MSH Health & Wellbeing Community Interest Company

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

Services we do not rate

We regulate sexual health services, but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff understood how to fulfil their responsibilities to raise concerns and report incidents.
- Medicines management processes were fit for purpose and ensured people were kept safe from avoidable harm. This included the storage of refrigerated medicines in the main office and medicines used in the Queens Park sexual health service.

Summary of findings

- Deteriorating service users had their care reassessed and their care plan amended accordingly.
- Staffing levels were suitable with an appropriate skill mix to meet the needs of people who used the service.
- Staff adhered to the principles of infection prevention and control and demonstrated appropriate practice in hand hygiene and the use of personal protective equipment.
- All clinical staff had appropriate safeguarding training and demonstrated how they used this to protect people from harm.
- People supported by the domiciliary care service consistently told us staff who visited them were competent, well trained and professional in their approach to their work. Staff and their mix of skills were used innovatively to give them the time to develop positive and meaningful relationships with people to best meet their needs.
- Sexual health services were provided in line with national guidance from the British Association of Sexual Health and HIV. These services were monitored using four key performance indicator targets. The service performed better than the target for two indicators and variably in the two other indicators. Where performance was variable, staff identified contributing factors and ensured the service was maintained.
- Staff demonstrated a consistent focus on improving patient outcomes through opportunistic health promotion in sexual health services. This included providing free condoms, sexual health advice and signposting and smoking cessation support.
- Staff used information and records systems that ensured they always had patient history information for appointments. There was evidence of communication with GPs and other healthcare services when needed to provide coordinated care.
- People we spoke with consistently referred to staff as kind and caring people. All 123 Care Quality Commission comment cards received from sexual health services were positive and over 90% of people noted the friendliness and kindness of staff as key factors in their response.
- The provider ensured individuals were at the heart of their care, underpinned by a staff team who placed a high value on partnership working. The service encouraged those who received domiciliary support to maintain and maximise their independence.
- During all of our observations of care in sexual health services, staff demonstrated kindness, warmth and compassion. They involved people in discussions and decisions about their health and took the time to answer their questions.
- Staff were trained to provide emotional support to people attending sexual health services.
- The service provided domiciliary care and support that was focused on individual needs, preferences and routines. People's care and support was planned proactively and in partnership with them.
- Care plans were in place which outlined people's care and support needs. Staff were extremely knowledgeable about people's support needs, their interests and preferences in order to provide a personalised domiciliary care service.
- The provider placed a high level of importance on equality and diversity in respecting the needs and wishes of people who used the service and those who worked within it.
- Staff provided a responsive and individualised sexual health advice, screening and support service that met the needs of the local population. This included providing advice and guidance based on sexual risk as well as recognition of the different needs of people based on sexual identity. Sexual health services included a mix of walk-in and pre-bookable appointments, and on-demand private appointments were available seven days a week.
- Leadership within the organisation was visible. Communication was effective and the service actively sought and listened to the views of staff.
- All staff were demonstrably passionate and enthusiastic about the service. Clinical staff involved in sexual health services had clear future plans to develop the service that aligned with the changing needs of the local population, particularly those living with HIV into old age.

Summary of findings

However, we also found the following issues that the service provider needs to improve:

- The fire safety policy and the fire risk assessment were out of date.
- There was no process in place to formally audit success outcomes.
- Supervision of staff was not regularly recorded.
- Consent to provide support was not recorded consistently.
- There was no risk register in operation to demonstrate how risk was managed.
- There was no clearly defined deputy role to support the nurse manager in the event of any unplanned absence.
- There was no formal system in place to seek feedback from those who used the domiciliary support service.

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Services we looked at
Community health services for adults; Community health (sexual health services);

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Background to MSH Health & Wellbeing Community Interest Company

MSH Health & Wellbeing Community Interest Company has been registered with CQC since 1 November 2013. The service had a registered manager in place.

The service started providing sexual health services to private clients at their main location in Islington. They specialised in the LGBTQ community. The service expanded to provide sexual health services under contract to the NHS. The NHS contract came to an end at the beginning of April 2017. The private sexual health service is still in operation.

More recently, MSH Health and Wellbeing Community Interest Company started to offer a domiciliary service based on a care model from Amsterdam. This is to try to encourage independent living for the elderly community for as long as possible, as well as identifying any health problems that the patient may be suffering with. The aim of this system is to reduce hospital stays and allow patients to remain within their own surroundings. This is a nurse lead model.

This provider is registered to provide the following regulated activities:

•Personal care

•Nursing care

•Treatment of disease, disorder or injury

•Diagnostic and screening procedures.

Our inspection team

Our inspection team was led by:

Chair: Nicola Wise, Head of Hospital Inspection

Team Leader: David Harris, Inspection Manager

The team included three CQC inspectors; one with experience in sexual health and one with experience in domiciliary care.

Why we carried out this inspection

We inspected this core service as part of our comprehensive sexual health and domiciliary care services inspection programme.

How we carried out this inspection

We attended the Islington registered location and met with the full management team. We interviewed each member of the team as well as visiting service users in different locations. During the course of our inspection, we received comment cards from service users and also spoke to some of them via telephone.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 1 and 2 February 2017. During the visit we observed how people were being cared for and

Summary of this inspection

reviewed care or treatment records of people who used their services. We met with people who used their services and they shared their views and experiences of the core service.

Information about MSH Health & Wellbeing Community Interest Company

- The main service of the provider is sexual health services for adults. In addition the provider delivers a small domiciliary care service providing care for people in their own homes.
- In addition, the provider was commissioned as part of a pilot project (My Care, My Way) by three local authorities to provide a range of support which did not include personal care. There were approximately 80 people supported by this service. This service was not included as part of the inspection as it was not carrying out any regulated activities. However, some of the staff we spoke with worked across both services.
- The nurse manager had overall responsibility within the service; he was the CEO and one of the directors. The second director was also the CQC registered manager. They had a number of colleagues and managers that reported directly to them. These were the development nurse, an education welfare and companions manager, a compliance manager and a clinical trials lead.
- The service was led by a registered manager and a nominated individual, who also acted as the nurse manager. We inspected MSH@Home, a regulated part of the service which supported people in their own home with their personal care, and sexual health services.
- MSH@Home was a nurse led personal care service in people's own home, and people are supported by health support personal assistants. At the time of our inspection, there were two people receiving support from the service.
- Three sexual health services were available. These included a private sexual health service operated by MSH Wellbeing, a chlamydia screening programme for three London boroughs operated by MSH Health & Wellbeing CIC and an NHS sexual service operated by MSH@Queens Park.
- Sexual health services were provided from a dedicated clinical room at the provider's main office in Angel (Islington) and through the MSH@Queens Park NHS commissioned outreach service. A counselling room was available at the Angel site. Sexual health services were provided to a diverse local population and were delivered to meet individual needs, regardless of age, gender identity or sexual identity.
- Contraception including contraceptive implants, sexual health screening and treatment and point of care rapid HIV testing were offered at both of the organisation's sites.
- During the course of this inspection, we looked at people's care records and 10 staff records. We visited a person who was receiving domiciliary support in their own home. We spoke with three people from the My Care, My Way pilot project, since their carers also worked as part of the regulated service. We also spoke with six members of staff and a local healthcare case manager.
- In our inspection of sexual services, we spoke with three registered nurses and a healthcare support worker (HCSW). We observed the care provided by the HCSW and two senior nurses as well as the service provided by two receptionists. We spoke with four people who used the services, reviewed 123 Care Quality Commission Comment cards and reviewed 23 care records.
- The MSH@Queens Park service was due to close in March 2017 due to a commissioning decision.

Summary of this inspection

What people who use the service say

- People who received support from the MSH@Home service were invited to provide feedback and comments using comment cards supplied by CQC.
- Without exception, all comments received were positive and people said that staff were compassionate, kind, respectful and skilled at their job. They also said they felt included in all plans related to their support. One person said how they looked forward to their support worker coming. Another said “when MSH@Home enter my flat it feels like a family visit.”
- Responses from relatives noted that they were able to relax in the knowledge that their relative was in safe hands. They also said their relative was always more responsive and engaged following their support.
- We received 123 completed cards from people who used the sexual health services, all of which were positive. Consistent themes included high levels of privacy, dignity and respect and over 90% of respondents commented on the friendliness and positive communication of staff. One person commented, “Incredible service. Easy to book appointment – very good use of technology. All staff from the receptionist to the nurses were professional, kind and sincere. Staff were well informed and gave great advice.” Another person wrote, “Great staff, very professional and make patients feel relaxed. They listened to my fears of blood tests and were very nice about it. The environment very safe and hygienic.”

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff understood how to fulfil their responsibilities to raise concerns and report incidents.
- Medicines management processes were fit for purpose and ensured people were kept safe from avoidable harm. This included the storage of refrigerated medicines in the main office and medicines used in the MSH@Queens Park sexual health service.
- Those who used the domiciliary care service received support to manage their medication safely.
- Those who received domiciliary support in their own homes had their care reassessed and their care plan amended accordingly.
- There were safe recruitment procedures in place.
- Staffing levels were suitable with an appropriate skill mix to meet the needs of people who used the service.
- Staff adhered to the principles of infection prevention and control and demonstrated appropriate practice in hand hygiene and the use of personal protective equipment.
- All staff who provided domiciliary support had appropriate safeguarding training and demonstrated how they used this to protect people from harm.
- This included sexual health services, where staff were able to provide services to young people.
- Staff maintained appropriate care records at sexual health service locations that included patient history and documentation of any safety concerns.

However,

- The fire safety policy and the fire risk assessment were out of date.
- Staff used Patient Group Directions (PGDs) to administer medicines in the sexual health service. Although most of these were maintained, we found two had expired.

Are services effective?

- People supported by the domiciliary support service consistently told us staff who visited them were competent, well trained and professional in their approach to their work.

Summary of this inspection

- Staff and their mix of skills were used innovatively to give them the time to develop positive and meaningful relationships with people to best meet their needs.
- Staff were aware of people's individual preferences and had the skills, knowledge and ability to meet their needs.
- Training was appropriate and available to all staff.
- Links with health and social care professionals were good.
- Sexual health services were provided in line with national guidance from the British Association of Sexual Health and HIV. These services were monitored using four key performance indicator targets. The service performed better than the target for two indicators and variably in the two other indicators. Where performance was variable, staff identified contributing factors and ensured the service was maintained.
- Staff demonstrated a consistent focus on improving patient outcomes through opportunistic health promotion in sexual health services. This included providing free condoms, sexual health advice and signposting and smoking cessation support.
- A practice development nurse was in post and provided clinical training and competency checks to nurses and healthcare support workers. Healthcare support workers were working towards the national care certificate.
- Staff used a system to contact people who did not act on sexual infection test results that required them to seek treatment. This ensured people were supported to access timely treatment and care, including when they were difficult to reach.
- Clinical staff used information and records systems that ensured they always had patient history information for appointments. In addition, consent was always documented and there was consistent evidence of communication with GPs and other healthcare services when needed to provide coordinated care.

However,

- There was no process in place to formally audit success outcomes.
- Supervision was not regularly recorded.
- Consent to support was not consistently recorded on domiciliary support records.

Are services caring?

- People who used the domiciliary support service consistently referred to the registered provider and their staff as kind and caring people.

Summary of this inspection

- People supported by the domiciliary care service told us they felt safe with the staff who supported them. Staff frequently went beyond their contracted duties to ensure people were safe and comfortable.
- The provider ensured individuals were at the heart of their care, underpinned by a staff team who placed a high value on partnership working.
- The domiciliary support staff understood the importance of encouraging people to maintain and maximise their independence.
- During all of our observations of care in sexual health services, staff demonstrated kindness, warmth and compassion. They involved people in discussions and decisions about their health and took the time to answer their questions.
- All 123 Care Quality Commission comment cards received from sexual health services were positive and over 90% of people noted the friendliness and kindness of staff as key factors in their response.
- Staff were trained to provide emotional support to people attending sexual health services, including for pre and post-HIV test counselling. During our observations we saw staff were skilled in reducing people's anxieties and recognising when they were worried about test results.

Are services responsive?

(Domiciliary care service)

- The service was responsive to supporting people and provided care and support that was focused on individual needs, preferences and routines.
- People's care and support was planned proactively and in partnership with them. People felt consulted and listened to about how their care would be delivered.
- Care plans were in place which outlined people's care and support needs. Staff were extremely knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.
- People told us they were supported by staff who knew them and consistently met their needs.

(Sexual health service)

- The provider placed a high level of importance on equality and diversity in respecting the needs and wishes of people who used the service and those who worked within it. An advanced

Summary of this inspection

sexual health educator provided sex and relationship education services to local schools and colleges. This included body development classes for children from the age of six and more complex psychosexual support to college-age students.
- Staff provided a responsive and individualised sexual health advice, screening and support service that met the needs of the local population. This included providing advice and guidance based on sexual risk as well as recognition of the different needs of people based on sexual identity.
- Sexual health services were provided within an equality and diversity policy and service standards framework that prioritised respect, dignity and privacy for each individual. We saw staff adhered to this during all of our observations.
- Staff provided sexual health events, outreach services and chlamydia screening to colleges in local boroughs. This included providing targeted health promotion information and individualised guidance for students on reducing the risk of sexually transmitted infections.
- Staff ensured people who were vulnerable received appropriate care and support. This included people who were at risk of sexual exploitation or harm or young people who were sexually active below the legal age of consent.
- Sexual health services were offered flexibly. This included through a mix of walk-in and pre-bookable appointments and on-demand private appointments were available seven days a week.

Are services well-led?

- Communication was effective throughout the organisation. The service actively sought and listened to the views of staff.
- The registered provider had a clear understanding of what was required of a quality service and this was evident from the feedback we received from people supported by the service.
- All staff were demonstrably passionate and enthusiastic about the service. Clinical staff involved in sexual health services had clear future plans to develop the service that aligned with the changing needs of the local population, particularly those living with HIV into old age.
- The management advisory group provided structured governance into the operation of sexual health services and included input from service users and clinical specialists.

Summary of this inspection

- From speaking with members of the management advisory group, it was clear the group's role included capacity to challenge decision-making and to contribute to service development.

However,

- In the absence of audits, the provider was unable to be assured of outcomes for those who used the service and of areas of the service which required improvement. However, governance structures and feedback from clients provided reassurance of the high standards of the service.
- There was no risk register in operation to demonstrate how risk was managed.
- There was no clearly defined deputy role to support the nurse manager.
- There was no established auditing programme.
- There was no formal system in place to seek feedback from those who used the domiciliary service.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

- The service was led by a registered manager and a nominated individual, who also acted as the nurse manager. We inspected MSH@Home, a regulated part of the service which supported people in their own home with their personal care, and sexual health services.
  - MSH@Home was a nurse led personal care service in people's own home, and people are supported by health support personal assistants. At the time of our inspection, there were two people receiving support from the service.
  - Three sexual health services were available. These included a private sexual health service operated by MSH Wellbeing, a chlamydia screening programme for three London boroughs operated by MSH Health & Wellbeing CIC and an NHS sexual service operated by MSH@Queens Park.
  - Sexual health services were provided from a dedicated clinical room at the provider's main office in Angel (Islington) and through the MSH@Queens Park NHS commissioned outreach service. A counselling room was available at the Angel site.
  - Contraception including contraceptive implants, sexual health screening and treatment and point of care rapid HIV testing were offered at both of the organisation's sites.
  - In addition, the provider was commissioned as part of a pilot project (My Care, My Way) by three local authorities to provide a range of support which did not include personal care. There were approximately 80 people supported by this service. This service was not included as part of the inspection as it was not carrying out any regulated activities. However, some of the staff we spoke with worked across both services.
- During the course of this inspection, we looked at people's care records and 10 staff records. We visited a person in their own home and spoke with three people who used the service and six family members. Some of these were from the pilot project, whose carers also worked as part of the regulated service. We also spoke with six members of staff and a local healthcare case manager.
- In our inspection of sexual services, we spoke with three registered nurses and a healthcare support worker (HCSW). We observed the care provided by the HCSW and two senior nurses as well as the service provided by two receptionists. Who spoke with four people who used the services, reviewed 123 Care Quality Commission Comment cards and reviewed 23 care records.

Community health services for adults

Summary of findings

We found the following areas of good practice:

- Staff understood how to fulfil their responsibilities to raise concerns and report incidents.
- Medicines management processes were fit for purpose and ensured people were kept safe from avoidable harm. This included the storage of refrigerated medicines in the main office and medicines used in the MSH@Queens Park sexual health service.
- Deteriorating service users had their care reassessed and their care plan amended accordingly.
- Staffing levels were suitable with an appropriate skill mix to meet the needs of people who used the service.
- Staff adhered to the principles of infection prevention and control and demonstrated appropriate practice in hand hygiene and the use of personal protective equipment.
- All clinical staff had appropriate safeguarding training and demonstrated how they used this to protect people from harm.
- People supported by the service consistently told us staff who visited them were competent, well trained and professional in their approach to their work. Staff and their mix of skills were used innovatively to give them the time to develop positive and meaningful relationships with people to best meet their needs.
- Sexual health services were provided in line with national guidance from the British Association of Sexual Health and HIV. These services were monitored using four key performance indicator targets. The service performed better than the target for two indicators and variably in two indicators. Where performance was variable, staff identified contributing factors and ensured the service was maintained.
- Staff demonstrated a consistent focus on improving patient outcomes through opportunistic health promotion in sexual health services. This included providing free condoms, sexual health advice and signposting and smoking cessation support.
- Staff used information and records systems that ensured they always had patient history information for appointments. There was evidence of communication with GPs and other healthcare services when needed to provide coordinated care.
- People we spoke with consistently referred to staff as kind and caring people. All 123 Care Quality Commission comment cards received from sexual health services were positive and over 90% of people noted the friendliness and kindness of staff as key factors in their response.
- The provider ensured individuals were at the heart of their care, underpinned by a staff team who placed a high value on partnership working. The service encouraged people to maintain and maximise their independence.
- During all of our observations of care in sexual health services, staff demonstrated kindness, warmth and compassion. They involved people in discussions and decisions about their health and took the time to answer their questions.
- Staff were trained to provide emotional support to people attending sexual health services.
- The service provided care and support that was focused on individual needs, preferences and routines. People's care and support was planned proactively and in partnership with them.
- Care plans were in place which outlined people's care and support needs. Staff were extremely knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.
- The provider placed a high level of importance on equality and diversity in respecting the needs and wishes of people who used the service and those who worked within it.

Community health services for adults

- Staff provided a responsive and individualised sexual health advice, screening and support service that met the needs of the local population. This included providing advice and guidance based on sexual risk as well as recognition of the different needs of people based on sexual identity. Sexual health services included a mix of walk-in and pre-bookable appointments, and on-demand private appointments were available seven days a week.
- Leadership within the organisation was visible and there was a strong emphasis on continually striving to develop and improve the service. Communication was effective and the service actively sought and listened to the views of staff.
- All staff were demonstrably passionate and enthusiastic about the service. Clinical staff involved in sexual health services had clear future plans to develop the service that aligned with the changing needs of the local population, particularly those living with HIV into old age.

However, we also found the following issues that the service provider needs to improve:

- The fire safety policy and the fire risk assessment were out of date.
- There was no process in place to formally audit success outcomes.
- Supervision was not regularly recorded.
- Consent to support was not recorded consistently.
- People who used the service were not given written information on how to make a complaint.
- There was no risk register in operation to demonstrate how risk was managed.
- There was no clearly defined deputy role to support the nurse manager.
- There was no established auditing programme.
- There was no formal system in place to seek feedback from those who used the service.

Are community health services for adults safe?

Incident reporting, learning and improvement

- Staff used an electronic system to report incidents, which was accessible remotely at any time. This enabled them to submit incident reports when they occurred out of the main office, such as at the MSH@Queens Park service. All staff regardless of job role and whether they were permanent or sessional had access to this.
- In the 12 months prior to our inspection there had been no reported incidents in sexual health services or in the domiciliary care service. However, staff we spoke with were aware of the reporting process and told us how they would raise any incidents on the electronic record and report the matter directly to their manager.
- The service reported one never event in sexual health services in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The never event involved the mishandling of 30 chlamydia screening samples by a laboratory. This resulted in some test results being significantly delayed and others being lost. The nurse manager contacted each person and advised them of the situation and arranged for re-testing where necessary. They also escalated the situation to the laboratory manager and local public health authority. As a result the service no longer used the services of the laboratory involved and instead used a service with a consistent and reliable track record.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- The nurse manager was the lead for the duty of candour and we saw evidence this was effectively applied. For example following an incident in which a laboratory lost patient blood samples, the nurse manager contacted each patient, explained the situation and why it had happened, offered an apology and immediate re-testing.
- The registered manager told us that whilst he had never had to perform the DoC in his current role, he was clear about his responsibility in relation to it and was able to demonstrate this. Staff we spoke with told us of the necessity for transparency and honesty in relation to the people whom they supported.

Safeguarding

- The service had procedures in place to minimise the potential risk of abuse or unsafe care. Policies and procedures were available to staff on the intranet. The safeguarding policy had been reviewed in October 2016. Domiciliary care staff and sexual health staff were familiar with this policy and knew how to access it.
- The chief executive had been trained to adult safeguarding level 3 and was due to undertake child safeguarding level 3 training in March 2017. The second director was trained to adult safeguarding level 2 and child safeguarding level 3.
- Nurses who offered sexual health services were trained to adult and child safeguarding level 3.
- The service had a whistleblowing procedure. Staff told us they were aware of the procedure. They said they wouldn't hesitate to use this if they had any concerns about their colleagues' care practice or conduct. The electronic reporting system took the member of staff directly to the Care Quality Commission website if they were reporting concerns about a manager.
- Staff who provided sexual health services demonstrated detailed understanding of the safeguarding needs of patients. This included individuals with complex circumstances or those who disclosed sexual coercion or abuse or where staff suspected rape. Staff were knowledgeable and trained to provide individualised advice and care to patients and we saw they were able to refer patients to local crisis teams and safeguarding officers, including in urgent situations.
- Staff used modified sexual history and assessment forms for patients under the age of 18 who presented for contraception and sexual health screening. This meant they could provide immediate support to people whilst establishing social risks and identifying safeguarding needs. Where people under the age of 16 presented, the modified form enabled staff to document a Fraser guidelines assessment. For example, where a person under the legal age of consent attended the walk-in service for contraception, the nurse ensured their immediate needs were met and liaised with a local safeguarding officer to ensure their ongoing protection.

Safeguarding (Domiciliary support service)

- Records seen confirmed that staff had received safeguarding vulnerable adults training as an integral part of induction training. However, it was not possible to determine what level of safeguarding this was and whether it was at the required level 2. Subsequent to this inspection, the provider sent us confirmation that all staff were booked to attend level 2 safeguarding training supplied by an external provider.
- The staff members we spoke with understood what types of abuse and poor care people might experience. They were very clear about their duty of care in relation to this and told us how they would raise a concern, electronically and by speaking with the manager.
- People who used the service told us how their safety was enhanced by the support from their care worker. They told us they were frequently reminded of how to remain safe within their homes and when out in the community. A family member told us their relative's care workers were very vigilant on occasions when strangers came to the door.

Medicines

- Medicines management processes were fit for purpose and ensured people were kept safe from avoidable harm. This included the storage of refrigerated medicines in the main office and medicines used in the MSH@Queens Park sexual health service.
- Staff employed by the service received medication training during their induction. Discussions with staff confirmed they had been trained and assessed as competent to support people to take their medicines.
- Medication administration records (MAR) demonstrated peoples medicines were being managed safely.
- Medication was in blister packs and staff were expected to complete the MARs every time they supported the person to take their medication. We saw there were no omissions on MARs that we looked at, either in a person's home or stored electronically. The nurse manager told us MARs were checked each time when he or the practice development nurse visited a person's home and also when back dated records were returned to the office.
- Nurses in the sexual health service administered medicines to patients using patient group directions (PGDs). All but two PGDs were up to date and had been signed by all staff involved with medicine administration, including the organisation's medical advisor. Two PGDs had expired in 2016 and had not been updated.

Environment and equipment (Sexual health service)

- A healthcare support worker was responsible for the stock rotation of consumables and ensuring suitable equipment was available for the provider's sexual health services at Queen's Park. We looked at the equipment and consumables used in clinical areas and found them to be within the manufacturer's expiry date and fit for purpose.
- However, the fire safety policy for the Islington premises was out of date and was last reviewed in 2013. The last recorded fire risk assessment of the premises was carried out in 2013.

Environment and equipment (Domiciliary support service)

- The Care Quality Commission's role in inspecting this service was to focus on the regulated activity of personal care and had no regulatory responsibility to inspect people's accommodation. However, we noted that an environmental risk assessment was made of the person's home at the initial assessment. This included slips, trips or falls hazards. It also included temperature, lighting and general house security.
- A person whose home we visited explained to us how his care workers had rearranged his furniture in such a way as to make movement around his home much safer.

Quality of records

- We looked at records of those people who used the domiciliary support service. Daily records were written in a log book kept in their home. These were removed on a regular basis and scanned into an electronic record. We saw this log when we visited a person's home. We noted that the record was legible and gave clear information for the next care worker to inform them on how the person had been. We also saw backdated scanned care worker records on the electronic record. It was evident that care workers recorded their activities on a regular basis and in accordance with the care plan.
- We looked at 23 records of patients who used sexual health services, including MSH@Queens Park. In each case we saw staff had documented a detailed sexual history and explanation of options with regards to screening, outcomes, tests and treatment.

Cleanliness, infection control and hygiene (Sexual health service)

- There were suitable arrangements in place for the prevention and control of infections, and the provider's infection prevention and control policy had been recently updated.
- The service helped to protect people from the risk and spread of infection. We saw that staff received training in infection control during their induction.
- A healthcare support worker was the lead for infection control in the provider's main office and treatment rooms. As part of this role they conducted weekly infection control audits, which they had received training for.

- We observed staff adhere to the principles of infection prevention and control during all our observations of clinical care, including during a college-based outreach event when staff provided a chlamydia screening service.
- In treatment rooms used for sexual health services sharps bins were correctly labelled, stored off the floor and with the aperture closed when not in use. This met the requirements of the European Council Directive 2010/32/EU in relation to the safe management of contaminated equipment.
- We observed nurses and a healthcare assistant in the clinical environment at MSH@Queens Park. We saw staff adhered to best practice hand hygiene and infection control processes, including washing their hands before and after patient contact and using alcohol gel between patient appointments.

Cleanliness, infection control and hygiene (Domiciliary support service)

- Personal protective equipment (PPE) is equipment that will protect the user against health or safety risks at work. Domiciliary support staff told us that they were supplied with disposable aprons and gloves to do their work safely. When we visited a person's home, we noted that the care worker was wearing PPE for the task they were performing, was bare below the elbows and washed their hands after they completed tasks.

Mandatory training

- All staff completed their mandatory training as part of their five day induction course. This included safe administration of medicine, home care manual, food safety and hygiene and health and safety. It also included dementia awareness, transgender awareness, and care planning and infection control.
- We looked at the staff training record and saw all staff were up to date with their training. The training record was set up so that it raised an alert when any training was overdue.

Assessing and responding to patient risk (Domiciliary support service)

- People had a full assessment prior to being offered a service. This was done with the person in their home and whoever else they wished to be there. An external professional told us how in their view, the assessment done by MSH@Home was the best they had seen. People's initial assessment was done by a nurse and included areas of the person's physical and mental health and support networks. Current health issues, fluid and nutrition needs, mobility, breathing and communication needs were also taken into consideration as part of the assessment.
- All staff were trained in how to take baseline observations. These included blood pressure, temperature and pulse. We saw these observations were taken on a regular basis for one person, as per guidance in the initial assessment.
- A care worker told us of an occasion when they observed a change in the person's temperature. They contacted the GP and nurse manager. Following a discussion between the GP and manager, it was agreed that the manager could attend the patient quicker and so a rapid home visit was made. There was a telephone consultation from the person's home and the GP recommended that the person's temperature was monitored on a regular basis for 24 hours. We later saw documented evidence on the electronic recording system to reflect all of this activity.

Assessing and responding to patient risk (Sexual health service)

- Staff provided the MSH@QueensPark service from a GP practice, which included safety equipment such as a defibrillator and a first aid kit. Although the GP practice was responsible for the maintenance of this equipment, MSH staff would use this in an emergency. We checked this equipment and found each item to be readily accessible and ready for use. A body fluid spill kit was also available and we saw this was in date, readily accessible and clinical staff had been trained in its use. MSH staff carried an anaphylaxis kit with them to the Queens Park site, which was checked regularly to make sure contents were up to date.

Staffing levels and caseload (Domiciliary support service)

- Staff we spoke with told us there were sufficient numbers of staff to do the work. They told us they had enough time to travel from one client to the next and

lateness was not an issue. In cases where they needed to have a colleague to assist with repositioning the person, their colleague's schedule was timed so that they could arrive when needed.

- People we spoke with told us care workers did not appear rushed when carrying out their duties. They also commented that there was little or no staff turnover which meant that they saw the same workers at all times which was important, especially where a person was living with dementia.

Staffing levels and caseload (Sexual health service)

- We spoke with the nurse manager about how sudden illness in staff was managed so that people were not left without support. He told us that they built a team of people around the person, which exceeded the number of workers required. In this way, when there was staff illness or holiday, there were other staff to call upon whom the person receiving the service was already familiar with.
- The registered manager and second director were also registered nurses and provided sexual health and contraception services along with five sessional nurses and two healthcare support workers. Leads were in place for contraception, genitourinary medicine and outreach and community engagement. Two healthcare support workers provided clinical support and reception cover.

Managing anticipated risks

- Domiciliary support staff were required to swipe in and out on an electronic system when they went to a person's home. This recorded their time of entry and departure. The manager told us that if a worker was more than 15 minutes late in swiping in, an alert was sent to his phone. He then made contact with the worker to see what the issue was. Where necessary, a replacement member of staff was sent to ensure that the person still received a service.
- We looked records of the electronic monitoring system for the four weeks prior to our inspection and found there were no missed calls or visits which started later than 15 minutes after their agreed time.
- A fire warden was in place at the provider's Angel office and all staff had undertaken fire safety training. However, the last fire safety risk assessment had been undertaken in 2013 and was due for review in 2014, which had not been completed.

Are community health services for adults effective?

(for example, treatment is effective)

Evidence based care and treatment

- We were told that whilst there was no formal system of measuring outcomes for those supported by the domiciliary service. The nurse manager told us how measurements of success for the MSH@Home service were evidenced by prevention and reduction in hospital admission and feedback from those who used the service and their relatives.
- The nurse manager told us that they did not have a formal system to track and audit these success outcomes at the time of our inspection. However, a recently appointed compliance manager currently shadowed the registered manager and we saw confirmation that they were booked onto a compliance course. After this, the expectation was that they would initiate a programme of audits in all aspects of the work done by the provider.
- Staff in the sexual health service provided chlamydia screening to patients under the age of 25 in line with the best practice guidance of the National Chlamydia Screening Programme, including electronic tracking of results.
- Sexual health services were measured against four key performance indicators (KPIs) set by the commissioning body. The service performed better than the KPI targets in two indicators and variably in two indicators. For example, one KPI was that 50% of people who attended the MSH@Queens Park service would be under the age of 25. Although staff actively promoted the service to young people, the majority of people who accessed the service were aged between 25 and 35.
- The service performed better against the KPI that set a 'did not attend' rate target of 11% for pre-booked

appointments, with an average rate of 8% in the 12 months prior to our inspection. In addition, the service exceeded the KPI that 25% of people who accessed the service would be from a black or minority ethnic (BME) background. Although the service did not achieve the KPI that 25% of attendances for sexual health screening be from gay or bi-sexual men, staff recognised that men who attended the service may not identify as gay or bi-sexual but still engaged in sexual activity with other men. This meant services were provided appropriately and according to individual needs.

- Staff provided sexual health services in line with national guidance from the British Association of Sexual Health and HIV and the nurse manager maintained professional links with that organisation to ensure care and policies were up to date.

Nutrition and hydration (Domiciliary support service)

- We were told that where relevant, a person's assessment would identify the need for staff to record their nutrition and fluid intake. One family member told us that staff were very particular about this and highlighted any concerns immediately if the person ate or drank less than usual. They told us they believed that this was a major contributory factor to their relative remaining in relatively good health.
- One person we visited in their own home told us how their care workers reminded them to eat and drink and either discussed options with them or arranged with a local café to deliver food of choice in accordance with their wishes. They told us this was reinforced by technology whereby the manager had added a repeat reminder to their electronic device which reminded them every two hours to have a drink. We saw backdated records of fluid and nutrition intake stored electronically and noted that recordings were made after each meal, in accordance with the care plan. Where there were concerns about low nutritional intake, a note was made that a fortified drink had been given. We saw on the care plan that this followed guidance from a dietician.
- Domiciliary support staff were very clear where a person required a particular diet. For example, we saw on the person's care plan that their food needed to be pureed. Each worker we spoke with who was involved with this support package understood this. They could describe to us how they pureed the food and assisted the person to eat in accordance with eating guidelines recommended by a dietician.
- A dietician had been appointed to the management advisory group and would provide nutrition and hydration guidance to staff in the delivery of care practices.

Technology and telemedicine (Domiciliary support service)

- One person who used the domiciliary support service demonstrated technology which the provider introduced them to. This was linked to their smart watch and smart computer device. We saw that there were reminders on the person's computer device, which included when to take a drink. They also told us that the provider entered any appointments they would have.
- The person told us how their smart watch acted as an alarm and told us of a recent event where they fell out of bed and could not reach their telephone. However, they used their smart watch as an alarm, which was linked with the nurse manager's phone. They tapped it, which alerted the manager to the fact that there was a problem and he was with the person within 30 minutes and was able to call for an ambulance.
- We spoke with the manager about cover on the occasions when he was unavailable due to annual leave or sickness. He told us that there was no alternative on-call arrangement in place since he assumed full responsibility for covering the service out of hours at all times. He told us he did not take annual leave and that he had not experienced any bouts of sickness since the service was established. The nurse manager acknowledged that this was something which he needed to reconsider in order to have a robust system in place to cover all eventualities.

Patient outcomes

- The provider did not collect any data from which to measure patient outcomes in relation to the MSH@Home service.

- Clinical staff discussed and identified additional risks during sexual health screening appointments including pregnancy status, immunisation status and blood pressure.
- Patients received test results from sexual health screening within two weeks of their tests. We saw this in practice and found staff proactively contacted patients when they did not return for treatment. For example, we saw documented evidence staff had sent text messages and an e-mail to a patient who received a positive test result for a sexual infection. As they had not replied, the service sent a printed letter and advised them of the next steps to take to ensure they received appropriate care. We saw this action taken in 100% of cases.
- Staff identified opportunities for health promotion and education during sexual health appointments, such as for reducing the risk of future infections and practical advice on how to reduce the risk of transmitting infections to sexual partners. During our observations we saw staff routinely offered each patient free condoms and helped them identify the most appropriate size and type for their needs.

Competent staff (Domiciliary support service)

- A practice development nurse (PDN) was in post who provided practical training and clinical competency supervision to clinical staff and healthcare support workers. The PDN also facilitated access to external training courses for staff in line with their professional development plans.
- New staff underwent a one-to-one induction with the nurse manager and had a period of supernumerary working during which time they worked with an experienced member of the team who ensured they were confident and clinically competent to work on their own.
- All recently appointed staff had been enrolled on the Care Certificate which is a set of standards that social care and health workers follow in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The practice development nurse assessed the quality of work done for the Care Certificate and signed it off accordingly.
- The registered provider prioritised training and understood the importance of having a well trained workforce. There was a mandatory training session held every four weeks where staff were paid to participate. A care worker told us the agenda was sent out in advance and training was of a good quality.
- Staff spoke of the support they received to develop in their role, especially where their previous background was not in care. This included the provision of specific training to better support a person. For example, a care worker described how recent training on dementia helped them understand aspects of progressive deterioration in a person living with dementia. One worker told us they had been supported to do a course related to assessment of the older adult and another told us they had been supported by the manager and practice development nurse to complete an access to nursing course.
- People supported by the service and external healthcare professionals consistently told us staff who worked for the service displayed a level of professionalism they had not previously witnessed from homecare services.
- Healthcare professionals told us the domiciliary care service had a very good reputation and was the homecare service they always turned to when they required support for their clients. We were told this was because the staff displayed the right competencies, knowledge, skills, experience and attitudes and could be relied upon to provide an excellent service.
- Staff were encouraged to develop within their field of interest including dementia care and mobility/ physical fitness.
- Staff we spoke with told us regular supervision and annual appraisals were in place. These were one to one meetings held on a formal basis with their line manager. Staff told us they could discuss their development, training needs and their thoughts on improving the service. One member of staff showed us their most recent record of supervision, which included a range of all of these topics.
- However, we could not find a record of supervision on seven out of ten records we looked at. We later spoke with the manager and practice development nurse

who acknowledged that whilst supervision did take place on a regular basis, there was not a robust system of formally recording them. They said this would be addressed immediately.

Competent staff (Sexual health service)

- All staff in sexual health services who had worked in the organisation for longer than 12 months had received an appraisal. Five members of staff had worked with the service for less than 12 months and had an appraisal scheduled.
- Discussions with the nurse manager confirmed careful consideration had been given to ensure staff offered employment shared the same values and beliefs of the registered provider to deliver high quality care alongside the existing staff team.A healthcare worker told us they were aware the provider had a very rigorous selection process which resulted in the recruitment of staff who were of a consistently high calibre.

Multi-disciplinary working and coordinated care pathways

- We saw evidence on people's records of referral to and consultation with other professionals, for example; GP, dietician, chiropodist and physiotherapist.
- We saw notes on one person's record where there was an increased level of contact with a local authority care manager. Negotiations took place between the nurse manager and the care manager to secure an increase in a person's support package. This was in response to concerns expressed by the support workers that the allocated amount of time was inadequate to meet all of the person's needs safely. We subsequently saw that the additional hours had been granted.
- We saw evidence clinical staff liaised with other services to coordinate the care of people who used sexual health services. This included social services, psychology services and GPs.

Referral, transfer, discharge and transition

- We saw evidence on people's records that the nurse manager made referrals as appropriate to the GP and local authority.
- We also saw that referrals were made to occupational therapists in a bid to maximise the person's mobility and maximise their independence.
- During our observations of care at the MSH@Queens Park service, staff provided patients with information on urgent out of hours services that could meet their needs. For example, staff told people how to access post-exposure prophylaxis (PEP) from hospital emergency departments. PEP is a course of medicine that can reduce the risk of HIV seroconversion if started within 24 hours of a possible exposure.
- Staff provided patients with detailed and easy to understand information about what to do after sexual health and HIV screening. This included how they would receive test results and what to do if they needed to be prescribed medicine or to access another service.
- Staff referred patients to an NHS sexual health provider in the event a person presented with complex needs or multiple co-morbidities that could not be treated by the service. Referrals were made against an existing service level agreement that enabled patients to attend a sexual health service that could provide more complex care immediately after attending an MSH appointment. This service operated seven days a week and where a patient was referred during an evening walk-in session, they were able to attend the next day.

Access to information

- In the MSH@Home service, people's care record, including their care plan, was retained in their home and could be referred to by the person, family members or their support staff at any time.
- People told us they would contact the office if there was anything they were unclear about. They also told us their support worker frequently clarified points of information for them.
- The provider supplied a leaflet outlining the service they provided to people.
- Staff used paper clinical records for sexual health services and an electronic tracking system for test and screening results. Paper records were stored securely on the site at which patients most often attended and could be securely transferred if needed, such as if

patients sometimes wanted to attend a different site. This meant staff always had access to patient notes in advance of a pre-booked appointment and immediate access to past records where a patient attended for a walk-in appointment. During out observations at the MSH@Queens Park service this worked well in practice and there were no instances where patients were not seen without appropriate access to information.

- Staff provided written information to GPs when they had consent from people, such as following a positive HIV result.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (Domiciliary care service)

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.
- The nurse manager told us that MCA awareness was touched on during induction. However, he said there were plans for this to be introduced as a stand-alone training session. He also told us that MCA assessments were led by local authority social workers.
- We found that whilst people were familiar with the principles of gaining consent before initiating care, we saw little evidence of formalised written consent to care on people's records for the MSH@Home service.
- Staff we spoke with told us they ensured they were doing what was in the client's best interest and with their consent. They also told us how they explained and reaffirmed what they were doing before initiating any support.
- Workers told us how they returned to a task if it was initially refused by the person they supported. They also said that if it was obvious the person lacked capacity, a referral would be made back to the original referrer and a request made for them to do a capacity assessment. One person with responsibility for assessing new referrals to the service told us how they referred back to the referrer when they were concerned about a person's capacity to consent to care as a result of their alcohol dependency.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (Sexual health service)

- Staff had documented patient consent in all 23 sexual health records we looked at and we saw staff obtained this appropriately during our observations of care.
- All of the staff we spoke with in sexual health services demonstrated detailed knowledge of the MCA and of their responsibilities in relation to consent. This included the Fraser guidelines and Gillick competencies where a patient was under 16 years of age.
- During our observations of care at MSH@Queens Park staff explained to each person how their data and personal information was used and how they maintained confidentiality. We also saw examples of how staff maintained confidentiality in other areas. For example, when arranging sexual health appointments by phone, receptionists did not read out sensitive personal information or verbally repeat phone numbers to avoid this information being overheard in waiting areas.

Are community health services for adults caring?

Compassionate care (Domiciliary support service)

- Compassion was one of the provider's six core values. Staff we spoke with told us this was embedded in their practice and they were motivated to give the best possible care to those they supported.
- Staff we met or spoke with were highly motivated and wanted to ensure people received high quality, consistent support.
- People who used the MSH@Home service had a small team of staff that consistently supported them. This ensured continuity and enabled the person to develop a relationship with staff. Family members told us this was very important to their relatives. One told us how difficult it usually was for their relative to develop

trusting relationships and therefore accept support from others.This was no longer a problem since the team around their relative was the same every time and a strong trusting relationship had developed.

- Health professionals spoken with repeatedly described the service as professional, caring, efficient and consistent.
- Recent feedback from comment cards provided by CQC included praises for "compassionate and respectful" staff and for their "sensitive, kind and caring way of working."

Compassionate care (Sexual health service)

- During our observations of care at the MSH@Queens Park service we saw staff treated people with kindness, understanding and respect. This included when a person was upset about their last test result and a nurse was able to reassure them gently and with confidence. One person attended whose first language was not English and they needed extra time to communicate due to speech difficulties. We saw the nurse demonstrated patience and encouraged the person to communicate without rushing them or trying to finish sentences for them.
- We spoke with one person who attended the provider's private sexual health services. They told us they had chosen this provider for over two years as they found staff to be consistently friendly, welcoming and non-judgemental. Three people we spoke with at MSH@Queens Park told us they felt they would not receive the similar level of personal attention at other sexual health clinics and chose this service for the level of care and attention provided by staff.

Understanding and involvement of patients and those close to them (Domiciliary support service)

- People told us they felt fully informed about all aspects of their care or that of their relative. One person said their care workers gave explanations and suggestions during the course of their support.
- We observed how one care worker involved the person in their care. They asked the person if there was anything different they required and demonstrated a high level of understanding of the person and their life. They were able to engage the person in a wide ranging conversation about their working life and their family. The care worker told us they took particular care to understand a person's social history as described in their initial assessment and care plan. They said it helped to develop a stronger connection between them and enhanced the support they gave.
- Care workers described to us how they endeavoured to maximise people's independence, no matter how restricted a person's movement or abilities might have been.

Understanding and involvement of patients and those close to them (Sexual health service)

- We observed 12 patient appointments at the MSH@Queens Park sexual health service. On each occasion the nurse or healthcare support worker (HCSW) involved the patient in every step of the process. This included explaining the reason for individual tests, explaining how swabs and tests worked and encouraging each patient to act on their results. For example, during an observation of an HCSW, they introduced themselves to the patient and explained what they were going to do before they did it. This had a demonstrably positive effect on the patient who said they felt relaxed and less anxious as a result.
- We saw staff provided extra information to patients on request and did so using communication that avoided jargon. For example, during our observation of MSH@Queens Park screening appointments, a patient asked for more information on point-of-care rapid HIV testing and for information on how specific sexual infection tests worked. The HCSW explained how the HIV test worked and why it was reliable and offered a straightforward explanation about how other tests worked and why they took different lengths of time to receive the results. The HCA also checked the patient understood their explanation before continuing. During all of our observations staff were encouraging and demonstrated warmth to patients, such as reassuring one patient that their condition looked visibly improved.
- Where staff found it difficult to take blood samples due to challenging access to veins, they explained to patients why this happened and offered alternatives. For example, during one observation an HCSW was

unable to take blood after a second attempt and offered a finger prick test instead. They clearly explained why this could happen and explained how the different types of test worked.

- During our observations of a college sexual health outreach event, staff demonstrated the skills to speak with students from a diverse range of ages and backgrounds about their sexual health. This included understanding when students wanted to talk privately or adapting the information to make it suitable for a group of friends who approached staff together.

Emotional support (Domiciliary support service)

- One person we spoke with described how the nurse manager responded to their out of hours emergency call and remained with the person for four hours, until an ambulance came. The person described how their distress was minimised by the emotional support they received.
- We later spoke with the manager about this who explained that the ambulance service did not treat the call as a priority because they knew the person was safe and being monitored, hence the delayed response. We saw this episode was recorded on the person's electronic record.
- People who used the service told us they valued the support they received. They said the positive attitude of staff gave them the motivation to strive to improve and live their life as they wished.

Emotional support (Sexual health service)

- Nurses and a healthcare assistant provided emotional support to patients for sexual health screening and for HIV testing and results. The education, welfare and companion manager provided pre and post-test HIV counselling. In addition they provided advice on relationships and sex to young people and signposted patients to counselling services, including for drug and alcohol needs.
- We observed staff provided positive reassurance and emotional support to patients who were anxious about HIV testing or who were worried about receiving a positive result for a sexually transmitted infection.

Are community health services for adults responsive to people's needs?

(for example, to feedback?)

Planning and delivering services which meet people's needs (Domiciliary care service)

- A health care professional we spoke with told us how responsive and professional the service was when they needed to commission their services. They said their first choice for referral was always this provider. They told us that the initial assessment was very comprehensive and this was reflected in the person's care plan.
- Care worker skills were matched to each person, for example, there were care workers who had particular skills in working with those who lived with dementia and others who were especially skilled in promoting mobility. We saw where a person's care plan identified specific needs in those areas, those workers with enhanced skills were matched to the person.
- The practice development nurse told us how they supported a family member who wanted to be more involved in the care of their relative. Therefore, on occasions when the family member was in the house, the care worker supported them with carrying out simple tasks. This was recorded on the care record to indicate what the family member had done which we saw on previous records. For example, we saw written down that the family member had washed their relative's face.

Planning and delivering services which meet people's needs (Sexual health service)

- MSH@Queens Park sexual health service was due to close in March 2017. To ensure patients received continuity of care, the organisation displayed information on alternative services and provided clear information on the scope and cost of their private services.
- Staff conducted a comprehensive assessment of each patient who presented for a sexual health appointment. This included previous needs, a record of allergies and a discussion of any other individual

needs such as previous abnormal smear test results or mental health needs. We observed 12 such discussions and saw staff facilitated discussions in each case.

- MSH@Queens Park operated out of a GP practice and staff used MSH signage to ensure patients could recognise the service. Each clinical room used by MSH staff had a branded sign on the door that included the name and role of the member of staff using the room. In addition, staff displayed a sign on the bathroom door that reminded patients not to pass urine before a consultation. This helped staff to successfully obtain samples from patients as urine was often needed during screening.
- Staff wore different uniforms for the MSH@Queens Park and Angel office services as part of their approach to ensuring patients recognised the distinctions between clinics.
- An advanced sexual health educator provided sex and relationship education services to local schools and colleges. This included body development classes for children from the age of six and more complex psychosexual support to college-age students.
- The service provided sexual health promotion and chlamydia screening events at colleges in local boroughs. This included providing one-to-one advice to students, supplying free condoms and engaging students to talk more openly about their needs and concerns with regards to sex and relationships. We accompanied staff to one event and found it to be a well-organised, engaging and interactive strategy that students demonstrably found interesting and of importance to them. During the course of our observation staff engaged with 83 students and provided them with individualised information and on-site chlamydia screening as well as resources to enable individuals to find out more about sexually transmitted infections and other topics of interest to them such as support to understand more about drug and alcohol use.

Equality and diversity

- The provider had an Equality & Diversity Policy and was a signatory to a local authority Charter of Fairness & Equality.
- It was a social enterprise and as such, their policy stated they were particularly keen to ensure that any paid-for services were charged at fair and affordable rates, opening times were appropriate and convenient and facilities were accessible to people with childcare responsibilities.
- People were able to choose whether they wanted domiciliary support from a male or female and the provider would facilitate this. This also applied to whether a person required a female only assessor.
- People's care records included an assessment of their needs in relation to equality and diversity. Staff we spoke with understood their role in ensuring people's needs were met in this area.
- Staff provided the MSH@Queens Park sexual health service within a framework that included nine standards that patients could expect. These were prominently displayed in the clinic and ensured the service was provided equitably to all patients. For example the standards included confidentiality, the right to an interpreter, to be treated with respect and access for patients under the age of 16.
- Staff ensured all of their sexual health services were offered to everyone, regardless of gender, age, sexual identity, gender identity, race, religion or other personal factor as identified by the UK Equality Act (2010).

Meeting the needs of people in vulnerable circumstances (Domiciliary care service)

- Individualised care plans were used throughout the service that took account of people's individual needs and preference and were reviewed every six months or as required. Changing needs were alerted as a result of feedback from the person, their family or care worker. The named nurse then reassessed and amended the care plan accordingly. Any increased need was discussed with the referrer and initiated subject to funding agreement.
- We saw where a care plan review highlighted the need for additional support; the nurse manager had frequent contact with the care manager in order to access increased funding.
- To complement the care plan, there was a separate schedule which outlined the care worker's activities in

relation to the care plan. This schedule directly linked back to aspects of the needs assessment within the care plan, and enabled the care worker to understand the reasons behind completing certain tasks. For example, an amended care plan we saw included an increased level of monitoring of a person's blood pressure as a result of a recent hospital discharge.

- We were told that baseline measurements, which included blood pressure and temperature, were recorded regularly for one person. We saw from their backdated electronically stored copies that this happened on a regular basis, without any omissions.
- One person's care plan recommended that nutrition and fluids charts should be completed. We were shown backdated records which confirmed this. When we spoke with two care workers who were involved with the support package, they were able to tell us how and why this was necessary. We also saw that these records were audited by the nurse manager every four weeks, with no matters of concern reported.
- Progress notes were written at the end of each support shift. We saw these were comprehensive and alerted the following support worker to any issues or tasks to be completed. Backdated records of these notes were removed from the person's house on a regular basis and stored electronically for future reference.
- One healthcare professional said staff working for the service had an excellent knowledge of how to support people living with a mental health condition. They said what the service achieved with the person was exceptional and completely turned their life around.
- They also said that the service provided all round support to people to help manage their own care, which for most was a life changing experience.

Meeting the needs of people in vulnerable circumstances (Sexual health service)

- Staff noted if a patient had a history of fainting during blood tests, which meant safeguards could be put in place for sexual health screening appointments. For example, instead of taking blood samples whilst seated, staff ensured a trolley was available so the patient could lie down when taking blood. This reduced the risk of injury as a result of fainting in a chair.
- Staff were trained to act as chaperones during intimate examinations or testing and this was proactively offered to people. On occasion the walk-in MSH@Queens Park was operated by an all-male staff. Where this happened and a female wanted a chaperone during an appointment, staff offered self-swab kits so they could take their own samples privately without the need for an immediate examination.
- The education specialist provided sex and relationships guidance to vulnerable young people, including those at risk of female genital mutilation and risks associated with religious practices such as 'honour killings'. This member of staff had immediate access to safeguarding and crisis teams in the event they needed urgent support for a vulnerable person.

Access to the right care at the right time

- There was a rapid response to requests for assessment and support by the MSH@Home service. Records we looked at showed there was contact made with the referrer and the person who required support within three days of a referral being received.
- A health professional told us they found the provider to be very responsive. They said any referral they made was picked up within three days and they were kept informed throughout the assessment process.
- The MSH@Queens Park sexual health service operated twice weekly; between 5pm and 9pm on Thursdays and between 12pm and 4pm on Saturdays. The service offered a mix of pre-booked and walk-in appointments. Private sexual health appointments were available on-demand seven days a week through pre-bookable appointments.
- Staff used a partner notification service to enable the sexual contacts of patients to access screening and treatment services following a positive test result. For example, where a patient presented with a sexual infection, staff offered support to tell their partners about this to ensure they also undertook tests for infections. Staff could send a text message, e-mail or

letter to partners with a message to encourage them to contact the service. This enabled staff to offer appropriate screening and support whilst protecting the identity of patients.

- Reception staff at the Queens Park service used a triage process that enabled clinical staff to see patients according to the urgency of their need.
- Staff monitored the 'did not attend' rate for pre-booked appointments at sexual health services, which was consistently low at 8% in the 12 months prior to our inspection. This was maintained because each patient received a reminder text message on the day of their appointment. In addition, once a person was 15 minutes late for a booked appointment, a receptionist called them to find out if they were on their way or needed to reschedule. Where an appointment was missed, staff sent a retrospective text message to remind the person of the need to cancel an appointment in advance and to offer to reschedule this

Learning from complaints and concerns

- A complaints policy was in place that outlined the provider's procedure to resolve complaints or concerns. It also included details about how to make a complaint and what the expected response times were. The printed complaints policy was available for us to see at the time of our inspection. However, it was not readily available to people who used the service, either in the main office reception area or on the provider's website.
- After our inspection we confirmed that the provider made this information accessible through their website. The nurse manager told us there were printed copies in all clinical areas and in the homes of those who used the domiciliary support service.
- There were no formal complaints recorded for the service. The nurse manager told us how they dealt with any concerns as soon as possible. We saw an e-mail trail relating to a concern raised. The inspector subsequently spoke with the family member who raised the concern and they told us how the manager responded rapidly by telephone call and in follow-up e-mails. During the inspection, a member of the inspection team spoke with a service user to establish how their complaint had been dealt with. They said the matter was dealt with in a transparent way and was satisfactorily and speedily resolved.

Are community health services for adults well-led?

Service vision and strategy (Domiciliary support service)

- The nurse manager told us how they encouraged all staff to subscribe to the '6 Cs' throughout their work. These were instilled during supervision and appraisal. These were care, competence, compassion, communication, courage and commitment.
- We were told that the long term strategy was to further develop the nurse led personal care service. The plan was to have one nurse to coordinate the whole package of care for every 10 people who used the domiciliary support service. Their role would be to assess service user needs,complete all risk assessments, develop the care plan in partnership with the service user and oversee the care workers and the quality of care being delivered.
- Domiciliary support workers we spoke with told us they followed the 6 Cs. One told us how the application of the 6Cs was the best way in which to support a person and give them the best possible quality of life.

Service vision and strategy (Sexual health service)

- Clinical staff who provided sexual health services demonstrated an understanding of the changing needs of the local population and developed their future service vision and strategy on this. For example, nurses recognised that the first generation of older people living with HIV meant more individualised social care and home care services needed to be developed. In response staff were planning to integrate HIV care with the organisation's home care service to provide a targeted home service for people living with HIV in the future.
- All staff we spoke with were passionate and enthusiastic about the future of the organisation and had their own area of contribution to development.

For example, a receptionist was in a dual-role with marketing and website development responsibilities and said they had a feeling of pride in how the organisation was growing.

Governance, risk management and quality measurement

- There was a management advisory group (MAG) which met every three months. The makeup of this group included the nurse manager (nominated individual), the registered manager, a GP (medical advisor) and social worker (safeguarding advisor). It also included a dietician, physiotherapist, occupational therapist, two service users and a staff representative.
- Service user advisors for the sexual health and homecare services formed part of the MAG and contributed to quality assurance. For example, advisors were established professionals external to the organisation and provided guidance on the development of the organisation and succession planning following the planned closure of the MSH@Queens Park service. The chief executive maintained contact with MAG members between meetings, such as by sending them information on service developments and plans.
- It was unclear whether the MAG acted as a formal advisory group on clinically related matters. We were not assured whether it would challenge the nurse manager to ensure an agreed vision and direction for the service.
- The service did not have a formal risk register in order to record risks and identify potential trends and patterns.
- There was no established programme of audits at the time of our inspection. We were told that this situation would be addressed imminently, with the recent appointment of a compliance manager.
- There were safe recruitment procedures in place. We found relevant checks had been made before new staff members commenced their employment. These included Disclosure and Barring Service checks (DBS), and references. A valid DBS check is a statutory requirement for people providing personal care to vulnerable people.
- Gaps in employment were explained where a full employment history had not been provided. Two references had been received from previous employers. These provided satisfactory evidence about their conduct in previous employment. Where a person could not submit two employment references due to lack of employment experience, a character reference was taken up instead.
- These checks were required to ensure new staff were suitable for the role for which they had been employed.

Leadership of this service

- The nurse manager had overall responsibility within the service; he was the CEO as well as one of the directors. The second director was also the CQC registered manager. They had a number of colleagues and managers that reported directly to them. These were the development nurse, education welfare and companions manager, a compliance manager and a clinical trials lead.
- However, we found there was no robust provision in place to manage the service in the event of any unplanned long term absence of the nurse manager. During discussions with staff members it was apparent that they referred back to the nurse manager for all matters of clarification in relation to their work.
- Similarly, when we spoke with more senior members of staff about policies and procedures, where they were unclear, they told us they always contacted the nurse manager for guidance. There was no other obvious person within the organisation to whom such matters could be referred.
- People, relatives and staff spoke positively about the nurse manager and their style of leadership. All of those we spoke with, without exception, told us how visible and available they were. It was apparent that the nurse manager was knowledgeable and familiar with the needs of the people supported by the service.
- Staff who worked in sexual health services on a sessional basis also spoke positively of the organisational leadership and said they felt able to speak up and challenge decisions and plans.

- The nurse manager told us that caring for staff was equally as important to caring for people and that staff were always listened to. They told us they endeavoured to empower staff at all times and lead by example.

Culture within this service

- Domiciliary support and sexual health staff told us the culture of the service was very positive. They said there was strong teamwork and a good and experienced well led management team which enabled them to do their job to the best of their ability. An individual said they felt "well looked after" by the clinical team and said they always had the help they needed.
- Staff we spoke with frequently used the words respectful, transparent and supportive to describe the style of leadership.
- Others told us of how they were able to speak with the nurse manager and the registered manager about anything without fear of repercussion; their style of management was by example rather than dictate. Incidents were seen as an opportunity to learn from rather than blame being apportioned.
- The chief executive proactively encouraged each person with areas of responsibility in the organisation to be involved in the working culture. For example salaried staff, staff on sessional contracts and members of the MAG were invited to social events that attendees told us helped them to feel part of a dedicated team.

Public engagement

- The provider did not have a formal system of seeking the views of those who used the domicilary support service. The nurse manager acknowledged this and by means of explanation, told us that since the service was so small, there was almost daily contact with people. In this way, they were able to get their feedback and respond accordingly.
- Staff encouraged each patient who used the MSH@Queens Park service to complete a quarterly survey. This included details of each aspect of the service, including interaction with reception and clinical staff and waiting times for drop-in services.

Staff engagement

- The provider ran a staff survey, 21 staff (out of a possible 29) responded and the results for each question posed were largely positive. Ninety-five per cent strongly agreed and 5% agreed that the organisation was well led. When asked whether policies and procedures enabled staff to understand the needs of patients and deliver a service to them that is caring, 91% of staff strongly agreed and 9% agreed. When asked whether training was effective and developmental, 85% strongly agreed, 15% agreed and 5% remained neutral.
- There were no regular formalised staff meetings, however, the mandatory monthly training, which took place on Sundays for four hours, had space at the end of each session for staff to raise matters and have general discussions. Staff we spoke with told us they found this to be an efficient way to catch up with others and learn of developments within the service.
- The nurse manager sent a weekly report via e-mail to all staff within the service. We saw several examples of these and they included his weekly schedule and contact details when out of the office. It also included information relevant to each part of the service. The manager told us they always added a link to a relevant publication or practice development. We saw there were links to training videos on these weekly briefings which staff told us they found to be of great interest as they were often on subjects they would not normally be exposed to.
- Members of the MAG supported the senior team in project planning, including in analysis of the results of a staff survey and recruitment of volunteers to a pilot project. Members of the MAG we spoke with told us they felt able to contribute to the organisation and felt there were tangible differences in working for a relatively small organisation.

Innovation, improvement and sustainability

- The provider's innovative use of technology for those who received domiciliary support enhanced their safety and well-being. We saw how one person used it to ensure they remembered to drink an adequate amount of liquid, which had a positive impact on their health. The same technology could also be used to alert the provider that the person was in difficulty.

Community health services for adults

- The provider adapted an innovative nurse-led model of care of the patient in their own home. The nurse was responsible for the assessment, planning and coordination of patient care. A small team was built around the person which ensured familiarity and consistency.
- The senior team recognised the need to sustain the service through staff wellbeing and support and provided benefits and incentives to encourage staff to develop their careers with them. This included access to health services and parity across all grades with the London living wage.
- Sexual health services provided through the MSH@Queens Park service were tailored to the needs of the local population and we saw consistent, demonstrable evidence that this system worked to the benefit of people who attended it. The service was due to close in March 2017 and the provider had displayed information for people in the GP practice with alternative arrangements. This included other local NHS services and information on the MSH private sexual health services.

Outstanding practice and areas for improvement

Outstanding practice

- The use of technology to enhance the safety and well-being of those who used the domiciliary support service was innovative and provided an increased quality of care to people.
- The education programme for young people reflected the latest knowledge and best practice in sex and relationships education. This enabled young people, regardless of gender, sexual identity or religion, to access structured and appropriate advice and guidance.
- All members of staff and sessional nurses demonstrated an acute knowledge and understanding of the complex psychosexual needs of people and we saw they were able to adapt their communication and approach to the needs of each individual. This included where there were language barriers or significantly different levels of education about sexual health.

Areas for improvement

Action the provider SHOULD take to improve

- Accurately record supervision meetings.
- Clarify the breadth of the clinical management group's responsibilities.
- Ensure there is an up to date fire risk assessment of the premises carried out.
- Record all agreement to consent to treatment and support.
- Initiate a programme of audits.
- Establish a risk register.
- Establish a method of formally seeking the views of those who use the service.