City Health Care Partnership CIC

BD256

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)
BD256	Highfield Health Centre		
1-279570366	The Westbourne Centre		
1-286634785	Bransholme Health Centre		
BD256	Elliott Chapel Health Centre		
1-2071214626	Newington Health Centre		
BD256	Longhill Health Centre		

This report describes our judgement of the quality of care provided within this core service by City Healthcare Partnership CIC. 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 City Healthcare Partnership CIC and these are brought together to inform our overall judgement of City Healthcare Partnership CIC

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 community health services for adults as good because:

- There were systems in place for incident reporting, staff had received training in these systems and staff we spoke with were able to describe how they reported incidents. Managers were able to describe examples where they had carried out the duty of candour. Staff we spoke with could describe how they would report safeguarding concerns.
- Record keeping data was positive across the services and staff we spoke with told us they had access to the equipment they required.
- Staff were able to describe how they assessed and responded to patient risk and deteriorating patients in their services.
- Evidence based care guidance and treatment was used in the services and staff could describe the national guidance and protocols they used and had access to. Technology and telehealth was taken into account in community health services for adults and there was a telehealth service available for patients.
- We found staff to be competent in the services visited and staff told us of the training opportunities offered and the additional training they had undertaken to increase staff competency and skills.
- Compassionate care was provided to patients and staff made sure patient privacy and dignity was respected in the services visited. Friends and family test results were positive for the services. Patients, families and carer's we spoke with during our inspection were positive about the care they received.
- Services were planned and managed in order to meet the needs of patients. Community nursing operated 24 hours a day, 7 days a week. Telehealth services had been introduced in cardiac and respiratory services to provide care through technology from a distance.
- Referral to treatment indicators were mostly positive across the different services and were meeting national indicators.
- The services had plans to become an integrated care service and develop a single point of access system to all services offered. Managers were able to describe the future plans and vision for the services.
- The service had a risk register in place and this was regularly reviewed. Managers were able to describe the risks to the services and the action taken to mitigate the risks.

Summary of findings

Background to the service

City Healthcare Partnership CIC is a co-owned independent community healthcare service providing community services to the geographic region of Hull. The service provided a number of community services for adults in district nursing, community matrons, integrated care team services, rehabilitation services and specialist nursing services. There were three main nurse bases at Bransholme health centre, Longhill health centre and Priory Park health centre.

Community adults were part of the care group one at City Healthcare Partnership CIC.

During our inspection the service was going through changes in the way they provided care in community adults, the service was moving to an integrated care service where a single point of access was planned for April 2017.

Community district nursing services operated between 08:00 and 17:00 seven days a week, the evening service operated between 17:00 and 23:00 and the night district nursing service operated between 23:00 and 08:00.

We visited Highfield health centre, Bransholme health centre, Longhill health centre, Westbourne health centre, the Intermediate Care Team, Elliott chapel health centre and the Tuberculosis (TB) community team Newington Health centre.

During our inspection we spoke with 37 staff and 21 patients, relatives and carers. We looked at seven records during the inspection.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director

Team Leader: Helena Lelew, Care Quality Commission

The team included CQC inspectors and a variety of specialists: District Nurses, Health Visitors, School Nurses, Paramedic, End of Life Care Specialist Nurse and a Consultant in Palliative Care.

Why we carried out this inspection

We inspected the following core services as part of our independent health community health services inspection programme:

- Community Health Services for Adults
- Community Health Services for Children, Young People and Families
- Community Services for End of Life Care
- Urgent Care Services
- Integrated Sexual Health /Termination of Pregnancy Services

CHCP CIC also provided prison health, public health, dentistry, social care and GP practices. These services have not been included in this inspection but will be inspected as part of other CQC inspection programmes.

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

Summary of findings

organisations to share what they knew. We carried out an announced visit on 8 and 11 November 2016. Prior to the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 22 November 2016.

What people who use the provider say

- Patients and families we spoke with during our inspection were positive about the care they received. They were treated with dignity and respect and were involved in decisions about their care and treatment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider:

- Should ensure they develop systems and processes to ensure lessons learnt from incidents are cascaded to all staff groups in community health services for adults.
- Should ensure the safety of staff is maintained and lone worker devices are used by staff in line with organisation policy.
- Should consider an action plan to address the concerns around missed medication and medication incidents in the community services for adults teams

City Health Care Partnership CIC

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 in community health services for adults as 'good' because:

- Systems were in place for incident reporting and staff we spoke with were aware of how to complete an incident report. Staff we spoke with had received training on the incident reporting system.
- Managers were able to describe examples when they had carried out duty of candour.
- Staff we spoke with were able to describe the process for reporting safeguarding concerns and could describe who they would contact for advice.
- The different teams across community health services for adults had access to the appropriate equipment such as laptops and staff bases were generally spacious.
- Record keeping audit data was positive across the different services.
- We saw good levels of hygiene and staff adhered to the 'bare below the elbow' policy. Staff used good infection control techniques during visits.
- Staff told us mandatory training was accessible and they were up to date with their mandatory training. Compliance rates for most mandatory training was above the trust target.
- Staff assessed and responded to patient risk as necessary, for example the telehealth team reviewed patient results daily and checked for alerts. If there had been a deterioration, staff would contact the complex case managers and/or the GP. The service had introduced complex case managers to provide care to patient with complex needs.
- The services managed anticipated risks such as adverse weather and could describe the action they would take to manage these situations.

However,

- Shared learning from incidents and feedback to staff regarding incidents was not fully embedded in some of the services visited. Managers were aware of this and were developing systems to improve learning. The quality of incident investigation reports varied with some areas not being fully completed or signed off.

Good

Are services safe?

- Missed medications in community services was highlighted as a concern by the organisation. This had occurred on a number of occasions in September 2016 and October 2016 and was documented in the incident reports for the therapeutics and pathway group for the service. A report by the service highlighted they were going to review the processes around administration of medicines.
- There were vacancies across some of the services. Staff views on caseload levels varied, however it was highlighted that caseloads could become large and sometimes unmanageable. When this occurred staff shared caseloads amongst their teams to mitigate the risks.

Detailed findings

Safety performance

- Community services for adults participated in the NHS safety thermometer. Data for pressure ulcer rates showed that rates were between 2% and 10% between October 2015 and October 2016. Recent data for October 2016 was between 6% and 8%. This data was for 18 to 70 year olds.
- Safety thermometer data for falls was 2% in October 2015, however between November 2015 and October 2016, the rate was 0%. This data was for 18 to 70 year olds.
- New venous thromboembolism (VTE) data from the organisations safety thermometer varied between October 2015 and October 2016. For example, between October 2015 and June 2016 the new VTE data varied between 0% and 3%%. Between July 2016 and October 2016, this had increased to 11% in September 2016 and decreased to between 2% and 3% in October 2016. This data was for 18 to 70 year olds.
- Catheter and UTI data in the safety thermometer provided by the service was at 0% between October 2015 and October 2016. This data was for 18 to 70 year olds.

Incident reporting, learning and improvement

- The services visited had access to systems to record incidents, near misses and safeguarding concerns. Community services had access to an electronic incident reporting system on their laptop or at the staff bases used. Staff told us they had received training in use of the electronic reporting system.
- 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 service reported no never events between September 2015 and September 2016.
- The service reported five serious incidents between September 2015 and September 2016.
- The quality and integrated governance report in September 2016 highlighted data and information about incidents, trends and themes. The report identified that pressure ulcer incidents were high and that the organisation had identified concerns around missed medications in community services.
- A root cause analysis (RCA) tool was in place for pressure ulcers. This included a three stage process to complete the tool. The stages were react, record and respond. A number of headings were included within these stages such as clinical factors, physical factors and the assessment or contributing factors. The respond stage had a section for lessons learnt with the action to be taken and a date to be completed by. We found the root cause analysis we viewed to be mostly completed, however most of the RCA's had not been signed off and most RCA's did not have the lessons learnt section fully complete, for example the action to be taken. We saw four pressure ulcer RCA's.
- Staff we spoke with were aware of how to report incidents, staff would use the electronic reporting system and if required notify their manager. Managers we spoke with told us there was a no blame culture with regards to incident reporting.
- The service provided minutes from the adults and modernisation lessons learnt meetings. These included details on learning from incidents. These meeting minutes were from 2015. The service did not send minutes from recent meetings showing lessons learnt.
- Clinical team leads in the different services were responsible for completing incident investigations.
- Staff in some services could describe learning and improvements which had been made in response to incidents. Staff receiving shared learning and feedback from incidents varied in the different services, this was raised with managers who acknowledged there was

work to be done in order to develop a robust process for sharing learning from incidents and providing feedback to staff. Shared lessons learnt from incidents did not always happen in the different services.

Duty of Candour

- 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.
- Managers we spoke with were able to describe examples where they had carried out duty of candour. We saw an incident form which had been completed on the electronic recording system and duty of candour had been carried out after this incident had occurred, however not all staff we spoke with were aware of duty of candour.
- The quality monitoring dashboard for September 2016 showed there had been no breaches of the duty of candour between September 2015 and September 2016.

Safeguarding

- Safeguarding training for adults and children was part of the mandatory training requirements at the organisation. Staff we spoke with confirmed they had completed this training, however not all staff were aware of what level they had completed. The organisation provided mandatory training percentage information on safeguarding, however this information did not divide the completion rates by the level of safeguarding training. The average completion rate for safeguarding adults training in August 2016 was 89.2% and the average completion rate for safeguarding mandatory training in September 2016 was 89.4%.
- Safeguarding for children mandatory training average completion rates were 90.6% in August 2016 and 90.2% in September 2016.
- Staff in the tuberculosis (TB) service told us they had received safeguarding adults and children level 3 training. Staff in the anti-coagulation service had received level 2 safeguarding adults and children training.
- Staff we spoke with were able to describe how they would report a safeguarding concern. Staff told us they would contact the safeguarding team by telephone for advice and log the safeguarding on the electronic incident reporting form.

Medicines

- 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.
- The anticoagulation team were reviewing plans to implement a patient group direction (PGD) to enable some qualified staff nurses to provide specific medicines to patients. The effect of this was efficiency on nursing time as they would normally need to refer these patients to a separate team for the medicine, if a PGD was in place the staff in clinic would be able to provide this.
- Dressings were ordered weekly by the tissue viability team. If a new dressing was required, the district nurse or complex case manager would discuss this with the tissue viability team and complete a justification form which would be reviewed by the tissue viability team.
- Medicines checked were found to be in date.
- A recent quality and governance report in September 2016 had highlighted that there had been incidents relating to missed medication in community services. This had happened on four occasions in September 2016 and October 2016 with different reasons such as staff sickness and the patient list being across different sheets of paper. These trends were highlighted in the quality and governance report in September 2016 and the therapeutics and pathway group report for September 2016 to October 2016. The report highlighted that the service were going to review the processes around administration of medicines in community nursing.

Environment and equipment

- Most buildings and offices the community services for adults teams operated from were not owned by the City Healthcare Partnership CIC.
- Most areas visited for staff use were spacious. Staff had access to desktop computers as well as their own work laptops and office spaces often had an electronic board on display at all times to show caseload information for the day and night. These boards were used for handover

and communication meetings between teams. For example, the out of hours nursing service used the board to communicate the evenings work to staff for palliative patients.

Quality of records

- The different community nursing localities carried out regular record audits. Data provided by the organisation for the west community nursing locality showed a 100% score for the record keeping audit. Data for the north community nursing locality showed a score of 87%, this was above the target of 85%. Data for the east community nursing locality showed a score of 95% for the record keeping audit, this data related to April 2016. The spreadsheet used to record the audits had an action plan template attached to complete if the target was not achieved.
- The anti-coagulation team in community adults scored 100% for their record keeping audit in April 2016. This was better than the target of 85%.
- The TB team carried out peer review of their records. Generally this was completed 2 weeks after a new patient has commenced treatment, then 2 months and then 4 months after. The purpose of this peer review was to check all information that should be documented was present and to check that notes were complete.
- The service had recently changed to electronic records. The use of laptops to access records in the community had led to difficulty accessing records in a timely manner due to connectivity issues. During our inspection this was raised with managers and they were aware of the challenges around connectivity and had introduced an issues log to complete when there were issues and considering different ways of addressing the problem.
- Records we saw were accurate and complete during our inspection. We looked at seven records during the inspection.
- The services used a quality monitoring programme to benchmark against the essence of care benchmarks, for example, data benchmarking regarding record keeping showed that for all services in care group 1, they scored 87% and above. The highest achievable score was 100% and some services did not participate in some of the benchmarks.

Cleanliness, infection control and hygiene

- Average completion rates for infection control mandatory training for September 2016 was 83.9%.
- The service provided a document showing the hand hygiene assessment competency. The document showed that 151 staff had completed this competency out of 260 staff members required to complete the competency.
- We saw staff use good infection control techniques, for example staff washed their hands before and after seeing patients and where required wore gloves during procedures. Staff adhered to the 'bare below the elbow' policy. Staff used hand gel where required before and after visiting patients. Staff carried hand gel during visits.
- Staff bases and areas we visited were visibly clean and tidy.

Mandatory training

- Mandatory training was a mix of face to face and electronic training. Staff we spoke with told us mandatory training was accessible and they were up to date with mandatory training.
- The organisation provided data for care group one for mandatory training completion rates.
- Average completion for conflict resolution was 99.9% for September 2016. Average completion for risk management training for September 2016 was 94.8%. Average completion rates for equality and diversity for September 2016 were 99.7%. Average completion rates for COSHH training in September 2016 was 95.5%.
- Moving and handling mandatory training average completion rates for September 2016 were 67.0%. Fire safety average completion rates for September 2016 were 85.3%. The providers mandatory training target was 80%.

Assessing and responding to patient risk

- The telehealth team told us how they responded to patient deterioration in their services. Staff were able to view patient results through the electronic system and the system alerted staff when an abnormality was identified.
- Staff in the telehealth service could describe the action they would take if a patient deteriorated whilst using their service. Once the patient results were received into the telehealth service, if there had been deterioration, staff would contact the patient to check the results and would then contact the complex case managers and/or

the GP. If urgent, staff told us they would contact the emergency services. Staff told us telehealth data was reviewed daily and if there had been no alerts on the system, the patient would receive a six monthly review.

- Staff reviewed and assessed patients care during visits and we saw staff respond to patient's needs and conditions and provide advice appropriately. For example, staff would provide additional advice on care and treatment, seek advice if required and escalate to senior staff if necessary.
- Staff documented information regarding treatment and care provided to patients on their electronic system and on paper copies of records and communication sheets if necessary. This could then be seen by the different teams attending to the patient.
- The community lymphoedema service would complete an initial clinic follow up appointment at one month and a post assessment follow up appointment at three months.
- Staff in the community lymphoedema service saw patients in clinics and undertook patient visits. Staff told us that if a patient's condition had deteriorated they would contact the local GP and if urgent attention was required, they would contact emergency services.
- The service had introduced complex case managers who provided and managed the care of patients with complex care needs.
- The anti-coagulation team had key performance indicators in place. New deep vein thrombosis (DVT) patients were to be seen within 24 hours and atrial fibrillation (AF) patients were to be seen within 5 days. Data the service provided was highlighted as being for care group three, data showed that the percentage of existing/initiation of DVT service users who were offered to be seen and assessed within 24 hours of referral was at or above the 95% target between November 2015 and October 2016.

Staffing levels and caseload

- The staffing budget for qualified nursing in care group one was 439.8 whole time equivalent (WTE) with WTE vacancies of 68.
- The staffing budget for non-qualified nursing in care group one was 168 WTE and the vacancies WTE was 9.2.
- Staffing levels and skill mix in the services visited were managed by the local team leader or manager. There were services which did have vacancies and agency staff were used in some community teams. District nursing teams were made up of various grades of staff and were managed by a team lead.
- The tuberculosis community team were at full establishment for registered nurses, health care assistants and administrative staffing.
- Managers highlighted that staff retention was considered a risk, in particular recruiting to nursing and therapy services. Managers confirmed they were attending recruitment fairs to try and address this. The services had also considered skill mix of staff and developing certain roles, for example developing some band three roles into band four practitioner assistant roles.
- Caseloads varied amongst the different community health services for adult's teams. Some staff we spoke with told us that caseloads were manageable, however this could vary from day to day. Some staff said on some days it could become unmanageable and caseloads could be large and staff would have a high number of visits. Staff would seek assistance from other team members during communication meetings and handover if the caseload was high.
- We saw staff discuss caseload and the locality of patients during handover. Staff altered caseloads in accordance with patient requirements. The district nursing service had regular morning and afternoon meetings to discuss caseloads and would adjust as necessary.
- Staff in the intermediate care team had their own caseloads; the team had a twice weekly meeting where new patients would be allocated to a team member's caseload.
- Agency staff were used in some teams in community health services for adults, for example in the intermediate care team they had two agency staff to support the team.
- Caseload management in district nursing was organised by aligning district nurses with specific GP practices, these GP practices would then become the district nurses caseload. Managers in nursing services told us that if a caseload becomes too big, the senior nurses would share the caseload out to other members of the team.

Good

Are services safe?

- The community cardiac rehabilitation team were made up of three specialist cardiac rehabilitation nurses. There were no vacancies in this team. Staff told us they shared the caseload between staff members.

Managing anticipated risks

- The service had a service continuity plan for nursing and conditions incorporating community nursing and end of life care. The plan included action to take on severe staff shortages and/or peaks in activity and travel disruption.
- A lone working policy was in place. This included information on responsibilities and control measures. This policy review date was August 2018.
- Community services for adults had access to a 4 x 4 vehicle during the winter months in case of severe weather and disruption. Managers were able to describe the action they would take in terms of prioritising community work and caseloads with staff in the event of severe weather. Managers told us the service would prioritise patients and consider risks such as vulnerable persons and whether medication was required urgently.

Good

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

We rated effective in community health services for adults as 'good' because:

- Staff in the different services visited could describe examples of National Institute of Health and Care Excellence (NICE) guidance, national guidance and the local policies and protocols used in their practice.
- Mobile working had been introduced and there was a plan to move to mobile working across all integrated services. This had only been introduced around one month prior to our inspection and there had been issues with connectivity, however an issues log was in place and managers were actively seeking solutions to these issues.
- A telehealth service was available for cardiac and respiratory patients and provided patients with care, treatment and monitoring from a distance. Patients were assessed, equipment provided and setup and were monitored through technology by telehealth staff.
- Staff we spoke with during our visits were competent and had undertaken a number of additional training to better the care they provide and develop their knowledge and skill set. Additional training and qualifications were generally available if requested and applicable to the role.
- New staff to the service were supported by qualified registered nurses and received preceptorship for the first six months of their service.
- The intermediate care team had a key performance indicator for referrals for ensuring service users were seen and assessed within two hours following a referral from an ambulatory care or frailty unit. The target for this was 95% and the service achieved 100% between April 2016 and November 2016.
- There was multi-disciplinary team working in the intermediate care team and other teams and staff in the telehealth services had regular multi-disciplinary team meetings.

Detailed findings

Evidence based care and treatment

- The anticoagulation team could describe guidelines and protocols they used, for example National Institute of Health and Care Excellence (NICE) guidelines Atrial Fibrillation. They also had access to the organisations protocols and used National Patient Safety Agency (NPSA) guidance where required. Staff had access to clinicians with a special interest for advice.
- The tuberculosis team used NICE guidance alongside the organisation protocols for TB. The service had a NICE guidance folder which included the TB pathways used, for example diagnosis of latent TB in adults.
- The community lymphoedema team had two pathways in place for their services. The service were able to describe some of the national guidance they followed, for example, best practice for the management of lymphoedema.
- The cardiac rehabilitation team had been accredited because they were meeting the service framework required. This had highlighted some areas for improvement and an action plan was in place to address the improvements required. Most areas of the action plan were either complete or on track.

Pain relief

- Staff told us pain was assessed on initial assessment and pain care plans were included in care plans.

Nutrition and hydration

- The electronic system used by the district nurse teams and other specialist nursing services allowed staff to complete information on nutrition. Staff were able to refer patients to dietetic services if requested or required.
- The cardiac rehabilitation community team had a number of patient information leaflets such as eating well advice leaflet.

Technology and telemedicine

- Telehealth was used in the anticoagulation clinic. Patients would submit their information by telephone and the anticoagulation team would respond by telephone meaning care could be provided without a clinic visit.

Good

Are services effective?

- Mobile working had been implemented around a month prior to our inspection in November 2016. Staff views on how well the mobile working worked varied. Some staff reported few concerns regarding the connection to the laptop when out visiting patients; however a number of staff raised concerns and frustration around the time taken to use the mobile laptops during visits. The effect of this not working immediately was the staff member had to attempt to log on whilst visiting patients which could take time depending on how long it took to log on.
- Managers were aware of the issues around mobile working and the connectivity issues and had taken a number of steps to try and address it. An issues log was in place which staff were to use when they had an issue; this was then forwarded to the information technology team to review. Managers had also tried different connectivity options to try and address the issues.
- Operational managers attended meetings with IT and were able to raise issues at these meetings around mobile working and receive updates on progress.
- There was a telehealth service available for cardiac and respiratory services. This service provided care, treatment and monitoring to people from a distance using electronic systems to communicate. Patients using the telehealth service received the equipment they required to access and use the service, for example an electronic tablet computer or a blood pressure machine.

Patient outcomes

- Staff in the intermediate care team told us they used goal attainment scores for patient outcomes and that these were set with patients.
- Staff in the community lymphoedema team told us they reviewed patients once referred into their service and review the patient when being discharged, this allowed the service to see if a patients condition had improved during their treatment.
- Community services for adults participated in the 2014 national intermediate care audit. Results from the audit highlighted that the intermediate care service scored 100% for the question information available to staff regarding the patient condition, patient awareness of goals was 100%, trust and confidence in staff was 100%, patient involvement in discharge decision making was 66.7% and patient feeling less anxious on discharge from the service was 83.3%. These results were above the national averages, however information given to patient was 83.3% and patient involvement in goal setting was 50%; these were below the national averages.

Competent staff

- Most staff told us they had been able to attend additional training and conferences when requested if relevant to their role. Staff were encouraged to attend further training and development.
- Staff in the TB team had attended advanced tuberculosis training to develop their skills further. The TB team had regular clinical supervision, this was around every 6 weeks and staff would also carry out ad-hoc supervision where necessary.
- Appraisals were carried out yearly in community services for adults. 86.3% of staff had completed an appraisal. In the annual colleague survey, 76.4% of respondents in care group one stated their development review was valuable to them.
- In the annual colleague survey in 2016, 49.1% of respondents stated they had training in full which was identified in their development review and 29.3% of respondents stated they had received training in part which was identified in their development review. This data related to care group one.
- All staff recruited to the service attended a four day induction. New starters to the service received monthly supervision from a senior nurse. An induction pack was in place which would be worked through by the new starter and signed off once deemed competent by their mentor.
- Newly qualified staff at City Healthcare Partnership CIC were supported through preceptorship for six months. This included an initial review, two weekly supervision, a review after three months and after six months.
- Some staff in the services had link roles. For example, there was a link role in infection control in the TB service.
- We spoke with senior nurses who had undertaken further training to practice as practice development teachers where they would support district nurses through their training. We also spoke with a number of complex case managers in district nursing who had completed further development in prescribing medication.

- Staff in the community lymphoedema service had trained in additional aspects of training to provide further care to patients, for example, some staff had trained in multi-layer lymphoedema bandaging.

Multi-disciplinary working and coordinated care pathways

- The intermediate care team was made up of occupational therapists, occupational therapy technical instructors, registered nurses, health care assistants and physiotherapists. The service had access to an occupational therapist who assisted in adaptions to patient homes where required. The local acute hospital were able to refer to these services when patients were discharged from hospital.
- Occupational therapists worked closely with the physiotherapists and nursing teams to provide a multi-disciplinary team approach to care.
- The intermediate care team attended multi-disciplinary team (MDT) meetings once each week at the bedded units they provided care at. These MDT meetings consisted of a consultant, physiotherapist, occupational therapist, social services, unit manager and an intermediate care nurse.
- Staff in the community lymphoedema service told us they would carry out a joint assessment with the community district nurses to patients who could not attend clinic if required.
- Staff in the telehealth service for respiratory and cardiac conditions told us they had weekly MDT meetings with consultants and nurses. A respiratory physiotherapist would also attend if required.
- Tissue viability nurses and complex wound management leads were available for advice on tissue viability and dressings. Where different types of wound dressings were required, staff would discuss this with the tissue viability nurses and be required to complete a justification form for the dressing which was then reviewed by the tissue viability team.

Referral, transfer, discharge and transition

- The intermediate care team had referral criteria in place, patients who were over 18 and registered with a local general practitioner could be referred to the service. Referrals were received by fax for the service and the intermediate care team had a key performance indicator (KPI) for ensuring service users were seen and assessed within two hours following a referral from an ambulatory care or frailty unit. The target for this was 95% and the service achieved 100% between April 2016 and November 2016.
- Staff in the intermediate care team had their own caseloads. There were twice weekly meetings where patients were allocated to the caseload of the team members for that week. Patients received up to six weeks of treatment from the intermediate care team following discharge from the service they were in and if care and treatment was required after this six week period, staff would refer the patient to the community rehabilitation team for continued therapy if required.
- The service were moving to a 'trusted assessor' model of care for discharge from a local acute trust. This service would rely on the assessment of patients being completed by the acute staff for discharge. The discharge care plan would then be forwarded onto the City Healthcare Partnership CIC teams who would complete a full assessment upon discharge to their service and develop a reviewed care plan. The 'trusted assessor' service was currently being piloted in a number of areas during our inspection.
- Managers told us there were meetings fortnightly to discuss the 'trusted assessor' pilot. These were between both the local acute trust and City Healthcare Partnership CIC.
- Staff in the different services we visited were able to describe their referral processes. For example, the TB community service told us they received referrals from their GP, other health professionals and they accepted self-referred patients into the service. Referrals would be electronic or paper referrals scanned and emailed to the team.
- The anticoagulation team were able to describe their referral criteria and the process of accepting a referral. Referrals were received from GP's and hospitals by fax. The administrative team or a member of nurse staffing would complete a checklist for the referral to determine if the referral had been completed correctly before being added to the service.
- There was no current single point of access for referrals into community services, however managers told us the service was moving to a single point of access model in 2017.
- Transfer of care was highlighted on the risk register for community nursing. The risk register detailed the action

being taken was around the implementation of the single point of access service being implemented in April 2017, however this risk had been logged on the risk register for six years.
- The community lymphoedema team discharged patients after 6 months; however staff told us patients were able to self-refer back into the service for a following 12 months after discharge.
- Referrals for the telehealth service were received from GP practices and local hospitals. Staff in the telehealth service could describe the referral criteria used and telehealth services were provided for cardiac and respiratory patients. Once a referral was received, staff would visit the patient and assess them and explain the service to them at this appointment.

Access to information

- The service used an electronic reporting system for incident reporting. Electronic patient records were available.
- The TB service had access to a folder which contained details on National Institute of Care and Clinical Excellence and the pathways used in the service, for example the diagnosing latent TB in adults and a pathway for new entrant TB screening.
- The integrated care teams which included district nursing, complex case managers and the intermediate care teams had access to laptops for mobile working with access to the electronic care records for patients. These had been recently implemented and there had been connectivity issues when staff were connecting to access the systems and not all care plans were currently on the system.
- The systems provided access to an electronic care record which staff would complete whilst completing patient visits. This meant that staff would complete and input the up to date information during their patient visit. Staff would also complete the patient's paper care record to update the information documented in the paper record.
- Caseloads were not on the systems used during our inspection, staff used paper copies to view their daily caseload.
- We looked at the standard operating procedure folder in the intermediate care team and found most procedures to be in date.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The recording of capacity was logged on the service risk register. The electronic system used in community healthcare for adults did not currently allow for staff to record capacity on the system. Managers were aware of this risk and were working to develop a new area on the system to document that capacity had been checked during patient visits.
- We saw staff ask for consent during visits to patients and staff could describe when they used verbal consent. This was documented on the electronic system used.
- Staff we spoke with told us they reviewed patient capacity as part of patient visits. This review of capacity would be added to the system once the system allowed it to document that staff had reviewed capacity.

Good

Are services caring?

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

Summary

We rated caring in community health services for adults as 'good' because:

- Staff provided patients with compassionate care and spoke with patients in a way which they understood. Staff also checked with patients that the information being provided was understood.
- Staff maintained privacy whilst caring for patients and treated patients with dignity and respect.
- Friends and family test data was positive in the community nursing teams and intermediate care teams. Patients and families we spoke with during our inspection were positive about the care they received.
- Staff would refer patients onto other services if this was requested or required. This included services such as community dietetic services.
- Staff interacted with patients and families in a compassionate way and answered questions relating to care and treatment and provided additional advice and support where required.

Detailed findings

Compassionate care

- During visits with district nurses, out of hours nursing and the intermediate care team we saw staff provided consistently compassionate care and spoke with patients in a way they understood the care being given and what was being said.
- We saw staff provide reassurance to patients, explain the care being provided and discuss the care with patients.
- Patients, carers and families we spoke with during our inspection were positive about the care received. We spoke with 21 patients, relatives and carers during our inspection.
- Staff treated patients with dignity and respect. Staff maintained patient privacy and dignity whilst caring for patients.

Understanding and involvement of patients and those close to them

- The organisation participated in the friends and family test (FFT) survey. Results between April 2016 and September 2016 for community nursing scored 99% of people who would recommend the service. There were 445 respondents. FFT for the intermediate care team between April 2016 and September 2016 was positive with a score of 100% of people who would recommend. There were 94 respondents.
- We saw staff provide support and reassure patients where necessary. Staff in the intermediate care team were also able to provide support and advice on adjustments such as handrails in people's homes.
- Staff responded to different patient needs and provided person centred care. Staff would refer patients onto different services where this was found to be appropriate during treatment and care.
- We saw staff take time to interact with patients and their family and be respectful and considerate to patient's needs.

Emotional support

- Staff provided reassurance to patients when required and answered further questions patients, carers and family had regarding the care.
- Staff in the intermediate care team and the community cardiac rehabilitation team used the hospital anxiety and depression scale to assess patients during their treatment. If the responses to the questionnaire raised concern, staff told us they would refer the patient to the local counselling service. These referrals could be completed by the staff member or self-referred by the patient.

Good

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 in community health services for adults as 'good' because:

- Services were planned and delivered in a way which met people's needs and managers were able to describe future service plans and could describe the way they worked with commissioners to provide services.
- Services operated at a number of different times to allow flexibility to patients and choice. The district nursing teams and complex case manager teams were available 24 hours a day, seven days a week to ensure continuous nursing service to patients.
- Staff took into account the needs of people in vulnerable circumstances. Additional assistance such as advice and changes to people's homes was provided. There were systems to ensure patients with complex needs received the necessary support.
- Telehealth services were available which provided patients with care and treatment from a distance through technology.
- Waiting time indicators and access to services met national indicators.

However,

- The service had not yet implemented a process and system to help reduce 'did not attend' appointments; however plans were in place for a text reminder service.

Detailed findings

Planning and delivering services which meet people's needs

- The TB community service provided outreach services in Hull to provide the service to patients who did not access the services of the community team.
- Managers told us they had considered local areas in terms of the service they provide and would support the local needs of people where required.
- Staff in the community lymphoedema service told us they were able to refer patients onto other services such as podiatry if requested.
- Managers we spoke with were able to describe the way they worked with commissioners when planning services and also confirmed they had regular meetings with commissioners.
- Telehealth was available to cardiac and respiratory patients. This provided patients with treatment and monitoring from a distance.

Equality and diversity

- The intermediate care team was able to provide advice on adjustments to people's homes once they had been discharged from hospital. This included advice on alterations which could help mobility.
- The organisation had access to interpreter services. Staff we spoke with in a number of services confirmed they had used these services and that they were accessible.
- We visited services such as the cardiac rehabilitation service which had a number of patient information leaflets available to provide to patients. These could be provided in different languages.

Meeting the needs of people in vulnerable circumstances

- The service used the 'butterfly scheme' for recording patients with dementia. This could be then seen by healthcare professionals to raise awareness of patients with dementia.
- The service had recently implemented the role of the complex case manager. Their role was to provide care to patients where the care and treatment required was complex. These staff were available 24/7 through different shifts.
- Community services carried out patient visits and attended the patient for care, treatment and assessment and the telehealth service provided a service to cardiac and respiratory patients from a distance using technology which carried out initial assessments and ongoing care. The telehealth service would send an engineer to visit patients and set up any equipment required to enable use of the service.

Access to the right care at the right time

- Data for referral to treat (RTT) for completed pathways within 18 weeks was above the 95% indicator between

September 2015 and September 2016, for example, during August 2016 the organisation achieved 100% for completed pathways RTT's and during September 2016 the organisation achieved 97.4% for completed pathways RTT's. This was better than the national average of 92%.

- Data for referral to treat (RTT) for incomplete pathways within 18 weeks was above the 95% indicator between September 2015 and September 2016, for example, during August 2016 the organisation achieved 98.6% for incomplete pathways and during September 2016 the organisation achieved 99%. During October 2016, this had reduced to 92%.
- The service had not yet implemented systems to reduce 'did not attend' (DNA) rates; however managers confirmed they were considering implementing text message reminders to reduce 'did not attend' occurrences. The DNA rate for community nursing was 4.23% in October 2016; the DNA rate for long term conditions for March 2016 was 2.7%.
- The intermediate care team provided 40 minutes for an initial appointment and 20 minutes for a follow up appointment, staff told us the assessment time depended on the clinical need of the patient and the service was flexible in terms of appointment times.
- The anti-coagulation team service operated between 08:00 and 17:00 Monday to Friday and 10:00 to 14:00 each weekend. The service also had an evening service clinic between Monday and Friday between 17:00 and 18:00 for pre-booked appointments.

Learning from complaints and concerns

- Community services for adults had received 12 complaints between January 2016 and August 2016. The services we visited told us they had received few complaints in the previous 12 months. These complaints were associated with different teams such as community nursing, lymphoedema clinics and the intermediate care teams. Ten were associated with community nursing, one complaint to the intermediate care team and one to the lymphoedema clinic.
- Staff we spoke with were aware of how to inform patients on how to complain about the service if necessary. Learning from complaints was highlighted at the adult and modernisation lessons learnt meetings. The organisation provided minutes from these meetings, however these minutes were from June 2015.
- Complaints were documented in the quality and integrated governance report. The organisation provided the report from September 2016 and this showed the number of complaints. This allowed managers to track complaint levels in care group one.
- The quality monitoring programme document from September 2016 showed that 100% of complaints were investigated within the timescale agreed with the complainant between September 2015 and September 2016. The target was 100%.

Good

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 community healthcare services for adults in well led as 'good' because:

- The service had plans to develop into a single point of access service and managers we spoke with could describe the plans for this and the changes to the services.
- A risk register was in place and reviewed monthly. Managers were able to describe the risks that were documented on the risk register and the action being taken to mitigate these risks.
- There was a leadership structure in place with managers responsible for the different services in community adults who reported to the care group one director.
- Staff we spoke with were mostly positive about working at City Healthcare Partnership CIC and described a culture of team work. Most staff we spoke with felt respected and valued by the service.
- There were team meetings across the different services visited. Staff told us most managers were approachable and there was visible senior leadership across the services.
- Senior managers could describe the monthly reports they received to monitor performance on the services managed and told us they would consider how the service could be managed if performance had deteriorated.

However,

- The colleague survey report highlighted varied results in a number of areas for care group one.
- Recent changes to the service had contributed to low morale in some of the different teams on community healthcare services for adults. This was documented on the risk register and managers were aware of the issues around low morale in the teams.
- Staff we spoke with were not always aware of the strategy, vision and values of the organisation but most staff were able to describe the community aspect of the organisation.
- Lone worker devices were not always used by staff; this did not mitigate the potential risks of lone working.

Detailed findings

Leadership of this service

- Community services for adults sat within the care group one service. There was a clear management structure in place for care group one. The service had team leaders who reported to a service manager. The service manager then reported to the director of care group one. The director reported to the organisations senior management team.
- Staff we spoke with told us that managers in the different teams in community adults were approachable. There was clear visible senior leadership in community services for adults and staff spoke positively about senior leadership.

Service vision and strategy

- The organisation had a set of values which were service and excellence, equality and diversity, creativity and innovation and co-operation and partnership.
- Community health services for adults was going through a service model change during our inspection. The service was transferring from their previous service model of different services, with different contact and referral pathways to a single integrated community service with the aim of providing a 24/7 111 single point of access for all services. This change had resulted in disruption to staff roles in some areas and the way in which teams worked. Managers told us that staff had been informed in the varying different stages of the changes and this was corroborated by staff, however some staff felt the changes were happening very quickly. Managers confirmed that the pace of change in the organisations was on the risk register.
- Care group one had a business plan and this was used to direct the services and used as a strategy for the year ahead.
- Staff were not always aware of the strategy, values and vision of the organisation; however most staff were able to describe the community aspect of the organisation.

Good

Are services well-led?

Governance, risk management and quality measurement

- The service created monthly quality monitoring reports to measure quality. These report detailed information such as referral to treat (RTT) data, never events, number of serious incidents and number of complaints received.
- Care group one had a risk register, this detailed information such as the risk type, the risk rating, description of risk and review dates. All review dates were for December 2016.
- Managers were able to describe the risks and the action being taken in most risks identified. There was a risk identified relating to referrals from a local acute trust. This had been on the risk register for six years and was still not resolved. Managers told us they had previously regularly attempted to mitigate the risk; however the risk remained amber on the risk register.
- Service managers had access to a quality and integrated governance report which included quality and governance information for the services, for example the report highlighted incidents that had occurred and their severity, trends and themes around incidents, infection, prevention and control and complaints.
- We reviewed three senior management team meeting minutes for the care group one in community adults. These minutes included a key issues section for finance or risks.
- Team leads in services we visited were able to describe the risks to their services and the action being taken to mitigate these risks.
- Managers told us that if performance was deteriorating they would consider how they could manage the service to improve patient outcomes. They received a monthly data report which included key performance indicator data. Managers told us there was a bi-monthly meeting to review service performance.
- The newly created integrated community services team met fortnightly and would discuss risks to relevant to care group one.

Culture within this service

- The service had undertaken a 2016 colleague survey. The response rate for care group one was 60.6%. Sixty three percent of respondents in care group one stated they would recommend CHCP CIC as a place to work to friends and family. 90% of staff would recommend CHCP CIC as a place for treatment to friends and family. Responses to the 2016 colleague survey varied in care group one with positive and negative responses in different aspects of the survey.
- Seventy nine percent of staff said they had the opportunities to use their skills, however only 37.9% of staff said they had involvement in decision making on departmental changes, 62.8% of staff said they received the support to carry out their role and 68.9% of staff said they were encouraged to suggest new ideas for improving services.
- Eighty one percent of staff in care group one stated they knew what their goals and objectives were, however only 44.1% of staff stated they had enough time to carry out all of their work and 46.5% of staff stated that senior managers acted on staff feedback.
- Staff we spoke with mostly felt respected and valued by managers. There was an open door policy for managers we spoke with.
- Staff were issued with lone worker devices across the services, however during our inspection staff told us these were not regularly used as they were not user friendly. This was not on the risk register. Staff in the evening nursing service attended visits in twos. A lone working policy was in place with a review date of August 2018.
- Most staff we spoke with throughout the different services offered in community adults were generally positive about working at City Healthcare Partnership CIC. Most staff we spoke with felt respected and valued by managers.
- There was good team work and support within the teams visited. Staff we spoke with were proud of the patient care they delivered.
- Staff we spoke with told us there were regular team meetings in the different services. We saw examples of an evening handover meeting where the out of hours nursing team discussed the caseload for the evening, however staff in community nursing told us communication between teams could sometimes be improved. We also saw a morning meeting regarding the caseload for the intermediate care team. This was attended by occupational therapists and physiotherapists in the team.

Good

Are services well-led?

- Morale varied in community health services for adults. The recent changes to services had contributed to low morale. This was highlighted on the risk register and managers were aware of the issues around low morale in the teams.

Public engagement

- The integrated community service undertook an annual patient experience questionnaire. Data from this was broken down into the different community adult services.
- Patient comment cards were in use in a number of services we visited.
- The community cardiac rehabilitation team held education talks in community locations twice a month to provide education around cardiac rehabilitation to the public. The service had developed an education video they were able to show to patients. Staff also attended a cardiac support group for patients.
- The telehealth team told us they attended a three monthly focus group with COPD patients.
- The community lymphoedema team had participated in the lymphoedema awareness week and had a local stand in a health centre to provide information on the service and the condition.

Staff engagement

- Community nursing had staff meetings; We reviewed staff meeting minutes from these for January 2016, July 2016 and August 2016. Subjects discussed included recruitment and integrated pathways
- There were adults and modernisation team meetings in community adults. We reviewed three of these team meeting minutes from April 2016, June 2016 and September 2016 and topics discussed included patient advice and liaison (PALS) and recruitment.
- The organisation had a 2016/2017 employee engagement strategy and plan in place. This included information on how the organisation engaged with staff. This included ways such as a weekly blog, staff awards and the staff friends and family test.
- Staff we spoke with were aware of senior leadership and there was a suggestion box where staff could feedback information directly to the chief executive.
- The service used a 'we said, you did' system for staff feedback. Staff surveys were used annually to gather staff feedback.

Innovation, improvement and sustainability

- The service was transferring from the current service model of services having their own referral pathway to a single point of access service where service users could contact one number and be referred onto the relevant service required.
- Staff in the tuberculosis service were part of a national TB strategy board. The tuberculosis team were able to describe task and finish groups they were part of, for example there was a task and finish group for TB education and training courses.

This section is primarily information for the provider

Enforcement actions

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.