Your Healthcare Community Interest Company

1-328569033

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-727827222	Hollyfield House		KT5 9AL.
1-727899272	Surbiton Health Centre		KT6 6EZ
1-727827967	Cedars Unit (Tolworth Hospital)		KT6 7QU.

This report describes our judgement of the quality of care provided within this core service by Your Healthcare Community Interest Company . 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 Your Healthcare Community Interest Company and these are brought together to inform our overall judgement of Your Healthcare Community Interest Company

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

Contents

Summary of findings

Overall summary

Overall, we rated adult community health services as good for safe, effective, responsive, caring and well led.

- Your Healthcare Community Interest Company provided adult community services to support people in staying healthy in their homes and after discharge from hospital and sought to prevent unnecessary hospital admissions.
- We rated safe as good because their safety performance data was better than the national average for most of the time. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff followed processes to report safety incidents and manage risks. There was a pro-active approach to following patient safeguarding procedures.
- Staff understood their responsibilities to raise concerns and report incidents and staff told us they received feedback from reported incidents. Safeguarding was embedded in the service and medicines were stored, managed and administered appropriately and safely.
- We rated effective as good because people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- There was well-established multidisciplinary team (MDT) working across all the teams we visited. Staff had mandatory training and most had had appraisals and access to personal development.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- We rated caring as good because feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile and we witnessed this during our inspection.
- Patient and their families received compassionate, focused care, which respected their privacy and dignity.
- Patients and relatives expressed satisfaction with the service and we found a caring and compassionate approach from staff in the areas we visited.
- We rated responsive as good because services were planned and delivered in a way that met the needs of the local population. The needs of different people were taken into account when planning and delivering services. Staff respected the equality and diversity of patients and their families.
- The service had many examples of responsive teams working collaboratively to meet their patients' needs. They provided care close to or within the patients' home environment, thus reducing hospital admissions.
- We saw examples of very responsive and accessible services such as rapid referral and quick assessment of patients.
- We rated well led as good because the provider had a clear statement of vision and values which was integrated within the teams. Staff we spoke with were aware of and based their care around the provider's values.
- Staff in adult community services told us they were well supported by local team leaders and managers and felt empowered to develop local solutions based on good practice.

However;

- Staff did not always manage to update patient records with all the assessments required.
- IT connectivity problems and pressures on staff time meant there were risks of delayed recording and sometimes incomplete records.
- Risk management and public engagement needed to be improved.

Summary of findings

Background to the service

The adult community health services covered all services provided to adults in their homes or in community-based settings. The main focus was on providing community nursing services, community therapy services, community intermediate and rehabilitation care services following illness or injury, ongoing management of long-term conditions and care for people with multiple or complex needs.

Your Healthcare provides community health services to all patients registered to a Kingston GP (203,854: NHS Digital October 2016). This exceeds the resident population by 17.5% as some patients resident in another borough are registered with a Kingston GP. There are 22 GP practices within the Kingston CCG area.

During the inspection we visited four of the clinics (including the headquarters for the service) and accompanied staff when they visited people in their own homes where we observed care, treatment and support being provided. We spoke with 25 members of staff and 29 patients and their relatives. We reviewed policies and performance data and looked at 15 copies of patient notes.

Our inspection team

Chair: Professor Iqbal Singh, consultant physician

Team Leader: Roger James, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Occupational Therapist, Physiotherapist, Speech and Language Therapist, Nurse Specialists, Pharmacist and an expert by experience (carer of people who had used community services).

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

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 Your Healthcare, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced visit on 15 -17 November 2016. Before and during the visit we held focus groups with a range of staff who worked within the service, such as nurses, specialist nurses, therapists, managers and BME staff. We spoke with people who use services, observed how people were being cared for, and spoke with carers and family members.

During our inspection, we spoke with fifty-two members of staff of all disciplines and grades. We also saw two staff handovers involving thirteen staff.

Summary of findings

We visited staff bases and spoke to managers, team leaders, the matron, community nurses, district nurses, care support workers, physiotherapists, occupational therapists, community matrons, tissue viability nurses, therapy assistants and administrators.

We looked at fifteen paper and electronic care records and spoke with fifteen patients and ten relatives/carers. We accompanied staff on fifteen home visits and saw staff providing care and treatment in patients' homes and looked at the paper based care records in the home environment.

What people who use the provider say

The majority of patients were positive about the services provided by the provider. Comments received included:

"We are very happy with the service from the therapists and nurses."

One patient said the provider's staff were a "Highly commended team, they are all so good to me". They also said, "They will always phone if they unable to visit or they are going to be late."

Another relative said, "All the team are very good and they ask about both of our health".

One relative said, "This service is amazing. I could not have got through the last six months without it".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure staff update patient records in a way that kept patients safe.
- Ensure IT connectivity problems are resolved
- Ensure timely recording and updating of patients records.
- Ensure an improvement in risk management and public engagement.
- Ensure the assessments of patients' nutritional and hydration status should be consistently carried out and personalised.
- Monitor Informal complaints.
- Ensure that staff, including some managers, are be made aware on how to record best interest decisions when patients were not able to consent to treatment.

Your Healthcare Community Interest Company

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because;

- Staff used an electronic incident reporting tool to report and record safety incidents, near misses and allegations of abuse, and these were escalated and investigated using root cause analysis (RCA) when appropriate.
- There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- There were systems to assess risks and monitor the quality and safety of care provided including performance dashboards and the Safety Thermometer.
- Clinical areas were clean, and staff washed their hands and used hand gel between treating patients.
- There were processes in place to ensure all staff were aware of the prevention and detection of pressure ulcers.

However;

- The quality of record keeping was variable, especially care plans in patients' homes, and not all patients had appropriate and up to date risk assessments.
- There were high vacancy rates of the following services; 17.69% for community nursing services, including infection control, leg ulcer and tissue viability nursing staffing and safeguarding staffing. The high vacancy rate and staff turnover meant staff were working under pressure.

Safety performance

- Service managers ensured incidents were correctly classified, including those considered a serious incident (SI) or Never Event. Never Events are serious incidents that are wholly preventable as guidance or safety

Good

Are services safe?

recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- The service monitored safety information through regular quality dashboard reports on safety indicators such as pressure ulcers, falls and medication errors. There was an improvement from the report we were provided with.
- The service completed information on Safety Thermometer. The Safety Thermometer allows providers to establish a baseline against which they can track improvements in harm free care and compare themselves with similar providers.

Incident reporting, learning and improvement

- The service used a recognised electronic reporting system. All staff we spoke with told us that they used the system. Hollyfield House reported six serious incident requiring investigations (SIRI) in the time period between 18 June 2015 and 11 February 2016. Four of these SIRI were type one, 'unexpected or avoidable death or severe harm of one or more patients, staff or members of the public' and two were type four, 'allegations, or incidents, of physical abuse and sexual assault or abuse'.
- Staff we spoke with knew how to recognise and report incidents on the providers' electronic recording system. They told us they were able to discuss the reported incidents with their line managers. They gave us examples of a range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. However, due to lack of equipment or IT connectivity issues, staff could not always access on-line reporting in the community, but had to return to a hub office to do so; this could cause delays in reporting incidents.
- Staff used regular team meetings or newsletters to share learning and trends from incidents; this was confirmed by community nurses in both localities who had attended meetings with other teams where actions from incidents or good practices had been shared. They told us that they felt confident to discuss or raise concerns. Senior staff were required to produce evidence that actions had taken place. However, some staff said that not all teams had regular team meetings, so not all senior staff shared this information.
- Incidents were reported through to managers and reviewed at governance or quality and safety meetings including details of the actions plans put in place as a result.
- All the community nurses told us that incident reporting, including near misses, was positively encouraged. One of the nurses gave us an example of an incident that they had reported. They said their manager supported them through the process and they felt there was a 'no blame' culture.
- Staff followed national guidance on the prevention of pressure ulcers. All skin damage from grade 1 to grade 4 was reported as an incident. All grade 3 and 4 ulcers required further investigations including safeguarding referrals.

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. A duty of candour policy was available which detailed how patients should be communicated with following a reportable patient safety incident.
- All staff we spoke with were aware of duty of candour regulations and could give examples of when this had been or would be used. We saw evidence that the duty of candour was included as part of the RCA process. Some staff we spoke with were aware of their responsibilities to be open and honest following incidents that had caused moderate or severe harm to a patient. However, other staff told us that it was their understanding that the service usual practice was for informal verbal feedback with the patient.

Safeguarding

- Staff we spoke with were aware of their responsibility to keep people safe and, when needed, report any safeguarding concerns they had. Staff were able to identify safeguarding leads within the organisation for both adults and children. Team leaders told us they

discussed any learning from safeguarding incidents during team meetings and hand over meetings. Staff told us they had received feedback from safeguarding concerns and referrals they had made. This was cascaded from the provider's safeguarding team to frontline staff through their line managers.

- There were safeguarding policies and procedures, and a safeguarding lead could provide guidance and support to staff in all areas of safeguarding concerns during normal working hours.
- Staff received training in adult safeguarding as part of their mandatory training. All community nursing staff received safeguarding adults' level two training, and those working with children were provided with safeguarding children level 3 training. Staff received training updates at a level appropriate to their area of work. Training data for 2015/16 in relation to safeguarding showed that approximately 98% of staff in adult community services had completed level 1 & 2 safeguarding training. This was above the providers' target of 95%.

Medicines

- We witnessed community nursing staff administering medications in people's homes, for example insulin and anticoagulants, and found that these were appropriately prescribed on a medication administration record (MAR). We observed staff checking the MAR before administering medicines in line with good practice. We also noted that community nurses completed a record of each medicine they administered.
- Most of the district nurses were independent prescribers, which meant they could respond to patients' needs and prescribe appropriate medication in a timely way; they told us they received quarterly prescribing updates and supervision from a registered pharmacist.
- We were told that no patient group directives (PGDs) were in use except flu vaccines. A nurse prescriber gave flu vaccines to housebound patients under a PGD.
- We found that community nursing staff were appropriately trained in the administration of medicines, including for high risk procedures involving medicines such as the intravenous administration of antibiotics. We observed one patient who had a controlled drug pain relief patch removed and a new one applied. The nurse demonstrated good practice with regards to the administration, record keeping and disposal of this medicine, in line with guidance and legal regulations.
- We saw patients been encouraged to manage their own medication and nurses monitored use of medicines and observed the individual's regime and any changes in their condition to inform potential dose alteration. When changes to medicines were required, community nurses would communicate this to patients' GP on their behalf.
- We observed nurses talk through the use of different medicines with patients and advised on self-medicating. We were told the service promoted this approach.

Environment and equipment

- During our inspection, we visited community team bases, clinics and patient homes. The premises we visited had procedures in place for the management, storage and disposal of clinical waste.
- Environmental cleanliness and prevention of healthcare acquired infection guidance procedures were available to ensure equipment was regularly maintained and fit for purpose.
- Community nursing staff said there were no problems getting equipment such as standard pressure relieving cushions and hospital beds, pressure relieving mattresses and commodes in a timely manner. The provider maintained and safety checked equipment we looked at.
- Staff told us they asked for advice from the tissue viability specialists when required. Care plans we saw detailed the severity and improvement of pressure ulcers and we noted appropriate pressure relieving equipment was in use.
- Community nursing staff saw patients in a wide variety of locations throughout the provider service areas ranging from health centres, residential homes and in their own homes.

Quality of records

- The service used a combination of electronic records and paper clinical records. Paper records, which

included care plans, were kept at patients' home. Electronic records were available only to authorised staff. Computers and computer systems used by staff in community nursing teams were password protected. Some community nursing staff were testing portable electronic device (Tablet) which allowed access to records when they were on a visit to patient's home. This was a pilot programme.

- Community staff should ensure all patients had up to date care plans. We accompanied community nurses on home visits and observed that not all care plans, kept at patients' home, were up to date. In some care plans, there were no patients' individual risk assessments such as dementia screening assessment, malnutrition risk assessment or skin integrity risk assessment. However, where assessments were found to be available, these were comprehensive. For instance, on a home visit to a patient with a leg ulcer that required daily dressing, care plans and progress notes were found to be clear and up to date, signed and dated. On another home visit to an insulin dependent diabetic patient, a comprehensive initial assessment was completed, as well as a wound assessment chart, Waterlow score and malnutrition universal screening tool (MUST).
- Paper records were kept at the patient's home for all people involved in the person's care to document their actions, conversations and the patient's wishes and outcomes. This meant healthcare professionals, who visited them at home, had access to up to date information and knew of any changes or developments in the patient's health. However, not all information was transferred to the nursing IT system and not all home records were up to date.

Cleanliness, infection control and hygiene

- Clinical areas we inspected appeared clean, and we saw staff washing their hands and using hand gel between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited. Personal protective equipment, such as gloves and aprons, was available for staff use.
- Staff who visited patients in their homes carried protective equipment with them. We observed appropriate infection control practice, including aseptic techniques in the home of a patient who had dressings changed by community nurses.
- We accompanied community nursing staff on visits to patients' homes and found that appropriate personal protective equipment (PPE) was used; we only saw one occasion when a nurse did not use an apron when it would have been appropriate to do so. We observed community staff performing hand hygiene and adhering to the 'bare below the elbow' policy.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and home environments.

Mandatory training

- Mandatory training provided by the service provider included modules such as fire safety, basic life support, moving and handling, safeguarding adults and children, health record keeping, infection control, consent, equality and diversity, the Mental Capacity Act, deprivation of liberty safeguards (DoLS), bullying and harassment awareness, health and safety, information governance and medicines management. Mandatory training was delivered through a combination of face to face sessions and e-learning.
- When we asked staff about their training most told us that they were up to date. Staff in the different teams described good access to mandatory training.
- Mandatory training was highlighted by managers we spoke with as an area of concern for the organisation, and this was listed on the organisational risk register. It was evident from the risk register that uptake of mandatory and statutory training had been low early in 2016. It was not known how accurate the mandatory training record was, because of the issues with the online data for mandatory training.
- We viewed the "neuro rehabilitation" team's staff training spreadsheet. We saw that staff mandatory training was up to date. Staff told us there was a problem with the provider's electronic training record, as staff had completed training and their training records had not been updated to reflect this.

Assessing and responding to patient risk

- When patients first started using services they underwent a full risk assessment to ensure they would be protected from avoidable harm. A nurse asked about appropriate factors such as current and previous health

problems, medicines being taken and family history of illness. They were assessed, where appropriate, for specific risks such as the risk of falls and eating and drinking.

- We also saw that patient home visits were allocated based on staff skill mix and patient need. Where appropriate, risks to patient care and treatment was discussed with them. There were daily discussions of complex patients and their comprehensive risk assessments and any changing risks including falls risk assessments were noted.
- Staff could articulate what to do if a patient deteriorated and were aware of the escalation processes for senior manager support and what they would do in an emergency.
- The 'Single Point of Access' team had developed clear triage process and the use of key words to trigger escalation of cases to qualified staff such as pain relief for patients at the end of their lives.
- Patients and their families were advised to contact their GP or to attend the emergency department if they became unwell or their condition suddenly deteriorated. GP meetings were held regularly to discuss care of patients at the end of life and any other complex cases.
- We observed two staff handovers. One for a rapid response team and one for a community nursing team. Both handovers were well attended by all relevant staff and it was apparent that all staff had a good understanding of the patients. We observed a comprehensive patient report for all patients on the teams' caseload. Staff discussed issues relating to individual patient risk and spoke about the need for specialist input where required, for example tissue viability or continence nurse involvement.

Staffing levels and caseload

- Almost all staff we spoke to in community nursing and therapy teams told us that staffing was an issue. However, staff reported that they frequently worked over their hours to meet the needs of the service. Staff in the majority of teams told us that they regularly worked more than their contracted hours to ensure patients' visits were undertaken.
- Staff in all areas told us they often completed patient records, paper and electronic, in their own time.
- Recruitment was seen as a problem and senior staff were looking at flexible options for example to invite newly qualified staff in to the team and upskill them so that they can become valuable members of the team.
- We observed a community team handover and saw that staff allocation and skill mix was agreed for each shift. We were told that caseload allocation was based on units. Each unit was 15 minutes and staff were usually allocated 20 units per day depending on the severity of the cases on their books. Travel time between patients', completion of referrals and entering data on to the patients' electronic record were additional to the units or visits allocated.
- There were high vacancy rates of the following services; 17.69% for community nursing services, 20.94 for leg ulcer and tissue viability nursing, 28.57 for safeguarding and infection control staffing and 63.36% for sexual health and contraceptive services.
- Some teams had high numbers of staff turnovers. The managers' told us it was a challenge to keep up with the high turnover of staff. The total number of turnover of all substantive staff leavers in last 12 months was 15.38%.
- Agency and permanent staff were positive about their work. Managers told us they tried to ensure patients were seen by the same staff whenever it was possible, but the nature of the service and working pattern of staff meant that was not always possible.
- The effects of being short of staff in some areas impacted on patient care. Staff told us there had been times when they were not able to make the expected visit to patients or went much later than planned. They prioritised according to patient need and adjusted their workload to manage the demand on their time.

Managing anticipated risks

- Community health services undertook a range of environmental risk assessments to ensure that staff were working in a safe working environment.
- The service had lone working policies and guidelines and staff were provided with emergency alarms.

Good

Are services safe?

- Where risks had been identified prior to a visit, all staff took appropriate measures including alerting other staff of where they were to ensure they were safe.
- All of the community nurses we spoke with were aware of lone working policies and procedures and told us they followed them at all times. Staff were provided with personal alarms for their safety. Staff knew what action they would take if a potential risk to a colleague was identified. Staff told us they would use their mobile phone in an emergency to seek help and assistance.
- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather.

Major incident awareness and training

- There was a business continuity plan regarding major incidents which was reviewed annually. It identified key contact details and a process for staff to follow. The plan covered electrical failure, telecommunications failure and IT failure. There had not been a simulation drill to test these.

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 as good because:

- Care was delivered that took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines.
- There was evidence of multi-disciplinary working across all teams and also evidence of collaborative working with the local authority.
- Staff with specialist skills and knowledge were used by community teams to provide advice or direct support in planning or implementing care.
- The neuro gym service provided a range of specialised sessions to support patient rehabilitation as well as maintenance of movement, based on latest evidence.

However

- Assessments of patients' nutritional and hydration status were inconsistently carried out and where they were done, they were not personalised.
- The provider did not use telemedicine in any form.
- Staff, including some managers, were unsure about how to record best interest decisions when patients were not able to consent to treatment.

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance was used by staff. Staff told us they received monthly bulletins and emails from managers regarding updates to NICE guidance. Community staff referred to NICE guidelines in discussions, and policies and procedures quoted NICE and other professional guidance. An example was the incorporation of latest guidance on treatment of leg ulcers.
- Medication audits were regularly undertaken and outcomes monitored. If any issues were raised, then immediate training on medicines management and administration would be arranged for targeted staff and targeted where needed.
- The Community Neurological Rehabilitation Team (CNRT), Musclo Skeletal (MSK) and Cardiac Rehab services told us they followed guidance from a range of national organisations and Royal Colleges to inform their services. They told us there were plans for lead roles for different conditions and development of pathways in line with latest NICE guidance and plans for a NICE guidelines and protocols group.
- We spoke with specialist teams across the service including cardiac rehabilitation, neuro rehabilitation, speech and language therapy (SALT), tissue viability and they all used best practice guidance to inform the care and services offered.
- The neuro gym service provided a range of specialised sessions to support patient rehabilitation as well as maintenance of movement, based on latest evidence. The service undertook action research on measuring a patient's arm recovery following their recovery programme. The results showed a good recovery for patients in terms of time and duration taken for recovery.
- Patient's we spoke with told us staff always gained their consent prior to providing care or treatment. We observed nursing staff explained procedures to patients and gained verbal consent to carry out the procedures.

Pain relief

- On home visits with district nurses (DNs), we observed them undertaking pain assessments and pain management. For instance, we observed a nurse seek permission from the patient to discuss the pain with their GP.
- On another home visit we noted options for pain relief were discussed with the patient and their family. We also observed a home visit where a patient's self-management of pain was discussed including use of a patch to enable a patient to have more sustained relief from pain.
- Community nurses were supported by specialist palliative care team from the local hospice for pain

management. In a multi-disciplinary meeting, professionals discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would facilitate their independence in activities of daily living.

Nutrition and hydration

- We were told by the nursing leadership that screening tools were used to determine how best to support patients in need of nutrition and hydration. A patient in receipt of end of life care, for example, will be assessed using the Malnutrition Universal Screening Tool (MUST). The assessment will then determine the nutrition and hydration intervention needed by the patient. However, we did not see this in practice. Some of the care records we reviewed did not contain any of the above mentioned assessments. The MUST charts were not completed at appropriate intervals and did not contain relevant information.
- There were no personalised care plans on nutrition and hydration to ensure that the patient and their family's views and preferences around nutrition and hydration were explored and addressed.
- Staff told us they used the Malnutrition Universal Screening Tool (MUST) scale to help identify patients who may be at risk of malnutrition.

Technology and telemedicine

- Staff we spoke with from therapy teams told us IT issues could often be challenging due to connectivity problems. Concerns were also raised about IT processes being time consuming and access to computer terminals which was an issue for staff who did not have a permanent desk.
- Community nursing and therapy staff we spoke with told us they were duplicating work by completing paper and electronic records and that it was time-consuming returning to base to complete electronic records because of the lack of mobile working devices to complete this at the point of care.
- There was no evidence of teleconsultations or remote patient monitoring Telemedicine is a system that records and stores patients' observations electronically so they are available to health professionals to review and monitor their health and advise on self-care without the need to visit patients.
- Staff noted that whilst 'mobile' and 'remote working' technology was used by other providers, the absence of this in their service had a significant impact on the use of staff time as it meant that they had to attend to their local base in order to seek patient information or upload details of any care, treatment or support they had provided to someone's record.
- The provider was piloting a new electronic patient record system (Tablet) for use by the community nursing team. This enabled community nursing staff to access patient records and communicates details of patient care with other care partners when out on a visit. However, this was at its infancy and had not been audited to determine its effectiveness.

Patient outcomes

- Staff used outcome measures to monitor patient progress. Key outcome measures were Braden Assessment of pressure ulcer risk and nutrition scoring. However, in most of the records we reviewed, these assessments were not completed accurately, and there were no results provided to the inspection team.
- Falls and wound audits were undertaken and changes were documented in patient records. Documented falls risk assessments and appropriate falls prevention strategies were in place, for example the service used Eden Alternative social model of care to maintain independence and dignity. This was coordinated by the falls management and prevention programme team.
- Staff told us about clinically driven local audits, which aimed to improve practice and patient care. For example, staff told us an audit of pressure ulcers showed that the incidence of pressure ulcers had reduced by over 20%. The community team were also auditing care plans, DNACPR and the use of MUST and Waterlow scores to maintain record keeping standards.
- The Intermediate Care and Reablement Services participated in The National Audit of Intermediate Care (NAIC) for the 2nd year and have reviewed the outputs of this national audit to inform future service development. The NAIC is a partnership between various organisations including the British Geriatrics Society and the Association of Directors of Adult Social Services. This has been running for three years and now covered 75 CCGs, 124 providers, 472 services and over 12000 service users' responses in the last audit.

Good

Are services effective?

- Your Healthcare staff had led on around 32 audits in 2015/16, including record keeping, governance, DNACPR, falls prevention etc. A snap shot of clinical records audit of five services, revealed that although data entry quality was good there were concerns regarding the use of acronyms and/or jargon. However, this was only evident in under half of the records audited. The service had planned to repeat the audit on a quarterly basis in 2017.
- Performance reports were used to review and monitor service delivery standards such as referral, acceptance rates and face to face contacts. For example the results for tissue viability and leg ulcer nursing was 57%.These figures were monitored by the lead managers.
- We found opportunities to participate in bench marking, peer review, accreditation and research were proactively pursued by the service provider. Information about the outcomes of people's care and treatment was routinely collected and monitored to improve patient care.

Competent staff

- Records that showed 100% of new staff had attended a corporate induction programme. Staff told us new staff also received an induction at locality level.
- Nurses, healthcare assistants, and other staff providing community services were competent and knowledgeable when we spoke with them. Staff told us they were provided with numerous development opportunities and career development, which made their job interesting.
- Staff appraisals were completed yearly. The majority of staff that we spoke with about appraisals told us that they were up to date. Many told us that these were reviewed every six months. The community adult staff appraisal rate was between 95% - 100%. Staff of different grades confirmed that training needs were identified as part of their appraisals.
- Team meetings were used to provide peer group supervision and case study discussions. A manager told us about a clinical supervision programme that was running in the community nursing and therapy team. This was the team supervision programme; ensuring all levels of nursing and therapy staff received clinical supervision on a quarterly basis with a more experienced colleague. This included looking at individual cases, caseload management, effectiveness, issues and concerns. Other staff members working in this team told us that they found the supervision very supportive.
- Staff told us they were supported to gain further qualifications relevant to their role. We saw that senior community nurses held specialist qualifications, and we spoke with a number of staff who had been supported to become non-medical prescribers.

Multi-disciplinary working and coordinated care pathways

- All the community staff we spoke with told us that they worked effectively with both secondary (the acute hospital services) and primary care (general practice and community staff). They told us that they were able to refer patients into secondary care when needed. Community matrons focussed on patients with long-term conditions and complex needs. They held regular meetings with their patients' GPs to discuss and agree their care and treatment.
- All staff were very positive about the weekly multi-disciplinary team (MDT) meetings which involved a full range of staff providing care and treatment including a GP, nurses, therapists and social workers.
- Staff we spoke with at all levels described good MDT working amongst colleagues. We found examples of effective multidisciplinary working both within and across teams. For example, specialist nurses in tissue viability, multiple sclerosis, motor neurone disease and palliative care were available for staff to consult for advice and support.

Referral, transfer, discharge and transition

- There were a range of services and teams with clear referral criteria, designed to meet the needs of patients along care pathways. There was evidence of teams referring patients appropriately to services that best meet their needs. Senior staff for nursing, therapies and podiatry told us that referrals were received via telephone or fax.
- The rapid response and the impact teams provided a comprehensive service to patients requiring additional support on discharge from hospital. The rapid response

Good

Are services effective?

and district nursing teams provide urgent access within two hours if needed and access to a range of therapy staff including physiotherapy and occupational therapy staff.

Access to information

- Staff access to IT systems was variable. Staff told us the IT system worked well at base locations, but there was often poor access out in the community. The limitations of the IT systems had affected the effectiveness and performance data of all teams, for example, the inability to extract the training details of staff.
- Information was available for staff on standard operating procedures and contact details for colleagues within and outside the organisation. This meant that staff could access advice and guidance easily.
- Staff at all locations we visited showed us where they could find the providers' policies and procedures on the intranet. We reviewed information on the providers' intranet and saw the information was clear and accessible.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We spoke with staff who explained procedures for gaining consent from patients before delivering care and treatment. The service providers' policy on recording mental capacity assessments, detailed what information had to be recorded in case notes.
- Patient's we spoke with told us staff always gained their consent prior to providing care or treatment. We observed nursing staff explained procedures to patients and gained verbal consent to carry out the procedures.
- Staff had received mandatory training on Safeguarding Adults, Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were confident about seeking consent from patients. However, there was no standard format or guidance on recording best interest decisions.
- We observed staff discuss mental capacity assessments at community team multi-disciplinary meeting. They recognised the need to document assessments and decisions and said they documented these in case notes. However we did not see any evidence of this during our home visits with the clinicians.

Good

Are services caring?

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

Summary

We rated caring ad good because;

- Staff treated patients with dignity and respect.
- Staff were passionate about the care they delivered and this was reflected in the positive comments made by patients and their relatives. Patients felt supported physically and emotionally.
- Patients were positive about the quality of service they received.
- Patients were involved in planning their care and were provided with enough information to make informed decisions.
- The majority of the comment cards completed had complimentary feedback.

Compassionate care

- The community nursing team reported they had received positive feedback from the patients' survey. We observed community nurses delivered respectful and compassionate care with attention to their patient's privacy and dignity. A good rapport existed between nurse and patient, and any carers or relatives.
- We observed clinic staff preserved patient privacy and dignity, and ensured the door were locked and the curtains drawn. Staff spoke with patients in a reassuring, considerate and respectful manner.
- We observed a number of staff and patient or carer interactions during our inspection. This included 12 home visits and four observations of clinic appointments. We observed consistently caring and compassionate staff.
- During a home visit, we witnessed one patient saying to a member of staff 'I didn't know there were people like you to help'. This patient also told us that 'the staff were wonderful'.
- We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance. All patients we spoke with spoke positively about the care and treatment that they had received.
- Staff had developed trusting relationships with patients, their relatives and loved ones. Throughout the inspection, we witnessed patients were treated with compassion, dignity and respect. We observed staff communicated with patients in a respectful way in all situations. Staff maintained patient privacy and dignity when attending to their care needs.
- As part of the inspection process, we sent comment card boxes for patients to give us feedback. Out of the 46 comment cards received, majority were positive about the care and support they had received from staff.

Understanding and involvement of patients and those close to them

- Community nurses involved patients in their care; they communicated well with them and provided them with simple information on how to manage their condition and options of treatments available.
- Patients were involved in planning of their treatment and nurses acted on patients wishes. When patients asked questions, these were responded to appropriately and where further information needed to be obtained by a nurse patients were informed in advance.
- All patients we spoke with told us they were very happy with the service. They told us nurses arrived on time, were polite and friendly and always explained everything.
- On a home visit, staff gave good explanations to the patient of wound healing and progress. The patient's wife told us they felt the care given by the nurses and other therapy staff was excellent and felt fully informed of the plans of care and was not afraid to speak to the team members if there were any concerns or queries.
- On another home visit to a patient with a leg ulcer that required daily dressing, there was good, clear communication between the patient and nurse. The patient told us they felt involved in their care and felt they were listened to by the nurses that visited.

Good

Are services caring?

- We observed a consultation between a patient and a speech and language therapist and saw that the therapist worked with the patient and encouraged the patient to set their own goals.

Emotional support

- Throughout the inspection, we witnessed many examples of kindness towards patients and their relatives, from well-motivated committed staff. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns.
- Patients and carers felt emotionally supported and reassured by the community nursing visits.
- We observed community staff (including nurses, occupational therapists and physiotherapists) giving holistic care including support for close relatives. For example, we saw a community dementia nurse specialist checking the welfare and emotional wellbeing of a patient's spouse as well as the patient. Staff paid particular attention to how the spouse was coping with the change in circumstances that meant they had to act as carer for the patient during their ill health. Staff offered support to the patient's spouse and it was clear that the offer was appreciated.
- We saw a community nurse providing advice and support for a patient's relative who was struggling to cope with the patient's condition. The nurse was patient, empathetic and understanding.

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 good because;

- Services were planned and delivered in a way that met the needs of the local population and staff respected the equality and diversity of patients and their families.
- Patient visits were categorised depending on complexity and the waiting list trends showed a majority of services were meeting waiting time targets.
- There were numerous initiatives underway to alter and redesign the model of care being provided to better support the needs of people using the service and provide better outcomes.
- We saw evidence of staff been responsive to meeting the needs of vulnerable patients including those living with dementia, a cancer diagnosis and learning disabilities.
- There were good examples of staff and teams working responsively to reduce unnecessary hospital admissions, and promote faster discharge from hospital.
- There was a rapid response team which could act acted quickly when patients needed treatment and care packages.

However;

- Informal complaints were not monitored.

Planning and delivering services which meet people's needs

- We found that the provider had a wide range of services in place to meet the needs of its population. Services were provided at 26 GP locations in two localities (north and south localities).
- Patients' needs were assessed and care planned accordingly. Where appropriate, care planning involved joint visits with staff from other specialties or GPs.
- Patients with complex needs including those who were housebound were discussed between services and a co-ordinated multi-disciplinary plan of care was agreed. Service users could access community nursing services directly and request visits and appointments.
- Patients who were mobile travelled to clinics such as the MSK clinic, cardiac clinic and other clinics in Surbiton Health Centre and Hollyfield House to have their condition reviewed regularly.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or social services.
- The service had a tissue viability nurse who was supporting community staff, and those the provider managed in care homes, in the prevention, early identification and treatment of pressure ulcers.
- There was a rapid response team and impact team. Their services were either to facilitate early discharge or prevent hospital admission. The services were flexible and were seen as effective by the services user as mentioned in the patient survey results. The service could help to develop urgent packages of care at home for people who were at risk of falling.
- The provider had produced written information for people accessing the community health service. For example, information was available on healthy eating. Written leaflets could be requested, when required, in a different language or format.

Equality and diversity

- Staff told us how they accommodated religious and cultural diversity of patients and how it had informed individual care plans of these patients.
- Staff we spoke with told us that translation services and interpreters were easily available when required and staff were clear about how to access these services. Face to face and telephone interpreting services were available.
- Staff described their experiences in accessing interpreters to help them communicate with patients. They said it helped them to understand the patient's

care needs and helped them gain consent before providing any support. Any identified cultural needs were recorded in the clinical record as part of the care and treatment plan.

- Mandatory training for all staff included equality and diversity awareness. Majority of staff had completed this and could demonstrate an understanding of equality and diversity.

Meeting the needs of people in vulnerable circumstances

- Patients' needs and wishes were recorded in their notes. Nurses and therapists assisted them to meet their needs, such as to improve mobility or meet their own rehabilitation goals.
- Nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties.
- The community matron and dementia nurse specialist offered support for patients with long term conditions and acted as specialist nursing support for the community teams.
- We saw that nursing and therapy staff liaised with other agencies, families and carers to maintain routines and support patients in vulnerable circumstances. Staff were flexible with visits and adjusted appointments to accommodate patient needs.

Access to the right care at the right time

- Staff told us they responded to urgent referral requests the same day and could respond within two hours if required. Non-urgent referrals would be followed up the next day. Triage arrangements were in place to ensure referrals were prioritised appropriately. The service received 766 more referrals in 2015/16 compared to the previous year (a 50% increase).
- Community nursing services were able to respond to urgent referrals within 24 hours; it included district nurses who were working day and night across the borough.
- There was a single point of access to the nursing service. Referrals were triaged immediately and the workload allocated accordingly. The community nursing service prioritised patients on a daily basis, particularly those requiring end of life/palliative care support. The service received 10,416 referrals through the Single Point of Access (SPA) in 2015/16, which was an 11% increase from the previous year.
- The tissue viability nurses provided care in community and hospital inpatient setting. This included supporting district nurses in wound care and management.
- The service collated data on waiting times against their commissioning targets. Waiting times were variable across the community services. However, therapy services had a triage system in place to identify urgent and non-urgent appointments. This was reviewed on a regular basis and if a patient's condition changed, then they would be reassessed.
- The Rapid Response Team received 2,310 referrals in 2015/16; this represented a 50% increase from the previous year. Flexible appointment times were available for patients at a time to suit them. This meant that the service was responsive to the needs of the population it served.
- Community teams had close working relationships with social workers and GPs and liaised with hospices and other end of life care providers when needed. We were given examples of joined up working across these services that had taken place for one patient, which meant they had the care they needed when they needed it.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.
- Community nursing service reported 16 complaints between 1 September 2015 and 31 August 2016. Eight of these complaints were upheld, two complaints were ongoing and one complaint was referred to and upheld by the Ombudsman.
- Community nursing staff described how they had met with a patient following a complaint and steps taken to ensure they improved their communication with patients and their families in a timely manner.

Good

Are services responsive to people's needs?

- Staff told us that complaints were fedback through team meetings. Staff described how they had learned from previous complaints and discussed some examples; the nursing team gave an example of a missing appointment which led to a complaint by the service user and how the complaint was dealt with.
- Staff told us that informal complaints related to rescheduling of visits or staff running late were not recorded as these were dealt with locally by a team leader. This meant that the service was unable to fully monitor patterns in order to improve the service. Where complaints were appropriately recorded, we saw that they were responded to and staff were aware of them.
- Senior managers we spoke with were aware of the complaints that had been received relating to their service, their outcome and the learning that had come from them. Staff told us that they got feedback on complaints and any lessons learnt from them.
- Patients told us that they knew who to contact if they wanted to make a complaint and there were leaflets and posters informing patients on how to make a complaint about the service.

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

- The vision and values for the community nursing service were well developed and encompassed compassion, respect and dignity.
- The provider had mechanisms in place to communicate with staff on a regular basis and staff told us they felt engaged and valued by the provider.
- The majority of staff in the service told us that senior staff were also engaged with the service and provided support where needed.

Service vision and strategy

- The providers vision was to provide great care, be a great place to work and deliver great value for money. The aims were to deliver care that is safe, joined up, simple and easy to access, and based on the best available evidence.
- The provider had developed a manifesto to support their vision. There were clear priorities to help deliver the vision. The manifesto highlighted the status of the provider as a social enterprise with the freedom to use their resources to improve patient care.
- Staff were aware of the vision and values of the service in putting people first and took pride in what they did. There was a clear focus on patient care through the development and implementation of the provider's manifesto commitments.
- There were initiatives put in place to improve the efficiency of the service and the quality of care which staff were proud of. There was a focus across the service of achieving efficiency savings whilst maintaining quality standards.

Governance, risk management and quality measurement

- Governance structure, risk management and quality monitoring were in place through the locality structures, locality leads and locality teams. The structure also included a number of committees that reported into the Integrated Governance Committee, which provides assurance for the Audit & Assurance Board on care quality, information governance standards, and the establishment of effective risk management.
- Each team across the service had weekly and monthly meetings to review incidents, performance issues and planning, amongst other topics.
- We saw evidence that serious incidents such as pressure ulcers and falls were fed through the board reporting structures by the quality committee. We saw evidence of sharing feedback from incidents across localities to drive an improvement in the quality of service.
- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff, however some of them were not familiar with the providers' governance structures and its effectiveness.
- The feedback from the top of the organisation to staff did not seem entirely effective. A number of staff were not aware of key performance indicators set by commissioners. The community adult team were well managed at a service level and felt management listened to them.
- There was some uncertainty within the community adult services about the uncertainty caused by the decision to implement Kingston Coordinated Care.
- The failure of the service provider to deliver the full functionality of the IT and electronic record system was a risk to the service, which was on the corporate risk register, however the frontline staff were not aware of this as a risk to the organisation.
- In a recent Deep Dive Audit of Continuing Health Care (CHC) commissioned by Kingston CCG, the provider achieved nearly 100% green RAG rating on its assurance and operational processes.
- There were daily handover meetings by the community nursing team where all relevant safety information was shared with the teams and these were supplemented by

Good

Are services well-led?

weekly briefings and monthly team meetings. Staff told us they found team meetings very useful as it was a means of keeping up-to-date with local and organisational matters. Staff were positive about team meetings and valued them as a source of valuable feedback and the opportunity to discuss and escalate issues.

Leadership of this service

- Senior staff told us their management team were approachable and visible. Local team leadership was effective and staff said their direct line managers were supportive. This was confirmed by our experience at various locations during our inspection including community nursing bases, clinics and the head office.
- We found that staff were consistently positive, friendly, helpful and approachable. We were told that morale with the community nursing and therapies teams was good.
- Senior managers took responsibility for governance and risk, clinical leadership, nursing, rehabilitation and therapies.
- The managing director was well established in her role and known to staff in community services. Staff felt there was clear leadership at the senior management / executive level. Staff told us the managing director was approachable.

Culture within this service

- There was a strong culture of teamwork and a focus on key outcomes such as reducing hospital admissions or pressure ulcer incidence. In one team, a new staff member said it was the best team they had worked in, and that the team appreciated the different skills each brought to the group.
- All the therapy staff we spoke with were positive about integrated services and felt positive about their role and contribution in adult community services. They said they were proud to work for their team and enjoyed their role.
- All staff we spoke with said that senior staff were very approachable. One said they had a 'fantastic supportive team, I love my job. I feel very well led and have never been happier'.

Public engagement

- Senior staff in the community nursing and rehabilitation teams told us that felt that patient engagement within the teams had been good, and were still looking for opportunities to make it even better to improve their profile.
- The provider carried out friends and family tests; a nation-wide initiative to help organisations to assess the quality of their services by asking people who used the service whether they would recommend the service. Although over the organisation as a whole we were told 95% of respondents would recommend the service to their family and friends.
- An example of public engagement was noted at Surbiton Health Centre, where Your Healthcare teamed up with Friends of Surbiton & Tolworth Health Community and launched a photographic competition to brighten its walls. Local residents were invited to take part in the competition with the chance of winning John Lewis vouchers. The themes for the images were health, local activities and Kingston.
- The provider asked people living within the community served by Your Healthcare to join as a member and provide their views on services. A membership council was held four times a year and fed into the main board.

Staff engagement

- Senior staff in community nursing teams told us that communication with staff was seen as a priority and that they were using social and print media for this. The Quality Matters Newsletter had helped to keep staff informed of what was happening across the organisation.
- The staff survey from February 2016 was very positive for the organisation as a whole. The highlights showed excellent staff engagement and that staff felt they could contribute to important team decisions, future planning and service priorities, and staff felt recognized and valued for their work. The provider had achieved 74% response rate to their staff survey in 2015/16. Within the frontline staff, 83% of them agreed that Your Healthcare provided equal opportunities for career progression or promotion.

Good

Are services well-led?

- Staff told us they had regular team meetings, which provided them with an opportunity to express their views, share experiences, discuss challenges in their day-to-day work and learn from one another.

Innovation, improvement and sustainability

- We found several examples of innovative practice which aimed to improve the quality of care for patients. The community dementia nurse specialist role and the neuro gym concept were well liked by all service users.
- Staff told us the provider was an inclusive organisation and it encouraged staff to innovate in line with its core business values.
- Schwartz Rounds were conducted; this is a forum in which staff can openly and honestly discuss social and emotional issues that arise in caring for patients. The provider had supported staff to participate in the "Rounds".
- During 2015, the Rapid Response team working in partnership with the London Ambulance Service and commissioned by Kingston CCG, delivered a six month pilot scheme which saw record numbers of people successfully treated at home rather than in A&E or hospital. However, we were not provided with the data of the pilot program to confirm its effectiveness.
- The Rapid Response team provided integrated healthcare and focused on prevention of unnecessary A&E attendances and hospital admissions. The pilot allowed the team to respond to 999 calls and if a person fitted certain criteria, the team was despatched to help them at home. During the pilot, 366 out of the 557 (68%) people avoided a hospital stay. The team was nominated for the 'Value and Improvement in Community Health Service Redesign' award.
- As a service, we found that teams were looking for opportunities to improve the quality of the services delivered and teams were encouraged to develop ideas to make improvements.