Provide Community Interest Company

Quality Report

900 The Crescent
Colchester Business Park
Colchester
Essex
CO4 9YQ
Tel: 01621 727325
Website: Provide.org.uk

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Core services inspected	CQC registered location	CQC location ID
Community Health services for adults	St. Peter's Community Hospital Ward Braintree Community Hospital Ward	1-223517978 1-283687220
Community inpatient services Community end of life care	Braintree Community Hospital Ward Halstead Community Hospital Ward St. Peter's Community Hospital Ward	1-283687220 1-223332623 1-223517978
Community services for children, young people and families.		

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	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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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

Provide Community Interest Company is a community social enterprise, which cares for patients across a wide range of services, delivered from 54 sites. They work from a variety of community settings, such as three community hospitals, community clinics, schools, nursing homes and primary care settings, as well as within peoples' homes to provide over 50 services to children, families and adults. The service provides services across Essex and in Peterborough and Cambridgeshire, as well as the two London boroughs of Waltham Forest and Redbridge. Provide employs approximately 1,100 staff, serving a patient population of more than one million

This was the organisations first inspection under the current name using our comprehensive inspection methodology. We had previously inspected this organisation under its previous name Central Essex Community Services (CECS) that changed to Provide in September 2013 during our pilot-testing phase in 2013 but we did not publish any ratings.

There had been two compliance action issued against this provider at the time of our last inspection, these were issued under 2010 regulations, which were superseded by new regulations in 2014. Compliance actions are now known as requirement notices. In our 2013 inspection we found that the service provided was not meeting legal requirements and we set two requirement notices in relation to:

- Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.The provider did not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.
- Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.The provider did not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

We carried out this comprehensive inspection between the 12 and 15 December 2016. We also carried out an unannounced inspection on 22 December 2016.

We inspected the following core services:

- Community health services for adults
- Community health services for children, young people and families
- Community end of life care
- Community health inpatient services

We did not inspect the following Primary Medical Services at the time of this inspection

- Steeple Bumpstead Surgery.

Overall, we found the organisation was performing at a level, which led to the judgement of good, with some elements of outstanding. We inspected four core services all were rated good overall

Our key findings were as follows:

- A culture of putting the patient first was evident throughout the organisation.
- Staff were committed to providing and ensuring patients received a good care and treatment.
- Across the organisation, we found staffing levels were generally meeting the needs of patients, we received very little feedback from staff that staffing levels were of concern to them. Similarly, we did not receive feedback relating to concerns about staffing levels from patients, relatives or carers. There were some staffing vacancies but these were being appropriately managed.
- Patients could access the right care at the right time, including those with urgent needs. The organisation was achieving all of the referral to treatment times.
- Services were plan and delivered in a way that met the needs of the local population. The different needs of

Summary of findings

patients were taken into account and we saw that the service was meeting the needs of meeting the needs of patients in vulnerable circumstances such as those living with dementia**.**

- We observed staff to be complying with best practice with regard to infection prevention and control policies.
- There were infection prevention and control policies and procedures in place, which were readily available to staff on the organisation's intranet. Infection prevention and control was included in the mandatory training programme and high numbers of staff across all core services had completed this.
- There had been no MRSA bacteraemias since April 2015.
- Recent patient led assessment of the care environment (PLACE) data that demonstrated a high compliance rate of cleanliness in the ward areas of 99.82%, which is above the national average of 98.1%.
- Without exception, patients were treated with kindness, compassion, dignity and respect throughout all of the services we inspected and feedback from patients, families and carers was consistently positive about the way staff treated them.
- Our inspection teams across all core services found that local team leadership was effective. Without exception, staff we spoke with said their line managers supported them and local leaders were visible and approachable.
- We found an open, honest and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice.
- Morale was mostly good throughout the organisation. The majority of staff were happy in their jobs and liked working for the organisation.

We saw several areas of outstanding practice including:

- The specialist healthcare team delivered child specific training to professionals and carers. This service contributed to the safety, health and wellbeing of children with complexed needs across mid Essex.
- There was a sensory room at Moulsham Grange clinic, which provided a stimulating environment for children with additional needs. Parents could reserve a time slot for their child to use at the families convenience. Parking was directly outside of the clinic to enable easy access to the external ramped entrance.
- Therapy staff at Moulsham Grange clinic used motorised wheelchairs to teach children's motor functions. Staff offered children with mobility issues the opportunity to move when other children were developing and learning to walk.
- Lone working devices, which looked like a car fob, had a panic button and Global Positioning System (GPS) tracker, had been introduced, which improved the safety of staff working alone in the community.
- The speech and language therapy team utilised skype and facetime for patient consultations, which was more convenient for the patients, meant speech, and language therapy staff saved travel time.
- At Courtauld Ward, we observed staff arranging for a packed lunch, bread and milk to be sent home with a patient who was being discharged that day.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

Team Leader: Simon Brown, Interim inspection manager, Care Quality Commission

The team included CQC inspectors, inspection managers, an inspection planner and a variety of specialists including: paediatrics and child health professionals, specialist nurses, community matron, safeguarding lead, director of nursing, physiotherapist and a strategic lead for equality and diversity.

The team also included three experts called Experts by Experience. These people had experience as patients or users of some of the types of services provided by the organisation.

Why we carried out this inspection

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

How we carried out this inspection

We inspected this service in December 2016 as part of the comprehensive inspection programme.

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 service provider and asked other Organisations to share what they knew.

We met with the executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades. Prior to the visit, we held 12 focus groups across two locations and during the inspection, a further two focus groups with a range of staff who worked within the service across the geographical area covered by the provider. We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were cared for, talked with carers and family members, and reviewed care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the service.

Information about the provider

Provide Community Interest Company is a community social enterprise, which cares for patients across a wide range of services, delivered from 54 sites. They work from a variety of community settings, such as three community hospitals, community clinics, schools, nursing homes and primary care settings, as well as within peoples' homes to provide over 50 services to children, families and adults.

The service provides services across Essex and in Peterborough and Cambridgeshire, as well as the two London boroughs of Waltham Forest and Redbridge. Provide employs approximately 1,100 staff, serving a patient population of more than one million

Summary of findings

A social enterprise is a business that trades to tackle social problems improve communities, people's life chances, or the environment. Social enterprises reinvest their profits back into the business or the local community.

Provide offers a range of community based services including, inpatient services, community nursing and therapies, rehabilitation, children's services, podiatry, sexual health services, outpatients and day case surgery.

Before 2006 services currently delivered were part of three NHS Trusts becoming Provide community interest company in 2014.

Provide is in receipt of an annual income of approximately £54 million, with the main purchasers of services being the clinical commissioning groups (CCGs) acting on behalf of patients in Essex and surrounding areas.

What people who use the provider's services say

The NHS Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Between December 2015 and November 2016 Provide Community Interest Company scored an average of 98% for patients who said that they would recommend the service they had used to their family and friends. Scores were above consistently above the England average of 95%.

A total of 175 comment cards were collected across all of the locations where services were delivered. The overwhelming majority of patients who completed a comment card felt staff listened to them, were kind and caring, supportive and compassionate.

Good practice

- The specialist healthcare team delivered child specific training to professionals and carers. This service contributed to the safety, health and wellbeing of children with complexed needs across mid Essex.
- There was a sensory room at Moulsham Grange clinic, which provided a stimulating environment for children with additional needs. Parents could reserve a time slot for their child to use at the families convenience. Parking was directly outside of the clinic to enable easy access to the external ramped entrance.
- Therapy staff at Moulsham Grange clinic used motorised wheelchairs to chest children's motor functions. Staff offered children with mobility issues the opportunity to move when other children were developing and learning to walk.
- The organisation used an electronic caseload analysis tool (eCAT) for workforce planning. Patient dependencies were scored based on both nursing and patient criteria. The tool was able to identify both planned and unplanned workload and the skill mix of the nursing teams
- The Carecall control room exceeded its response time targets on all but two occasions between April 2016 and December 2016.
- The central point of access team response times consistently met or exceeded targets.
- The early supported discharge (stroke) team worked closely with the local hospital and attended board rounds three times a week to identify suitable patients, according to the referral criteria, for discharge.
- Lone working devices, which looked like a car fob, had a panic button and Global Positioning System (GPS) tracker, had been introduced, which improved the safety of staff working alone in the community. The devices were monitored by Carecall.
- The speech and language therapy team utilised skype and facetime for patient consultations, which was more convenient for the patients, meant speech, and language therapy staff saved travel time.
- The organisation was participating in the NHS England Improvement programme called the Emergency Care

Summary of findings

Improvement Programme (ECIP), in order to review order to maximise the flow of patients through the community inpatient hospitals to ensure patients were received timely and safe care in the appropriate place.

- At Courtauld Ward, we observed staff arranging for a packed lunch, bread and milk to be sent home with a patient who was being discharged that day.

The ward matron at St Peter's Ward had developed 'The Big 4'. This was tool used to provide a focus for staff and prioritised the education and training that was needed.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that they meet the requirements of the duty of candour requirements when this is required.
- The provider should ensure that all staff undertake mandatory infection control training.
- The provider should ensure staff at Courtauld Ward receives Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- The provider should ensure all staff on St Peter's Ward have an annual appraisal.
- The provider should ensure hand wash basins in the patients' rooms at St Peter's Ward are compliant with regulations set out in the Health Building Note (HBN) 00-09 Infection Control in the Built Environment.
- The provider should continue to take actions to ensure that apology letters are sent to patients and families when things go wrong with their care and treatment in line with the duty of candour regulation.
- The provider should continue to take action to ensure that staff record patients' observations and national early warning scores (NEWS) appropriately and the correct escalation is followed
- The provider should ensure staff have attended mandatory training in line with the organisations target.
- The provider should ensure staff complete the allergy status on all patient records.
- The provider should consider reviewing the integrated care team service specification.
- The provider should consider introducing routine auditing of restraint and consent processes.
- The provider should consider developing action plans to address did not attends for appointments.
- The provider should consider monitoring the fast track process for end of life patients.

Provide Community Interest Company

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall, we rated the safety of the services as good. The team made judgements about four services. All four services were rated as good.

Our key findings were:

- Openness and transparency about safety was encouraged across the organisation. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Systems, processes and standard operating procedures in infection prevention and control were reliable and appropriate to keep patients safe. Staff demonstrated a good understanding of infection prevention and control and throughout the organisation, we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection.
- Across the organisation, we found staffing levels were generally meeting the needs of patients, we received very little feedback from staff that staffing levels were of concern to them. Similarly, we did not receive feedback relating to concerns about staffing levels from patients, relatives or carers.
- There was a good understanding of safeguarding children and adults amongst staff. Staff were proactive in their approach to safeguarding and was focussed on early identification.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose.
- Effective business contingency arrangements were in place to ensure patients continued to receive essential care during periods of adverse weather or major incidents.

Our findings

Incident reporting, learning and improvement

- Openness and transparency about safety was encouraged across the organisation.
- At our last inspection, we were concerned about the inconsistency in reporting practice. There was varying

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ability and awareness amongst staff to identify and consider serious incidents, incidents, near miss incidents and risks and what to then do with that information, however at this inspection were we found staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.

- At our last inspection, we found inconsistency concerning classification and reporting of pressure ulcer incidents. We did not have any concerns in relation to this during this inspection
- The organisation had an electronic incident reporting system. Between December 2015 and November 2016 there was 2059 incidents reported through the electronic reporting system. Of the incidents around 20% resulted in no harm, around 62% resulted in low harm and around 17 % in moderate harm. Incidents resulting in death accounted for around 0.14% of all incidents.
- Provide Community Interest Company reported 16 serious incidents requiring investigation (SIRI) in the time between 2 October 2015 and 26 August 2016. Eleven SIRI were type '3' a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population', and five were type '5', loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation'. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- There were no never events for the year preceding our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- There was a well-established system for investigating incidents using root cause analysis methodology. Incident reports that we examined were detailed with good depth and rigour being evident.
- At our last inspection, we were concerned at the inconsistency in practice in regards to learning from incidents and sharing of that learning both within individual teams and across the organisation. During this inspection, we found that all incident investigations outlined areas for learning. Our inspection teams saw examples of changes that had been introduced because of learning from incidents and saw examples of where this had been shared across the organisation.
- There was a clear governance structure for monitoring incidents. The board had oversight of trends and learning from incidents.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 was introduced in November 2014. This regulation required the providers to notify the relevant person that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.
- The organisations had a Being open and Duty of Candour policy in place and staff demonstrated an awareness of their responsibilities under duty of candour.
- The electronic reporting system incorporated a duty of candour element and prompted staff to offer an open and honest explanation to patients if an incident had affected patient care.
- We reviewed a number incidents where duty of candour would need applying and saw that this had been done, however within community health inpatient services we saw four serious incidents had not had the full duty of candour applied although we did see that a documented verbal apology that had been given to one patient and their family.

Safeguarding

- Staff had access to suitable safeguarding adult and children's policies and procedures as well as advice from the safeguarding team.
- All staff we spoke with had an understanding of how to protect patients from avoidable harm. We spoke with staff who could describe what safeguarding was and the

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process for referring concerns. Staff were able to give examples of where they would raise safeguarding concerns and were able to tell us about concerns they had raised in the past.

- There was a safeguarding telephone advice line manned by a safeguarding named nurse, which practitioners could access for advice and support. Staff told us they found this a useful resource, however, sometimes it was busy but a call back system was in operation.
- The organisation delivered one to one safeguarding supervision to all health visitors and school nurses on a quarterly basis. The organisation delivered group or one to one safeguarding supervision to allied health professionals on a quarterly basis.
- Staff had robust knowledge of serious case reviews and the necessary actions and recommendations from them. For example, all of the staff we interviewed were very knowledgeable about their caseloads and could identify any children who were on a child protection plan.
- The organisation had a domestic abuse specialist nurse and looked after children's (LAC) specialist nurse. Staff told us they were aware of this resource. Children (under 18) may be 'Looked After' by Local Authorities under a number of legal arrangements. Authorities place looked after children and young people in a variety of placements: from foster care to kinship care, children's homes, specialist units/centres and young offender institutes. The organisations record showed there were 390 looked after children on their records.
- Across all services, there were sufficient numbers of staff trained to the appropriate level in safeguarding, domestic violence, child sexual exploitation and female genital mutilation.

Medicines management

- The organisation had 55 services, clinical and none clinical. Medicines management were involved in all of the clinical services, including specialist respiratory services.
- The medicines management team procured medicines from the local NHS trust. Clinical pharmacist from PROVIDE visited each ward once weekly, supported by a pharmacy technician, to do medicines reconciliation, clinical interventions, attend ward round and on stoke rehab participate in the MDT.
- There was 9am to 5pm access to a pharmacy Monday to Friday with out of hour's service provided by the local NHS Trust.
- The pharmacy team was involved in the community service delivery for example district nurse and health visiting teams. They provided medicines management training were involved in specific patient's care for example complex antibiotic regimes on discharge.
- The pharmacy team had developed standard operating procedures for insulin administration and an algorithm flow chart on steps to follow for safe administration of insulin.
- There was a policy in place to allow patients to administer their own medicines. This is important because patients should be encouraged to be as independent as possible and where appropriate manage their own medicines on rehabilitation wards.
- There was a standard operating procedure for the transcribing of medicines in the home and in community hospitals (review 2018) available for the children's specialist service to access from the internet.
- The specialist healthcare team provided child specific competency-based training in healthcare intervention including artificial feeding and medicines administration.
- There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines and administering of medicines.
- Across all core services, medicines were stored appropriately.
- All of the community nursing staff we spoke with were consistent in their management of patient medicines. Nursing staff did not routinely transport patient medicines, patient's families were asked to collect medicines or local pharmacies delivered them to the patient's home. Nursing staff routinely carried adrenaline and saline used to flush intravenous or peripherally inserted central catheter (PICC) lines. In addition, nurses worked with GP surgeries to offer flu vaccinations for their patients. The vaccinations would be stored in a fridge at the GP surgery and transported by the nurse in cool boxes.
- The organisation had recognised a trend of incidents in 2015 relating to the administration of insulin and introduced a revised community nursing prescription chart in September 2015. In addition, staff received

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additional training and patients in residential care were provided with individual insulin boxes for their medication. We reviewed an audit from April 2016, comparing incidents relating to insulin administration before and after the interventions. Audit findings showed a 10% reduction in insulin administration incidents and an increase in the number of incidents reported, which demonstrates an improving safety culture. Staff we spoke with we aware of the incidents and the changes to procedures and prescription charts.

Safety of equipment and facilities

- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose, which meant patients were safe. Equipment was accessed through a local community equipment service. None of the staff we spoke with raised any concerns with accessing equipment and told us equipment could arrive in the patient's home within the same day.
- The provider used syringe driver pumps for end of life patients requiring a continuous infusion to control their pain. A continuous infusion is a controlled method of administering intravenous medicines without interruption. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features.
- We found electrical testing and equipment maintenance was up to date in the areas we inspected.
- The organisation leased some buildings from other organisations, some staff told us repairs were difficult to resolve. However, of the premises we visited all environments were well maintained and suitable for intended use, however hand washbasins in the patients' rooms at St Peter's Ward were not compliant with regulations set out in the Health Building Note (HBN) 00-09 Infection Control in the Built Environment. The basins were small, had overflow outlets and separate taps that needed to be operated by hand.

Records management

· With the exception of the community inpatient wards that used a paper based system, all community nursing staff used an electronic system to access patient records. This was the same system used by some GPs. With patient consent, records could be shared between different teams within the organisation.

- We reviewed the management of records across the services and saw staff completed records in accordance with the organisations record keeping policy. Records were accurate, complete and legible. When care plans were updated, these were printed off and placed in the paper records within patient's own homes.
- The organisation undertook a yearly audit of records. The latest audit compiled in January 2016 showed 1364 records were reviewed across the organisation as a whole, of which 94% were electronic records. Although this information was not detailed, enough to provide results for the individual community teams, the data showed an overall improvement in the quality of record keeping across the organisation for the period 2015/16 compared with a similar audit in 2014/15. For example, there was an improvement in the recording of allergies/ sensitivities within the electronic record; however, the organisation acknowledged these results were lower than required at 35.9% (compared with 11.47% in 2014/ 15). The organisation planned to continue with training and repeat the audit.

Cleanliness and infection control

- There were infection prevention and control policies and procedures in place, which were readily available to staff on the organisation's intranet. Infection prevention and control was included in the mandatory training programme and high numbers of staff across all core services had completed this.
- There had been no MRSA bacteraemias since April 2015. MRSA is a type of bacterial infection and is resistant to many antibiotics.
- Since April 2015, there had been one outbreak of C. difficile. Following this incident, a comprehensive root cause analysis (RCA) was carried out to determine the cause and help prevent reoccurrence. We saw a robust action plan had been developed and implemented as a result and staff across the three-inpatient hospital wards was able to describe the actions that had been taken as a result.

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- The organisation monitored IPC practices, for example compliance with hand hygiene, on the infection prevention dashboard. Information from the dashboard was reported at the organisation infection prevention committee each month.
- All areas we visited during our inspection were visibly clean. This was supported by most recent patient led assessment of the care environment (PLACE) data, which demonstrated a high compliance rate of cleanliness in the ward areas of 99.82%, which is above the national average of 98.1%.
- We observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash their hands or use hand-sanitising gel between patient contact. There was access to hand washing facilities on the inpatient wards. Personal protective equipment, which included gloves and aprons, was available both on wards and during home visits.
- All staff were observed to be adhering to the organisation dress code, which was to be 'bare below elbows'. Patients commented that all staff washed their hands before and after treatments.
- Staff had adequate supplies of gel hand sanitiser and personal protective equipment (PPE).

Mandatory training

- Mandatory training compliance was monitored and was mostly completed using an on-line electronic system, although some modules were provided as face-to-face sessions.
- Mandatory training included information governance, infection prevention and control, safeguarding adults and children, health and safety including manual handling, fire safety, basic life support, continuing health care assessor and awareness, dementia and learning disability awareness and Mental Capacity Act training.
- The organisation provided mandatory training data prior to our inspection. Compliance rates for all mandatory training across the core services were mostly in line with or above the organisation target of 95%.

Staffing levels and caseload

- The integrated care teams used an electronic caseload analysis tool (eCAT) for workforce planning. Patient dependencies were scored based on both nursing and patient criteria. The tool was able to identify both planned and unplanned workload and the skill mix of the nursing teams. This tool was used to provide evidence of staffing requirement to the commissioners of the service. It also allowed staff to close caseloads where visits were no longer required, enabling staff to prioritise care
- Across the organisation, we found staffing levels were generally meeting the needs of patients, we received very little feedback from staff that staffing levels were of concern to them. Similarly, we did not receive feedback relating to concerns about staffing levels from patients, relatives or carers.
- Staffing levels were monitored every month and reported to the board bimonthly. We reviewed reports that were presented at meetings in May and July 2016 and saw staffing numbers, had been reviewed and discussed, along with the impact on patient care. Where vacancies were identified the organisation was addressing these and had taken action to reduce the risk.
- The executive team and board monitored staffing vacancies, staff turnover and the use of bank and agency staff through a monthly workforce metrics report. We looked at these reports and found them to contain depth and rigour.
- In the workforce metrics report (September 2016) organisation staff turnover was 23.7% Staff sickness levels in the same report were 3.28%. These figures were lower than the same period in September 2015.

Managing anticipated risks

- The organisation provided business continuity plans. We reviewed the service business continuity plan together with the winter contingency arrangements for one of the integrated care teams. These plans gave clear direction for staff in the event of loss of services such as telephones and IT and in the event of adverse weather.
- Staff told us, in the event of severe weather, they would contact patients by phone to assess their needs. The service had access to local volunteer drivers with "four by four" vehicles, who were willing to assist with the transportation of staff to essential visits during episodes of severe weather.
- The organisation used a vulnerability tool integrated into the electronic patient management system, which allowed practitioners to identify vulnerability factors within the patient record such as emotional health,

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alcohol abuse, drug abuse and domestic violence. This enabled an oversite of the vulnerability of all of the caseloads. Staff could obtain reports from the system for individual caseloads or within a team of professionals, which identified caseloads of high need requiring additional support and intervention.

Are services effective?

Good

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 of findings

Overall, we rated the effectiveness of the services as good. The team made judgements about four services. All services were rated as good.

Our key findings were:

- Evidence based practice was embedded throughout the organisation. The care staff provided was evidence based and reflected national guidance.
- A range of audits was undertaken across the services. Findings from audits were used to drive up improvement .
- Overall, we found patients were referred, transferred and discharged appropriately.
- There was effective multidisciplinary team (MDT) working throughout the core services. Staff had a good understanding of each other's roles, valued, and respected the contribution each other made.
- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way.
- Staff were able to demonstrate a good understanding of the principles of mental capacity act.

Our findings

Evidence-based care and treatment

- Evidence based practice was embedded throughout the organisation. The care staff provided was evidence based and reflected national guidance. For example, risk assessments and care implemented for patients who were at risk of falls and pressure ulcers were in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Care provided to stroke patients reflected the Royal College of Physicians (2016) National Clinical Guideline for Stroke, and the NICE Clinical Guideline CG162.
- Staff knew the national guidelines relevant to their scope of practice. They told us the organisation supported them to follow this practice
- There were a range of clinical policies and procedures in place for staff to follow which reflected current guidance. For example, NICE guidance on Pressure Ulcers (CG029). Staff knew how to access policies and guidelines and they were readily available.
- There was an organisation wide governance process to ensure policies and procedures were up to date and in line with best practice.

Pain relief

- Without exception, all patients we spoke with told us staff asked if they were comfortable and if they had any pain. They told us staff offered pain-relieving medicines regularly and did all they could to control their pain.
- Patient care records included assessments for pain including the Abbey Pain Scale, which was specifically for the measurement of pain in people living with dementia who cannot verbalise when they are in pain.
- We observed staff asking patients about their pain and comfort levels. Patients were offered pain relief prior to uncomfortable treatments such as leg ulcer dressings.
- Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain.
- Pain relief was reviewed for effectiveness and changes were made as appropriate to meet the needs of individual patients.
- End of life care patient had anticipatory medicines prescribed (medication that patients may need to take to make them more comfortable).

Nutrition and hydration

- All patients were assessed for their risk of malnutrition using a nationally recognised tool and had their dietary needs documented.
- For those patients who required specialist input, dietitians and speech and language therapist were available.
- Meals at Courtauld Ward were cooked on site and provided by the local trust. Staff from the local trust, also served the meals to patients. At Halstead and Braintree, frozen food was reheated in specialist ovens in the ward area and then served to patients. Provide staff delivered this service.

Are services effective?

Good

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.

- All wards had protected mealtimes, which allowed patients to eat their meals without unnecessary interruption and for staff to focus on assisting those patients unable to eat independently.
- The organisation monitored breastfeeding rates. The average percentage of mothers who had continued breast-feeding at six to eight weeks for the period March 2016 to October 2016 was 48% this was against an organisational target of 48%.
- An adult nutrition and hydration policy November 2016 was also available to staff based on NICE clinical guidelines

Use of technology and telemedicine

- We saw plans for therapy staff within the stroke service to introduce electronic hand held devices. These would be used to allow patients to use programmes to support therapy and to assist staff achieving more treatments
- The organisation provided a service called Carecall, which was an alarm system for people living in their own home to call for emergency help. It consisted of an alarm button, which when pressed sent an alarm to a control centre. The control centre was manned 24 hours per day. The alarm button activated a microphone enabling the patient to talk directly with control room staff and could automatically identify the address of the call.
- We saw the Carecall alarm buttons in patients' homes and patients told us they would not be without it and had received a prompt response when they had used it. There was a charge for the Carecall service.
- The organisation used digital technology to communicate and share information throughout the organisation, this reduced environmental impact and increased efficiency.

Outcomes of care and treatment

- The organisation had a clear audit programme, which was monitored by the audit committee.
- A range of patient outcome measures was used across therapy services. For example EQ-5D questionnaire for measuring generic health status, ICIQ questionnaire to assess the impact of symptoms of incontinence on quality of life, Oswestry Disability Index to quantify disability for low back pain.
- The organisation also contributed to the Sentinel Stroke National Audit Programme (SNAPP). SSNAP measures the quality of care stroke patients receive throughout the whole care pathway up to 6 months post admission to hospital.
- The organisation audited the preferred place of care/death for patients. Data showed that between April and June 2016, 91% of patients achieved their preferred place of care/death.
- The organisation undertook a multi-agency case audit (July 2016) to demonstrate how they worked together with other agencies and how they used learning to plan and deliver improved outcomes. This included findings, recommendations and action planning. There were four recommendations; we saw evidence of action planning to address these. This included reviewing training materials, audit themes to present to the organisation, sharing key themes with the Essex Safeguarding Children's Board (ESCB) and continued involvement with the multi-agency case audit.

Competent staff

- Many staff told us they had opportunities for training and development. The organisation supported staff to undertake a variety of training including access to master's level study, non-medical prescribing and the specialist district nurse qualification.
- The organisation had provided support for registered nursing staff on revalidation with the nursing and midwifery council. Revalidation is the process all nurses completes to renew their nursing registrations and continue practising.
- A new role of clinical facilitator had been introduced to the inpatient wards; this was a senior nurse who provided education and training in the clinical area. Staff we spoke with said the clinical facilitator was visible and able to support training.
- Staff told us they were supported to seek out additional training to develop professionally. They gave examples of dementia training and tissue viability training they had recently completed.
- Healthcare assistants (HCA) completed the care certificate and had their competence assessed before performing clinical tasks. The care certificate is government requirement to ensure HCA have the fundamental skills in order to provide safe and compassionate care.

Are services effective?

Good

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.

- Staff had access to clinical supervision. A clinical supervision toolkit was available to staff, which enabled them to make the best of the supervision session by focusing on challenges and achievements.
- In conjunction with the local clinical commissioning group (CCG),local mental health and acute trust there was a rotational programme for band 5 nurses with a focus on care for the older person.

Multi-disciplinary working and and co-ordinatation of care pathways

- We observed effective multidisciplinary team (MDT) working throughout the core services. Staff had a good understanding of each other's roles, valued, and respected the contribution each other made.
- Social care service representatives were involved in care planning and invited to multi-disciplinary team meetings when necessary in order to improve patient care and outcomes.
- Patients received care and support from a variety of sources such as, consultants, nursing staff, GPs, community nursing teams, dieticians, physiotherapist and occupational therapists.
- Information provided by the organisation demonstrated clear co-ordinated pathways for patients for example for the transferring of information from maternity services to health visiting and health visitor to school nurse.
- We reviewed patient electronic records, which demonstrated evidence of referral to other specialist agencies to support patients.

Referral, transfer, discharge and transition

- Overall, we found patients were referred and transferred and discharged appropriately.
- Patients were referred to the inpatient wards from the local acute trust through the community assessment service (CAS). There was a clear standard operating procedure (SOP) which identified the process for the referral and transfer of patients from the acute hospital for rehabilitation.
- There was a multi-agency transition protocol for young people with disabilities and additional needs moving from childhood to adulthood version one (September 2011). This was in partnership with the local authority and three NHS health organisations.
- Patients were referred to the end of life care services through a number of routes including through GP or consultant referral, or they could visit local hospices or self-refer. The service actively used the Gold Standard Framework to plan the right care for people as they neared the end of their life
- Referrals to the integrated care teams were made through the organisations central point of access team, which operated from 8am to 11pm seven days a week. After 11pm, urgent calls from patients were managed by the GP out of hour's service. The integrated care team and GP out of hour's service verbally hand over any outstanding patient issues at 11pm and 8am. Information could also be communicated through the electronic patient record system, which was also used by the GP out of hour's service.
- The transition clinics handed the young person over to adult services at 18 years, however, staff assessed patients on an individual basis and some young people remained with the clinic until 19 years. Staff told us of a young person aged 17 years with special educational needs who had delayed transition to adult services until aged 19 years to allow for an increased level of independence planning achieving self-injecting of a medication.
- We saw referral criteria and exclusion criteria for all the therapy services developed in partnership with the clinical commissioning groups.
- Discharge planning was discussed within the multidisciplinary teams and with patients from initial referral.

Availability of information

- Policies and procedures were available electronically through the organisations intranet system.
- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way.
- With the exception of inpatients wards the organisation used an electronic patient record system, which meant staff could access patient records flexibly. Staff worked remotely when conducting visits and clinics in the community using a laptop.
- A majority of GPs jointly accesses electronic patient records. This promoted joined up working and effective communication between professionals. In addition, consultants wrote to GPs after appointments outlining the outcome of the appointment and future treatment.

Are services effective?

Good

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.

- Staff working within end of life care in both community and inpatient settings had access to a 24-hour advice line from specialists at the local hospice.
- All staff working in the community had mobile telephones and could contact other members of staff for advice or any changes in planned caseload.

Consent

- The organisation had a policy, which identified the roles and responsibilities of staff in order to safeguard patients from un-necessary or inappropriate deprivation of their liberty. Staff were aware of this and the process for applying for DoLS.
- Staff had a good level of knowledge about the MCA and could give examples of when then had needed to complete mental capacity assessment for patients.
- The organisation provided evidence of a consent to examination or treatment policy (review 2018). This included the concept of Fraser and Gillick competence.
- Staff working in children services understood and could explain both Gillick competency and Fraser guidelines.
- Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent to treatment appropriately.
- During our inspection, we reviewed seven DNACPR orders; all of the orders had been appropriately completed in line with national guidance.
- We saw the Use of Restraint when Working with Patients policy, which was reviewed April 2016 to incorporate the most recent safety alert on the topic. It included lawful and unlawful restraint practices and DOLs. Awareness of the policy was included in conflict resolution training, mandatory for all staff.

Good

Are services caring?

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

Summary of findings

Overall, we rated the caring as good. We made judgements about four services and rated one as outstanding and three as good.

Our key findings were as follows:

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care, which was kind and promoted dignity and respect.
- Patients were treated with kindness and compassion throughout all of the services we inspected.
- Patients understood and were involved in their care
- Staff consistently helped patients and those close to them to cope emotionally with their care and treatment.
- Staff supported patients to manage their own health and care and where possible, to maintain independence.

Our findings

Dignity, respect and compassionate care

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care which was kind and promoted dignity and respect
- Patients were treated with kindness and compassion throughout all of the services we inspected.
- We spoke with many patients, relatives and carers during our inspection. They were consistently positive and complimentary about staffs attitude and support. We saw examples of how staff had gone over and above what was expected of them to provide compassionate care.
- Staff respected patients' social needs. For example within stroke services at St Peter's Ward, patients were encouraged to socialise with other patients during their time on the ward. For example, patients were encouraged to complete activities such as puzzles in the day room together. At Halstead Ward, we observed patients eating their meals in the day room, sitting together in small groups around tables, which provided a social environment for eating.
- The NHS Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Between December 2015 and November 2016 Provide Community Interest Company scored an average of 98% for patients who said that they would recommend the service they had used to their family and friends. Scores were above consistently above the England average of 95%.

Patient understanding and involvement

- Overall, patients understood and were involved in their care. We saw some excellent examples of how staff took time to clarify patients understanding of their care and treatment.
- We observed staff providing family members with an update of their relatives' condition. Staff were respectful and supportive, checked relatives had understood what had been said and gave time to answer any questions they may have had.
- Patients told us they felt included in the planning of their care. On one of the contact cards we reviewed, a patient had written " I especially like that they explain and consult about treatments"
- Staff took time to speak to patients and their relatives in a way they would understand. The terminology that was used was understandable, checks were made to make sure patients, and their relatives understood their care. We saw staff giving information leaflets to patients when required to ensure they add additional information to patients understanding.

Emotional support

- All staff considered emotional support as part of their role. Staff completing home visits demonstrated knowledge of patients and their individual situations. Emotional support was tailored to each patient's and care givers separate set of circumstances and we saw that appropriate emotional support was provided
- Staff consistently helped patients and those close to them to cope emotionally with their care and treatment.
- Staff supported patients to manage their own health and care and where possible, to maintain independence.

Good

Are services responsive to people's needs?

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

Summary of findings

Overall, we rated responsive as good. We made judgements about four services all were rated as good.

Our key findings were as follows:

- Services were planned around the needs of individual patients.
- There was a range of services offered to vulnerable groups.
- Staff on wards had taken steps to improve the environment so it was more suitable for patients living with dementia
- Patients could access the right care at the right time, including those with urgent needs.
- The organisation was achieving all of the referral to treatment times.
- We found evidence throughout the organisation that people were supported to raise concerns, complaints and compliments

Our findings

Planning and delivering services which meet people's needs

- Services were planned around the needs of individual patients and the organisation worked well with the local clinical commissioning groups (CCGs) to plan and deliver services across Mid Essex.
- Integrated care pathways were in place, which incorporated primary, secondary and acute care, integrated care teams worked closely with other providers such as acute and social care services to ensure the most appropriate care package was in place for patients.
- Staff worked with other providers and voluntary organisations, to provide support and services to patients. Clinics and support groups were set up and based out in local communities to meet the needs of local people.
- Service specifications were in place for key elements of community adult services.
- The organisation used a specialised software package, which gave a greater insight into its population and service users based on their demographic characteristics, lifestyles and behaviour. This information was used to tailor health education programmes to the population needs.

Meeting the needs of people in vulnerable circumstances

- Community matrons led on managing care of patients with long-term conditions, frailty and those with complex care needs. They made sure care was planned and co-ordinated across the multi-disciplinary team.
- Staff were knowledgeable about their caseloads and especially if they had any vulnerable patients on them.
- Across the three-inpatient wards, all staff had received training in dementia awareness.
- The Patient-Led Assessments of the Care Environment (PLACE) 2016 audit looked at how the environment was designed to meet the requirements of a patient living with dementia. On average, the three-inpatient wards achieved 78%, which was above the national average of 75%.
- Staff on wards had taken steps to improve the environment so it was more suitable for patients living with dementia. Activities boxes were available for patient living with dementia, which included distraction therapy.
- The organisation provided a support role for families who were experiencing challenges and required additional support with complex care issues. Staff provided information and guidance for families and young people about a range of support services if required.
- Staff at Moulsham Grange clinic used specialist-motorised wheelchairs for children with mobility difficulties. Staff used the wheelchairs to support the development of motor functions and movement.
- The delivery of child specific healthcare intervention training meant children and young people could access clubs, activities and go to school with their peers. Staff trained people working at schools, clubs and services to ensure there were fewer barriers for children wanting to access activities. One member of staff said, "Training is not a barrier to access".

Access to the right care at the right time

- The central point of access team had a screening process in place in order to prioritise calls. Categories were urgent - within four hours, non-urgent/same day -

Good

Are services responsive to people's needs?

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contact within 24 hours and visit within 48 hours if required. If staff were concerned about a call, there was always a clinical member of staff available for advice, support, and a clear emergency escalation process. The reported response times for November 2016 were 99% for a four-hour response, 99% for a 24-hour response and 93% for a 48-hour response. We reviewed previous month's reports from April 2016 to October 2016 and all the response time percentages were consistently above 99%.

- School nurses offered a range of services for children and young people, which were accessed through 'drop-in' clinics, by appointment, at home visits and in school. Staff told us they accommodated a majority of visits out of school hours to minimise disruption for the children during the school day.
- Information provided by the organisation demonstrated between November 2015 and October 2016 the organisation achieved their referral to treatment time (RTT) of 18 weeks for children's community nursing, continence and enuresis, occupational therapy, physiotherapy, speech and language and community paediatric services. The average waiting times for these services for the same period was between six to nine weeks.
- The organisation monitored the time taken from referral for patients to have an initial assessment by podiatric surgery. The average time was 51 days, which was significantly better than the national target of 126 days.
- The time taken from referral for patients to have an initial assessment for minor operations, varied from 29 to 54 days depending on the type of operation required. For all operations, this was significantly better than the national target of 126 days.
- The organisation worked in conjunction with the local acute trust. Provide staff were based in the local acute accident and emergency (A&E) department, and worked alongside the acute trust's discharge team and social care teams to prevent unnecessary admissions to the A&E department. This meant if appropriate, patients would be sent to the frailty unit of the acute trust or straight in to the community hospital beds, rather than to an acute hospital ward.

Complaints handling and learning from feedback

- There was an up to date complaints and compliments policy available on the intranet.
- The customer service coordinator managed the complaints process and facilitated responses to the complainant as well as overseeing the complaints procedure. Complaints information was recorded on the electronic risk management system allowing any links between a complaint and a reported incident to be identified. Data from complaints was reported through the clinical governance structure and to the board, minutes we reviewed confirmed this. There was a sense that the organisation took a genuine interest in patient feedback.
- Provide Community Interest Company reported 179 complaints between 1 September 2015 and 31 August 2016. Sixty three of these complaints were upheld, 34 were partially upheld. No complaints were referred to the Ombudsman. The top three complaints themes related to communication, access to services and equipment.
- The chief executive did not sign off complaints; however, the chief executive confirmed he had oversight of all level two complaints.
- We reviewed a total of six complaints files; one of these was a complaint from a patient in vulnerable circumstances. All complaint responses offered an apology. All six complaints were graded as good and demonstrated good practice.
- The organisation had an external review of their complaints and whistleblowing process by an external provider in 2015/ 2016. The review concluded that there was adequate assurance in the complaints and whistleblowing policy.
- We found evidence throughout the organisation that people were supported to raise concerns, complaints and compliments. Information was widely available.
- Patients and relatives told us they would feel comfortable raising a complaint with ward or community nursing staff if necessary.

Are services well-led?

Good

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 of findings

We rated the organisation as good for well led because:

- There was a statement of vision and values, driven by quality and safety.
- The vision values, values and strategy had been developed through a structure planning process including staff and key stakeholders.
- Staff understood and knew the vision and values of the organisation.
- There was an established governance structure, which was there to support the provision of assurance to the board.
- A culture of putting the patient first was evident throughout the organisation.
- The Chief Executive, Chairman and clinical and operations director were visible and many staff commented on the strong leadership they provided.
- Staff were shareholders in the organisation with voting powers this helped engage staff to ensure their voices were heard and acted upon.
- Mechanisms were in place to support staff and promote positive wellbeing.
- Morale was mostly good throughout the organisation. The majority of staff were happy in their jobs and liked working for the organisation

Our findings

Leadership

- The executive team at Provide was made up of the chief executive (CEO), executive clinical and operations director, executive organisational development and human resources director, executive finance director and executive director of the integrated pathway hub. A chair and non-executive directors supported the executive team.
- The Executive Team was responsible for strategic financial management and planning, strategic risk management, overall organisational development, staff development and the effective management and operation of all services, including compliance with required legislation and standards. The team worked collaboratively with local Commissioners, strategic leaders and key healthcare and community partner organisations.
- The executive leadership in the organisation was very stable. The Chief Executive had been in post for seven years and was very well respected both internally and by external stakeholders. An equally respected Chairman who had been in post since August 2015 led the board.
- The Chief Executive and Chairman worked well together but their relationship had an appropriate balance between challenge and support.
- The Chief Executive, Chairman and clinical and operations director were visible and many staff commented on the strong leadership they provided.
- The organisation had a highly engaged board committed to working in partnership with the senior management team and leaders in the organisation. The board worked well with the council of governors.
- The Non-Executive Directors were a skilled, experienced, and had varying backgrounds. We saw evidence of challenge in board meetings.
- The board had been through a development programme and had taken time out to get to know the strengths and skills of each other.
- The board regularly visited different areas across the organisation; this ensured good communication with staff and patients, as well as seeing safety and quality of services first hand.
- The organisation had introduced a “manager’s survival programme” which was linked to the Institute of Leadership and Management. This supported managers in their role as well.
- Both the chief executive and the executive clinical operations directorate were well known, approachable and respected by staff.
- Our inspection teams across all core services found that local team leadership was effective. Without exception, staff we spoke with said their line managers supported them and local leaders were visible and approachable.

Vision and strategy

- The organisation had a vision to provide a range of outstanding services that care, nurture and empower individuals and communities to live better lives

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- The organisation had 10 functional strategies, such as the estate, people, clinical and the operational service strategy. These were aligned to the overall corporate strategy.
- All strategies were aligned to the vision and values of the organisation and built on work completed in 2015-2016.
- Each business unit had set key priorities for 2016-2017, which would assist in the organisation achieving the three-year goals.
- The organisation had a commercial focus, which was also centred on providing the best possible care for patients. This had made the organisation well placed to respond and adapt to changes in direction arising from new local and national policy.
- The organisation operated within a wider health and social care economy. Its main purchases of care were clinical commissioning groups across Mid Essex. Information received prior to the inspection suggested the organisation was well respected by all of these organisations.
- The organisations values were care, innovation, compassion and fun. Staff across all core services delivered care in line with these values.
- The council of governors worked collaboratively with the board of directors to prepare the organisations vision and values and developing the organisations strategy prior to submission to the board.

Governance, risk management and quality measurement

- The organisation had an established governance structure, which was there to support the provision of assurance to the board. A range of board sub committees was in place such as the quality and safety committee and the finance and risk committee. These committees reported regularly to the board.
- The board met monthly, bi monthly was the business board meetings and bi monthly was the strategy focused meetings
- The Board Assurance Framework (BAF) and corporate risk register identified the strategic and operational risks. The BAF was reviewed by the board and was linked to the strategic risks. We saw evidence of this in July 2016 board minutes.
- There was a risk management policy in place. Risks were categorised using a risk matrix framework based upon the likelihood of the risk occurring and the severity of the impact.
- The Board and senior managers had oversight of the reported risks and had measures in place to manage reported risks.
- There was a high-level comprehensive quality dashboard in place, which covered areas such as patient centred care, dignity and respect and consent, it was a useful tool for the board to monitor performance. It provided a range of performance metrics for the board as well as giving information for individual clinical teams. A detailed report accompanied this dashboard as further reassurance for the board.
- Board business agenda's covered a range of appropriate and relevant organisation business.
- Board papers demonstrated robust comprehensive papers particularly in areas such as quality and safety. We saw evidence of improved reporting through dashboard developments and detailed supporting reports.
- Minutes of board business meetings demonstrate that executives were held to account. We noted debate, discussion and actions from board minutes. Action logs were used at each board and reviewed to ensure actions had been complete.
- The organisation had received an inspection by NHS protect, following on from this the organisation were reviewing their response systems to possible fraud.
- At our last inspection, we found the risk management systems were immature and pose a risk to the Board's ability to have a clear oversight of risks to quality in the organisation. We did not find this to be the case on this inspection and could see that action had been taken to enhance staff ability and awareness to identify and consider serious incidents, incidents, near miss incidents and risks and what they should do with that information. We found that staff across all core services were aware of how to and what to report as incidents and all had access to the electronic reporting system.
- We issued two requirement notices to the provider at our last inspection. We followed both of the requirement notices up at this inspection, and found that the organisation were compliant with the 2014 regulations. We found that there were sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. We also found there were effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.

Are services well-led?

Good

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Culture across the provider

- Staff were committed to providing and ensuring patients received a good care and treatment.
- We found an open, honest and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice.
- A culture of putting the patient first was evident throughout the organisation.
- Morale was mostly good throughout the organisation. The majority of staff were happy in their jobs and liked working for the organisation
- The organisation had an annual awards ceremony to recognise staff contribution and achievements.
- The organisation were committed to ensuring all employees were treated with dignity and respect at work and not subjected to any form of unacceptable behaviour from colleagues. The organisation had a 'zero tolerance' to harassment and bullying.
- All staff we spoke with during focus groups and during our inspection felt they were respected and valued by the organisation. They knew how to raise concerns and felt at ease doing so. Staff were supported to raise concerns.
- The organisation took account of the health and wellbeing of staff and between 2015 and 2016 had engaged 23% of employees in working well activities. Working well activities included the provision of picnic benches at two locations so staff could take lunch outside, table tennis kits, back massage and static exercise bikes. There were designated health and well-being champions.
- We saw and were told of several examples where the organisation had made changes to improve staff well-being and safety.
- There was a positive regard for staff welfare across the organisation.

Fit and proper person requirement

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. The regulation intends to make sure senior directors are of good character and have the right qualifications and experience.
- The recruitment and selection policy outlined clear mandatory employment checks in line with the NHS Employment Check Standards, this included requirements to FPPR.
- There was a specific FPPR policy in this organisation.
- We looked at the file for six directors, which included the chief executive, executive clinical and operations director, and a non-executive director.
- The organisation secretary undertook "due diligence" checks for each director yearly or where information warranted such checks being made. If the company secretary had any concerns, these were raised with the chair of the board. We saw evidence in the board minutes for July 2016 discussing FPPR.
- Not all directors had enhanced disclosed and barring service checks in place. The organisation had made a decision that where directors were not clinical directors this was sufficient, all directors were subject to barring list checks. We saw evidence that the organisation considered informal sources of information about directors in files, such as disqualifications from professional bodies.
- Evidence of 'Right to work' checks to ensure directors were able to work in the United Kingdom were evident in the files we reviewed.
- A register of hospitality and gifts received was maintained for each of the board members; however, this was not kept with the personal file.
- Annual declarations of director's personal interests were on file.
- The organisation had a process for the management, discipline and dismissal of directors.

Staff engagement

- The organisation held yearly clinical summits. The summits were aimed at engaging front line staff to share learning from incidents through interaction and reflection on serious incidents.
- In the 2015 staff survey, of the 25 questions mapped to those asked in 2014, 22 showed an improved position, two showed no significant change and one showed deterioration. The organisation was working to address the areas of no significant change and the area of deterioration. Sixty-one percent of staff responded to the survey, this is a high percentage of staff and shows a high degree of confidence that the scores are representative of the views of the staff within the organisation.
- The Staff Friends and Family Test was launched in April 2014 in NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would

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recommend their service as a place of work. The organisation had added these questions to their staff survey for 2015. In the 2015 staff, survey 85% of staff would recommend the organisation as a place to receive care this was higher than similar NHS community trusts who scored 74%. The second question related to how likely staff were to recommend the organisation to friends and family as a place to work. In the 2015 survey 71% of staff said they would recommends the organisation as a place to work compared to just 55% in similar NHS trust.

- Employees owned the organisation and every employee was given the opportunity to become an owner of the company for just £1. As an owner, they had a say in the future direction of the company. They could make suggestions for improvements and influence how any surpluses were reinvested. Owners also elected governors to act as their representatives in the Council of Governors. This helped the organisation to be employee led on key decisions.
- The organisation had a policy in place to support staff volunteering in the local community for two days per year. They would give back staff two days annual leave for the days spent volunteering.

Public engagement

- The organisation met with the Patient Participation Groups (PPGs) which were linked to GP surgeries located in the area in which they delivered service. This was an important way of capturing views of services.
- The organisation also worked closely with local groups such as Essex Multicultural Activities Network and the Stroke association.
- The organisation employed as of September 2016 84 volunteers in a diverse range of roles. Volunteers were supporting services in many areas such as wards, administrative roles and therapies.
- The organisation told gathered information on people's views and opinions through a variety of ways such as in writing, by telephone, by e-mail, the internet, social media, questionnaires, focus groups and surveys. All feedback was collated in an electronic system and formed part of the patient experience report, which was discussed at the business board bi monthly.
- The organisation had reinvested over £1.2 million pounds into local community initiatives and charity schemes.

Equality & Diversity

- As part of our inspection we reviewed how well Provide was adopting the Workforce Race Equality Standard (WRES) and working towards achieving workforce race equality. WRES is mandatory for NHS community providers, including those providing NHS services. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- The organisation had a staff group of 1265. The percentage of staff from a visibly black and minority (BME) community background in the organisation was 5.9%; a comparably higher percentage than BME communities represented in the general population of Essex. White staff constituted 83.1%. The remaining percentage was either 'non-disclosed' or 'undefined'.
- The organisations WRES (Workforce Race Equality Standard) report was located under the HR policy section. However, a detailed WRES action plan had not been produced. Reference was made to the Single Equality Scheme (SES) action plan, which lacked detail and failed to elaborate on robust WRES actions or milestones for expected progress against the WRES indicators.
- In the organisational structure, leadership for equality and diversity sat at a senior level under the remit of the executive director of human resources and organisational development.
- The organisation did not have an established approach to embedding equality, diversity and human rights into the culture of the organisation. Attempts had been made to establish a Corporate Equality and Diversity Working Group (CEDWG) chaired by the Executive HR & Organisational Development Director, however, the group could not be sustained due to non-attendance. The idea behind the group's membership was to reflect key corporate and clinical areas. The aim was to oversee all corporate plans, schemes and strategies, which related to equality and diversity, to keep them under review and ensure the effectiveness of the Single Equalities Scheme.
- During the course of the inspection we carried out on one BME senior managers' focus group, (a focus group scheduled for BME staff groups was not conducted due

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to non-attendance by staff). We also interviewed the organisations Equality and Diversity Lead (who was also the Executive Director of HR and Organisational Development).

- All staff underwent Equality and Diversity training at induction, and managers training also included a module on managing equality and diversity.
- The organisation also worked closely with Essex Multicultural Activities Network (EMAN) a Community Interest Company createdtosupport andempowerblack and minority ethnic (BME) communitiesin Essex, with a special interest in South Asian communities.

Innovation, improvement and sustainability

- The organisation used an electronic caseload analysis tool (eCAT) for workforce planning.
- The organisation used Mosaic Insight a customer segregation tool. This allowed the organisation greater insight into the customer and service users and helped shaped the future of services.
- The organisation has launched 'Stop Smoking' application for users of the service linked to the lifestyles service; this enabled additional personal support to be provided to the user.
- The organisation had invested in Friends and Family applications on staff mobile devices to make feedback about services easy as possible. The organisation had committed more investment to additional devices for clinical areas.
- In conjunction with the local clinical commissioning group (CCG), local mental health and acute trust there was a rotational programme for band 5 nurses with a focus on care for the older person.
- The organisation used digital technology to communicate and share information throughout the organisation, this reduced environmental impact and increased efficiency.
- The use of interactive real time video applications meat that Speech and Language Therapists did not need to travel to the patient and vice versa.
- The organisation had established a research portfolio and funding of a permanent post to facilitate research.