City Health Care Partnership CIC

Quality Report

Business Support Centre,
5 Beacon Way,
Hull HU3 4AE
Tel: 01482 347620
Website: www.chcpcic.org.uk

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Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults	Highfield Health Centre Bransholme Health Centre Longhill Health Centre The Westbourne Centre Elliott Chapel Health Centre Newington Health Centre	BD256 1-286634785 BD256 1-279570366 BD256 1-2071214626
Community Health Services for Children, Young People and Families	Marfleet Health Centre Highland Health Centre Orchard Centre	BD256 BD256 BD256
Community Services for End of Life Care	Brandsholme Health Centre Westbourne Health Centre Bilton Grange Health Centre	1-286634785 1-279570366 1-279570410
Urgent Care Services	Bilton Grange Health Centre Bransholme Health Centre The Freedom Centre The Westbourne Centre The Wolds Primary Care Practice	1-459758269 1-286634785 1-279570042 1-279570366 1-564420575
Termination of Pregnancy	Wilberforce House	1-402694327

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

Summary of findings

Contents

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We inspected CHCP CIC from 19 to 22 November 2016 and undertook an unannounced inspection on 22 November 2016. We carried out this inspection as part of the CQC's independent community health services inspection programme. The core services inspected were:

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

Although we regulate termination of pregnancy services we do not currently have a legal duty to rate them. For these services, we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

The following services operated by the provider were not inspected as part of this visit, prison health care, GP services, dentistry, public health and social care.

This report only comments on what we found in relation to the community health services that we inspected. We have not rated City Healthcare Partnerships CIC as a provider for each of the five key questions or as an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

Our key findings were as follows

- Feedback from patients and their relatives was consistently positive about the care they received. All staff consistently communicated with patients in a kind and compassionate way, treated them with dignity, and respected their privacy.
- There were processes for being open and honest when things went wrong and patients given an apology and explanation when incidents occurred. However, some staff did not fully understand when duty of candour would be applied.
- Most staff understood their responsibilities to raise concerns and use the mechanisms to record safety incidents and near misses however staff understanding of what incidents to report and sharing of lessons learnt were not consistent in all services.
- All areas inspected were clean. Most staff followed the 'arms bare below the elbow' national hygiene guidance; however, some staff in community health services for children, young people and families were not following this guidance.
- There were some excellent examples of multidisciplinary team working particularly in end of life care to ensure that quality of care could be maintained closer to home and prevent unnecessary hospital admission.
- Staffing levels were planned and reviewed and any staff shortages were being managed adequately.
- Services were planned and delivered to take account of people with complex needs. There were arrangements to enable access to the service for people in vulnerable circumstances.
- People could access care and treatment in a timely way. Action was taken to minimise the time people had to wait for treatment and care.
- There were systems for the management of complaints, and evidence of improvements following complaints.
- Information showed that most intended outcomes were being achieved for people who use services.
- There were processes to consider risk and quality management however, areas such as clinical audit, effectiveness, and measures to identify escalating risks required further improvement.
- Senior and local site managers were visible to staff. Staff were proud to work in the organisation and spoke highly of the quality of care provided.
- There were good levels of constructive engagement with users of the services and staff, including equality groups.

We saw several areas of outstanding practice including:

- Urgent care services participated in a falls response pilot scheme with the ambulance service, fire and rescue and other health services. Emergency care practitioners (ECPs) based in urgent care provided

Summary of findings

clinical input and had trained ten fire officers involved in Hull FIRST. Where a clinical assessment or medical treatment was needed following a fall, ECPs worked with other clinicians at the patient's home or at the scene of the fall to help avoid unnecessary transfer to hospital.

- The End of Life Academy attracted staff from a variety of specialisms and services in the area to increase their skills and understanding of needs at the end of life. The service has received enquiries from around the UK about end of life educational delivery.
- The End of Life service had established one of six national pilot sites of integrated community end of life services based on the Motala model in Sweden. This model sought to provide direct care and support to patients in the last 12 months of life to prevent unnecessary hospital admissions and enable them to live at home and die in the place of their choice. This was achieved through early referral, home-based clinical intervention and joint working with community based services including primary care.
- The sexual health service was piloting a Skype clinic with community gynaecology patients and was planning to include the service for male sexual dysfunction and HIV clients. This reduced the need to attend face-to-face appointments and lowering barriers to access.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that there is assurance processes for Abortion Notification Forms HSA1 completion and HSA4 submission to the Department of Health within the legal timeframe of 14 days.
- Implement a surgical safety checklist for vasectomy patients.
- Ensure patients are informed that their anonymised data from HSA4 (notification for pregnancies terminated) forms is shared with the Department of Health (DH) for statistical purposes.

The provider should:

- Ensure there are processes to formalise arrangements for access to a specialist palliative care consultant 24 hours a day.
- Review the Incident and Near Miss Policy to ensure that it clearly defines the triggers for implementing duty of candour; and that staff are aware of the triggers to implement duty of candour.
- Ensure effective systems and processes so that lessons learnt from incidents are shared with staff groups consistently.
- Review assurance and clinical auditing systems to effectively identify, monitor and mitigate risks.
- Ensure that all services are undertaking audits to assess compliance with evidence based guidance from the National Institute for Health and Care Excellence.
- Review arrangements to ensure that there is appropriate board level representation for children's services, as recommended by the National Service Framework for Children (2003).
- Ensure that all staff have completed the level of children's safeguarding training relevant to their role.
- Review how wait times for termination of pregnancy patients are monitored against DH requirements of 5 working days from referral to consultation and 5 working days for consultation to treatment to provide assurance that extended waiting times are due to patient choice or appropriate clinical delay.
- Consider providing patients attending for medical abortion a time alone with the assessing nurse or consultant to give them a private opportunity to disclose any concerns regarding abuse or coercion.
- Continue to work with social care to ensure that processes are in place to meet the statutory requirement of providing an initial health assessment to all looked after children within 28 days.
- Ensure consultation rooms in urgent care services have signage to show when rooms are occupied.
- Ensure that lone worker applications for staff during home visits are used consistently and in line with organisation policy.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

- Most staff understood their responsibilities to raise concerns and use the mechanisms to record safety incidents, concerns and near misses. The provider was aware of its obligations regarding duty of candour.
- There were processes to ensure adults and children were safeguarded from abuse. Staff understood their responsibilities and followed safeguarding policies and procedures.
- Staffing levels, skill mix and caseloads were planned and reviewed to ensure patients received safe care and treatment. Most areas had sufficient staffing levels. Medical staffing in end of life care services did not meet national guidance; however, actions had been taken to mitigate the risk.
- Services maintained a resilience and business continuity plan to enable them to respond appropriately to adverse events affecting service delivery.

However

- The trigger for implementing the duty of candour was not clearly defined in guidance, which meant that some staff we spoke with, although they had an understanding of being open and honest, were less clear about when the duty of candour would be applied.

Duty of Candour

- The provider was aware of its obligations in relation to duty of candour. The Incident and Near Miss Policy included guidance on the application of the duty of candour and training was included in the information governance-training module. However, the guidance did not clearly define the trigger for implementing the duty of candour.
- Some staff we spoke with did have a broad understanding of the need to be open and honest but were less clear about when the duty of candour would be applied.
- The quality-monitoring dashboard for September 2016 showed there had been no breaches of the duty of candour between September 2015 and September 2016.

Safeguarding

- An internal audit of safeguarding vulnerable adults was included in the internal audit plan for 2015/2016 to provide assurance to CHCP CIC on the processes and controls in place.

Summary of findings

The review identified that the design and compliance with the control framework overall was good however; there were areas where the controls could be improved. There was an action plan to address this.

- The Director of Quality and Non-Medical Professions attended the Safeguarding Delivery Partnership Group meeting, which was a sub-committee of the Hull Safeguarding Adults Board. Members of the Board attended the CHCP CIC Safeguarding Adults Working Group to allow for links between the Local Authority and CHCP CIC.
- Within CHCP CIC, information was reported to the Safeguarding Adults Working Group and each quarter a report was produced for the Quality and Safety Board and the Operations and Delivery Board to provide the executive with intelligence on the performance of CHCP CIC.
- CHCP CIC provided an annual report for safeguarding children, reporting on the activity and outcomes of safeguarding related work and actions for the following year.
- The lead for adult safeguarding was employed for only one day a week. There was a business case to recruit a full time adult safeguarding specialist.
- CQC received no safeguarding alerts or concerns for CHCP CIC between August 2015 and August 2016.
- The corporate risk register identified that there was a lack of systems and processes for referrals entering the Multi-Agency Safeguarding Hub (MASH). There was a review of internal processes in the safeguarding adult's team and action taken to meet safeguarding adult requirements.
- Data for October 2016 showed 93% of staff had completed level 1 children's safeguarding training, 92% level 2 and 83% level 3, 92% of staff had completed safeguarding adults training (the training was every three years).

Incidents

- There was an incident, near miss and serious incident reporting policy, which set out the reporting framework for managing all significant risks as, required by the CHCP CIC Integrated Governance Strategy.
- Staff reported incidents of harm or risk of harm using a risk management reporting system. Staff were trained in basic incident reporting. Incident investigators received specialist training which included the principles of root cause analysis (RCA), report writing and completing the investigation on the incident reporting system. 52 staff had completed root cause analysis investigation training at the time of the inspection.

Summary of findings

- A quality and integrated governance report was prepared monthly, which included an overview of incidents that had occurred in services. Incidents were graded according to severity. Themes, trends and learning from the investigation of incidents was summarised for staff to review learning from incidents in other parts of the service as well as their own.
- Staff were able to give examples of learning from incidents, which had been shared with them at team meetings. The organisation had identified the need to develop further its learning from the investigation of incidents, for example in providing feedback routinely to members of staff who submitted details of an incident.

Staffing

- In community adult services, the local team leader managed staffing levels and skill mix. There were services, which did have vacancies, and agency staff were used in some community teams. District nursing teams had various grades of staff that were managed by a team lead.
- The 0-19 children and young people service had been reconfigured to meet the commissioner's strategy of a seamless service. There was a 0-11 team consisting of health visitors and public health nurses (previously band five school nurses). The 0-11 service caseloads were 405 children per full time health visitor, which was in line with national recommendations.
- Medical staff providing services relating to termination of pregnancy and integrated sexual health were either employed by or sub-contracted to CHCP CIC. The medical director was responsible for the supervision, appraisal and dealing with concerns relating to the practice of medical staff. Doctors we spoke with said they had annual appraisals and they in turn provided supervision for junior staff on rotation.
- Specialist palliative care nurse staffing met the national guidance with 6.2 whole time equivalent Macmillan specialist palliative care nurses.
- Medical staffing in end of life care services did not meet national guidance including out of hours consultant cover; however, action had been taken to mitigate the risk. CHCP CIC had no community palliative care consultant despite continued efforts to recruit to this post. A specialist doctor had provided regular clinical support to the service but had left eight weeks prior to the inspection. The post of palliative care consultant had remained vacant for some time and the failure to recruit had been escalated to the Care Group Director.
- Between April 2015 and March 2016, the staffing vacancy rate was 5.3%, turnover 14.8% and sickness was 4.4%.

Summary of findings

- Between May 2015 and August 2016 bank and agency, staff filled 16,451 hours.

Major incident awareness and training

- Services maintained a resilience and business continuity plan to enable them to respond appropriately to adverse events affecting service delivery. Examples of these events included inclement weather and unexpected peaks in demand for services.
- The provider had a policy to protect staff who may be lone workers. Staff had mobile phones with a lone working application. This was to be activated on each home visit; however, staff told us they did not use it if they were going to a visit where the family were known to the service.

Are services effective?

- Community services used relevant and current evidence-based guidance, standards and legislation to develop how services, care and treatment was delivered.
- Staff worked together to plan and deliver effective care when people moved between teams or services, including referral and discharge.
- There were some excellent examples of multidisciplinary team working particularly in end of life care to ensure that quality of care could be maintained closer to home and prevent unnecessary hospital admission.
- Patient outcomes were monitored and reviewed in most areas. Data showed outcomes were similar or better than national averages and action was taken where these fell below target.
- There were local agreements and referral pathways in place with local NHS trusts and other providers to ensure patients received the necessary care.
- There were processes and guidance for obtaining consent from patients within the organisation.

However:

- Managers reviewed and implemented relevant guidance however; some services such as end of life care did not conduct audits against compliance with palliative care NICE guidance.
- A revised audit framework and annual audit plan, which strengthened the use of clinical audit, had been agreed with commissioners and the audit programme for 2017-18 was in development at the time of our inspection.

Evidence based care and treatment

Summary of findings

- The organisation was registered as a National Institute for Health and Care Excellence (NICE) stakeholder for key service areas so that it could be consulted about guidelines and quality standards being developed which affected clinical services. Work with NICE guidance was undertaken jointly with commissioners.
- The organisation's quality accounts for 2015/16 gave details of activity in relation to the review of NICE guidance. During 2015-2016, the organisation reviewed 158 new NICE publications and shared relevant publications for consideration and action to the appropriate service.
- The organisation's NICE guidance review group considered guidance published by NICE each month to assess how it applied to services. Newly published NICE guidance was then circulated to NICE leads within services. The number of items reviewed or outstanding was reported and summarised in the monthly quality and integrated governance report. Staff in a focus group confirmed their use of the latest NICE guidance supported by the work of the review group.
- Managers reviewed and implemented relevant guidance however; some services such as end of life care did not conduct audits against compliance with palliative care NICE guidance.
- The quality accounts for 2015-2016 confirmed that only one national clinical audit was undertaken which covered the NHS services provided by the organisation with 65 local clinical audits started, 21 were completed and 44 were ongoing.
- The audit committee chaired by a member of the executive approved the annual audit plan. The clinical effectiveness group met quarterly to review actions from national and local clinical audits. Revisions to the clinical audit process and policy for the year ahead were discussed at the clinical effectiveness group in September 2016. Audits, which supported the development of service quality, were prioritised.
- A revised audit framework and annual audit plan, which strengthened the use of clinical audit, had been agreed with commissioners and the audit programme for 2017-18 was in development at the time of our inspection.

Patient outcomes

- The service reported on a range of performance indicators to their commissioners. In end of life care, the target for the number of patients who achieved their preferred place of care where their preference was stated during the reporting period

was 60%. The service achieved 100% from April to August 2016. Ninety nine per cent of all patients referred to the end of life services in 2015/2016 achieved their preferred place of care. This outcome was monitored on a monthly basis.

- The target for service users seen within 10 days of referral to the specialist palliative care clinic was 95% and the service achieved 98% from April to August 2016.
- The secondary referral admission rate for patients who attended urgent care services was 6-7%.
- In sexual health services, compliance rates were good: rhesus status and prophylaxis, VTE risk assessment and STI risk assessment were all 100% and 39 out of 40 patients had chlamydia screening. Three out of 40 patients had not taken part in a telephone follow-up although it had been offered.
- As of March 2016 in Hull, 86% of families received new birth visits from health visitors, within 14 days of birth. 81% of families received a follow-up visit by the time their child was eight weeks old. 93% of children received a 12-month review in the month of their 1st birthday. Eighty nine per cent of children received a 2 to 2.5 year review. There was no data available to compare these statistics against the England average.
- Immunisation rates for MMR were comparable with the England average at 97% for first dose and 91% for the second dose uptake.

Multidisciplinary working

- Staff worked together to plan and deliver effective care when people moved between teams or services, including referral and discharge.
- There were some excellent examples of multidisciplinary team working particularly in end of life care to ensure that quality of care was maintained closer to home and prevent unnecessary hospital admission.
- There were local agreements and referral pathways in place with local NHS trusts and other providers to ensure patients received the necessary care.
- Care was co-ordinated for patients with complex needs.
- Staff worked closely with other agencies to meet the needs of children and families, for example, the local authority, children's centres and schools. Practitioners acted as link staff between GP's, schools, children's centres and nurseries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Summary of findings

- Staff we spoke with understood the Gillick and Fraser guidelines and gave examples of how they had applied them in practice. Staff explained that the consent process actively encouraged children and young people to be involved in decisions about their care.
- Most staff demonstrated an appropriate understanding of legislation and guidance related to consent and the Mental Capacity Act 2005 (MCA). Staff were briefed and aware of Deprivation of Liberty Safeguards.
- The DNACPR forms we reviewed demonstrated consideration of mental capacity in the decision-making process. Audits of the quality of documentation for DNACPR forms were not undertaken as these were the responsibility of the GP service and the hospital consultants. However, the provider did attend regular meetings with agencies where these areas were reviewed and monitored.
- We observed staff interacting with patients and obtaining consent in an appropriate way prior to providing care.

Are services caring?

- The objectives of the company were to carry out activities, which benefited the community. The mission to provide high quality and safe services, which were personally responsive, caring and inclusive of all, was evident in the organisation.
- Feedback from patients and their relatives was continually positive about the care they received.
- All staff consistently communicated with patients in a kind and compassionate way, treated them with dignity, and respected their privacy.
- People who used services were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.

Compassionate care

- Results from the National Friends and Family test showed high levels of patient satisfaction (96% would recommend the service). Patient survey results also showed 98% of patients were satisfied with the standard of care and support they received and 96% received the care that mattered to them.
- The ongoing trends regarding compliments reported to local commissioners related to the quality and value of the services provided. Where compliments regard staff, this was mainly around staff being friendly and helpful, especially in relation to putting service users at ease.

Summary of findings

- Throughout the inspection, we observed that staff took the time to interact with people who used services and those close to them in a respectful and considerate manner. People's privacy and dignity was respected.

Understanding and involvement of patients and those close to them

- Staff recognised when people who used services and those close to them needed additional support to help them understand their care and treatment and enable them to access this.
- Staff communicated with people in a very understandable way so that patients understood the assessment of their condition and the care and treatment that staff had identified was needed. Treatment plans were explained to the patient and self-care was promoted.
- Staff demonstrated understanding and flexibility to meet family needs when planning care.

Emotional support

- People who used services were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Where required patients were referred to other support or counselling services.

Are services responsive to people's needs?

- The provider worked with other external stakeholders to plan co-ordinated services.
- Services were planned and delivered to take account of people with complex needs. There were arrangements to enable access to the service for people in vulnerable circumstances.
- People could access care and treatment in a timely way. Action was taken to minimise the time people had to wait for treatment and care.
- Systems were in place for the management of complaints, and there was evidence of improvements following complaints in most areas.

Service planning and delivery to meet the needs of local people

- The provider worked with external stakeholders such as Hull and The East Riding CCG's during the procurement and commissioning process.

- The CCG had worked to review pathways with CHCP CIC in areas such as bladder and bowel services to ensure the needs of patients were being met. The CCG and CHCP CIC were working in partnership to review key performance indicators and to enable patients to be seen and treated within 4 weeks.
- CHCP CIC worked with various partners across Hull such as Refugee Council, Asylum and Refugees in Hull, Humber All Nations Alliance seeking information and opinion on service design and delivery.
- The organisation participated in the Hull dementia collaborative to meet the aims of the government's 2020-dementia challenge. There were a number of objectives to identify MDT pathways to ensure people and families living with dementia received person centred and responsive care.

Meeting needs of people in vulnerable circumstances

- The tuberculosis (TB) team found ways of reaching vulnerable groups such as asylum seekers, refugees and migrants and were working in partnership with Open Doors offering new entrant TB screening as a drop in session. The uptake of the screening had proved to be very positive with trends showing ethnic/gender groups were more likely to uptake screening.
- The Wellbeing Service worked in partnership with primary and secondary health care services, voluntary organisations and health promotion, to promote annual health checks for people in Hull who had learning disabilities. Links to easy read resources had been developed and were available through the organisations website.
- The end of life service was extending its support to hard-to-reach groups by liaising with specialist healthcare services. The service was developing links with the Huntington's Disease Nurse Specialist and cardiovascular specialist nurses linked into palliative care and joint care planning with the Macmillan team.
- The annual report for looked after children 2015/2016 outlined the scope and needs of looked after children in Hull. Between April 2015 and March 2016, 53% of children received an initial health review within the statutory requirement of 28 days and 80% of review health assessment. The report recommended that work should be undertaken to improve the timeliness of notifications from the local authority when children became looked after. This was on the risk register for the children's service.

Summary of findings

- The community adult service had implemented the role of the complex case manager. Their role was to provide care to patients where the care and treatment required was complex. Staff were available 24/7 through different shifts.

Access to right care at the right time

- The percentage of end of life care patients or carers receiving a visit within seven days of the initial referral from April to August 2016 was 95%. The monthly target was 98%. However all patients in need of an urgent referral received a visit within two hours.
- Referral to treatment times in community adult services were being met in most areas.
- Hull Clinical Commissioning Group had a local measure of four weeks for referral to treatment for vasectomy patients, 46% of patients were seen within this timeframe, and this was an improvement trajectory rather than a fixed target. Ninety five percent of patients had been treated within 18 weeks.
- Paediatricians were meeting national indicators of 18 weeks to see children with medical conditions and developmental delay. In the three months prior to inspection, the time from initial referral to treatment was nine weeks.

Learning from complaints and concerns

- Information from NHS Hull CCG showed there had been four formal complaints received for CHCP CIC since 25 July 2016. All these complaints were regarding decision making for Continuing Healthcare, which follows a National Framework and national operational model.
- CHCP CIC provided monthly reports to local commissioners regarding the prevalence of comments, compliments, complaints and concerns (4C's). The volume of 4C's reported by CHCP CIC had reduced from 128 per month in 2014/15 to 37 per month in 2016/17. In August 2016, the type of 4C received was largely positive with 32 compliments, 8 concerns, 6 complaints and 1 comment.
- We looked at five complaints. There was evidence of support and an apology. Investigations were thorough and there was change and learning documented in all five complaints.
- Patients received a Your Views Matter Card to gain their feedback and a complaints guide.
- Themes form complaints were discussed at Care Group meetings and the Quality and Safe Care Group.

Summary of findings

Are services well-led?

- There was a clear strategy and vision for the service with clear links to the overall organisation strategy, which most staff understood.
- Senior leaders were aware of the challenges to good quality care and could identify the actions needed to address them. Leaders were visible and approachable. There were supportive relationships amongst staff. The staff engagement strategy was well developed and embedded in core services.
- Culture was centred on the needs of people who used the service. Staff were proud of the difference that they made to people's lives and how well teams worked together to achieve this.
- The view and experiences of people were gathered and acted on to shape and improve services. Services achieved high levels of patient satisfaction.

However

- Although there was a governance framework to support the delivery of the strategy and good quality care, some areas such as clinical audit, effectiveness, and measures to identify escalating risks required further improvement.
- Governance meeting minutes, showed evidence of review of incidents, complaints, and risk registers. Actions were agreed and there were mechanisms for ensuring follow-up actions. However, in children's services we found that the risk register had been under review and mitigated for two years without progress. Staff in this service reported that when issues were identified, responses were slow. Action plans from meetings did not clearly identify timescales, responsibility or how learning was shared.

Leadership of the provider

- There had been changes to the leadership structures, following the integration of care groups. An executive board led the company with a care group director responsible for each of the integrated service areas.
- The medical director had recently become an executive director with a seat on the executive board and had a commitment of four days a week. The director of nursing had retired; the CEO was currently the acting professional nursing lead on the Board.
- The Company Secretary had on average a 5.5 hours per month contract and was responsible for establishment and advice of the corporate governance arrangements including the Articles of Association.

Summary of findings

- Staff we spoke with said the chief executive was approachable and communicated well with staff at all levels. Staff told us the executive team were well informed and supportive. Staff said they felt comfortable speaking with members of the executive.
- There were two non-executive directors (NED) on the Executive Board. We found the NEDS were clear about the issues that needed challenge, and about holding the CEO and directors to account through the remuneration committee. Both were aware of the issues facing the company and the current challenges.
- The CEO was the executive director for children at Board level.
- There was a learning and workforce development strategy, this was monitored through the business plan and reported to the executive board.

Vision and strategy

- The organisation's values were service and excellence, equality and diversity, creativity and innovation and co-operation and partnership.
- Corporate objectives reflected the organisation's corporate mission and values and included five overarching strategic goals with target dates.
- The organisation's business plan for 2016-2017 contained four quality and integrated governance team corporate objective plans and actions, measures and deadlines.
- Most staff understood the organisations vision and values.

Governance, risk management and quality measurement

- Overall responsibility for the management of risk and clinical governance was with the Chief Executive as the Accountable Officer who signed the annual Statement on Internal Control. The CEO also acted as the organisation Chief Quality Officer (CQO), working with and supported by a senior management and leadership team who formed the Quality and Safe Care Group.
- The integrated governance strategic framework was relatively new and developed in June 2016. It set out the framework for the monitoring and delivery of CHCP CIC's strategic objectives. The framework was supported by policies and guidelines, which ensured that processes were followed and implemented internally and externally.
- The Quality Monitoring Programme was the organisations chosen approach to demonstrating adherence to the Essence

of Care benchmarks developed by the Department of Health. Scores submitted by service area for 2016/17 showed good complaince against most targets. However some areas did not participate in all the benchmarks.

- The Operations and Quality Board received the key integrated business intelligence information, which provided the current position with regard to performance in the company, and was in line with the Boards Terms of Reference.
- The Executive Board received information on areas identified as high risk and assurance reports from the main services who dealt with these through local governance systems. The Safe, Quality Services Committee reviewed risks, which were mapped through the company risk register. This Committee had overarching responsibility for risk and referred any significant risks to the Executive Board.
- As the structure of a single Board Assurance Framework did not meet the requirements of CHCP CIC, risk was managed through the Integrated Governance Strategic Framework. Each associated company had a bespoke governance framework with exceptions reported to the Board for assurance.
- There were various governance and risk committees such as infection control, health and safety, information governance and clinical effectiveness. Each committee had specific terms of reference to monitor and assure that services were delivered safely and effectively. There were plans in place to refresh the committee and reporting mechanisms from the care groups.
- Governance meeting minutes, showed evidence of review of incidents, complaints, and risk registers. Actions were agreed and there were mechanisms for ensuring follow-up actions. However, in children's services we found that the risk register had been under review and mitigated for two years without progress. Staff in this service reported that when issues were identified, responses were slow. Action plans from meetings did not clearly identify timescales, responsibility or how learning was shared.
- The medical director recognised that there are some gaps in governance particularly around clinical audit and this was being reviewed. When informed of the insulin incidents in adult services, the medical director acknowledged this was not the first insulin related incident and that he was looking into this element of service. There were no clinical dashboards to alert around concerns in front line teams or triggers to identify escalating issues.

Summary of findings

- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care was delivered and to achieve transparency and overall improvement in healthcare. CHCP CIC achieved 100% of CQUIN targets.
- There was a lessons learnt forum, which included sharing of lessons from HR cases, patient complaints, safeguarding, and security and information governance. Any risks were escalated to the Safe, Quality Services Committee.
- Non-Executive Directors (NEDs) were able to describe the systems and processes to give them assurance about the monitoring and reporting of quality and safety. They felt they could ask questions and challenged the Board where issues were raised or assurance was unclear.

Culture within the provider

- The CEO attended staff meetings in the different localities. There was a visible presence in services of the senior leadership team.
- Staff spoke positively about the culture of the organisation and of their own services. Staff said their colleagues were patient focussed, professional and pleasant to work with. Staff felt there was an open, friendly and positive culture.
- Staff were enthusiastic and passionate about the service they provided and the quality of care they gave to patients and their carers. Staff told us they felt most proud of the difference that they made to people's lives and how well the disciplines worked together to achieve this.
- Most staff felt communication from the Executive Board had improved and that they were listened to and valued.
- The recent changes to services had contributed to low morale in some areas of community adult services. This was highlighted on the risk register and managers were aware of the issues around low morale in the teams.
- 96% of staff said they would know where to raise concerns about bullying and harassment.

Fit and proper persons

- There was a Fit and Proper Persons Policy, which set out the process and responsibilities under Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors are fit and proper to carry out this important role.
- Following discussions with the Director of People and Engagement and Deputy Chief Executive, it was identified that the pre-employment checks in relation to Fit and Proper in

respect of Directors and Non-Executive Directors had not been completed. The rationale for this was that all Directors were in post prior to Regulation 5 coming into effect in November 2014 therefore only the annual declaration was circulated for completion. The HR department was rectifying this and had already gone some way in ensuring all the searches were conducted and evidenced on the files.

- We looked at all the executive and non-executive director (NED) employment files. The annual candidate declaration of fitness forms was completed. There was evidence of Disclosure and Barring Service (DBS) checks.
- In the non-executive files, there were no references. However, we were informed that as part of the transitional arrangements, the then PCT interviewed and appointed interim NEDS and references were completed. Also in 2013 when the Articles of Memorandum and Association which varied the number of NEDS, the revised NEDS came up for re-appointment and where subject to a formal interview process. The Directors of CHCP CIC, a Shareholder Representative and an independent Chief Executive of another Social Enterprise conducted this. This tested their competencies and examined performance for the proceeding three years. Therefore, the two current NEDS were appointed.
- Director's details were subject to Companies House.

Staff engagement

- There was a well-developed employee engagement and strategy plan 2015/2016.
- The 2015/2016 colleague survey showed that 90% of staff said they would be likely to recommend the service to their family and friends should they need care and treatment.
- Staff received a weekly email communication to update them on current business activity and events and local and national policy. There was an Intranet forum site for staff to pose questions to the Chief Executive.
- Staff involvement was created through the opportunity for staff to send ideas and suggestions directly to the Chief Executive through an area on the intranet site where staff could post suggestions and comments about improvements they would like to see or that would make their role/job better.
- Staff were given the opportunity of co-ownership of the organisation and 77% of staff were shareholders.
- In addition, there were dedicated time slots for staff to call the Chief Executive directly on his mobile with any queries, concerns or suggestions.

Summary of findings

- A staff charter defined the values of the organisation and a set of expectations (what staff can expect from CHCP CIC and what CHCP CIC can expect from staff). These values were linked to the recruitment and induction process to ensure new recruits understood the culture and values of the organisation and the context in which they were working to support staff engagement.
- A shareholder forum 'It's everybody's business' was held three times a year and was attended by shareholder representatives from each core service area along with the CEO and Directors of CHCP CIC to provide an opportunity for staff to influence key decision makers and take responsibility for the direction of the organisation.
- Improvements to quality and innovation were recognised through an internal staff award scheme and the nomination of staff for external awards. For example, the Hull FIRST team received an external award in 2016.
- The organisation's quality accounts for 2015/16 gave details under "Sharing and celebrating our successes" of awards and national recognition achieved by staff. Staff in a focus group spoke positively about the organisation's approach to the support of innovation and best practice. For example, they had attended "Innovation and best practice brunches" which provided a setting for teams to share ideas and ways of working using a speed presentation format.

Public engagement

- A quarterly performance report prepared for commissioners gave information about patient experience activities, which included the results of national surveys including FFT survey results. For the previous 12 months, the organisation was in the middle 60% when compared with similar services nationally. Results were fed back to services for action where appropriate.
- Following feedback from patients, the service had worked with Hull and East Riding Institute for the Blind to make the National Family and Friends Test more accessible for people with a visual impairment. This included designing an accessible version of a printed card to make it easier for patients to complete by hand, visual awareness training for staff, changes to the provider website including screen readers, zoom functionality and inverted colours.
- The wellbeing team had recruited two volunteers with learning disabilities to join the team. The learning disability training which the team provided to organisations across the city had

received positive feedback. This service aimed to address the physical health inequalities experienced by people with a learning disability, to raise awareness of these issues, reduce stigma and increase social inclusion.

- The CHCP CIC stakeholder survey 2015 showed that over 80% of stakeholders (commissioners, partners, and voluntary and community groups) agreed that CHCP CIC was a provider of excellent health care services (based on a 17% response rate). However, over 20% of schools did not agree. In response to the question of what CHCP CIC should improve over the next three years schools identified more doctors for community paediatric services and early help, keeping staff with the same school.
- CHCP CIC worked in partnership with the commissioners and other healthcare providers to provide a medical, health and social care academy with a local sixth form college. This allowed local students to develop key skills and encourage them into healthcare careers in the local community.

Equalities and Diversity – including Workforce Race Equality Standard

- The Equality and Diversity Annual Report (2015-2016) detailed the activities and work carried out by CHCP CIC to enable the organisation to demonstrate its commitment to the equality and diversity agenda.
- The Equality Strategy explained CHCP's CIC commitment to promote equality in accordance to the Equality Act 2010 and the public sector equality duty. The strategy included the organisations strategic objectives and the organisations values. The strategy was refreshed three yearly and included an action plan which was reviewed annually with the equality steering group monitoring its progress on a quarterly basis.
- The Equality and Diversity Steering Group monitored the Equality Strategy action plan and completed the Workforce Race Equality Standard (WRES), the results of which were published on CHCP CIC website.
- CHCP CIC was successful in gaining the Investors in Diversity Award at stage 2, an award obtained through the National Centre for Diversity (NCF). The award was received following the organisation completing a number of activities and assessment by the NCF. The activities were identified through an action plan, which was managed and monitored through a working group, which fed into the equality steering group.
- 98% of respondents in the 2015 Staff Survey said that CHCP CIC acted fairly about protected characteristics.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director

Team Leader: Helena Lelew, Care Quality Commission

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

Information about the provider

City Healthcare Partnership CIC (CHCP) is a co-owned for better profit business providing a wide range of health and care services across numerous geographical areas including Hull and East Riding. CHCP CIC, previously NHS Hull provider services, officially formed on 1 June 2010 as an independent health services provider separate to the commissioning organisation, NHS Hull. The organisation now provides services from various locations with an income of about £78.4 million, and employs more than 1,400 staff.

It provides services to a population of over half a million. Key performance indicators for 2015/2016 showed there were:

- 39, 744 attendances in urgent care services
- 100% of patients were seen and treated within 4 hours in the minor injury units
- health and social care team supported 99% of patients preferred place of death at the end of life
- sexual and reproductive health services delivered 52,614 advice, testing and treatment appointments

Summary of findings

- 1,560 patients were seen and treated by the cardiology and cardiac rehabilitation services.

What people who use the provider's services say

- Feedback from patients and their relatives was continually positive about the care they received.
- Patients felt supported and said that staff really cared about them. Patients told us they were happy with the service they received and said staff were friendly towards them.
- Patients and their relatives and carers told us they appreciated their assessment, care and treatment. They told us staff explained things to them well so that they understood the relevance of the diagnosis and treatment they received.

Good practice

- Urgent care services participated in a recently established falls response pilot scheme with the ambulance service, fire and rescue and other health services. Emergency care practitioners (ECPs) based in urgent care provided the clinical input and had trained ten fire officers involved in Hull FIRST. Where a clinical assessment or medical treatment was needed following a fall, ECPs worked with other clinicians at the patient's home or at the scene of the fall incident to help avoid unnecessary transfer to hospital.
- The End of Life Academy attracted staff from a variety of specialisms and services in the area to increase their skills and understanding of needs at the end of life. Following an article appearing in the Macmillan publication Mac Voice, the service has received enquiries from around the UK about end of life educational delivery.
- The End of Life service had established one of six national pilot sites of integrated community end of life services based on the Motala model in Sweden. This model sought to provide direct care and support to patients in the last 12 months of life to prevent unnecessary hospital admissions and enable them to live at home and die in the place of their choice. This was achieved through early referral, home-based clinical intervention and close collaboration with community based services including primary care. The service had achieved 100% for a patients preferred place of care.
- The sexual health service was in the process of piloting a Skype clinic with community gynaecology patients and was planned to expand to male sexual dysfunction and HIV clients. This reduced the need to attend face-to-face appointments and lowered barriers to access.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Importantly, the provider must:

- Ensure that there is assurance processes for Abortion Notification Forms HSA1 completion and HSA4 submission to the Department of Health within the legal timeframe of 14 days.
- Implement a surgical safety checklist for vasectomy patients.
- Ensure patients are informed that their anonymised data from HSA4 (notification for pregnancies terminated) forms is shared with the Department of Health (DH) for statistical purposes.

The provider should:

- Ensure there are processes to formalise arrangements for access to a specialist palliative care consultant 24 hours a day.

Summary of findings

- Review the Incident and Near Miss Policy to ensure that it clearly defines the triggers for implementing duty of candour; and that staff are aware of the triggers to implement duty of candour.
- Ensure effective systems and processes so that lessons learnt from incidents are shared with staff groups consistently.
- Review assurance and clinical auditing systems to effectively identify, monitor and mitigate risks.
- Ensure that all services are undertaking audits to assess compliance with evidence based guidance from the National Institute for Health and Care Excellence.
- Ensure that all staff have completed the level of children's safeguarding training relevant to their role.
- Review how wait times for termination of pregnancy patients are monitored against DH requirements of 5 working days from referral to consultation and 5 working days for consultation to treatment to provide assurance that extended waiting times are due to patient choice or appropriate clinical delay.
- Consider providing patients attending for medical abortion a time alone with the assessing nurse or consultant to give them a private opportunity to disclose any concerns regarding abuse or coercion.
- Continue to work with social care to ensure that processes are in place to meet the statutory requirement of providing an initial health assessment to all looked after children within 28 days.
- Ensure consultation rooms in urgent care services have signage to show when rooms are occupied.
- Ensure that lone worker applications for staff during home visits are used consistently and in line with organisation policy.

City Health Care Partnership CIC

Detailed findings

Are services safe?

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

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

Summary of findings

- Most staff understood their responsibilities to raise concerns and use the mechanisms to record safety incidents, concerns and near misses.
- There were processes to ensure adults and children were safeguarded from abuse. Staff understand their responsibilities and followed safeguarding policies and procedures.
- Staffing levels, skill mix and caseloads were planned and reviewed to ensure patients received safe care and treatment. Most areas had sufficient staffing levels. Medical staffing in end of life care services did not meet national guidance; however, actions had been taken to mitigate the risk.
- All areas were clean. Most staff followed the 'arms bare below the elbow' national hygiene guidance; however, some staff in community health services for children, young people and families were not following this guidance.
- There were systems and processes to ensure that risks to patients were monitored and appropriate action was taken.
- Some of the root cause analysis reports from incidents in Community Adult services were not fully completed.
- Not all staff in integrated sexual health services or children young people and families were meeting the safeguarding children level 2 and 3 training targets.

Our findings

Incident reporting, learning and improvement

- Community services reported no never events between September 2015 and September 2016.
- The quality and integrated governance report in September 2016 highlighted data and information about incidents, trends and themes. The report identified that pressure ulcer incidents were high and that the organisation had identified concerns around missed medications in community services.
- A root cause analysis (RCA) tool was in place for pressure ulcers. This included a three-stage process to complete the tool. The stages were react, record and respond. A number of headings were included within these stages such as clinical and physical factors,

assessment or contributing factors. The respond stage had a section for lessons learnt with the action taken and a date for completion. We looked at four root cause analyses relating to pressure ulcers which were mostly completed, however these had not been signed off or did not have the lessons learnt section fully complete, for example the action to be taken.

- There were 22 incidents reported in urgent care services, between April and September 2016. Incidents were categorised according to type of incident and represented a variety of causes. The most frequently occurring category was security, with five incidents.
- Care Group one reported 39 incidents between October 2015 and September 2016. There were 29 no harm incidents, five minor harm and five moderate harm incidents. Themes and trends resulting from incidents were monitored and discussed at the Care Group One Safety and Quality Forum. The care group reported an average of 128 incidents a month of which a monthly average of 61 were directly related to internal services. The remainder were attributed to external agencies such as the GP and staffing agencies. End of Life services reported 13 incidents from April to September 2016 that were directly related to their service. The most common theme was around communication about night sitter arrangements.
- The integrated sexual health service reported 42 incidents between October 2015 and October 2016. There were no particular themes. Two of the incidents were in relation to the termination of pregnancy service.
- There were 57 incidents had been reported in children's services, between October 2015 and September 2016. There was one catastrophic incident related to a child death. Of the incidents graded as no harm and negligible, most frequently they were reported as information governance issues. Communication and information governance issues accounted for 45% of incidents overall. Senior managers were aware that this was a concern, but it was not recorded as a risk for the service at a local level but was included on the corporate risk register.

Duty of candour

- The Incident and Near Miss Policy included guidance on the application of the duty of candour and training was included in the information governance-training module. However, the guidance did not clearly define the trigger for implementing the duty of candour. Staff we spoke with did have a broad understanding of the need to be open and honest but were less clear about when the duty of candour would be applied.
- In end of life care we were given six examples of where duty of candour had been applied; however, of these incidents, four did not result in patient harm but were related to the management of night sitters and two were related to pain control. It was not clear how these incidents had been identified as requiring duty of candour.
- A Quality Management and Performance (QMP) dashboard showed that 3 out of 5 sexual health staff audited could describe the circumstances when duty of candour would be triggered.
- During the reporting period from 1st April 2015 there were 8 incidents reported within children's services that required a duty of candour response, and evidence was provided.

Safeguarding

- There was a safeguarding children team. The team consisted of a named nurse for safeguarding children, four specialist nurse practitioners, a safeguarding trainer and three administrative staff. The named nurse also acted as the designated nurse for looked after children.
- The local clinical commissioning group provided medical provision for the safeguarding team.
- There was an established process of referrals to social care, so the safeguarding team had an oversight of referral rates and individual cases.
- The team had a specialist role in training, supervision, advice giving and representing the team/organisation on specialist panels such as MARAC (multi-agency risk assessment conference).
- The children's team provided level 2 and 3 training for staff, in line with the Royal College of Paediatrics and Child Health intercollegiate document. Most staff had received safeguarding training at the level appropriate to their role however there were some areas such as sexual health /termination of pregnancy and in children and young people services where targets for level 3 children's safeguarding was not meeting targets. December 2016 data showed 25% and 66% for children safeguarding, 2 and 3 respectively for integrated sexual health services.

Are services safe?

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

- Staff across children's services received quarterly safeguarding supervision, in line with national policy recommendations. Staff could also access additionally supervision from the safeguarding team.
- The organisation had policies and procedures for staff to follow for cases of female genital mutilation (FGM) or sexual exploitation and staff were clear what actions they needed to take in this situation. There was an identified service for FGM and women could be referred into this or refer themselves.
- Data for Care Group One, which included End of Life Care services, showed the training level for adult safeguarding was 93% in September 2016. Safeguarding children training compliance was 95% for Level 1 and 94% Level for 2 in September 2016.

Medicines management

- Staff completed a non-medical prescribing passport to enable them to maintain a record of competence to practice in their specialist field of healthcare. The passport was reviewed at clinical supervision and development reviews by the line manager as evidence of staff competence. The passport was maintained as part of staff continuing professional development as required by the relevant regulatory bodies.
- Medicines were well managed. Policies for medicines management were in place and accessible to staff and symptom control medicines were prescribed using guidance from the regional prescribing committee. Staff were updated on medicines management by a CHCP CIC publication called 'Medicines Matter'. The pharmacy also issued Medication Safety Alerts when required.
- Community patients who were identified as requiring end of life care were prescribed anticipatory (or 'just in case') medications to manage symptoms that commonly occur at the end of life. These medicines were held in the patient's home and were available as and when needed. Having these drugs available meant that nurses could administer timely symptom relief and avoid the need for admission to hospital.
- The service ran a Specialist Palliative Care Clinic, which included input from a Macmillan nurse, Macmillan pharmacist and GP with a special interest in palliative care. Patients who were referred to the clinic for complex pain or symptom management received a medication review.
- Staff used a local joint formulary for primary and secondary care in Hull and East Riding. The joint formulary provided recommendations for drug treatments, and other approved treatments that may be prescribed by a specialist or on advice of a specialist. The formulary also provided information on the traffic light classification of drugs and linked to national and local guidelines.
- A quality and governance report in September 2016 had highlighted that there had been incidents relating to missed medication in community services. This had happened on four occasions in September 2016 and October 2016 with different reasons such as staff sickness and the patient list being across different sheets of paper. These trends were highlighted in the quality and governance report in September 2016 and the therapeutics and pathway group report for September 2016 to October 2016. The report highlighted that the service were going to review the processes around administration of medicines in community nursing.

Safety of equipment and facilities

- There were processes in place for the checking of equipment; Records showed that equipment safety checks were completed. In all services, there was adequate equipment to support the delivery of safe care.
- In end of life services CHCP CIC used one model of syringe driver device, which met the requirements for specific safety features. There was a policy and detailed protocols for the use of the device in order to reduce the risk of medicine administration error.
- Automatic external defibrillators, oxygen and analgesic gases were provided in the consulting rooms in the urgent care centres.
- In the 2015/2016 colleague survey 76% of staff said they had adequate equipment to do their work.
- At a previous inspection, there were concerns about a lack of confidentiality at the reception desk in the urgent care centre. The service had addressed these concerns and told us that privacy was seen as paramount. A notice about privacy was displayed at the reception and patients were given the option of speaking in a private area if they preferred.

Records management

- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient. Hard copy records were kept in the

homes of patients receiving end of life care and these were updated by visiting services such as the GP, community nursing and Macmillan services. Electronic records were updated either at the time of the visit or as soon as possible.

- Audits of records were completed in accordance with quality benchmarking standards used in the service and were undertaken by clinical team leaders. Feedback was provided for staff on the results of audit. Benchmarking data on record keeping showed that for all services in Care Group 1, services scored 87% and above against a target of 85%. In sexual health services, a record keeping audit for May 2016 showed compliance of 92%. The 0-11 service were benchmarked at 94% compliance, family nurse partnership team at 95%, and the 11-19 team was 93% compliant.
- Medical abortion information leaflets gave patients information regarding "How we use your Information". Although this explained that information would be shared for specific purposes it did not cover submission of HSA4 (abortion) data to the Department of Health.
- We reviewed seven Do Not Attempt Resuscitation (DNACPR) forms in the community and a further three in records held at the health centre. The responsibility for the completion of the DNACPR form was the responsibility of the GP and not of CHCP CIC. Of the ten forms reviewed, eight were completed fully. One DNACPR form was not immediately available; although it was recorded in the records as being signed, it was missing from the notes. Staff reported this to the team leader for follow-up.

Cleanliness and infection control

- There were two-experienced Infection Prevention and Control (IPC) nurse leads recently (October 2016) promoted to senior nurses following the change programme. Both were directly accountable to the Director of Infection Prevention and Control who was the Medical Director. The leads were establishing themselves into their new roles and maintaining the business required but recognised they did not yet have capacity to look at innovation.
- The IPC leads produced a rag rated performance report across various IPC domains and enabled benchmarking internally. All care groups received a report identifying any improvements. The management teams monitored action plans, which were followed-up by the IPC leads at a subsequent audit.
- The IPC committee was part of the integrated governance structure and reported to the Operations and Delivery Board up to the Board through performance reports and the annual report.
- Quality teams completed 12 IPC audits per year. The target was 85%, the majority of services showed they had met the target.
- Areas we inspected were clean. Most staff followed the 'arms bare below the elbow' national hygiene guidance; however, some staff in community health services for children, young people and families were not following this guidance.
- IPC leads attended external networks to ensure they kept professionally up to date. Staff completed training in IPC. Data for September 2016 for Care Group 1, which included End of Life Care services, showed 84% of staff had completed IPC training against a target of 85%. Average completion rates for community services adults was 83.9%. The 0-11 children's service achieved 93%.

Mandatory training

- There was a programme of mandatory and statutory training available for all staff, which covered areas such as moving and handling, basic life support, safeguarding, information governance and infection control. The target was 80%.
- Most services were meeting the mandatory training requirements; however, in end of life care 10 out of 16 modules had compliance rates over 80%. 88% of staff in children's services completed training as of October 2016. Most of the community adult services were achieving targets with the exception of moving and handling. Urgent care centre staff achieved all training targets with the exception of moving and handling. Training data for sexual health services/termination of pregnancy services indicated that there were some areas where training compliance was below target, such as practical moving and handling, prevent, safeguarding children levels 2 and 3 and adult safeguarding.
- Training for moving and handling was on the risk register due to CHCP CIC staff not being able to access training for six months from another provider due to the retirement of the trainer. An alternative provider and training sessions had been sourced and this was monitored.

Are services safe?

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

- All qualified nurses in the end of life services received syringe pump training and community nurses we spoke to confirmed that they had received syringe driver training.

Assessing and responding to patient risk

- An average of 86% of patients with an urgent need were seen and assessed in the urgent care service within two hours of direct referral April to August 2016. Performance in August 2016 was 100%. There was no stated target for this indicator.
- End of Life patients received a holistic assessment of needs through implementation of the advanced care plan including assessments for areas such as mobility, pain management and nutrition. Staff involved patients and those close to them when completing these assessments and made referrals to the specialist palliative care clinic when their expertise was required to manage complex symptoms.
- The anti-coagulation team had key performance indicators in place. New deep vein thrombosis (DVT) patients were to be seen within 24 hours and atrial fibrillation (AF) patients were to be seen within 5 days. Data the service provided was highlighted as being for care group three, data showed that the percentage of existing/initiation of DVT service users who were offered to be seen and assessed within 24 hours of referral was at or above the 95% target between November 2015 and October 2016.
- Specialist care was available seven days a week as the In-Reach team worked each weekend and was available to respond to changes in palliative care needs.
- In the urgent care service, we observed that the NHS Early Warning Score (NEWS) was available for use and information about this was displayed in patient consulting rooms. Clinical staff told us that although they were aware of NEWS, they were unlikely to use the tool in practice, as the patient was usually not in the department for long enough for this to be appropriate.
- For patients who were not suitable for treatment at the termination of pregnancy service on medical grounds or because gestation was over nine weeks there were referral pathways to the local NHS trust for surgical abortion up to 12 weeks or to another independent provider who provided termination of later pregnancy.
- Early Medical termination of pregnancy patients had a 24-hour helpline number to contact should they need advice or support following discharge from the service. The calls automatically went to the GP out of hour's service when their service was closed.
- The family nurse partnership undertook DANCE (Dyadic Assessment of the Naturalistic Caregiver Experience) assessments. This allowed the practitioner to assess mother and child interactions and provide interventions to promote outcomes.
- Staff used a range of risk assessment tools to assess and manage individual risks, for example, maternal mood assessments, safety assessments and pressure areas.
- Health visitors and public health nurses undertook a holistic assessment of children, which enabled them to identify risks and protective factors.

Staffing levels and caseload

- Macmillan nurse caseloads were usually 10-15 patients per specialist nurse but that this could increase to 20 patients. The nurses conducted up to four visits a day but this could occasionally increase to six visits per day.
- Caseloads varied amongst the different community health services for adult's teams. Some staff we spoke with told us that caseloads were manageable; however, this could vary from day to day. Some staff said on some days it could become unmanageable and caseloads could be large with a high number of patient visits. There were escalations processes for other community teams to assist if caseloads were high.
- We were informed that although no formal staffing model was in place, the approach used for staff planning was based on service demand and the skills of available staff. E-rostering was used for staff planning. Staff we spoke with confirmed they felt there were enough staff available in urgent care services.
- There were two whole time equivalent vacancies for community paediatricians. The organisation had been trying to recruit to these posts for two years. They had been trying to recruit as a joint post with the local NHS hospital as a more attractive position. However, the recruitment was still ongoing. Locum paediatricians covered the gaps in paediatric clinics. This was identified on the corporate risk register.
- The family nurse partnership team had caseloads of 20 families, per practitioner, against a commissioned 25 families.

Are services safe?

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

- Agency staff were used in some teams in community health services for adults, for example in the intermediate care team; they had two agency staff to support the team.
- Caseload management in district nursing was organised by aligning district nurses with specific GP practices, these GP practices would then become the district nurses caseload. Managers in nursing services told us that if a caseload becomes too big, the senior nurses would share the caseload out to other members of the team.
- Managers highlighted that staff retention was considered a risk, in particular recruiting to nursing and therapy services. Managers confirmed they were attending recruitment fairs to try to address this. The services had also considered skill mix of staff and developing certain roles, for example developing some band three roles into band four practitioner assistant roles.

Managing anticipated risks

- A business continuity/resilience plan was in place for services. This demonstrated how to respond to incidents and disruptions in order to continue operations at an acceptable level, for example adverse weather conditions, activity peaks and staff shortages.
- The provider had a policy to protect staff who may be lone workers. Staff had mobile phones with a lone working application. This was to be activated on each home visit; however, staff told us they did not use it if they were going to a visit where the family were known to the service.

Major incident awareness and training

- The urgent care service was one of a range of organisations involved in major incident awareness and training with police, fire and rescue and ambulance services. We saw that resilience planning was applied as part of the major incident plan for the city of Hull. Actions were rehearsed which included the mobilisation of medical staff and equipment for an appropriate emergency response. Recovery arrangements included an appropriate assessment of risk.
- Major incident awareness training was completed as part of staff induction.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

- Care and treatment was evidence based across the services that we inspected. Staff had access to policies and procedures and other evidence-based guidance.
- Patients had access to pain relief as appropriate. Care plans included assessments of nutrition and hydration needs and patient choices about their food and drink preferences.
- The organisation held Level 3 UNICEF baby friendly accreditation. The UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation.
- There was a telehealth service, which provided care, treatment and monitoring to people from a distance using electronic systems to communicate.
- Services reported on a wide range of performance indicators to commissioners. Information showed that most intended outcomes were being achieved for people who use services.
- Staff confirmed that learning and development was valued in the organisation. There was dedicated clinical training allocated to each care group to ensure that staff maintained their clinical skills.
- There was effective multi-disciplinary working across teams to assess and monitor on-going care.

Our findings

Evidence-based care and treatment

- End of life care needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines including Actions for the End of Life 2014/ 2016 (NHS England). The service referred to best practice tools including the Sheffield Profile for Assessment and Referral (SPARC), the Supportive and Palliative Care Indicator Tool (SPICT) and the Macmillan Clinical Nurse Specialist template.
- The cardiac rehabilitation team had been accredited because they were meeting the service framework required. This had highlighted some areas for improvement and an action plan was in place to address the improvements required. Most areas of the action plan were either complete or on track.
- Treatments for early medical abortion were given at 24 or 48 intervals, which was in line with Royal College of Gynaecologists (RCOG) guidance.
- Family nurse partnership was evidence based and preventative programme for vulnerable, first time young mothers. It was delivered from pregnancy until the child was two years of age. The service was delivered within a licenced programme, which was regularly audited, to ensure staff were delivering care within the well-defined and structured service model.

Pain relief

- There was clear guidance on symptom management and prescribing of anticipatory medicines for end of life patients. This was printed on the back of the medication administration record for ease of access. There were suggested medicines and doses to manage pain, restlessness, nausea and excess secretions as required and for administering symptom relief via continuous sub-cutaneous infusion. The information also included contact telephone numbers for advice on specialist palliative care drugs.

Nutrition and hydration

- The electronic system used by the district nurse teams and other specialist nursing services allowed staff to complete information on dietetics. Staff were able to refer patients to dietetic services if requested or required.
- The advanced care plan included assessments of nutrition and hydration needs and patient choices about their food and drink preferences. Patient records showed completion of the malnutrition universal screening tool (MUST) risk assessments.
- The organisation held Level 3 UNICEF baby friendly accreditation. The UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships.

Use of technology and telemedicine

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The anticoagulation clinic used telehealth. Patients could submit their information by telephone and the anticoagulation team would respond meaning care was provided without a clinic visit.
- There was a telehealth service available for cardiac and respiratory services. This service provided care, treatment and monitoring to people from a distance using electronic systems to communicate. Patients using the telehealth service received the equipment they required to access and use the service, for example an electronic tablet computer or a blood pressure machine.

Approach to monitoring quality and people's outcomes

- Services reported on a wide range of performance indicators to commissioners. Information showed that most intended outcomes were being achieved for people who use services.
- There was a process form monitoring, auditing and benchmarking the quality of services and the outcomes for people receiving care and treatment. However, the clinical audit programme required further development.
- The organisation undertook some benchmarking reports against the five Essence of Care Standards (2001). These measured compliance for record keeping, communication, care environment, which include infection control, promoting health and well-being, privacy and dignity, and safeguarding patients. However, services did not provide data for all the benchmarks.

Outcomes of care and treatment

- The target for end of life care patients seen within 10 days of referral to the specialist palliative care clinic was 95% and the service achieved 98% from April to August 2016.
- The target for the number of patients who achieved their preferred place of care where their preference was stated during the reporting period was 60%. The service achieved 100% from April to August 2016. Ninety nine per cent of all patients referred to the End of life services in 2015/2016 achieved their preferred place of care. This outcome was monitored on a monthly basis.
- Community services for adults participated in the 2014 national intermediate care audit. Results from the audit highlighted that the intermediate care service scored above the national averages in a number of areas, however information given to patient was 83.3% and patient involvement in goal setting was 50%; these were below the national averages.
- No vasectomy patients had suffered complications between April 2016 and September 2016. And two were referred to secondary care.
- Uptake of primary immunisations in the year 2015/16, were 97%. This was above the England average of 94%. Immunisation rates for MMR were comparable with the England average at 97% for first dose and 91% for the second dose uptake.
- Flu immunisation uptake was 59%. Uptake of the HPV vaccine was 79% for first dose and 72% for second dose, which was below the England average of 86% in 2013/14.
- The anti-coagulation team had key performance indicators in place. New deep vein thrombosis (DVT) patients were to be seen within 24 hours. Data for care group three showed that the percentage of existing/initiation of DVT service users who were offered to be seen and assessed within 24 hours of referral was at or above the 95% target between November 2015 and October 2016.

Competent staff

- Staff received an annual appraisal. The rates for community services ranged from 100% (End of Life Care) 88% (Urgent Care Service) 86% (Community Adults) 88% (Sexual Health) 88 % (Children and Young People).
- The Macmillan practice development nurse specialist led the development of the End of Life Care Academy that provided a structured programme of educational sessions to nurses, pharmacists, therapists and health care assistants. The academy ran the programme three times a year, was aimed at registered nurses, and allied health professionals; it was recently extended to healthcare assistants.
- In urgent care services, all staff received regular supervision. The clinical adviser for urgent care undertook clinical supervision; for example, clinical team leaders received a clinical assessment of their practice.
- All staff in community adult services completed a four-day induction programme. A competency based

induction pack was completed and signed off by a mentor once the member of staff was deemed competed. Newly qualified staff were supported through a six month preceptorship.

- Registered Nurses in the sexual health service had received training regarding family planning and sexually transmitted infections. Recently appointed staff completed the Faculty of Sexual and Reproductive Healthcare's (FSRH) electronic Knowledge Assessment (eKA) which assessed a candidate's theoretical clinical knowledge.
- The children's community team developed their competencies in partnership with a local NHS hospital trust. Staff were able to access training materials online, attend teaching sessions and there were opportunities to work in the trust. For example, to develop specialised skills in oncology, this promoted opportunities for children to receive treatment at home.
- Staff confirmed that learning and development was valued in the organisation. The lead for learning and development had been in post for over two years and said they had not seen a reduction in the training budget. There was dedicated clinical training allocated to each care group to ensure that staff maintained their clinical skills.
- As part of the organisational change for 0-19 year's Public Health Nursing Service contract, staff had been supported with additional training. Identification of training needs was recognised as an importance, to continue to provide evidence based service to support children and young people within Hull. Staff recognised that some knowledge and skills were lacking in areas such as 5-11 years. The Health visitors continued to be supported in the 0-11 year team by Public Health Nurses, and identified that they needed specific knowledge to support their clinical decision making when referrals were being triaged as part of the wider duty role.
- Public Health Nurses had training planned to continue to support them during the re-organisation. This was done in conjunction with the changes to SystmOne and their responsibilities around caseload management. Health visitors were providing individual caseload supervision to support the safeguarding workload they had.

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

- The end of life service multidisciplinary (MDT) team included Macmillan nurses, palliative care GPs, pharmacists, occupational therapists and a physiotherapist. There was daily communication between the Macmillan team and community nursing, GPs, care homes and specialist nurses.
- The urgent care service worked with the local acute trust in referring patients for treatment following assessment, where this was appropriate, including for example physiotherapy and mental health services. The service was able to refer patients to the local acute hospital services using agreed pathways and urgent care practitioners had admitting rights for certain agreed services.
- The intermediate care team attended multi-disciplinary team (MDT) meetings once each week at the bedded units they provided care. These MDT meetings consisted of a consultant, physiotherapist, occupational therapist, social services, unit manager and an intermediate care nurse.
- Occupational therapists worked closely with the physiotherapists and nursing teams to provide a multi-disciplinary team approach to care.
- As part of the Hull Integrated Sexual Health Service, the service worked in partnership with other agencies who delivered the preventative services within Hull. As part of this arrangement, staff told us they delivered a holistic service to working women within the Saunas and Parlours service providing accessible prevention advice, support and screening and contraceptive services.
- Health visitors worked towards joint assessments with nurseries for two and three year olds to promote readiness for school.
- The adolescent team had developed good working relationships with agencies to ensure looked after children were prioritised.

Referral, transfer, discharge and transition

- There was single point of access for end of life care patients and carers to access the palliative care team 24 hours a day, seven days a week. This meant that one telephone number could access eleven different referral routes. At the time of inspection, community-nursing staff covered weekday nights and weekends but a 24-hour seven-day call centre service was being considered.
- The intermediate care team had referral criteria in place, patients who were over 18 and registered with a local

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general practitioner could be referred to the service. The team had a key performance indicator (KPI) for ensuring service users were seen and assessed within two hours following a referral from an ambulatory care or frailty unit. The target for this was 95% and the service achieved 100% between April 2016 and November 2016.

- Patients were able to access termination of pregnancy series every day except a Saturday. The service provided 24 hours per day and seven days a week advice line for post-abortion support and care, which was in line with Required Standard Operating Procedures set by the Department of Health.
- We were told of examples were there had been problems with communication between midwives and the 0-11 teams. Community children's nurses told us of examples where there were difficulties in transferring children with long-term conditions into adult services. There was a transition pathway in place.

Availability of information

- Staff accessed policies, procedures and guidance through the organisational intranet.
- The integrated care teams, which included district nursing, complex case managers, and the intermediate care teams had access to laptops for mobile working with access to the electronic care records for patients. These had been recently implemented. There were some connectivity issues when staff were connecting to access the systems and not all care plans were currently on the system.
- The single point of access service received and coordinated all referrals and enquiries to ensure information was sent to the relevant part of the service. They had full access to the electronic management system.
- Clinic letters from integrated sexual health services and community gynaecology clinics were typed by a subcontracted service. The turnaround service was one to two days, then letters were checked by the consulting doctor before being sent by post to GPs.

Consent

- Children and young people were involved and supported by staff in making decisions about their health care and treatment. Staff demonstrated good knowledge of relevant legislation about consent, for example applying Gillick competencies and Fraser guidelines for children and young adults.
- Care records reviewed for termination of pregnancy and sexual health services contained signed consent from patients. Possible side effects and complications were recorded and the records showed that these had been fully explained. Patient information gave the complication or failure rates of each type of treatment and this was discussed with patients.
- There was access to guidance and policies for staff to refer to concerning Mental Capacity Act (MCA). Staff we spoke with told us they had received training regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) which was delivered as part of protection of vulnerable adults training.

Are services caring?

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

Summary of findings

- Feedback from patients and their relatives was continually positive about the care they received.
- All staff consistently communicated with patients in a kind and compassionate way, treated them with dignity, and respected their privacy.
- Staff created a strong, visible, person-centred culture; they were highly motivated and inspired to offer the best possible care to patients. Patient's emotional and social needs were valued by staff and were embedded in their care and treatment.
- Patients were involved and encouraged to be involved in their care and in making decisions. They received sufficient information in a way they could understand.

However

- In the termination of pregnancy, service staff did not inform patients that their anonymised data from HSA4 (form of notification for termination of pregnancy) forms were shared with the Department of Health for statistical purposes.

Our findings

Dignity, respect and compassionate care

- The organisation participated in the friends and family test (FFT) survey. The most recent results from the Friends and Family Test for sexual health services showed 96.2% of patients would recommend the service.
- Results between April 2016 and September 2016 for community nursing scored 99% of people who would recommend the service. There were 445 respondents. FFT for the intermediate care team between April 2016 and September 2016 was positive with a score of 100% of people who would recommend the service. There were 94 respondents.
- Community children nursing showed 100% of people would be 'extremely likely' to recommend the service from 32 responses. Out of 57 responses, 93% would be 'extremely likely' to recommend the community paediatric service. Out of 56 responses, 60% would be 'extremely likely' to recommend the health visiting service and 42% of 137 responses to school nursing would be 'extremely likely' to recommend the service to a friend or family.
- We observed a very caring and compassionate approach from all staff during their interactions with patients and family members. Patients were addressed appropriately and their dignity protected.

Patient understanding and involvement

- In all services, patients were encouraged to be involved in their care. Staff spent time listening to patients and their relatives and carers. Staff communicated in a way so that patients understood the assessment of their condition and the care and treatment they required. Treatment plans were explained to the patient and self-care was promoted.
- Family members were supported in understanding and managing end of life care symptoms by being involved in discussions with members of the specialist palliative care clinic team during their assessment of the patient at home.
- Health care assistants involved family members while providing physical care to the patient and were sensitive in their interactions while explaining what care they were providing.
- Young people were supported in making decisions. Staff spoke with young people sensitively about sexual health needs. During consultations for termination of pregnancy, staff explained all the available methods for termination of pregnancy that were appropriate, depending on the gestation of the patient's pregnancy and their clinical assessment. Nurses provided verbal information about what to expect following each appointment and encouraged patients to contact the clinic if they were worried or concerned.

Emotional support

- Children and families were provided with emotional support from the services. Staff could refer children to child and adolescent mental health services if more specialised support was required.
- Staff helped patients and their relatives and carers to cope emotionally with their care and treatment. We observed staff as they provided emotional support to patients and their relatives and carers in the health centres and during home visits. For older patients with some cognitive impairment, staff provided reassurance.

Are services caring?

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- Staff in the intermediate care team and the community cardiac rehabilitation team used the hospital anxiety and depression scale to assess patients during their treatment. If the responses to the questionnaire raised concern, patients were referred to the local counselling service.
- Staff signposted or referred patients, to other organisations, that could offer practical help and support should a patient need them.
- Staff referred bereaved children to the family support team at the local hospice where they could receive art therapy and music therapy to assist in coping with the loss of a family member.
- Therapists offered alternative therapies to end of life patients including relaxation and massage techniques to support symptom management. They also offered guidance on fatigue management.

Are services responsive to people's needs?

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

Summary of findings

- The provider worked with other external stakeholders to plan co-ordinated services. There were examples of continuity of care and patient choice in delivering care and treatment.
- There were arrangements to enable access to the service for people in vulnerable circumstances.
- People could access care and treatment in a timely way. Action was taken to minimise the time people had to wait for treatment and care.
- Systems were in place for the management of complaints, and there was evidence of improvements following complaints. Responses to complaints met timescales.

Our findings

Planning and delivering services which meet people's needs

- The use of the virtual ward model for palliative care patients meant that patients could be referred in by GPs, health and social care professionals, patients and family members and staff could monitor their condition and level of need using an electronic information board. This formed the hub for effective communication between community and specialist palliative care services
- At the time of our inspection, the urgent care service was in the process of further integration of community services in response to commissioner's requirements. Services based at Bransholme health centre were being extended to provide integrated urgent care seven days a week, 24 hours a day from April 2017.
- Treatment was carried out under NHS contracts with Hull and East Riding CCGs and Hull and East Riding City Councils (CCs) to provide a termination of pregnancy service for the patients of Hull and East Riding. The service also provided services for out of area patients as required, including students temporarily residing at the local universities and colleges. There was a process in place for recharging CCGs or CCs where necessary.
- The 0-19 children service had recently been reconfigured. Teams, which included health visitors and public health nurses, provided care for children up to 11 years old. This was to provide continuity of care for families, for example, families with older children who were receiving safeguarding support only had to work with one team of practitioners, rather than both health visitor and school nursing teams.

Equality and diversity

- There was an equality and diversity policy, which was accessible to staff on the intranet. Staff received training on equality and diversity as part of mandatory training, most staff in care group one had completed this training
- Staff could access interpreter services, including a face to face translation service. Staff who could communicate in Makaton (a language programme using signs and symbols to help people communicate) were available to help patients with these communication needs.
- The urgent care facilities we visited provided access for people with disabilities. We were informed that the buildings had been designed to provide disabled access. Wheelchairs were available at the front of buildings.
- Equality and diversity training was part of mandatory training and

Meeting the needs of people in vulnerable circumstances

- CHCP CIC had purchased an allotment and were planning a sensory nature garden for end of life patients and families to enjoy. The occupational therapy team were planning to offer container gardening and create a garden that offered a peaceful environment.
- The Carers' Information and Support Service (CISS) was a service dedicated to supporting carers. The service helped carer's to access respite breaks, register with their GP for assistance with arranging appointments and managing prescriptions, attend outreach sessions throughout the city and receive support over the phone.
- The service used the 'butterfly scheme' for recording patients with dementia. This raised awareness amongst health care professionals of patients with dementia.
- The public health team and the adolescent team could refer children to the specialist sexual health team for young people. The consultant in that team specialised in the care of young people and those with learning disabilities.
- Patients with mental health needs were referred to specialist mental health services during their triage or at

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

their assessment. Patients could be signposted to the Let's Talk service, which provided an initial level of support and signposting to crisis resolution, or other specialist mental health services.

Access to the right care at the right time

- Community paediatricians accepted referrals from health professionals, schools and social services. There was a referral criterion and a community paediatrician triaged referrals. The service was meeting national indicators of 18 weeks. In the three months prior to inspection, the time from initial referral to treatment was nine weeks.
- The end of life care service provided access to night sitters to enable family members to rest at night. These were arranged through the single point of access and the service was supported by a local staffing agency. Continuing health care funding supported patients to receive this service.
- The service had not yet implemented systems to reduce 'did not attend' (DNA) rates; however, managers confirmed they were considering implementing text message reminders to reduce 'did not attend' occurrences. The DNA rate for community nursing was 4.2% in October 2016; the DNA rate for long-term conditions for March 2016 was 2.7%.

Complaints handling and learning from feedback

- 33 complaints were received across community services.
- Staff we spoke with were aware of how to inform patients on how to complain about the service if necessary. Learning from complaints was identified at the adult and modernisation lessons learnt meetings. The organisation provided minutes from these meetings; however, these minutes were from June 2015.
- The quality monitoring programme document from September 2016 showed that 100% of complaints were investigated within the timescale agreed with the complainant between September 2015 and September 2016. The target was 100%.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

- There was a clear strategy and vision for the service with clear links to the overall organisation strategy, which most staff understood. In community adults services changes to care models had resulted in disruption to staff roles in some areas and the way in which teams worked. This was on the risk register and managers were aware of the issues around low morale in the teams. There was a programme of engagement with staff to share the strategy of the organisation.
- The organisation was aware of the impact on quality and delivery of services due to financial constraints and reductions in service provision by other health care providers. The Safe Care Quality Committee reviewed and monitored efficiency plans regarding quality.
- Leaders were visible and approachable. There were supportive relationships amongst staff. The staff engagement strategy was well developed and embedded in core services.
- Culture was centred on the needs of people who used the service. Staff were proud of the difference that they made to people's lives and how well teams worked together to achieve this.
- The view and experiences of people were gathered and acted on to shape and improve services. Services achieved high levels of patient satisfaction.

However

- Although there was a governance framework to support the delivery of the strategy and good quality care, some areas such as clinical audit, effectiveness, and measures to identify escalating risks required further improvement.

Our findings

Leadership

- Staff were positive about the support received at service level and also reported senior managers to be visible and approachable. Staff told us they could communicate directly with the chief executive if they had concerns and felt they were listened to.
- There was a clear management structure in place for each care group. Services had team leaders who reported to a service manager. The service manager then reported to the director of the care group. The director reported to the organisations senior management team.

Vision and strategy

- The end of life service had a clear vision of the quality of care that it wished to provide. Staff were very aware of this strategy and the aims of the service and talked about the impact of the specialist palliative care clinic and the virtual ward as two examples of integrated working assisting the patient to achieve their preferred place of care.
- CHCP CIC did not have a local strategy for end of life services as they formed a part of the strategy for end of life services across the city. This was under development at the time of inspection and led by the clinical commissioning group through the Palliative Care and End of Life Working Group.
- Staff were aware of the corporate values and felt particularly supported to achieve 'service and excellence' and 'creativity and innovation' through their work.
- Community health services for adults were going through a service model change during our inspection. The service was transferring from their previous service model of different services, with different contact and referral pathways to a single integrated community service with the aim of providing a 24/7 111 single point of access for all services. This change had resulted in disruption to staff roles in some areas and the way in which teams worked.
- Staff in community adult services were not always aware of the strategy, values and vision of the organisation; however, most staff were able to describe the community aspect of the organisation.
- The provider had a strategy for children services within the care group directorate. The vision for the directorate was to provide an integrated model of care, which provided a seamless service, and to work closely with Local Authority strategies.
- There had been a programme of engagement with staff to share the strategy of the organisation. We were given examples from staff about how they had been involved in the development of the new teams of health visiting and school nursing.

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- Staff were able to articulate some of the values of the organisation.
- The service vision and mission were an integral part of staff performance and development reviews. We saw staff displayed the values of the organisation by their behaviour and attitude to patients throughout our inspection.
- The service managers were knowledgeable about the organisation strategy and understood how this affected local provision of services.
- Managers told us the service had undergone wide organisational change when they were awarded sexual health contracts from commissioners. They had planned for a small and safe service and were now looking to develop it further. Plans were being drawn up to provide a minor procedure suite as part of a Commissioning for Quality and Innovation (CQUIN) programme.

Governance, risk management and quality measurement

- The care group produced a quality and integrated governance report which covered incident reporting and identified trends, implementation of duty of candour, complaints and compliments, claims, patient experience data, training levels, implementation of NICE guidance, central alerts and the care group risk register.
- Managers were able to describe the risks and the action being taken in most risks identified. There was a risk identified relating to referrals from a local acute trust. This had been on the risk register for six years and was still not resolved. Managers told us they had previously regularly attempted to mitigate the risk; however, the risk remained amber on the risk register.
- Managers in community adult services told us that if performance was deteriorating they would consider how they could manage the service to improve patient outcomes. They received a monthly data report, which included key performance indicator data. There was a bi-monthly meeting to review service performance.
- Risks for termination of pregnancy and integrated sexual health services were recorded on the care group risk register. Recorded risks included the roll-out of the electronic patient record, as there was no longer a project manager and an identified lack of specialist IT support to manage and develop the system.
- Staff were clear about the lines of escalation; however, some areas such as children's and young people services reported that responses to issues escalated were slow.
- We saw a sample of team meeting minutes across children services held between August 2016 and October 2016. Minutes were variable across teams as to the standing agenda items, and how actions were recorded. There was a lack of timescales applied to actions across the team meetings.
- We looked at 10 patient records and found that all forms included two signatures and both doctors had clearly documented the reason for the termination under 'decision to proceed'. In all cases, doctors had agreed that one and the same grounds for abortion had been met.
- We observed that nurse / midwives checked the HSA1/ HSA4 forms were completed correctly before any aspect of treatment was initiated. However, we did not see a specific audit or data collection process to be assured that the service was 100% complaint with this legal requirement.

Culture across the provider

- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the service.
- Staff told us the service had an open culture and felt they could approach managers if they felt the need to seek advice and support. They told us they would be comfortable to raise concerns with them and that they would be taken seriously.
- Staff were encouraged to be part of the solution to problems. A staff member gave an example of raising a concern about the medicines reconciliation process. This became an objective on their personal development plan at appraisal and they became involved in solving the issue.
- Morale varied in community adult services because of recent changes. This was highlighted on the risk register and managers were aware of the issues around low morale in the teams.

Public and staff engagement

Are services well-led?

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- The telehealth team attended a three monthly focus group with COPD patients. The community lymphedema team had participated in the lymphedema awareness week and had a local stand in a health centre to provide information on the service and the condition.
- In conjunction with commissioners, the re-organisation of urgent care services was the subject of extensive public consultation, which included postal surveys and patient participation groups.
- Staff were working towards involving young people in the development of services through a youth forum. We saw an example of how information leaflets had been developed and presented for feedback from young people as to which best met their needs.
- The Carers Information and Support Service had a Facebook page, which provided information about events, courses and how to access support for unpaid carers. During the annual Carer's Week, the service had a mobile unit that attended events in the city to reach as many people as possible. Ninety percent of employees in Care Group One were likely to recommend CHCP CIC to friends for treatment and 66% as a place to work. The Care Groups had an action plan in place to respond to areas in the 2016 staff survey where staff engagement needed to improve.
- The chief executive also provided a comments box for staff to post their views. Staff we spoke with were aware, and referred positively, to the chief executive's survey "snapshot". Feedback to staff was included in the weekly newsletter. Staff told us they felt communication with staff had improved further in recent months.

Innovation, improvement and sustainability

- The organisation was aware of the impact on quality and delivery of services due to financial constraints and reductions in service provision by other health care providers. The Safe Care Quality Committee reviewed and monitored efficiency plans regarding quality.
- Mobile working had been implemented around a month prior to our inspection in November 2016. Staff views on how well the mobile working worked varied. Some staff reported few concerns regarding the connection to the laptop when out visiting patients; however, a number of staff raised concerns and frustration around the time taken to use the mobile laptops during visits. Managers were aware of the issues around mobile working and the connectivity issues and had taken a number of steps to address this. An issues log was in place, which staff used when they had an issue; this was then forwarded to the information technology team to review.
- Improvements to quality and innovation were recognised through an internal staff award scheme and the nomination of staff for external awards. For example, the Hull FIRST team received an external award in 2016.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 9(3) (g) providing relevant persons with the information they would reasonably need (about the provision of care and treatment). Inform patients of the requirement to submit abortion data to the Department of Health and explain how this information is anonymised.

Regulated activity	Regulation
Termination of pregnancies	Regulation 20 (Registration) Regulations 2009 Requirements relating to termination of pregnancy Regulation 20 (Registration) Regulations 2009 Requirements relating to termination of pregnancy Ensure that there is assurance processes for Abortion Notification Forms HSA1 completion and HSA4 submission to the Department of Health within the legal timeframe of 14 days.