ensure patients had the right equipment and care package to remain at home. She also reported that this close working relationship was essential in providing the right care at the right time and reducing hospital admissions.
- The community nursing teams had close working relationships with the GP surgeries for their areas and were able to access advice and prescriptions for patients when needed.
- The neurology lead told us that three neurology teams worked across the provider locations and the teams included nurses and therapists. She also told us that multidisciplinary working was essential to achieve the best outcomes for patients.



Are services effective?

- Staff in the hospice at home team told us they attended monthly Gold Standards Framework meetings at local GP surgeries. District nurses also attended these meetings. Each district nurse was assigned to a surgery and would be the main community nursing case manager for end of life patients at that surgery. Staff told us these meetings involved multidisciplinary discussion of patients on the palliative care register. This meant that all staff involved in end of life care had an opportunity to discuss patients' care with other members of the multidisciplinary team.
- There was a joint meeting between the hospice at home team and the district nurses once a month to share practice.
- Staff in the hospice at home team attended palliative care multidisciplinary meetings at the local acute hospital. We saw good multidisciplinary working between the hospice at home team and the occupational therapist from the out of hospital team on a visit to a patient's home.
- The hospice at home team, out of hospital team and district nursing teams worked together flexibly to meet the needs of patients. Staff in these teams were based in the same building and told us they had face to face discussions or discussions over the telephone to arrange joint working and support for each other in terms of caseload management. For example, staff in the out of hospital team told us that they could provide additional care calls to patients to support the hospice at home team if needed.

Referral, transfer, discharge and transition

- All contact and referrals went through the East Coast Community Access (ECCA) telephone exchange system and were distributed electronically to the appropriate service or team. For urgent referrals, the ECCA team contacted the appropriate team directly to ensure that the patient requests were expedited as soon as possible.
- The OOH teams commenced discharge planning on initial referral as the service was only contracted for 14 days.
- The team leads reported that staff referred patients to other internal services, staff completed paper referrals and faxed them to the relevant service.
- One of the clinical services leads told us that the community nursing, OOH teams and hospice service worked closely with the local NHS trust to transfer

patients from hospital to their home. We saw collaborative documents for example the syringe driver prescription and administration records for community and hospital use.

- Referrals to the hospice at home team came through the organisation's single point of access. We saw referral criteria for the service. Referral criteria stated that patients must be over the age of 18 must be identified as 'amber' or 'red' on the Gold Standards Framework and must have a GP in the Great Yarmouth and Waveney area. The criteria stated that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) must have been completed and preferred place of care discussed. The patient must already be known to the district nursing service.
- Referrals could be made by any healthcare professional. Staff told us that most referrals came from the local specialist palliative care team. From November 2015 to October 2016, there were 289 referrals to the hospice at home service.
- Staff told us that as the service was small and new, there was some overlap in roles between the hospice at home team, the district nursing team and the out of hospital team.

Access to information

- All of the community and OOH staff used the electronic patient records accessed by a laptop or computers at the bases. This ensured that physiotherapists, occupational therapists and nurses had access to the same information and could see the most recent activity in a patient record as well as the patients GP.
- The electronic system was only accessible with internet access and staff reported that access was not always possible in rural areas but good in urban areas. This meant that staff did not always have access to patient records and pertinent risks associated with a home visit. The provider's information technology department was aware of the issue and it was logged on the corporate risk register with actions to try and resolve.
- The OOH team kept a whiteboard in the team office with patient details, diagnosis and current plan including advanced care planning decisions. This enabled the triage nurse and co-ordinators to see at any minute the daily workload. The whiteboard was not visible outside the office, protecting patient's confidentiality.
- Staff recorded the administration of medicines on paper records left in the patient's own home.

Are services effective?

- Hospice at home staff that they could access notes made by GPs and the local specialist palliative care team as these teams used the same electronic system for documenting patient records. Two local GP surgeries used a different electronic system. Staff told us that they requested any information the needed directly from these surgeries and had not experienced any problems with this.
- The service did not use the Electronic Palliative Care Coordination System (EPACCS) at the time of our inspection. Instead they were using the 'pink star system' which was a local version of EPACCS. However, senior staff told us that a pilot of EPACCS was due to start the week after our inspection. We saw three sets of meeting minutes dated from April to August 2016 for the Palliative and End of Life Operational Group, which included discussion of this pilot.
- We reviewed 16 patient records and saw that staff had gained patient consent to care during each visit in all cases.
- We observed care given in patients' own homes and in clinics and saw that staff consistently gained patient verbal consent before providing care to the patients.
- We spoke to 11 members of staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards, all reported that they had completed this training.
- One occupational therapist told us that she worked with community patients to resolve issues with deprivation of liberty caused by wheel chairs. She reported that most of the patient issues were easily resolved with equipment adjustments.
- Discussions and decisions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were carried out by the patient's GP. Staff in the hospice at home team were aware of good practice around DNACPR decisions and told us that they would liaise with GPs to ensure that appropriate conversations took place.
- Training on mental capacity assessment and Deprivation of Liberty Safeguards was included in staff mandatory training. Compliance with mandatory training in the hospice at home team was 92.78% in October 2016 for the hospice at home team.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Are services caring?

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

Summary

We rated caring as good because:

- Friends and Family Test (FFT) was very positive across the service.
- Staff went the extra mile to meet patients' needs. For example, staff supported a patient with complex needs to move into the area to spend Christmas with their family.
- Staff were kind and compassionate with all patient contacts.
- Staff respected patients dignity at all times and were sensitive to patient's needs.
- We observed staff explaining and ensuring that patients and carers had a good understanding of procedures before obtaining consent.
- Patients and carers were always involved in planning their care.
- We witnessed staff giving time to patients to allay their concerns and offering support where needed.

Compassionate care

- We observed a wide range of staff from the district nursing service and the out of hospital team delivering care in patient's homes and in leg ulcer clinics. Their interactions were professional, friendly and kind.
- Results from the NHS friends and family test showed consistently positive results. From September 2015 to October 2016, the community adult services consistently scored between 95-100%, with an average of 70-80 respondents per month across the community nursing service, the out of hospital service and the specialist clinics.
- Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.
- We observed casual discussions with patients about family members and pets with staff being knowledgeable about home circumstances and concerns. This all helped to put patients at ease.
- All of the staff we spoke with took great pride in their work and were committed to providing the best care they could. This sometimes led to staff 'fitting in' an extra patient on to a morning or afternoon session or

timing their visits to suit a patient's circumstances despite it impacting on their break or finishing time. Staff commented that 'you just do what you can to provide the best care for the individual'.

- Staff treated patients with privacy, respect and dignity and this was seen when they protected patients from cold and exposure, using blankets to maintain dignity.. In the clinics the curtains were drawn and doors closed to ensure privacy. Staff knocked on doors before entering.
- Staff took the time to explain and interact with patients and relatives, they were sensitive to patients needs offering explanations and being supportive when patients expressed concerns. This was noted when a patient was concerned regarding changes in treatment by the GP, the staff member sat down with the patient and explained why the treatment had been changed and offered reassurance.
- Patients commented that staff were "angels", and that "we could not get better care anywhere".
- All of the patients we spoke to were complimentary regarding the care and efficiency of the community staff. Comments such as "they are amazing and always there when I need them", "gold star service, and top of the class" and "I could not do without them" were very common.
- The staff respected the confidentiality of patients and did not discuss or display confidential information in the hearing of others.
- One patient said that the community nursing staff were very kind and always maintained their dignity during care.
- We saw staff in the hospice at home team completing care visits for patients near the end of their life with kindness, sensitivity and compassion. For example, we saw staff communicating sensitively with a patient who had developed a moisture lesion and explaining the benefits of checking the patient's skin, whilst ensuring the patient's privacy was protected as much as possible. This was in line with the Leadership Alliance for the Care of Dying People: five priorities for care, which recommends "sensitive communication takes place between staff and the dying person, and those identified as important to them.

Are services caring?

- Staff went the extra mile to meet patients' needs. For example, a patient who had wanted to come to the area to visit their family for Christmas. The patient was near the end of her life and needed support with personal care, equipment and medications. Staff told us how they worked with the local specialist palliative care team and GP to arrange for the patient to be supported over the Christmas period. This meant that the patient was able to spend Christmas with her loved ones.
- Staff adapted their assessments and treatments to meet the individual needs of each patient. For example, there were times when certain standardised assessments might not be appropriate, as they could be distressing or invasive for a patient in the last days of their lives. Staff considered each patient as an individual and made sure the patient's wellbeing was their first priority.
- We spoke to five relatives who told us that they felt involved with the care that the nursing staff provided to their relative and felt able to ask for help at any time.
- Staff kept a yellow folder in people's homes with DNACPR advanced life decisions for end of life (EOL) patients so that they were easily accessible if needed.
- We spoke to five patients' carers and relatives, who told us they felt cared for "on all levels" and felt comfortable contacting the service if further support or input was needed.
- One patient's friend described to us how the service had "taken the pressure off" the patient's relative, who had previously been caring for her mother without support.
- Staff included patients and their families in decisions about their care. For example, we saw one member of staff talking to a patient about different options for support. They told the patient "We'll be guided by you and your family" when discussing what level of support the patient needed. This was in line with the Leadership Alliance for the Care of Dying People: five priorities for care, which recommends, "The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants."
- Staff training was focused on improving understanding of the patient experience. For example, in one training session staff were given the opportunity to consider what they would put in their yellow folder in terms of their own end of life choices and advanced care plans. This exercise was aimed at improving staff sensitivity and understanding of how this process might feel for a patient.
- We saw individualised advance care plans in patients' homes, which reflected the choices and preferences of the patient. Advance care planning is the process of discussing and documenting the patient's wishes for future care, which enables health professionals to understand how the patient wishes to be cared for.

Understanding and involvement of patients and those close to them

- All staff interactions we observed demonstrated good communication with patients and their carers and relatives. In the leg ulcer clinics, we observed nurses discussing the planned care with patients. In addition, the staff gave one patient written information on their first attendance to the clinic. Staff did not use jargon when speaking to patients to ensure they understood what was happening and explained equipment and the procedure before carrying out invasive procedures.
- Staff explained procedures in a manner that was easily comprehensible and took the time to ensure that explanations were understood, so that patients knew what they were consenting to.
- We saw that staff involved patients and their families in planning care and treatment. Staff caring for patients with life limiting and long term conditions discussed the individual needs with patients and developed the best and most effective plans for addressing their needs in partnership with patients and their relatives. An example of this was the balance between evidence based treatment for leg ulcers and the patient's ability to purchase footwear that would accommodate the type of bandaging necessary to promote healing.
- All patients we spoke to told us that staff had discussed their care with them and used appropriate language so they understood their plan of care.
- On two occasions, we observed nurses ask for the patient's preference of wound dressings during a home visit.

Emotional support

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



Are services caring?

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

- The provider had introduced a health coaching model and this was used to help empower patients to manage their own health, care and well-being and to maximise their independence. This was especially important in the field of long-term conditions such as neurology and respiratory disease.
- The Myalgic Encephalitis/Chronic Fatigue Syndrome (ME/CFS) team emotionally supported a large volume of patients across Norfolk and Suffolk both in patient's homes and in clinic to learn to recognise their 'triggers'. They also used basic cognitive behavioural knowledge and a graded exercise programme to help patients manage their condition.
- We observed the community nursing staff give emotional support to patients and taking account of their spiritual needs during our inspection.
- One patient said the nurses had given her emotional support following her mastectomy surgery with the change in body image. She felt emotionally ready to start chemotherapy after the supportive care she received from the community nursing team.
- We saw staff giving emotional support to an elderly patient on the first appointment in one of the leg ulcer clinics. The patient was worried attending clinic as they had reduced mobility and kept apologising for causing a problem. The nurses explored the patient's concerns discussing them with the patient and arranged home visits for leg ulcer care. The patient relaxed following this discussion and engaged well for the rest of the assessment.
- Personal, cultural, social and religious needs were addressed. Staff we spoke to were aware of their patient's specific needs such as those with strong religious feelings and some staff had developed links with local clergy to help support patients.
- Staff offered emotional support for patients and their loved ones. For example, staff completed bereavement visits to patients' families after the death of a patient.
- The hospice at home service offered short respite visits for patients' loved ones in situations where care responsibilities were having a negative impact on their wellbeing. This meant that patients' loved ones were supported to take some time off from their role in providing care for the patient.
- Staff considered patients' emotional needs and provided support. For example, a patient who had expressed a preference to die at home but called the team in a state of anxiety. Nursing staff worked with the GP to review medications to improve the patient's symptoms and reassured the patient about the support that was available. The patient decided that they wanted to remain at home, as they felt well supported and this was their preferred place of care.
- Staff considered the spiritual needs of patients. For example, a nurse in the hospice at home team told us about a patient whose religion meant that it was important for them to take Holy Communion once a week. The team therefore organised the patient's visits so that they would not interfere with the patient taking her communion. The nurse also told us about how the team kept the patient's family updated on any deterioration in the patient's condition so that there was no delay in the patient receiving last rites, as this was a spiritual need identified by the patient.
- Staff told us they had good links with the local hospice and would signpost patients there for further emotional support. We saw minutes from the Palliative and End of Life Operational Group dated August 2016, which showed that leaders of the service were focused on increasing patient awareness of local counselling and bereavement services.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Staff had a good understanding of the differing needs of the communities they served.
- The Out of Hospital (OOH) team operated a triage system to ensure that people were assessed and treatment planned in a timely manner.
- Staff made adjustments to account for patient preference regarding visits and appointments.
- Complaints were investigated and managed appropriately with learning identified shared with staff.
- The hospice at home service provided visits to patients that were flexible dependent on patients' needs and preferences. Staff gave each patient a yellow folder, which contained information including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and documentation of advance care plans. This meant that all staff visiting patients in their own homes had information on each patient's individual needs and preferences.
- Staff had access to translation services for patients who did not speak or understand English. Staff could access face to face or telephone translation services dependent on the patient's needs.
- Leaders of the hospice at home service attended a Palliative and End Of Life Care Operational Group, which focused on coordinating palliative care delivered by different local organisations.
- The hospice at home service measured the response rate to patient referrals. This service had set a goal to see patients within one week of referral. From November 2015 to October 2016, 96% of patients were seen within one week. In this period, 65% of patients were seen within 24 hours.

However:-

- We had concerns regarding the responsiveness of community nursing due to the temporary suspension of twilight shifts.

Planning and delivering services which meet people's needs

- The community nursing service planned services in conjunction with the local clinical commissioning group (CCG) to meet the needs of the local population.
- There was evidence of the OOH teams working in conjunction with the local acute services, councils and adult social care providers to meet the needs of patients and carers.
- Each community nurse managed a caseload of about 25 patients. District nurses discussed caseloads with each community nurse monthly to advise about patient management plans.
- We spoke to three nurses about caseload management and all of them told us they planned visits and care for the patient caseload.
- One district nurse told us that she met with staff monthly to support junior staff with their caseload management and discuss any concerns they had. They also reported that she discussed patients with complex needs more frequently with the junior staff.
- The community nursing service and the OOH team had quite diverse challenges covering very rural affluent areas and deprived urban areas. Staff had a good understanding of the differing needs of the community they served.
- The OOH team in Lowestoft had 'board round' three times a week whereby staff participated in discussion about current patients on the whiteboard.
- We saw that the community nursing service had developed a 'catalogue of care' for the local CCG based on best practise and NICE guidance. This set out the type of treatment and care package on offer to patients with specific complex needs.
- The clinical service co-ordinator discussed the reintroduction of personalized care plans so patients keep a paper record of their own goals and can identify their own triggers for ill health.
- The hospice at home service offered visits of up to an hour in length and up to three visits per day. This meant that staff could take the time to provide care to patients in a sensitive way. We saw staff explaining this to patients and explaining to patients how visits would be arranged. The frequency of visits was directed by patients and their loved ones and was dependent on each patient's individual needs.

Are services responsive to people's needs?

- Nurses in the hospice at home team told us that they liaised with continuing healthcare nurses and with the out of hospital team to ensure that patients who decided that they no longer wished to remain at home could spend their last days of life in their preferred place of care.
- A nurse in the hospice at home team told us that patients could access occupational therapy assessment for equipment within 24 hours. This meant that patients could access the equipment needed to support them at home in a timely way.
- Leaders of the hospice at home team were part of a Palliative and End Of Life Care Operational Group, which focused on coordinating palliative care delivered by different local organisations. We saw three sets of minutes from these meetings dated from April to August 2016. These showed that meetings were attended by representatives from the local hospital, local hospice, clinical commissioning group and East Coast Community Healthcare and included discussions for how to improve coordination of care.
- Staff gave each patient a yellow folder, which contained information including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and documentation of advance care plans. This meant that all staff visiting patients in their own homes had information on each patient's individual needs and preferences.

Equality and diversity

- During our inspection, we saw staff providing individualised high quality care to all patients. Patients' cultural and religious needs were included in the individualised care plans following an ongoing assessment of needs.
- We visited leg ulcer clinics in four locations and found them easily accessible for those with poor mobility or who needed to use mobility aids.
- There was an interpreter service available for non-English speakers although we did not see it being used during the inspection. Some staff members commented that it was not always easy to access translation services whilst in people's homes and that, on occasion, they had resorted to using applications that patients had already downloaded on their mobile phones. Staff told us that they had to make advance bookings for the translation service and this was not always practical for home visits. One member of staff gave us an example of how they had sourced a translator for a patient who

spoke an uncommon Lithuanian dialect. They also said that they had access to information leaflets in different languages for their patients whose first language was not English.

- One of the clinical services co-ordinators told us that a review carried out in 2015 had indicated the service provision for local ethnic minorities, for example, Portuguese patients required further work. She reported that the provider was developing a strategy in the provision of more inclusive service for ethnic minorities.
- We saw information leaflets about the hospice at home service printed in different languages.
- Staff were aware of different cultures within the local population and could give examples of how services were planned to take account of the needs of different groups.

Meeting the needs of people in vulnerable circumstances

- The community matrons worked closely with the wider multidisciplinary team for example social workers and GPs to ensure patients in vulnerable circumstances had support to remain independent or stay in their own homes.
- One of the matrons told us that she worked with all disciplines within the community to manage patients with complex needs. She gave examples of liaising with social workers to adjust social care packages to meet the increased needs of patients. She also told us that the matrons, community nursing, and therapies staff worked closely to manage patients in vulnerable circumstances.
- Senior staff in the hospice at home service told us that they had taken part in a thematic review on hard to reach patients and were aiming to develop work on meeting the needs of local populations through the Palliative and End Of Life Care Operational Group and Programme Board meetings.
- Staff in the hospice at home service were trained in caring for patients with dementia. An Admiral nurse (a specialist dementia nurse) provided this training.

Access to the right care at the right time

- The Out of Hospital (OOH) team assessors liaised with referrers and visited patients whilst still in hospital to assess their needs on discharge. This ensured that the right package of care was in place when needed. The service provided care for up to 14 days, if longer care



Are services responsive to people's needs?

was required this was assessed and arranged prior to the end of the 14 day period. The OOH team had access to 12 ring fenced beds in local residential homes, which could be utilised for 9-14 days for patients who were assessed as needing care or supervision that was more than the OOH team could offer. Patients received assistance with activities of daily living but the OOH team attended to provide all nursing assessment, treatment, physiotherapy and occupational therapy.

- The OOH team also provided a rapid assessment for the admission prevention service (APS), assessors attended at the request of GPs, paramedics and community nurses.
- Community nursing services accepted referral from all sources, including referrals from patients, relatives of patients and other health professionals.
- Community nurses reviewed urgent patients on the same day on receipt of a referral. The community nursing teams triaged and allocated all non-urgent referrals based on the information received.
- One district nurse told us the response times for urgent referrals or calls was two hours, these included catheter problems, and end of life patient's needs. She reported that staff reviewed patients within 24 hours of a non-urgent referral or call, for example wound care, and pressure ulcer concerns.
- The neurology service accepted referral from other healthcare professionals for patients that met the required criteria for the service. The service accepted patient self-referrals following discharge when patients required additional support.
- The neurology service lead told us that the referral to treatment time target from the clinical commissioning group (CCG) was 18 weeks. She reported that the service aimed to review new patients with motor neurone disease within four weeks and the service triaged and prioritised all other referrals.
- We observed a nurse in a leg ulcer clinic changing her appointment schedule to accommodate a patient who was unable to attend the only time slot left available.
- We did have concerns regarding the temporary suspension of twilight shifts for the community nursing service due to lack of staff. There were no community nurses on duty between five or six pm (depending on community nurse base) until eight pm when the night shift came on duty. The OOH team covered any emergency requests for this time period, and staff were auditing all requests. The OOH staff admitted that if they

had to decide between attending an urgent assessment request to prevent admission such as a request from a paramedic, or a patient in the most southerly area (not currently funded) who needed pain relief, they would prioritise their own work first. This meant that patients in pain or who had non urgent concerns such as catheter blockage would have to wait for two-three hours until the night staff came on duty.

- The hospice at home service measured the response rate to patient referrals. This service had set a goal to see patients within one week of referral. From November 2015 to October 2016, 96% of patients were seen within one week. In this period, 65% of patients were seen within 24 hours.
- The hospice at home service was available seven days a week from 8am to 10pm. There was one day per week when a registered nurse was not available. During this time, nursing support was provided through the on call district nurse or through the out of hospital team.
- There were no designated community inpatient beds for patients with end of life care needs. However, staff in the hospice at home team told us they could access 'beds with care' in two local care homes for patients with end of life care needs. Beds on the community inpatient ward at Carlton Court could also be used, although staff told us that these beds were used less frequently for patients with end of life care needs.
- The service monitored the number of patients who died in their preferred place of care. From November 2015 to October 2016, 96% of patients under the care of the hospice at home team died in their preferred place of care.

Learning from complaints and concerns

- The organisation reported that 121 complaints were received during the period September 2015 to August 2016. The adult community service accounted for 76 of the 121 and the community nursing service received the largest proportion of complaints to the organisation accounting for 44 of the 76. A review of the seven community nursing complaints received in July and August 2016 showed that four related to a delay in treatment, two to staff attitude and one to removal of a patient's surgical stockings.
- We saw the report of eight recently closed complaints and were assured that the appropriate actions and apologies were made and lessons learned.

Are services responsive to people's needs?

- One of the clinical services co-ordinators and two team leads told us that they did not receive many complaints. The clinical services co-ordinator reported that the main theme for complaints she had received were, not meeting patient's expectations.
- The clinical service co-ordinator told us that they investigated all complaints about their teams. They shared learning from the investigation with individual staff members involved and anonymously to the wider team.
- One of the team leads told us that they discussed any complaints and learning from complaints at monthly team meetings. We saw the meeting minutes from August 2016, which evidenced a complaints discussion.
- We spoke to four members of staff about complaints and all of them knew the complaints process, they reported that they had feedback about complaints that have been received at monthly team meetings.
- We spoke to two patients about complaints and both reported that they knew to contact the patient advocacy and liaison service to make any complaints.
- From June 2015 to May 2016, there was one complaint about end of life care services. This complaint related to clinical care and coordination of services provided to a patient in their last days of life. We saw records to show that this complaint had been investigated and actions for improving care in the future had been identified.

Are services well-led?

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

Summary

We rated well led as good because:

- There was strong and visible local leadership.
- Staff felt well supported by local management.
- There was a clear governance structure with communication to the executive team.
- There was an open culture with staff feeling able to raise concerns to their line manager.
- The organisation was pro-active in celebrating staff achievements with several members of the adult community teams receiving awards recently.
- Leaders of the service gave us examples of strategies they had in place to achieve their vision of integrating local palliative care services. For example, a pilot project for the Electronic Palliative Care Coordination System (EPACCS), which was due to start the week after our inspection.
- Leaders of the hospice at home service shared information on incident reporting and complaints with staff at monthly team meetings. This meant that staff received information on how to improve practice in response to incidents and complaints.
- There were processes in place for sharing information on quality outcomes and development of end of life care services with senior leaders of the organisation.

However:-

- There was a high level of staff sickness in the community nursing service.
- Junior staff felt disconnected from the executive team due to poor cascade of information.

Leadership of this service

- The community nursing teams were led by band seven team leads who reported to a clinical service co-ordinator (one each for the north and south of the area). The two Out of Hours (OOH) teams were each led by co-ordinators who reported to a service lead. The executive director of adult services had overall leadership of the adult community service.

- The executive team and other board members were visible to staff in the organisation and some had attended team meetings, and 'shadowed' staff in their daily work.
- We saw strong leadership at a local level with staff praising their local managers regarding their support and communication.
- We spoke to 22 members of staff about the leadership of the teams, all of them felt well supported by their line managers. Although staff felt well supported by their immediate line managers and the clinical co-ordinators, they felt there was a lack of support and representation from managers at a higher level.
- We found 10 members of the junior staff from the community nurses, occupational therapy and physiotherapy teams who felt disconnected from the executive team due to issues surrounding the cascade of information to junior staff.
- Two members of staff told us that their clinical services co-ordinator had supported them through serious health issues and their return to work. Another staff member explained how provision was being made for staff returning to work from long term sickness.
- There was a high level of sickness throughout the community nursing service with figures for August 2016 being 11%. For the reporting period September 2015 to August 2016 cumulative average of sickness absence was 9%. The clinical services co-ordinator for the south felt that the absence rate was partly due to the pressure staff were under due to staff shortages but that it had recently improved although figures were not provided to substantiate this.
- The hospice at home service was led by the clinical services coordinator who was responsible for strategic leadership of the service and coordination with other palliative care services in the local area.
- Clinical leadership was provided by a Band 7 district nurse team lead, who also had responsibility for two district nursing teams. Two Band 6 nurses supported day-to-day management of the hospice at home team.

Service vision and strategy

Are services well-led?

- There was no specific vision for the community adult service and only the more senior staff members knew the corporate vision 'We will be a ground breaking, forward thinking community focused social enterprise with a reputation for excellence and quality in improving health and wellbeing.' Staff did know the strapline 'providing high quality care – every time' and this was noted on the newsletter that we saw.
- One of the team leads reported that the organisation had a shared vision based on resilience and wellbeing for staff and patients. Developing staff in health coaching was part of the strategy in achieving resilience and wellbeing.
- One of the clinical services co-ordinators told us that strengthening staff resilience to strive for quality and invest in education was the wider community nursing team strategy.
- There were strategies for developing adult community services. The organisation had plans to expand the OOH team in Lowestoft to cover the population to the south encompassing the Beccles, Bungay and Kessingland areas which were the only areas without cover. The organisation was also reviewing the community nursing service and staff were excited about a new data analysis initiative, which would give them more oversight of their areas and teams.
- Leaders of the hospice at home service told us that the vision of the clinical commissioning group was to achieve integration between palliative care services in the area. The strategy for achieving this was through the Palliative and End of Life Care Operational Group, where representatives from different providers of end of life care in the local area met to discuss integration and coordination of care.
- The hospice at home leads gave us examples of strategies they had in place to achieve their vision of integrating local palliative care services. For example, a pilot project for the Electronic Palliative Care Coordination System (EPACCS), which was due to start the week after our inspection. We saw evidence of discussions about this project in meeting minutes for the Palliative and End of Life Care Operational Group, dated from April to August 2016, however, the local vision and strategy for the service was not formally documented.
- The organisation had eight governance committees covering audit, remuneration, policy, education and training, safeguarding, medicines management, health and safety (H&S) and infection control, which met on a regular basis. There was also an integrated governance committee (IGC) where a monthly clinical quality report was shared, which addressed all clinical quality & safety including safeguarding, complaints, compliments and friends and family test (FFT) data. The clinical quality report was comprehensive and we saw the minutes of the July H&S meeting and the October IGC meeting which showed that concerns were addressed and targets and actions identified in relation to risks to patients, staff and the organisation.
- Staff told us they knew how to escalate concerns relating to clinical governance. Ultimately, concerns would be raised with the clinical leads for each service. We saw that clinical governance meetings took place across the services and within specialities and reviewed a clinical quality report (CQRM) from a meeting in October 2016.
- We saw up-to-date copies of the corporate governance structure and local staff structure in all of the bases we visited.
- Senior staff told us that they had a good relationship with the executive team and attended regular governance and quality meeting at head office. Information from the governance and quality meetings was cascaded to staff through team meeting.
- The provider kept a risk register and all local risks were monitored on the one register. We reviewed the risk register and found 19 risks recorded for adult community services. Two of the risks were rated as extreme high and related to non-compliance with NICE guidance and risk of patient harm. Of the remaining 17 open risks, 10 were rated as high and related to concerns around staffing and capacity, lack of connectivity for the electronic patient records and environmental concerns.
- The OOH team lead had oversight of the local risks impacting on the OOH teams on the corporate register and was able to produce an up to date version with dates of opening and closing and comments relating to how the risk was managed.
- Managers had access to the electronic risk register; however, the junior staff were unable to access the risk register electronically.

Governance, risk management and quality measurement

Are services well-led?

- There were limited local risk registers and not all staff knew how to access the corporate risk register or what the risks for their area were.
- Team leads and clinical services co-ordinators told us that risk assessments relating to the safety of staff in individual patient homes was uploaded and stored in the patient record. None of the community nursing team leads or clinical services-co-ordinators kept a folder of active risk assessments. We were concerned that senior staff lacked oversight of risk assessments relating to staff safety.
- Leaders of the hospice at home service shared information on incident reporting and complaints with staff at monthly team meetings. This meant that staff received information on how to improve practice in response to incidents and complaints.
- There were local processes in place to make sure that staff working alone were kept safe. Staff told us that they recorded the location of their visits on the electronic patient records system and 'checked in' with each other. Staff told us that senior staff in the organisation supported staff to withdraw care if the environment of a patient's home was unsafe.
- The clinical services coordinator chaired the Palliative and End of Life Care Operational Group. Minutes from this meeting were sent to the palliative end of life programme board, which was run by the local clinical commissioning group and was attended by the organisation's director of quality and development. This meant that there was a process in place for sharing information on the development of palliative care services with leaders of the organisation.
- Quality outcomes were recorded in a clinical quality report, which was shared with leaders of the organisation at an integrated governance committee meeting. This meant that there was a process in place for sharing information on quality outcomes with leaders of the organisation.
- We saw a risk register for adult services, but there was no local risk register for the hospice at home service. This meant that risks specific to the hospice at home service were not formally recorded and managed.

Culture within this service

- The culture in the community nursing teams encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. Most staff felt

comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned.

- We spoke to 26 members of staff about the organisation culture and all of them reported that they enjoyed their jobs and felt valued. They all made particular reference to the no blame culture within the service and felt able to raise concerns.
- One staff member told us, "This is the best organisation I have worked for!" Other staff commented that working for the organisation was "like being part of a family".
- Another member of staff told us that she had made the choice to work for the provider based on the organisational values. She reported that staff demonstrated the organisation's values and they were respectful of each other.
- We observed a member of the community nursing team being assisted to report a potentially threatening incident involving a patient on the electronic system, and within five minutes of the form being uploaded the clinical service co-ordinator had contacted the member of staff to check whether they needed any support. On observing this another member of staff commented that this was fairly common of the sort of support that they received from their manager.
- A student nurse had received such a good experience with the organisation that she planned on applying for a job on qualifying, stating that they were "incredibly supportive".
- There was a positive culture within the hospice at home service and staff were positive about local leaders.
- Leaders of the hospice at home service gave us examples of how they supported staff well-being. For example, leaders told us how they had used a wellbeing assessment to identify areas of work-related stress for an employee and had set goals with the employee to reduce these areas of stress.
- The rate of staff sickness in the hospice at home service was 13%, which was high compared to other areas in the organisation. Senior staff told us this was due to having one member of staff absent from work due to long-term sickness. This reflected as a high sickness rate due to the small size of the team.

Public engagement

- The organisation sent out friends and family (FFT) questionnaires following episodes of care. The figures

Are services well-led?

for the months of July, August, and September were consistently 100% for the community nursing and occupational therapy services, between 96% and 98% for the physiotherapy service and between 91 and 100% for the OOH team. The organisation did not record the number of surveys handed out per service, patient contacts were recorded against positive feedback which meant the community nursing service had over 2,000 positive contacts, the occupational therapy between 350 and 400, the physiotherapy teams averaging around 420 positive contacts and the OOH teams 150.

- The neurology team held patient engagement events, 50 patients attended the last event. They also held a monthly motor neurone disease help group for patients and carers, which one of the neurology nurses attended. The organisation had links with a number patient support groups for conditions such as Parkinson's disease, Multiple Sclerosis (MS) and Motor Neurone Disease.
- The provider used the 'you said we did' approach to patient feedback and as a result has changed some processes. Examples given included asking care homes to put photographs of patients with communication difficulties on their drug charts and providing more detailed information regarding appointment waiting times.
- The organisation had developed 'patients as teachers' forums to allow patients to give current experiences of the care and treatment they had been provided with and identify service improvements. We saw evidence in an IGC meeting (August 2016) where patients had shared their concerns, and an action plan developed to address their concerns.
- The adult community service regularly received compliments from patients. During the reporting period September 2015 to August 2016 the organisation received 405 compliments overall of which 41 were for the community nurses and 32 for the OOH teams.
- Senior staff told us about a project they were working on with the local acute hospital and GPs to develop a 'local voices' questionnaire.
- We saw three sets of minutes from the Palliative and End Of Life Care Operational Group, dated from April to August 2016, which included discussion of strategies to increase public engagement with end of life care services.

Staff engagement

- A weekly newsletter provided staff with organisational updates from the executive team, accessible via the organisation's intranet facility. The chief executive wrote a weekly 'blog', which had been read by most of the staff we spoke with. We saw a copy of the newsletter, dated 01/11/2016, and found it to be informative and relevant to all, with sections on the latest training programme, latest news including the staff awards and salary sacrifice schemes.
- The community nursing teams held weekly team meetings which provided a forum for discussion of service delivery, quality, development and case load. The meetings were attended and chaired by the community matrons and all trained nurses and nursing assistants attended.
- The south clinical service co-ordinator chaired a monthly meeting for the community matrons where they all met for a whole day to discuss topics covering learning needs, service development and progress and governance.
- Staff throughout the community adult service felt let down by the lack of communication regarding the closure of some services at local community hospitals. Eight staff members commented that they only found out about the hospitals definitely closing a couple of days prior to closures although they had known that it was a possibility.
- Seven members of staff told us that information cascaded from the executive team was unclear. They gave us an example whereby there was a lack of clarity over changes to job roles following a consultation process.
- Ten further staff members told us that they felt disconnected from the executive team.
- Three senior members of staff in the hospice at home service told us that they felt listened to by senior leaders of the organisation.
- Two members of staff told us that senior leaders knew their name, which made them feel valued.

Innovation, improvement and sustainability

- The organisation recently celebrated the ECCH staff awards 2016 where colleagues nominated staff, and winners were invited to a ceremony and dinner and dancing. The clinical service co-ordinators of the district nursing teams, the north and south district nursing teams, the OOH lead and the north and south OOH teams, and several adult community individuals all won

Are services well-led?

awards in several of the 10 categories including innovation, inspirational leaders and ECCH champions. Staff were very proud of their nominations and awards and this fostered a sense of recognition for their work.

- One of the team leads had worked closely with local residential home to train nominated carers to administer insulin to patients. Once the carers had completed their competencies, nursing visits were reduced from once or twice daily to one visit per week in some of the residential home.
- Senior staff told us that they scanned any compliments received from patients onto the computer system and emailed these to staff, so that staff had access to feedback about the service.
- Senior staff told us about plans to pilot the Electronic Palliative Care Coordination System (EPACCS) to improve the coordination of palliative care services in the area. This system was due to be introduced the week after our inspection.