Care Plus Group (North East Lincolnshire) Limited

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

This report describes our judgement of the quality of care provided within this core service by Care Plus Group (North East Lincolnshire) Limited. 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 Care Plus Group (North East Lincolnshire) Limited and these are brought together to inform our overall judgement of Care Plus Group (North East Lincolnshire) Limited.

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Overall summary

This service was not rated as we do not currently rate this type of organisation.

At this inspection we found:

- Staff were aware of their safeguarding responsibilities and knew how to report concerns.
- Staff had access to up to date evidence based policies, procedures and guidelines and care was provided based on national guidance.
- Staff had the necessary qualifications and skills to carry out their roles effectively and had regular supervision and appraisals.
- There were good examples of multidisciplinary teamwork.
- Staff were aware of their responsibilities regarding the Mental Capacity Act.
- Feedback from patients was positive; staff were seen to be caring and compassionate.
- Services were planned and delivered to meet people's needs. Patients could access services in a timely way.
- Staff spoke positively about working for the organisation and staff engagement was encouraged.
- The organisation engaged well with the public and employed a number of volunteers.

However:

- We were not assured that there were robust processes in place to ensure all staff received feedback about incidents.
- We were not assured that action plans for serious incidents addressed all the issues sufficiently.
- No caseload weighting tools were used to inform staffing levels and data was not used consistently to inform complexity and support staffing.
- Local risk registers were not in place and risks identified by service leads were not captured fully on the corporate risk register.

Summary of findings

Background to the service

Care Plus Group is a social enterprise and takes the specific form of a Community Benefit Society, providing NHS adult community services, and end of life care in North East Lincolnshire.

Community services for adults included community nursing services (incorporating district nursing and complex case management), specialist nurses (diabetes, skin integrity, infection control, continence and stroke), discharge team, rapid response team, telephone triage, community cardiology service and a respiratory and falls service. The total number of permanent staff for community adults was 242.

The cardiology service was a new community service and commenced in August 2016. Its focus was on transformational changes and investment to support patients with cardiovascular conditions in primary care.

During our inspection we visited and spoke with seven community nursing teams, the discharge team, the skin integrity team, infection control team, continence team including a paediatric continence nurse, diabetes nurse specialist, rapid response team, telephone triage, respiratory and falls service and the cardiology service.

We included the paediatric continence service in our report as this was the only service providing direct care for children. The report also discusses children with regards to the telephone triage service.

We spoke with 48 members of staff including nurses, health care assistants, therapists, care workers, team leaders, managers and service leads. We spoke with nine patients and two volunteers. We accompanied nurses on visits to observe patient care, looked at 14 patient records and listened to four telephone triage calls.

Our inspection team

Our inspection team was led by:

Chair: Paul Morrin

Team Leader: Lisa Cook, Care Quality Commission

The team included CQC inspectors and specialists including community matrons.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 13 and 15 December 2016. During the visit we held focus groups with a range of staff who worked within the service. We talked with people who use services. We observed how people were being

Summary of findings

cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 22 December 2016.

What people who use the provider say

Comments we received from patients during our inspection were positive. Staff were described as kind and caring.

Good practice

The International Organization for Standardization (ISO) 9001 process provides a set of standards to help organisations to become better managed, more efficient and more customer focused. This was used for community nursing, rapid response and telephone triage, with a view to rolling it out to all areas. This meant a standardised approach was used to working. For example, community nursing administration staff had been based at eight sites with different ways of working at each one. As a result of using the ISO process, they were all brought together to provide consistency.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider MUST:

- Ensure action plans following incidents are thorough and robust and include the relevant staff.

The provider SHOULD:

- Consider how learning from incidents is shared across the service.
- Review the use information to inform complexity and support staffing.
- Ensure all staff are keeping prescription pads in line with organisational policy and national guidance.
- Ensure that community nursing team leaders have an awareness of risks.
- Ensure that all identified risks are contained on the risk register.

Care Plus Group (North East Lincolnshire) Limited

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

At this inspection we found:

- An electronic reporting system was in place and staff knew how to use it. However, there did not appear to be a robust process in place to ensure staff received feedback about incidents.
- We were not assured that action plans for serious incidents addressed all the issues sufficiently.
- Some staff took prescription pads home and we were not assured that they were kept secure in line with organisational policy and national recommendations.
- No caseload weighting tools were used to inform staffing levels. Staff used a tier of need assessment to determine patient's level of complexity. However, data was not used consistently to inform complexity and support staffing.
- Staff did not carry lone working devices or alarms. The lone worker policy stated that those staff in medium or high risk level roles should carry a personal alarm. However, service leads told us there were plans to issue staff with alarms.

However:

- Staff were aware of safeguarding procedures and how to report concerns.
- Risks to patients were assessed, monitored and managed. Comprehensive risk assessments were carried out including pressure ulcer risk, wound, nutrition, moving and handling, and mental health assessments. These were regularly reviewed.

Detailed findings

Safety performance

- Staff collected information for the Safety Thermometer. The NHS Safety Thermometer was a national improvement tool for local measuring, monitoring and analysis of, patient and harm free care. The tool monitors pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE).
- Data provided from the safety thermometer showed that in November 2016 there were 13 pressure ulcers reported, 18 falls with harm, one patient with a catheter with a urinary tract infection and no new VTE's. Over a

year from December 2015 to November 2016 the percentage of patients receiving harm free care ranged from 88.6% in March 2016 to 94.6% in February 2016. The average over the year was 92.2% harm free care.

Incident reporting, learning and improvement

- Incidents were reported through an organisation wide electronic reporting system. Staff were aware how to report incidents and had received training in electronic incident reporting. Staff said they received feedback if they had reported a serious incident.
- There was inconsistency between the staff we spoke with as to whether they received feedback about incidents within the organisation. The majority of staff said they received feedback at team meetings and via email.
- The diabetic specialist nurse told us that she did not routinely receive information about incidents involving diabetics and insulin administration.
- There did not appear to be a robust process in place to ensure staff received feedback about incidents. We reviewed team meeting minutes and there appeared to be no set agenda; different teams were therefore discussing different things. We saw evidence in some team meeting minutes of incidents being discussed, but not in others.
- There had been no never events reported. 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.
- Nine serious incidents requiring investigation were reported between September 2015 and July 2016.
- We reviewed two investigation reports. These included a background description of the incident, guidance considered, chronology of events, good practice, root cause of the incident and an action plan.
- However, on reviewing a serious incident report, we were not assured that the action plan was robust enough with regards to the action taken.
- Staff could tell us about a medication incident, as a result of which the documentation had been changed. However, we could not establish that any audits had been done after the implementation of the new documentation to ensure the practice had been embedded.
- There were 534 incidents reported between January 2016 and December 2016. The main theme from the incidents was pressure damage.
- The chief nurse attended multi-agency mortality review meetings.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It 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.
- We saw evidence of implementation of the duty of candour, including letters sent to patients following incidents informing them of the incident, the investigation that had been carried out and the outcome.
- Staff we spoke with could tell us about the need to be open and honest with patients and their families.

Safeguarding

- The service had recently reviewed policies for safeguarding adults and children available. However, the safeguarding children policy referred to 'Working Together to Safeguard Children' (2013). This guidance was updated in 2015; there was therefore a risk that they were not working to current guidance.
- The Chief Executive was the Executive Lead for Safeguarding and the Chief Nurse was the Named Nurse for Safeguarding.
- Staff we spoke with had safeguarding adults and safeguarding children Level 1 training. Team leaders had received safeguarding adults Level 2 training. Data provided by the organisation for training compliance between April 2016 and October 2016 showed that 85.2% of relevant staff had attended safeguarding adults Level 1 training and 73% had attended Level 2. Data for safeguarding children Level 1 training showed that 92.7% of relevant staff had attended. Targets for training compliance were 90%, to be achieved at the year end.
- We identified one nurse who required safeguarding children Level 3 training who was not up to date with this training. The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the

needs of a child or young person should be trained to Level 3 in safeguarding. We raised this with the executive team at the time of our inspection and it was confirmed that this had been addressed immediately.
- We followed this up during our unannounced inspection and the nurse had completed online Level 3 training and was making arrangements to attend face to face Level 3 training.
- Staff we spoke with knew how to make a safeguarding referral if they had any safeguarding concerns.
- The organisation had been involved in one serious case review. The serious case review had concluded that the organisation had acted appropriately throughout with no recommendations being made in respect of changes to practice.

Medicines

- We saw patient group directions (PGD's) for influenza vaccination. All were dated and signed. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.
- An up to date medicines policy was available to practitioners.
- Most of the community nursing teams that we visited accessed medication that required refrigeration from the GP practices. We saw one fridge that was the responsibility of the community nursing team, although it had no medication in it at the time of our inspection. Daily checks of the temperature were therefore not undertaken regularly, as medication was not stored in there all the time.
- Community nurses explained to us how they maintained the cold chain when visiting patients with medication that required refrigeration. They carried the medication in cool bags and only took the amount of medication they needed.
- Controlled drugs (CD's) were prescribed by a GP and delivered to the patient's house. Community nurses were therefore not having to carry CD's with them.
- Some of the community nurses held a community practitioner prescribing qualification allowing them to prescribe a limited range of medications and dressings.
- The organisation provided prescribing supervision and a prescribers forum to ensure that staff were kept up to date.
- Some of the nurses were taking their prescription pads home with them if they did not return to base after their last visit of the day and we were not assured that they were kept secure. This was contradictory to the organisations medicines policy, which advised that when not in use prescription pads should be stored securely, for example in a car boot which is fitted with an alarm. NHS Protect (2015) 'Security of Prescription Forms' guidance says: 'Prescribers on home visits should, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss'. There was no formal process in place to ensure only a small number of prescriptions were taken at one time and ensure prescription pads were kept safe and secure.

Environment and equipment

- Staff bases that we visited were secure.
- Staff we spoke with told us they had access to the equipment they needed. They knew how to report faulty equipment and when equipment needed servicing.
- Staff ordered equipment from an external supplier, such as beds and walking frames to support care in patient's homes. The supplier contacted the patient directly to arrange delivery.
- The rapid response team had access to an equipment store so that they could access equipment on the day needed.
- Staff completed a care plan for equipment in use and visited the patient regularly to review the need for the equipment.
- A database was kept of blood glucose meters; this allowed the nurse specialist to see whether they were checked as often as they should be. Records showed that these checks were completed.

Quality of records

- Patient records were electronic. Patients had paper records in their homes.
- We reviewed 14 patient records. Risk assessments were completed and individualised care plans were evident.
- Flags to indicate risks, such as environmental issues, were seen on the records. Any safeguarding risks were also flagged.
- Quarterly audits were undertaken of care plans. We saw the results of the audit for quarter 1 of 2016 which

showed 100% compliance for frequency of visits populated, care plan aim altered, goal populated, care plan in place and care plan adhered to. The section entitled 'is the referral relevant to the care plan' scored 76%. It was acknowledged in the audit that this was not due to non- adherence, but that a number of patients had additional care plans in place that differed from what they were originally referred for.

- Documentation audits were completed by the quality and performance team. During a documentation audit 10% of the records for a caseload were audited.

Cleanliness, infection control and hygiene

- Records showed that 76.3% of community adults staff had attended infection control level 2 training.
- The organisation employed three infection control specialist nurses whose role was to educate and support staff. Each nursing team had an infection control link nurse.
- The infection control link nurses carried out infection control essential assessments annually. Data provided showed that the majority of staff had achieved 100% for hand hygiene, personal protective equipment (PPE), aseptic technique and sharps management.
- We observed staff during visits to patients. Staff were arms bare below the elbows and complied with the infection control policy for handwashing.

Mandatory training

- Mandatory and statutory training was available in 13 core subjects including moving and handling, mental capacity act introduction, conflict resolution, fire safety and information governance.
- Staff had access to their training matrix which informed them of which courses they were required to do and which were due for renewal.
- The majority of staff we spoke with told us they were up to date with mandatory training. Those who weren't fully up to date were due to reasons such as return from long term leave or lack of access to the course.
- Data provided showed that mandatory training rates for adult community services between April 2016 and October 2016 were variable. For example, records showed that 97.8% of staff had completed moving and handling, 96.2% had completed electronic incident system training, 92.5% had completed fire safety, 82% had completed information governance and 93.1% had completed conflict resolution. We also saw that 79.2% of staff had completed basic life support training. Senior managers told us that the training compliance target was 90%, to be achieved at the year end. This target was cumulative of the 13 statutory and mandatory courses, but was also broken down for managers to individual team level. Basic life support training did not have a target set against it. There was therefore a risk that some staff could have low compliance with statutory and mandatory training that would not be recognised.

Assessing and responding to patient risk

- Staff undertook a range of risk assessments. These included pressure ulcer risk assessment, wound assessment, nutritional assessment, moving and handling assessment and mental health assessment. The assessments were reviewed monthly for long term patients.
- If any of the nurses were concerned that a patient was deteriorating they would contact the GP.
- All grade three pressure ulcers were reviewed by the tissue viability nurse. They all had a root cause analysis completed and were included in the performance report to the board.
- A pressure ulcer steering group met quarterly to look at the amount of pressure ulcers, categories and whether they were avoidable/unavoidable. If a specific theme was identified, the skin integrity team carried out an audit.
- Staff relied on other professionals to inform them of any risks at the home. When these were highlighted staff visited in pairs as required in the lone worker policy. Any risks would be flagged on the electronic patient record.
- Telephone triage staff assessed patient risk with an electronic triage tool. The triage tool was used for both adults and children. The tool provided a decision for care based on the information inputted by the staff member. Staff on the telephone triage were experienced Band 6 clinicians. They had access to online toxicology information, access to the British National Formulary and there was a telephone triage protocol in place if the clinical support software system failed. We were assured that systems were in place to recognise changes in a child's condition and manage that risk.
- The organisation had a complex case team. This was a team of senior nurses who supported the community nursing teams with patients who had complex needs. For example, patients with chronic obstructive

pulmonary disease, who had multiple hospital admissions. The complex care team supported the patient in self-management to reduce admissions and GP referrals.
- The continence team provided assessments for patients within 28 days of referral.
- Staff had attended sepsis training, carried sepsis cards and completed a sepsis template on the electronic patient record.

Staffing levels and caseload

- Nursing teams had one Band 7 nurse manager, one Band 6 team leader and a number of Band 5 community nurses and Band 3 health care assistants. Some teams had a Band 4 associate practitioner.
- Caseloads were not measured with a weighting tool to identify the number of staff required in each team. Geographical caseloads were allocated as individual caseloads to Band 5 staff, ranging between 20 and 40 patients each. Band 6 staff had smaller caseloads of more complex patients, for example, patients receiving end of life care. Band 7 staff monitored the caseloads through supervision meetings; however, these were not always on a daily basis.
- Individual teams had their own timescales for reviewing caseloads. Staff used a tier of need assessment to determine patients level of complexity. However, that data was not used consistently to inform complexity and support staffing.
- Due to vacancies in a couple of teams, staff were seeing increased numbers of patients. We were given one example of when a nurse saw 22 patients in one day.
- Staff said there was a lack of coordination in planning visits, which resulted in more than one member of staff visiting homes on the same street, or in a care home. However, staff in other teams we spoke with told us that their caseloads were manageable and were matched to their level of competence.
- Service leads told us that a decision had been made to progress to geographical deployment across the whole borough to maximize and flex resources.
- The telephone triage service was running at 50% capacity due to sickness. There were 3.87 whole time equivalent (WTE) vacancies. These shifts were filled by experienced bank staff. These staffing issues had been identified as a risk on the risk register.
- Between 4pm and 8pm the community nursing teams were coordinated by the rapid response team. The teams worked together. Out of hours, after 8pm, there was no planned care and the rapid response team responded to any issues that needed dealing with.
- On a weekend there were two Band 5 nurses for a geographical area overseen by a Band 6 nurse. Teams 'pooled' their patients geographically so that there were sufficient staff to cover the patients.
- Community nursing had 8.35 WTE vacancies. Data showed that for three months between September and November 2016 there were 1.9% of bank staff used.
- There was a vacancy for the operations manager for rapid response and discharge teams, with interviews due to take place in January 2017.

Managing anticipated risks

- An adverse weather and other emergency conditions policy was in place.
- Staff told us that they would make every effort to reach patients in times of disruption.
- A lone worker policy was in place which included ensuring visits were scheduled in diaries, risks assessments were in place for any patients that were a potential risk, staff carried mobile phones and staff were aware to ring base and use a particular phrase to alert other staff that they were in a difficult situation. However, staff did not carry lone working devices or alarms. The lone worker policy stated that those staff in medium or high risk level roles should carry a personal alarm. One staff member told us of an incident when she had been in a patients home and felt unsafe. Service leads told us that staff were to be issued with alarms.

Major incident awareness and training

- An emergency preparedness and resilience policy was available. The organisation was part of the Emergency Preparedness and Resilience Group (EPARG). This focused on the ability to co-ordinate a local response to a major incident.
- The Val Waterhouse Centre, which was the base for a number of teams, had a Lockdown procedure. This had been tested in June 2016 and an action plan developed from the outcome. Lockdown procedures would be used in response to an external incident that could threaten staff.

Are services safe?

- The organisation was part of the local resilience forum. Their role within resilience planning was to provide triage. They were a category one responder under the civil contingencies act.
- Staff gave an example of where they took on the role of briefing care homes about road closures in the area when there had been a visit from the prime minister. During this time the Val Waterhouse Centre was used as a communication hub. In preparation for the event and road closures, staff were redeployed to ensure they were available to do home visits.

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.

Summary

At this inspection we found:

- Care was provided in line with national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. Staff had access to up to date policies, procedures and pathways.
- Staff had regular supervision and appraisals.
- Our observation of practice, review of records and discussion with staff confirmed multi-disciplinary team (MDT) working practices were in place.
- Staff were aware of their responsibilities regarding consent and the Mental Capacity Act.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience.

Detailed findings

Evidence based care and treatment

- Staff had access to policies and guidelines on the organisational intranet. We saw examples of policies and procedures which were up to date and reflective of National Institute of Health and Care Excellence (NICE) guidelines, such as, guidelines for the prevention and management of pressure damage.
- Staff told us that policies were updated to reflect the most current NICE guidance. A clinical forum, which had representatives from each team and was chaired by the chief nurse; reviewed policies and the NICE guidance before policies were sent to the governance committee.
- The diabetes nurse specialist ran a Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme. DESMOND is a structured nationally recognised programme.
- The diabetes nurse specialist was involved in writing the diabetes care pathway and told us that the pathway would be updated as new NICE guidance was published.

Pain relief

- Patients pain was assessed using a specific system to measure pain, which included visual aids.
- The telephone triage service routinely asked all callers if they were in pain and carried out an assessment and provided advice.

Nutrition and hydration

- Nutritional assessments were undertaken using the Malnutrition Universal Screening Tool (MUST) as part of the initial assessment of all patients. The MUST helps to identify adults who are underweight and at risk of malnutrition, as well as those who are obese. We saw completed MUST assessments in patient records.
- We observed staff discuss nutrition with patients on home visits, for example in relation to their condition of diabetes.
- The falls rehabilitation and respiratory team had access to a dietitian, who would see patients at the Hope Centre.

Technology and telemedicine

- The telephone triage service used telemedicine to support patients. This used clinical decision support software, which analysed data to help the nurses make clinical decisions.

Patient outcomes

- The community falls and respiratory rehabilitation teams provided patient outcome measures for all patients. Data seen at the time of inspection demonstrated consistent improvements of patients abilities following the programme.
- An audit plan was in place which included local audits and audits of compliance with NICE guidelines.
- A pressure assessment audit carried out in June 2016 showed that there was variability between the teams as to the results. There was low compliance in the following areas: risk assessments completed, Tissue, Infection, Moisture and wound Edge (TIME) wound assessment completed, care plan meets the needs of the patient and the care plan was re-evaluated as necessary. Results showed that some areas of compliance had got better since a previous audit in

November 2015 but others had got worse. Each audit had an action plan that identified that the skin integrity team would work closely with those teams scoring a low percentage.

- Performance reports were produced quarterly. These included issues such as the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services and the reduction in the prevalence of grade 3 and 4 pressure ulcers.
- Results showed that for quarter two of 2016/2017, 94.4% of older people were still at home 91 days after discharge, this was better than the target of 91%. The target for grade 3 pressure ulcers was no more than 1% and grade 4 was no more than 2%. The actual figures were 0%.

Competent staff

- Staff we spoke with had regular appraisals. Data provided showed that 86.2% of staff had received an appraisal within the last 12 months in community adults overall. The target was 80%.
- Staff also received regular one to one supervision with their line manager and monthly group supervision.
- Staff told us they had opportunities for training, other than mandatory training. Staff said the organisation was supportive and encouraged them to identify opportunities for learning.
- The organisation provided training sessions on revalidation for nurses. All registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising.
- A six month preceptorship programme was in place for all new starters. Newly qualified nurses were not given a caseload initially until they had achieved required competencies, gradually building up a more complex caseload.
- We spoke with one new community nurse who said they felt well supported and were slowly building up their caseload with support. New nurses worked as health care assistants until they had their Nursing and Midwifery Council registration number confirmed.
- Link nurses were available in each team for diabetes, infection control and tissue viability.
- Staff could apply for the 'Val Waterhouse' bursary each year, which was available to fund training and development not accessible via the statutory and mandatory training programme.
- Ten health care assistants had completed competencies for insulin administration. The plan was for all health care assistants to be trained as part of their professional development.
- It was policy that the health care assistant could see the patient three times and then a qualified nurse would have to see the patient to review them.
- Data showed that 82.1% of staff, qualified and unqualified, had completed glucometer training.
- Staff undertook pressure ulcer competencies every two years. We saw examples of completed staff competencies.
- Bank staff were asked to provide certificates of attendance at training and were not allowed to do anything they were not trained to do. Bank nurses received supervision from a Band 7 manager.
- Volunteers undertook a 'mini' corporate induction. Appropriate checks were undertaken on volunteers to ensure they were suitable for the role.
- Staff were being asked by management to undertake the care certificate. This was a course normally completed by care assistants, however management wanted nursing staff to complete it to refresh their competence. Some of the registered nurses we spoke with said this made them feel undervalued.

Multi-disciplinary working and coordinated care pathways

- The discharge team consisted of multi-disciplined practitioners including nurse practitioners, social workers and admission and discharge coordinators. They worked closely with the acute hospital.
- The rapid response team were multi-disciplinary. Nurses, paramedics and social care workers were employed by the provider and therapy staff, employed by an acute trust hospital, worked as a team to provide rapid interventions for patients with the aim to reduce hospital admissions.
- District nursing teams and the complex case team attended GP led multidisciplinary meetings, along with the Macmillan team, to discuss palliative care patients receiving palliative care and those with more complex needs.
- The diabetic nurse specialist worked closely with the Clinical Commissioning Group (CCG) special project lead and provided education and training to primary care health providers.

Are services effective?

- The skin integrity team worked with care homes to increase staff knowledge with regards to pressure care.
- The infection control team also worked with care homes to improve quality of care.
- The falls and respiratory service used a multi-disciplinary specialist team which included physiotherapists, occupational therapists, specialist nurses, dietitians and a large number of volunteers.

Referral, transfer, discharge and transition

- Referrals to community services came from a variety of sources including GP's, hospitals, care homes, other community services and self-referrals.
- The rapid response team dealt with any health or social care urgent situation, assessing people in crisis and co-ordinating a rapid support service that responded to their needs.
- The telephone triage service dealt with any patient that contacted the service.
- There was a single point of access telephone number for referrals in to the services. This meant practitioners spent less time managing referrals in to the services.
- For referral between services in the community, staff completed an electronic referral on the electronic patient record. The skin integrity team had a referral pathway, which we saw. This provided clear criteria for who should be referred to the service.
- The complex case team accepted referrals for patients with two or more conditions. However, on speaking with community nursing staff it was not clear who or when they would refer, but was left to the individual nurse to decide. However managers informed us the referral criteria was reflected in the service specification
- The Discharge Team was part of an integrated multiagency hospital discharge team. Staff within the service were based in a variety of settings to provide comprehensive assessments and case management support to individuals with complex discharges.

Access to information

- Staff undertook electronic record keeping. The system for record keeping was shared by most GP's which enhanced the sharing of information.
- Some paper records were kept in the patients home, such as care plans and prescription charts.
- Community nursing teams had access to mobile working devices. This meant that staff had access to medical and nursing records in patients own homes, which ensured staff had up to date knowledge of patient needs.
- However, the rapid response service did not have access to mobile devices, therefore they did not have access to a patients record whilst in the home. However, they could contact the telephone triage service who could access the records and pass any relevant information on.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Introduction to the Mental Capacity Act (MCA) was one of the core statutory and mandatory training courses. Records showed that 97.3% of staff had attended Introduction to MCA and Deprivation of Liberty Safeguards (DoLs) training.
- We listened to four telephone triage calls. On every call the patient was asked for consent to view and share their medical record by the call handler.
- Staff were able to tell us about when they would undertake best interest meetings. We saw a completed mental capacity assessment and the decision from a best interest meeting.
- Nurses were observed, on visits to patients, obtaining verbal consent prior to carrying out any procedure.
- Consent to assessment and consent to treatment templates were completed on the electronic patient record for every new patient.

Are services caring?

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

Summary

At this inspection we found:

- Staff delivered compassionate care, they treated patients with dignity and respect.
- Service user feedback was positive.
- Staff provided emotional support along with physical support.

Detailed findings

Compassionate care

- We observed staff delivering compassionate care and meeting patients emotional needs.
- Staff were observed being polite and having a good rapport with the patients.
- Patients we spoke with told us they looked forward to visits and that staff were always kind and caring.
- Friends and Family Test (FFT) data from October 2016 showed that they had received 35 responses. From these responses 97% would recommend the service to friends and family. This was higher than the England average of 95%.
- Data collected from service user satisfaction feedback showed that 94.7% of service users rated the service as excellent or good between April and June 2016 and 93.4% between July and September 2016.

Understanding and involvement of patients and those close to them

- Staff demonstrated an excellent knowledge of their patients when caring for them. We saw patients and family members being included in the care and decisions made about care needs.
- Staff in the discharge team told us they would work closely with the patient to devise a care plan for a safe discharge. Families were included in the discussion if the patient wanted them to be involved.
- The diabetic nurse specialist ran education sessions for patients to give them the knowledge, confidence and ability to manage their condition day to day.

Emotional support

- Staff in the respiratory and falls service routinely undertook mental health assessments and initial assessments carried out by community nursing teams included assessments of mental health. This allowed staff to provide emotional support to patients where needed.
- One patient who was low in mood and lacked confidence told us the ‘staff were marvellous and had given her hope’.
- The discharge team and the telephone triage team worked in partnership with the mental health liaison team to provide support for patients who were experiencing problems with their mental health.

Are services responsive to people's needs?

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

Summary

At this inspection we found:

- Services were planned and delivered to meet people's needs.
- The telephone triage service and rapid response service provided 24 hour support for patients.
- The organisation had formed health and wellbeing collaboratives supported by community members that encouraged people to improve their health and wellbeing.
- Staff had attended dementia awareness training.
- Information was provided to patients on how to make a complaint.

Detailed findings

Planning and delivering services which meet people's needs

- The organisation had recently set up a community cardiology team. The team consisted of a consultant cardiologist, a specialist cardiology nurse and a specialist technician in echocardiograms. The purpose of the team was to deliver a community cardiology service, providing diagnosis, management, treatment and continuing care for patients.
- Referrals to the community cardiology team were accepted from GP's. Patients were able to see the clinicians and receive tests in one appointment. This meant less hospital visits for patients.
- The organisation had a well-established community falls and respiratory rehabilitation service. The service provided a rolling eight week rehabilitation programme, for patients who had suffered a fall, and one for patients suffering long term respiratory illness.
- Once the eight week programme had been completed patients could continue to access the service through a 'rehab plus' group. This was facilitated by the volunteers and supported patients to gain confidence and maintain achievements.
- The telephone triage service operated 24 hours a day. Patients were able to speak directly to nurses who could give them health advice.
- The rapid response team worked 24 hours a day, seven days a week providing a rapid support service that responded to patient need, aiming to reduce the need for admission to hospital or nursing homes.
- The organisation worked with community members to encourage people to improve their health, wellbeing and lifestyle.
- The skin integrity team were undertaking an audit in to leg ulceration and how many patients there were on a caseload, with a view to setting up a leg ulcer service.

Equality and diversity

- Staff told us that their population was mainly White British and they did not often need to use interpreting services, however they knew how to access an interpreter, either by phone or face to face, if required.
- Staff we spoke with said that if they needed leaflets in a different language or different print then they would contact the Quality and Performance team.
- The paediatric continence nurse used visual aids to support care and understanding of patients with learning disabilities.

Meeting the needs of people in vulnerable circumstances

- The organisation had recently implemented a dementia awareness training session. Thirty nine members of staff had attended this. Staff who had attended said it was really useful and they hoped there would be more.
- The falls and respiratory team had a specialist therapist in dementia.
- Staff had access to specialist equipment, for example bariatric equipment, to meet the needs of patients.
- The discharge team were able to put packages of care in place for those more vulnerable patients such as those with dementia, learning disabilities and drug and alcohol misuse.

Access to the right care at the right time

- The rapid response team provided a 24 hour, seven days a week service. They had been set response time targets by the CCG. These targets were: one hour for emergencies, two hours for urgent and up to six hours for all other referrals.

Are services responsive to people's needs?

- The team had only just started to measure their response times at the time of our inspection, therefore they could not provide any information as to how well they were meeting those targets.
- The community nursing teams had response time targets of: four hours for urgent, three days for less urgent and seven days for routine.
- Community nursing teams told us that they prioritised their work to ensure those with the most urgent need were seen. For example, patients receiving end of life care were prioritised and other visits rearranged if necessary.
- The community cardiology team had no waiting times for patients at the time of our inspection. Data indicated the number of referrals had risen from four in August 2016 to 105 in December 2016.
- The discharge team had a target that patients should be discharged within 48 hours of being declared medically fit. Staff told us that it was not very often that they had delays beyond this time. Staff were unaware of any audits that were undertaken, we were therefore unable to tell how well they were meeting this target. However, further information from the provider stated this was being monitored by the Quality and Performance Team.
- Two diabetes support groups had been set up, one of which was in the evening, meaning those people who worked during the day would have the opportunity to attend.

Learning from complaints and concerns

- Between November 2015 and October 2016 the service had received five complaints. Two were partially upheld and three were still under investigation at the time of inspection. The organisational complaints framework allowed 12 weeks to respond to complaints, which they were meeting.
- Staff told us that they tried to address complaints informally in the first instance.
- We saw leaflets provided to patients informing them how to make a complaint. These were provided in the patients notes in the home.

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

At this inspection we found:

- Staff were aware of the vision and values. We saw the values of the organisation displayed in staff areas.
- Leaders, including the executive team, were described as approachable, supportive and visible. Staff engagement was encouraged.
- Regular team meetings were held. Staff spoke positively about working for the organisation.
- The organisation engaged well with the public and employed a number of volunteers.

However:

- Local risk registers were not in use and some of the risks identified by the service leads had not been fully captured on the corporate risk register.

Detailed findings

Leadership of this service

- Staff we spoke with told us that managers were visible and approachable, they felt supported and listened to.
- Most teams had good clinical leadership. However, this was not the case for all teams, for example, one team raised concerns about their local leadership.
- Service leads told us they had an open door policy so that practitioners could access them at any time. Staff told us they could contact managers, at any level, at any time.
- The organisation offered an Aspire leadership programme to staff. This included six months of mentoring and workshops. Interviews were held to select those staff who wanted to participate.
- Role specific training was given to existing managers.
- Staff we spoke with spoke positively about the executive team and said they were approachable and visible. Staff said it did not feel that there was a hierarchy in the organisation.
- The ISO process is a risk based approach and is managed by processes. This was used for community nursing, rapid response and telephone triage, with a view to rolling it out to all areas. This meant a standardised approach was used to working. For example community nursing administration staff had been based at eight sites with different ways of working at each one. As a result of using the ISO process they were all brought together to provide consistency.
- There were some issues evident around the provision of leadership and supervision to specialist staff when there were small numbers. For example, one member of medical staff was employed and there had been challenges providing a Responsible Officer for support and supervision, although this had been put in place via securing an external resource.

Service vision and strategy

- The service vision was to provide safe, effective care and to keep patients at home as long as possible.
- Managers told us that they did not have a specific strategy for community adults but followed the organisational strategy. The strategy focused on being customer centred, with high quality services to benefit the communities they served. Their vision was 'to be leading care at the heart of our community'.
- The senior management team told us there were working to develop a service strategy and that a quality strategy was in draft form, but no timescales were given for when this would be completed. We did not see the draft strategy at the time of our inspection.
- We saw the organisation's values displayed around the bases we visited. The values were: putting people first, taking responsibility, working together, delivering quality services and investing in local communities. Staff we spoke with were aware of the values.

Governance, risk management and quality measurement

- The Chief Executive was the governance lead.
- The International Organization for Standardization (ISO) 9001 process provides a set of standards to help organisations to become better managed, more efficient and more customer focused. This was used for community nursing, rapid response, the discharge team and telephone triage, with a view to rolling it out to all

areas. This meant a standardised approach was used to working. For example, community nursing administration staff had been based at eight sites with different ways of working at each one. As a result of using the ISO process, they were all brought together to provide consistency.

- At an operational level, heads of service (HOS) managed risk working with their teams. For example, through the ISO process it was identified that there was not a standardised process for calibration of equipment. This was managed by the HOS and moved from a high, to moderate to low risk very quickly.
- Any high risks within the whole of the organisation were looked at by the board and were a standing agenda item. There was an action plan attached to each risk with a designated 'risk owner'. At the time of inspection there were four high level risks, however none of these were relevant to the areas we inspected.
- The service leads identified their top three risks as being; experience within the nursing service, complexity of patients and retention of staff. However, these issues had not been fully captured on the risk register. There was a risk associated with workforce capacity and capability which had been open since June 2011. This had been regularly reviewed and action taken by the delivery of a managers development programme.
- Staffing in the telephone triage service had been identified as a risk by senior management and was on the risk register.
- Community nursing team leaders did not appear to have a clear oversight of risks and local risk registers were not in use.
- Integrated governance committee meetings were held quarterly. Quality and performance reports were produced and presented to the board.
- There was a Risk Policy and Strategy in place which was regularly reviewed through the integrated governance committee.
- A monthly review took place of all outstanding incidents, complaints, actions and risks by the Chief Executive and Quality and Performance Team.
- Performance and quality issues were standing items on the board agenda.
- Nurse manager meetings were held fortnightly, nurse manager and team leader meetings were monthly and general managers meetings were monthly. These meetings ensured that relevant information was cascaded upwards and downwards in the organisation.
- Nurse managers provided feedback to teams at regular team meetings. However, there did not appear to be a standard agenda for team meetings.
- Community nursing team leaders did not appear to have a clear oversight of risks and local risk registers were not in use.

Culture within this service

- Staff we spoke with felt respected and valued.
- Staff enjoyed their work and enjoyed making a difference to people and patients. Staff told us they were focused on helping people to remain in their own home.
- Psychological supervision was available for staff. Six sessions were available each month which staff could book into. It was compulsory for clinical staff to attend three each year.
- A confidential care line was available for those staff requiring some support. Staff could also access an immediate course of confidential face to face counselling sessions via this service.
- 'Touch down' rooms were available for staff, to allow some time to reflect or have some privacy.
- There were policies and procedures in place for bullying and harassment. These had all been collated in one place on the intranet to aid ease of access.
- A freedom to speak up guardian had been established as a model of good practice and was in place at the time of our inspection.
- Staff told us they had worked hard due to staff shortages but were now seeing improvements in staff levels and were happy to have maintained the service.

Public engagement

- The organisation had over 200 volunteers who supported the community rehabilitation service. The volunteers and patients of this service regularly gave feedback about the service and ideas for improvement. The volunteers said they felt listened to and valued by the organisation.
- Service leads told us that they had involved service users in a review of community nursing services.
- The organisation had falls, respiratory and stroke collaboratives which comprised of staff and volunteers who worked to encourage people to improve their health and wellbeing.

Are services well-led?

- The organisation supported employment for the local community for individuals with a physical or learning disability (employability). This was linked to the apprentice programme and also supported placements in other organisations such as GP practices.
- The organisation also had links with a local academy and provided five vocational placements each summer.
- There was no patient representation at board meetings. However the council of governors had service users in attendance and some of the governors sat on the board.
- Patient feedback forms were used and the Quality and Performance Team contacted patients for feedback.

Staff engagement

- The council of governors had staff representatives.
- Staff could attend board meetings if they wanted to. We spoke to a staff member who had attended a board meeting and found it informative.
- Staff took part in the staff survey every year. Results from quarter two of 2016/2017 showed that 86.5% of staff would be extremely likely or likely to recommend Care Plus Group as a place to work.
- The senior management team held a 'red tape challenge' with staff to look at overcoming barriers and streamline processes such as recruitment.
- Feedback from staff was given when long service awards had been stopped; staff felt they were important so they had been reinstated.

Innovation, improvement and sustainability

- The organisation had set up an innovation fund which provided staff with money to implement new ideas that would benefit the patients. One of the continence advisors had bought a bladder scanner with money from the fund.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not been met: Action plans following incidents were not thorough and robust. Learning from incidents was not consistently shared with relevant staff.