Virgin Care Services Limited

1-351584301

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2086060515	Oldham Integrated Care Centre		
1-365636965	Farnham Hospital and Centre for Health		
1-365636607	Haslemere and District Hospital		
1-365627764	Milford Specialist Rehabilitation Hospital		
1-365628061	Jarvis Centre		
1-2008801464	Virgin Care Luton		

This report describes our judgement of the quality of care provided within this core service by Virgin Care Services Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Virgin Care Services Limited and these are brought together to inform our overall judgement of the provider.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Summary of findings

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Summary of findings

Overall summary

- There was a comprehensive 'safety management system', which took account of current best practice models. The whole team was engaged in reviewing and improving safety and safeguarding systems. Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. There was a positive, no blame culture towards incident reporting with effective mechanisms to investigate and learn from incidents.
- There was a thorough analysis and robust investigation of things that went wrong. Learning was clearly identified and all staff were encouraged to participate in learning to improve safety as much as possible. Robust safety monitoring and benchmarking systems were used to drive improvements across the organisation. The safety monitoring systems were based on a monthly clinical governance scorecard. Data reviewed showed high scores against KPIs and sustained improvement over time.
- Staff treated patients with kindness and compassion and respected patient's dignity at all times. We saw staff involving patients and their families and carers in decision making about their care and providing emotional support with great depth of understanding.
- The provider and individual staff were committed to developing services that considered individual needs and preferences. Services for carers were a strength and there was evidence of working with specific groups (such as the Nepalese community and the MND community) to ensure that their members wider needs were met.
- Community end of life care services were of a very high quality, followed the Gold Standard framework and ensured that effective multidisciplinary and interagency working was provided for the benefit of patients approaching the last days of life.
- There was a strong focus on multidisciplinary working within the organisation and with external agencies such as local acute care providers and adult social care.
- Staff had the appropriate skills and knowledge for their roles and received regular mandatory training, clinical supervision and peer reviews. The provider focussed on improving the quality of care provided through ensuring staff were trained and supported to work "At the top of their grade". The organisation actively supported staff to develop and extend their knowledge and competencies, and encouraged innovation.
- Staff were supported with strong local leadership and felt empowered to make changes that improved patient care. Staff felt valued and had a clear understanding of the organisations vision and strategy.
- Complaints were investigated and managed appropriately in a timely manner with learning identified shared, staff were able to give us examples of learning.

However:

- The vision and strategy for the care of patients with dementia was not embedded or understood by staff and there was a lack of training in dementia awareness.
- There was a lack of sepsis training and staff awareness about this condition.
- Do Not Attempt Cardiopulmonary Resuscitation forms were not always completed in accordance with the full national guidance. The provider had not yet introduced the new Recommended Summary Plan for Emergency Care and Treatment.
- There was high use of agency nursing staff.

Summary of findings

Background to the service

Virgin Care Services Limited (VCSL) provides community services on behalf of NHS commissioning groups in Surrey, in the Luton area, East Staffordshire and has recently acquired community adults' services contracts in Kent. VCSL provide a variety of adult community services including community nursing, occupational therapy, rapid response and rehabilitation services (RRaRS), diagnostics and treatment (DaT), physiotherapy, speech and language therapy (SaLT), wheelchair services and podiatry (treatment of disorders of the foot).

During this inspection, we observed a variety different care services including: physiotherapy, occupational therapy, nursing care, SaLT, district nursing, RRaRS, wheelchair services and DaT at six different locations. VCSL also provides specialist clinics for falls, blood transfusions, heart palpations and diabetes.

Virgin Care Luton provides community health services for adults over and under 65 years from two sites. A domiciliary service where rehabilitation is provided to people in their own home and at a local nursing home where therapy was provided by VCSL staff to patients being provided with commissioned nursing care by the home staff.

Virgin Care Luton has been registered with CQC since 13 April 2015 and has not yet been inspected by CQC. In Luton, there are a number of services that provide intermediate care. The Luton Intermediate Care Rehabilitation Service (LICRS) works closely with these partner organisations.

The Community Health Services provided by Virgin Care in the North West region comprises of Dermatology Services, known as "Oldham Total Skin Service". This service is provided at clinic rooms on the 5th floor of Oldham Integrated Care Centre. The Dermatology services have been commissioned to Virgin Care since July 2015. Prior to this, the service was run by a different provider, for two years, following the closure of the secondary care dermatology service, run by a local NHS trust. The service provides Consultant-led Dermatology services in the community. The aim of the service is to deliver holistic assessment and treatment pathways, including rapid treatment for patients with suspected cancer and to prevent patients from having to travel outside of Oldham to neighbouring hospitals for treatment. The clinical services delivered by the Oldham Total Skin Service are promoting self-management; outpatient community dermatology; outpatient complex dermatology; paediatric dermatology; dermatological minor procedure; skin cancer screening and skin cancer procedures. Since the service was commissioned, patient contacts have increased from just over 3,700 to over 15,000 patient contacts per year. From April 2016 to March 2017, there had been 15,181 patient appointments.

During the inspection of the Surrey services, we spoke with more than 40 members of staff including managers, community matron, physiotherapists, occupational therapists, district nurses, health care assistants, nurses and doctors. During our inspection, we visited patients receiving care in their homes, spoke with 18 patients and their relatives/carers, observed 12 episodes of care, and reviewed 11 patient care records and 11 medication charts. We reviewed a variety of data, for example meeting minutes, policies and performance data prior to, during and after the inspection. In Oldham, we spoke with 11 staff members, including managers, doctors, nurses, healthcare assistants and reception staff. We spoke to three patients; reviewed five patient records; five complaint files and one consent form for a patient who lacked capacity.

Our inspection team

Our inspection team was led by: Terri Salt, Inspection Manager, Care Quality Commission

The team included CQC inspectors and inspection managers and a variety of specialists: Senior community nurses/matrons and a community NHS trust medical director, a physiotherapist, community children's nurses, a deputy director of quality and governance, an adult and child safeguarding advisor and a senior nurse with sexual health experience.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We used this information to determine which locations would be visited to ensure we gained an accurate reflection of the overall quality of service provision,

We carried out announced visits during February and March 2017. Prior to the visits we held focus groups with a range of staff who worked within the service, such as nurses, therapists and ancillary and support staff. We talked with people who use services. We observed how people were being cared for and talked with patients, carers and family members about their experiences.

We reviewed care or treatment records of people who used services and service management records.

We carried out an unannounced visit on 27 February 2017 at Haslemere Hospital.

We met with members of the Board and executive team after the visits to enable us to understand how they monitored the quality and safety of services being provided nationally.

As part of this inspection we visited serviced in the Luton area, including community health services, rehabilitation and intermediate care services. A narrative report for these services has been used to provide specific local feedback and to inform the provider ratings. We completed an announced inspection of Luton community services on the 13 and 14 December 2016. During the visit, we spoke with the service lead, staff members and reviewed information relating to the development of the service, business plans and service specific policies and records. We spoke with 10 patients, their relatives, and 16 members of staff. We observed care and treatment and looked at 10 patient care records.

Prison Healthcare Services were not inspected, due to the specialist nature of the services provided.

What people who use the provider say

People we spoke with were entirely positive about their experiences of Virgin Care Services Limited. They described caring and compassionate staff who went the extra mile. Patients and relatives spoke of being included as partners in their care.

We did not receive any negative feedback either on site or by direct contact with CQC as part of this inspection.

Summary of findings

Good practice

- The 'Feel the difference' fund was accessible to all staff help implement ideas and innovations. Staff felt innovation was encouraged. Ideas that had been piloted through this route had been rolled out across the organisation.
- The motor neurone disease (MND) multi-disciplinary team from Farnham has been presented with the extra mile award by the motor neurone disease association for their exceptional care for people with MND.
- VCSL were part of the carers' collaborative that won the HSJ Commissioning for Carers Award. There was a strong commitment to working with carers through the carers club and commitment to John's Campaign.
- The focus on providing good leadership and developing staff ownership of the service led to high quality care and an engaged workforce.
- The quality and safety assurance framework and governance systems were highly effective and used to drive a cycle of continuous improvements. There were tangible examples of where the monitoring systems identified shortfalls in practice and led to organisational learning.
- Information Governance was a real strength and was supported by the wider Virgin Brand security experts, including advanced cybersecurity arrangements and advice.
- The community team in Luton carried out treatment sessions in the patients' home, which supported them best with their rehabilitation.
- The therapist and patients were able to develop enhanced therapeutic relationships, which enabled the therapist to identify any changes in the patients' underlying physical, emotional or mental health conditions. Team working was excellent across all services visited.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should review the completion of DNACPR forms to ensure they are in accordance with current best practice guidance.
- The provider should ensure staff are familiar with the identification and initial management of potential sepsis.

Virgin Care Services Limited

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- There was a comprehensive 'safety management system', which took account of current best practice models. The whole team was engaged in reviewing and improving safety and safeguarding systems. Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. There was a positive, no blame culture towards incident reporting with effective mechanisms to investigate and learn from incidents.
- At provider level the safety monitoring and improvement systems were highly effective and identified trends and emerging concerns at an early stage. Mitigating action was implemented swiftly across the entire organisation. There were very good processes for dissemination of information.
- Learning was based on a thorough analysis and investigation of things that went wrong. All staff were encouraged to participate in learning to improve safety as much as possible. Robust safety monitoring and benchmarking systems were used to drive improvements across the organisation. The safety monitoring systems were based on a monthly clinical governance scorecard. Data reviewed showed high scores against KPIs and sustained improvement over time
- Staff development and learning was highly valued by the provider. Comprehensive learning programmes were available to staff.
- A proactive approach to anticipating and managing risks to people who used services was embedded and was recognised as being the responsibility of all staff. There were systems, processes and standard operating procedures (for example in infection control and medicines management) that were reliable and kept patients safe. The provider gave safeguarding a high priority and staff knew how to escalate safeguarding concerns.
- Other external organisations were engaged in assessing and managing anticipated future risks. There was evidence that work with social care providers had contributed to a significant reduction in pressure damage.

However:

Good

Are services safe?

- Some staff had not undertaken sepsis (systemic infection) management training and lacked awareness of sepsis.
- There was high use of agency nursing staff.

Safety performance

- The provider participated in the patient safety thermometer to monitor harm free care. Staff captured data over the course of one day each month and looked at harm from falls, pressure ulcers, venous thromboembolism (VTE), catheter issues and urinary tract infections (UTIs)
- Between February 2016 and February 2017, community services reported 93 new pressure ulcers, 76 falls with harm, seven catheter UTIs and 39 VTE's.
- The community nursing bases we visited displayed the safety thermometer and managers had access to the safety thermometer data. Staff were aware of safety thermometer data and were able to describe what data was collected and why. This meant staff were informed and could monitor safety performance data.
- VCSL had very robust systems for monitoring the safety performance of individual teams based on an electronic central Clinical Governance RAG Scorecard. Teams were required to submit data monthly. The scorecard was used to inform business unit clinical governance meetings and to drive improvements. Across the organisation scores were sustained above 83%. Surrey Community Care and Rehabilitation team had a sustained score of over 90% in the year preceding inspection. The Eastern area services (Business Unit five) had sustained scores around 95% until new services were taken on when the score dipped.
- There was clear evidence of the provider improving services. In East Staffordshire, the service was RAG rated at 52% when the service had first been acquired in May 2016. By October 2016 the RAG score had risen to 69% and the data demonstrated a month on month improvement as opposed to a sudden peak.
- In Luton Intermediate Care Service there was a steady rise in RAG score from a low of 75% in July 2016 to 93% in February 2017.
- RAG scores were based on comprehensive key performance indicators such as whether the safeguarding and infection control audit plans had been updated. It also included scores around whether agency and locum staff had received peer review in accordance with the clinical practice policy.
- Across VCSL there were no unexpected deaths outside of the prison services between May 2015 and October 2016.

Incident reporting, learning and improvement

- There were no never events reported between September 2015 and September 2016 across VCSL. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The total number of Serious Incidents reported across all VCSL (including prison services) during the period October 2016 to October 2016 was 98.
- The provider monitored the number and grade of incidents through the Quality and Safety Tableau.
- The overall number of incidents reported had increased over time from 544 in October 2014 to 639 in October 2016. Whilst some of the increase was due to acquisition of services, there was also evidence from individual services that the reporting culture was encouraged an staff in newly acquired services reported increased numbers of incidents in the months after transfer. Services in North Kent (Business Unit 11) had increased the number of reported incidents from 14 in September 2016 to 110 in October 2016.
- In Surrey, there were 18 serious incidents in community nursing requiring investigation between January 2016 and February 2017. Of these incidents 94% related to pressure ulcers and 6% related to a safeguarding allegation. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in an unexpected or avoidable death of one or more patients, staff, visitors or members of the public, or serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm.
- In Oldham, from April 2016 to February 2017 there were 39 incidents recorded in the Oldham Total Skin Service. Of these incidents, five related to operational incidents;

Good

Are services safe?

10 to care, treatment or procedures; 11 related to admission, transfer or discharge; seven to communication; four to information governance and two related to health and safety.

- The provider undertook a root cause analysis (RCA) of all serious incidents which ensured any failings in care were highlighted and lessons learnt. We reviewed the RCAs for the pressure areas these showed that none were found to be avoidable and there was none attributable to any lapse of care.
- Staff who provided end of life care described an incident when controlled drugs were found to be missing from a patient's house. This was reported through the incident reporting system, there was a full investigation and changes made to the medicine checking and recording practice.
- One of the indicators on the Clinical Governance Scorecard was whether the service team had a member of staff trained to investigate incidents.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The incident reporting form was accessible for all staff via an electronic online system. Once reported, managers reviewed the incidents and, where necessary investigated.
- The Business unit head and clinical governance lead read every incident report personally.
- The chief pharmacist read all medicine related incident reports personally. This enabled them to see any cross organisation themes or risks that might affect different areas of the organisation. Where a concern was raised, they instigated a 'deep dive' review looking at potential impact across VCSL.
- The Head of Quality spoke with all business unit leads weekly. Any incident related communication was sent out only by the Head of Quality using an SBAR tool. The SBAR (Situation, Background, Assessment, and Recommendation) is an effective and efficient way to communicate important information. We were given an example where an incident relating to the cleaning of peak flow meters was investigated and disseminated centrally to all services within VCSL. Operational staff were able to tell us about the specific incident and the changes that had been made.
- All incident related data was scrutinised on a monthly basis and triangulated with complaints, safeguarding and feedback to identify where teams might require additional support.
- There was a positive attitude towards incident reporting and staff were actively encouraged to report incidents. Staff told us they had confidence in reporting incidents and gave examples including feedback from the investigation. For example, when staff had visited service users at home and discovered them on the floor as they had fallen.
- We attended a fast track meeting at the local trust hospital at which community staff were present and saw that recent incidents were discussed. For example, an end of life patient had been discharged from hospital and was immediately re admitted. Reasons for this were discussed and although the investigation was not yet fully complete, consideration was given to changes in practice that needed to be made to avoid this happening in the future. It was agreed that any difficult discharges or immediate re admissions would continue to be entered onto the incident reporting system.
- The provider undertook regular local audits of incidents. The results of the January 2017 audit in the Surrey community team showed that 100% of incidents were reported verbally to senior person on duty, that a preliminary investigation was conducted in 83% of cases. This showed there was a good culture of reporting incidents.
- We saw that reported incidents were a standard agenda item on the Community - Care and Rehabilitation Services Business, Clinical Quality and Risk Meeting. This meant there was a process for the monitoring, investigation and learning outcomes of clinical incidents.
- Staff told us that they had oversight of all incidents raised by staff in the community teams through departmental meetings, safety briefings and handovers. Staff were able to give examples of recent incidents that related to their speciality.
- We saw there was a Root Cause Analysis Panel (RCAP), which met monthly and reviewed all incidents that resulted in moderate or severe harm. This meant each incident was reviewed in detail by staff trained in root cause analysis (RCA) and a root cause identified if possible. We saw from November 2016 meeting minutes, pressure ulcers were discussed and

contributing factors identified. There was an action for each meeting and we saw sharing of any learning was nominated to the appropriate member of staff. This ensured staff were informed of learning outcomes.

- We reviewed the root cause analysis of two serious incidents and found them to be thorough, with appropriate recommendations for learning. We saw a standard RCA template was used for the investigation of serious incidents, this ensured all serious incidents were investigated and reported in the same way.
- The Board members were updated on all serious incidents. Extracts from the December 2016 Board report. One incident that occurred in East Staffordshire related to an inpatient pressure ulcer. The Chief Nurse visited the team to review the patients' pressure area care and to share learning.

Duty of Candour

- Staff knew about their duty of candour responsibilities under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was introduced in November 2014. "The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person."
- Staff gave examples of when duty of candour had been applied, such as when an avoidable pressure area had developed. We asked a number of community nursing staff about their understanding of candour and all were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.
- In Oldham, we reviewed five complaint files and found that duty of candour was clearly applied in letters to patients.
- We saw evidence that the processes for the duty of candour were in place and documented within the incident reporting system.

Safeguarding

- We saw the policies for safeguarding vulnerable adults and children, which were in date and referenced national guidance.
- There was a national Safeguarding Adults Lead and a national Safeguarding Children Lead. The national leads provided strategic safeguarding leadership and expertise across the organisation.
- Each business unit had a safeguarding adult's lead and a safeguarding children's lead who reported to the national leads for safeguarding. They in turn reported to the Chief Nurse and Executive Lead for safeguarding. Staff were able to tell us the names of their business unit safeguarding leads.
- There was a national Safeguarding Adults and Children Governance Group that was informed by the Business Unit Clinical Governance Committee and which reported to the national Clinical Governance Committee.
- All business units had safeguarding leads and each team had a safeguarding champion.
- We saw safeguarding was a standing item on every business unit clinical governance team meeting.
- The provider completed annual safeguarding audits and developed an action plan from the findings. There were separate audits for adult and child safeguarding.
- The 2016 combined adult and children's audit focussed on seven areas relating to safeguarding governance including management of complaints, recruitment and whistleblowing.
- This audit showed that all services completed the safeguarding audit and 93% were RAG (red, amber, green) rated green. The audit did not identify any significant concerns or risks across the organisation.
- All staff followed the safeguarding training in line with intercollegiate guidelines of children and the proposed guidance for children.
- Information supplied by the provider showed that at the time of reporting all (100%) adult community staff were up to date with adult safeguarding training with the exception of the rapid response and rehabilitation staff who were 88% compliant. This was better than the VCSL target of 85%
- Information supplied by the provider showed that at the time of reporting all adult community staff were up to date with child safeguarding training with the exception of the rapid response and rehabilitation staff who were 91% compliant. This was better than the VCSL target of 85%.
- The national safeguarding leads received exception reports monthly that advised where staff were approaching the renewal date from training.

Good

Are services safe?

- Staff we spoke with were knowledgeable about the safeguarding policy and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse.
- We saw information about the safeguarding lead and contact details and safeguarding flow charts on notice boards in all of the community bases we visited. The flow chart demonstrated the local safeguarding process for staff to follow in the event of a safeguarding concern.
- There was evidence that the provider considered and took action in response to national reviews for example the Francis report.
- The provider disseminated information to staff regarding updates and changes to the safeguarding policy. This included information on Prevent duty section 26 of the Counter Terrorism and Security Act 2015, Female Genital Mutilation and the Care Act 2014.
- All safeguarding risks were entered on a risk register and escalated to the national clinical governance committee.
- Safeguarding referrals were made via the children and adult Multi-agency Safeguarding Hubs (MASH).
- The Named Nurse for the Wiltshire services had recently been involved in developing a safeguarding traffic light assessment tool for non-mobile babies. They were now working with adult safeguarding colleagues to develop a risk assessment tool for non-mobile adults.
- When children failed to attend an appointment in Oldham, the parent was contacted by telephone to try to establish the reason for the failure to attend and a further appointment was made. Where further contact could not be established enquiries were made to establish if there were any safeguarding concerns and we were told that a safeguarding referral would be made if appropriate though this had never happened.
- A new template for a training tool had been rolled out across VCSL that allowed staff to record evidence of continuing professional development and practice in relation to safeguarding.
- The provider had a Safeguarding Supervision Policy which had been implemented through a 2 day cascaded training programme.
- Any updates about safeguarding or changes to policy were disseminated through the staff newsletter 'Something for the Weekend' as well as by direct email to all staff.
- VCSL had a Chief Pharmacist who had overall responsibility for the oversight of medicines managed by operational staff.
- They were supported at national level by two deputies with differing remits.
- The National Quality Pharmacist was responsible for medicines management policies, education and competency, and medicines management practice.
- The National Development Pharmacist was responsible for procurement and relationships with preferred providers, for mobilisation of new services where there was medicines optimisation with a 100 day plan from the time services were acquired.
- The development pharmacist was working to reduce the number of preferred providers from 60 to less than five to streamline medicines provision across the organisation.
- Each business unit had a designated lead pharmacist that was responsible for the safe handling of medicines in their region. They were line managed by the Chief Pharmacist.
- Each business unit had a Medicines Management Group that was operationally based and had representatives from all staff groups. This group escalated concerns to the business unit clinical governance meetings which had a direct link to the Medicines Optimisation Committee.
- An Annual Medicines Management Audit was undertaken with over 250 questions about how the services were providing medicines within their team. Any outlier teams identified through the audit triggered a review at business unit level and also as the national Medicines Management Committee.
- A medicine administration record chart audit from September and October 2016 looked at 161 patients' charts from 14 separate bases/hubs across Surrey community nursing, out of hours (OOH's) and rapid response. All types of medicine administration charts were included. The audit detailed location specific detail and gave clear outcome and action plans. For example, nurses should ensure when a medicine with a variable dose range was administered, the actual dose given should always be recorded on the chart. This ensured patient safety and allow for continuity of care when another healthcare professional visited the patient.

Medicines

Good

Are services safe?

- The Medicines Management Education Programme was accredited by the Royal Pharmaceutical Society. It consisted of a blend of practical, competency based workbook and online learning.
- When VCSL acquire a service a medicines audit was undertaken within 100 days of acquisition to establish a baseline for that service. An action plan was then created and monitored at business unit level. All staff were asked to complete a medicines competency assessment.
- There was a VCSL standard operating procedure (SOP) for the supply of pre-pack medicines, which was in date. This policy provided clear guidelines to staff working in Diagnostic and Treatment Centres regarding supplying medicines to patients.
- The rapid response and rehabilitation staff told us their role with medicines was mostly prompting patients to take their medication and checking to see if they had taken it. Medicines were delivered to patients by pharmacies or were collected from pharmacies by patient's carers.
- The majority of the patients in the community had pre prepared packs containing their medicines, which were prepared by a hospital pharmacy or chemist. This meant it was easy for staff to check if the medicines had been taken as each compartment of the blister pack was marked with the day and different times of the day.
- Some patients were given medicines in their homes by a registered nurse. We saw medicines administration record cards were used to record all medicines given. These cards also recorded any patient allergies and weight, with pages dedicated to regular medicines and separate pages for insulin prescriptions. We reviewed ten patient medicine charts and in all cases, we saw that the transcriber had recorded the patient's allergies and signed and dated the prescriptions.
- We observed when a member of staff from the Surrey response and rehabilitation team was undertaking their first assessment of a patient that they checked the patient's medicines on their discharge summary against the medicines they had in their home.
- The patients GP had overall responsibility for reviewing and prescribing medicines for patients. If the GP changed a patient's medicines, this was communicated to VCSL staff via telephone call or email.
- We saw minutes of the Adult Community Medicines Management Operational Group that included discussion about palliative care and disposal of cytotoxic waste for end of life patients managed in hospital and in the community.
- In practice we observed staff discontinuing a cytotoxic infusion and disposing of this in an appropriately labelled and lockable bin at the patient home. This was then taken to a secured clinical waste bin at the community hospital. The secured bin was outside the hospital and in a designated waste compound.
- Staff reported that GPs were competent in prescribing anticipatory medications. These are medicines prescribed when anticipating a change in the patient's condition and medicines are needed immediately.
- There was evidence of a policy that states carers and relatives can collect anticipatory medicines and they are supported by the district nurse to understand what their responsibilities are. On two occasions we saw staff discussing with patients and relatives in their own home the effect of medicines and how doses could be adjusted.
- The Chief Pharmacist was the accountable officer for controlled drugs at the time of the inspection but the organisation was moving to a more local model where business unit pharmacists were accountable officers for their region and attended the local controlled drug network.
- There was a Controlled Drug (CD) Management SOP. Controlled Drugs are medicines liable for misuse that require special management. The SOP provided guidance regarding the management of CD's within the community. For example, the policy stated that CDs held in the patient's home remain the property of the patient and as such, the patient and/or their carers were responsible for the storage of these medicines.
- For the administration of any controlled drug for a patient in the community, the visiting registered nurse was responsible for ensuring the maintenance of a full and accurate record of drugs given, balance reconciliation and advice on appropriate storage. The CDs stock chart was held in the patient's home records and maintained by the visiting registered nurse. The stock balance chart was updated each time a CD was used or received.
- The provider's Patient Group Directive (PGD) Policy set out explicitly how any PGDs were to be produced. All PGDs were drug specific and based on NICE guidance.

They were produced by the lead pharmacists and service lead working together. A draft PGD was sent to the lead Clinical Commissioning Group from the business unit for sign off.

- The Chief Pharmacist sat on the national PGD committee for independent healthcare at the Royal Pharmaceutical Society.
- Information and learning from medicines related incidents was shared from the corporate team via the business units, which included input from community staff, and information was cascaded to community staff. For example, we saw in meeting minutes that adrenaline should never be stored in the car and had to be taken into the patients home, office or nurses home which prevented exposure to extreme temperatures.
- We saw the Diagnostic and Treatment Centres kept medicines for use in an emergency for example in a severe allergic reaction. We checked four of these medicines and they were in date. There was an effective process which ensured these medicines were checked monthly which ensured they were available and ready for use.
- Adult Community Services undertook a medicine chart audit in September and October 2016. This audit showed that in Surrey 100% of charts were written clearly and legibly and 92% had the patient's allergy status recorded including no known allergy.
- The Oldham Total Skin Service had a medical consumables formulary that clearly detailed what drugs and medical products should be in stock and maximum ordering levels. There was clear guidance in place as to where the consumables were stored.
- At this location, we did find a small discrepancy in the drugs stored and recorded stock balance. This was brought to the attention of the Service Manager. There was a missing stock log and this was reviewed.
- In the preceding year staff had been encouraged to take the Medicines Optimisation Pledge. This asked to staff to consider what would make a difference to patients. An example given of a successful idea was the introduction of a 'Stop and Start tool' in patient medication reviews. As a consequence polypharmacy was reduced and more patients were only taking the medicines they needed.

Environment and equipment

- The Jarvis centre was one of four localities across Surrey that provided wheelchair services. The centre assessed clients for the provision of both manual and powered wheelchairs. Pressure relieving cushions for wheelchairs and equipment used to support a patient's body whilst standing or sitting were also supplied.
- The physiotherapists and occupational therapists assessed what type of wheelchair a patient required. The therapist either assessed the patient in the Jarvis centre or visited the patient at home. This meant that patients with limited mobility had access to the service.
- We observed a service user having a consultation when they received their new wheelchair. We saw the staff member took time to ensure the wheelchair was suitable for the service user and they understood how to use it safely.
- The general environment at all the community bases that we visited were clean, tidy, and corridors were clear of equipment.
- Staff visited people in their own homes and took equipment needed with them and occasionally left necessary dressings and sharps bins in people's homes for regular use.
- All equipment at the community bases were marked as clean and appropriately stored. This meant staff knew that equipment was clean and safe to use.
- All equipment and dressings were stored in well-organised storage cupboards in each community nursing base.
- We were told that equipment such as specialised mattresses are supplied by a third party. Staff told us equipment was easy to access and would be delivered to the patient's home in a timely way.
- There were peripheral stores of equipment at some community hospitals, which stored regularly required equipment such as Zimmer frames.
- We saw that the surgery hubs had a supply of syringe drivers for patient's use and these were appropriate for purpose and in line with professional recommendation. There was a policy that supported the use of these syringe drivers in the community setting.
- We checked four syringe drivers and they were clean, serviced and tested which provided a visual check that they had been examined and were safe to use.
- All syringe drivers for use was listed and checked by a competent registered nurse to ensure all were tracked and returned to the surgery when finished with.

Good

Are services safe?

- Staff at Milford hospital reported occasional problems with obtaining equipment from the store; this was due to the lack of an effective re-ordering system. Staff who removed items from the store were meant to re-order from the equipment supplier to replace the item but staff told us that this was not consistently done.
- We saw there were an adequate number of portable oxygen cylinders in the diagnostic and treatment centres for use in an emergency. We checked four cylinders, which were in date and labelled.
- Repairs and maintenance of equipment within the clinics was undertaken at local NHS trusts, equipment was transported on dedicated hospital transport. Staff reported a good service provided by the NHS trusts with repair being undertaken promptly and replacement equipment provided if required.
- We saw that electrical safety checking labels were attached to electrical items showing that it had been tested and was safe to use. We checked 11 pieces of electrical equipment and all had been tested within the last 12 months.
- We saw Health and Safety Control of Substances Hazardous to Health substances were stored in line with Health and Safety Executive guideline SR24.This ensured safe storage of substances, which could cause harm to staff and prevented unauthorised access. We checked seven clinical waste bins, which were stored securely in a locked compound, and all clinical waste bins were locked.
- We checked over 10 consumable (disposable equipment) items picked at random and all were within their expiry date, which showed they were safe to use.
- In Oldham, the service had equipment manuals to hand for all medical equipment used on the premises, such as a Dermlite; Dermatoscope and UVB machine.
- There was a large UVB booth in one of the Oldham clinic rooms for treating skin conditions such as psoriasis or eczema. This machine treated patients with ultraviolet B rays, but also produced low level electromagnetic radiation. The equipment was serviced once a year. We saw that it had last been serviced on 8 March 2017 and that all the paperwork around this was in order and indicated what checks had been carried out. Safety rules for operation of the UVB machine were displayed in the clinic room and staff were aware of the risks. They ensured that there was no exposure to the UVB rays by ensuring they were behind a curtain when the machine was in use.

Quality of records

- Some staff within the Surrey community adult service used an electronic patient record system, (EPRS) which provided a record of the assessments, care and treatment required by and provided for patients. The system could be accessed from office bases or remotely through the use of mobile computers when in the community.
- The electronic patient record system was planned for all community adult staff. However, due to network connectivity issues in some areas, this had been delayed.
- The staff who did not use EPRS kept paper records in patients houses and transposed the information onto the electronic system when they returned to one of the community bases. This meant all staff had access to the relevant information.
- We reviewed the information, which was written in the patients notes in their home against those documented on the electronic system, and they contained the same information. This provided assurances that the patient records in their home matched the electronic system.
- We reviewed seven electronic and four paper patient records and we found staff had recorded accurate information and all records had a timed and dated signature.
- We checked three further sets of notes for end of life patients that we accessed at a surgery hub and we saw that these were generally well completed.
- We were shown the End of Life Care Shared Care Communication Standard showing which documentation was to be kept within the patient home that all members of the multi-disciplinary team could use. This included four separate documents that included priorities for care, an essential plan of care and details of all professional services involved in the care. We saw this document being used to plan and record end of life care within the home environment.
- There was a Proactive Anticipatory Care (PACe) document in use for patients that the nurse and general practitioner completed to anticipate patient needs ahead of requirement. We saw this was in use in the

community and was fully completed. A further two sets of patient notes were checked and showed completed risk assessments and a holistic approach to patient care.

- We saw patient risk assessments for example pressure ulcer risk scores and venous thromboembolism (VTE) were consistently completed.
- Staff used a secure, electronic system to record assessment and treatment of patients. Staff also kept a folder in each patient's home, which contained information on care planning and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation (where appropriate).
- In Oldham, we reviewed five sets of patient notes and found that the name and grade of the doctor or nurse reviewing the patient was clearly documented; the diagnosis and management plan was documented; there was a completed assessment of the patient and their condition; consent was clearly document, including parental consent where this was applicable; the risks were assessed and documented; there was evidence of discussion with the patient about their condition and the options available; there was evidence of the patient pathway and referral and the next appointment date had been agreed. All the notes were signed or initialled and dated.
- VCSL undertook information governance (IG) audit across the organisation in November 2016. In business unit four this showed that between 01 November and 30 November there were 22 IG breaches or near miss IG breaches. The most common breach (14) was emails sent insecurely. This audit showed a good reporting culture of IG breaches or near misses. An action plan was developed to reduce the amount of IG breeches. The findings of the audit were shared with staff via the business unit newsletter 'top tips on IG security' and on the local intranet.
- One of the actions from the audit was to ensure all staff had completed IG training by the end of December 2016. Data supplied to us by the provider showed that most staff had completed the training.
- VCSL submitted a Community Healthcare Information Governance Toolkit is March 2016 for an independent assessment of evidence by an NHS internal audit agency. The audit scored 76% which gave the provider a rating of 'Significant Assurance'.
- The information governance team carry out site visits and local audits to review the security and confidentiality of information being held.
- Local teams undertook quarterly self-assessment confidentiality audits. When a service was recently acquired, the audits were monthly until the initial targets were reached.

Cleanliness, infection control and hygiene

- There was a VCSL Infection Control Committee which fed into the Clinical Quality Review meeting, who had overarching infection control and prevention responsibility.
- The infection control committee fed into infection control forum that was responsible for the day-to-day operations of infection control and prevention.
- VCSL produced monthly infection control and prevention (ICP) newsletters for staff. These provided information and details of who to contact if staff required support or advice relating to ICP.
- Staff adhered to the bare below the elbows (BBE) policy and wore gloves and aprons when providing care in people's homes and in the clinics to prevent the spread of infection.
- Staff used aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. This was in line with NICE guidance (QS49).
- We observed staff washing their hands and using alcohol hand sanitiser pre and post procedures in clinics and in patient's homes. For example, we saw seven members of staff wash their hands and eight members of staff use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'.
- Hand sanitiser bottles were readily available throughout clinical areas and community staff had hand sanitiser on their person.
- Hand hygiene and BBE audits were undertaken by the provider, between April 2016 and September 2016, 100% of community staff in Surrey were compliant with correct hand hygiene technique and BBE.
- In Luton, we reviewed hand hygiene audits for the service between April 2016 and September 2016. We saw compliance had improved. In April, compliance was 80%, May 98%, June 98%, July 99.5% August 99.5% and in September compliance was 99.5%. This demonstrated that the measures put in place by the provider to address non-compliance were effective.

Good

Are services safe?

- We saw labelled clinical waste and domestic waste bins were separated in clinical areas. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at Work Regulations.
- Nurses had access to hand washing sinks and personal protective equipment within clinic rooms used for patient care.
- Environmental infection control and prevention (ICP) audits were undertaken at the community bases clinics. Data showed between April 2016 and September 2016 these Surrey teams scored more than 85% compliance which was in line with the VCSL target.
- The annual IPC 2016-17 report, detailed performance data and priorities and action plans relating to ICP at VCSL. For example, one of the actions was to ensure 85% of staff were to complete the online ICP learning module by December 2016.
- Data demonstrated that ICP training compliance varied between 81% and 100% amongst all community staff. This was generally better than the VCSL target of 85% but with small pockets (notably administrative staff) where the target was missed.
- The clinics, Jarvis centre and community bases had schedules for cleaning of equipment, we saw the records were completed with no gaps. This was in line with the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals.
- All clinical staff were offered a flu vaccination voucher by the provider in September 2016. In Luton, we saw there had been a 100% response rate: all 23 staff had received a flu vaccination.

Mandatory training

- Mandatory training consisted of 12 different modules and was a mixture of on-line training and face-to-face learning. Subjects undertaken included safeguarding adults, fire awareness, manual handling, information governance and infection control.
- VCSL target for mandatory training compliance was 85%. Data showed high levels of compliance amongst all staff groups. For example, community nursing 96%, Milford Diagnostic and Treatment Centre (DATC) 97%, Farnham DATC 94%, rapid response (RR) non clinical 94%, RR clinical 83%, community rehabilitation team 97% and speech and language 100%. Figures supplied showed that 100% of staff in the Oldham Total Skin Service were up to date with mandatory training. This showed that all staff groups were in line or above the VCSL target.
- Staff told us that they were no problems accessing mandatory training and they also received a reminder when training was due.
- We saw the training records for staff, which were included within their appraisal. If staff were non-compliant with their training, it would be highlighted at their appraisal.
- Managers were able to show us up to date training records of all staff. This meant they were able to identify staff that were not compliant with their training.
- Reminders about mandatory training were also highlighted in the 'Governance Matters' newsletter to all staff. The February 2017 edition contained a reminder to staff about Information Governance training, with a deadline for completion.
- The provider had an IT platform called 'Jam' where staff could access learning and policies.
- Sepsis was not included as part of the mandatory training which clinical staff were required to complete. Whilst the services do not provide care and treatment of acutely unwell patients, they do provide for the frail elderly who are susceptible to overwhelming infection.

Assessing and responding to patient risk

- All teams had an informal verbal process for daily handovers to handover any caseload concerns. This meant staff were kept informed of any changes in a patient's condition or circumstances for example, if they had been admitted to hospital.
- The RR team had a 'patient whiteboard' of all patients receiving services; it was kept updated at all times, and included patient risks for example if a patient was prone to falling over.
- In Surrey, there were weekly MDT meetings which were a proactive way of responding of identifying and responding to patient risks. The meetings included community matrons, community nurses, district nurses, rapid response, hospital liaison, community psychiatric nurse, safeguarding, GP's, social services, integrated care team and mental health team. We attended one of these meetings; each staff member was given an excel spreadsheet with all current active patients. We saw that each patient was discussed by all MDT members involved in the patients care. This included the current

status of the patient, any safeguarding concerns, forward planning and contingency planning. Any urgent actions for key professionals were dealt with at the end of the meeting. Each patient was allocated unhurried time for discussion which ensured all their needs and risks were discussed. This was an effective way to ensure information sharing, anticipate risks and identify risks for the most vulnerable service users and referring to a named professional where required. This meeting demonstrated collaborative and cooperation amongst different teams, which ensured the best outcome for patients.

- There was a midday meeting of staff at the surgery hub where an informal review of patients took place and we observed there was information sharing and an informal risk assessment of patient needs at the time.
- We saw minutes of the monthly Gold Standard Framework meeting, which staff attended to monitor patients that may be at high risk in the community.
- Patient risk assessments were completed either on the electronic patient records or on paper records. We saw all patients had pressure area risk (Waterlow) scores and a malnutrition universal screening tool (MUST) assessment each month or more frequently if there is a change in patient condition. We reviewed 11 patient records and found pressure ulcer risk and MUST assessments had been completed for all of these patients.
- Staff were required to complete a moving and handling assessment as well as a falls risk assessment for each new patient, we saw these had been completed in the records we reviewed.
- All patients received a full assessment of their needs on the first contact appointment. We found all of the 11 patient records we reviewed had initial assessments completed. This was completed by a physiotherapist, occupational therapist, community matron, speech and language therapist or nurse depending on the specific needs of the patient.
- Staff gave patients a number for the organisation's contact centre, which they could contact 24 hours a day. This was in each patient's folder in their homes, patients and relatives told us they did not experience any problems using the contact centre.
- Patients who attended the diagnostic and treatment clinics at Milford Hospital and Farnham Hospital underwent a Camberwell Assessment of Need in the Elderly (CANE).This is a comprehensive needs assessment tool for use by professionals developed from the Camberwell Assessment of Need (CAN) to incorporate the special needs posed by the elderly. Twenty-four areas of individual need are assessed by the CANE, as well as two questions to assess the needs of the person's carer. The CANE collected information about the older person's needs from various perspectives, such as, the individual themselves, a key staff member, and carer. A summary of met and unmet needs was then produced from the information gathered, which can lead directly to possible interventions and care plans.
- Patients underwent initial CANE assessment to identify individual met and unmet needs, highlights areas of risk and a follow-up assessment to identify successful care package and highlight future problems, or changes in care plan. During our inspection, we saw two completed CANE's. Staff using the CANE assessment spoke positively about the tool as it provided a structured and standardised approach to needs measurement.
- The diagnostic and treatment centre at Farnham hospital provided a 12 week falls prevention course for patients at risk of having a fall and hurting themselves.
- The course followed best practice guidance on how to assess and manage people who fall. It aimed to treat any underlying problems that increased the chances of falling. It also considered the health of people's bones.
- VCSL provided 500 hours of education to nurses and healthcare assistants across different health and social care providers working with patients across Surrey. As a result of this initiative, the number of pressure ulcers in residential homes decreased by 57%. The incidence of pressure damage to patients being cared for by social care agencies in their own homes reduced by 35% subsequent to the training.

Staffing levels and caseload

- As of 16 December 2016, in business unit four, there was 256 staff employed within community services. Of these 156.04 whole time equivalents (WTE) were qualified nurses and 80.37 were health care assistants (HCAs) .There was an overall vacancy rate of 7.58 WTE for qualified nurses and 6.79 for HCAs.
- The business unit four community nursing team employed 127 WTE with an overall vacancy rate of 3%. There was 22 WTE in wheelchair services with an overall vacancy rate of 9% and 107 WTE within the rapid response team and an overall vacancy rate of 13%.

Good

Are services safe?

- Data provided to us showed between September 2015 and September 2016 there was 533.5 qualified nurses' shifts undertaken by bank or agency staff and 844 undertaken by agency or bank HCAs. In the same time period, there were 26 unfilled qualified nurses' shifts and five unfilled HCA shifts.
- Wheelchair services were led by a band seven and were supported by a team of physiotherapists, occupational therapists and a technician.
- Staff told us that they did not have set caseloads but all felt there caseloads were manageable.
- The provider had invested a large sum in the People Flourish programme to help support staff to transform services, to improve team working and reduce sickness absence. To date 20% of the workforce has been trained and completed the four modules. The programme has saved £160, 000 in recruitment costs in a few months as a result of lower staff turnover.
- The community rehabilitation team in Surrey told us caseloads had recently become more manageable. This was because previously they had been seeing patients across a large geographic area and considerable amount of time was consumed with travelling from one patient to another. This had been changed recently and now staff were allocated to cover specific geographical locations. Staff were positive about this change, as they had previously felt they spent more time travelling than patient care.
- Staff in in the rapid and rehabilitation response team told us that there did not seem to be a process for allocating the daily workload and this meant they often spent a long time travelling, rather than seeing patients in the same geographic location.
- The provider had been actively trying to recruit a substantive dermatology consultant for the Oldham site but had been unable to do so because of a shortage of dermatologists nationally. The issue was on the service risk register and the provider was investigating the possibility of improving that salary and benefits of the advertised post.

Managing anticipated risks

- The provider recognised that it was difficult for staff to leave work and attend briefings and workshops. The Quality and Clinical Effectiveness Lead (QCEL) built on the work of the acute sector safety huddles and introduced Quality and Patient Safety Briefings where they visited teams and talked with them about incident reporting, the details of information needed and feedback mechanisms. Discussions took place about the effectiveness of safety alerts, the Freedom to Speak Out guardian and staff safety. The QCEL had visited 180 staff to date.
- Staff in Surrey Heath raised concerns about lone working when the contract was changed to provide 8am until 8pm care, which meant staff were working alone in the dark during winter. The provider changed the policy to allow staff to visit in pairs when it was dark. Staff were sent reminders about the organisation's Lone Working Policy and guidance from the Royal college of Nursing about working alone.
- Community staff were required to ring the operations manager when they were making their first visit of the day and after their last visit of the day. This ensured that managers knew that staff had started their shift and they were safe and well at the end of their shift.
- Some of the rapid response and rehabilitation team expressed concerns regarding mobile phone coverage in some rural locations following a change in network provider. Managers told us staff always had the ability to call 999 regardless of a network mobile signal if they required emergency assistance. Managers told us that they had recognised this as an issue and had arranged with the network provider a signal booster. It was hope that this would improve mobile network coverage for staff.
- The service had measures in place to protect the safety of staff who worked alone and as part of dispersed teams working in the community. In Luton, all staff had a shared work diary: all team members and management could see where all staff were at any point in the day. All team members who had finished their shift were required to call in to the office to say they had finished and they were on their way home. A team member was allocated to ensure all staff were accounted for at the end of each day.
- The provider had an effective lone working procedure. If staff were working late, each team member had an allocated 'buddy': they were required to call in to their 'buddy' to say they had finished their work for the day and they were on their way home. The 'buddy' ensured the staff member were accounted for at the end of the day.

Good

Are services safe?

- Senior staff completed risk assessments for individual risks to staff for example patients with dogs and attached them to the patient's electronic record, whiteboard or daily caseload document. Staff confirmed such risks were communicated to them.
- All staff were required to complete conflict resolution training. Data supplied to us showed that compliance varied between 83% and 100%.Only two staff groups were below the VSCL target of 85% compliance these were both clinical and non-clinical staff in the rapid response and rehabilitation team.
- Staff from the rapid response and rehabilitation team told us they always undertook a risk assessment when entering a patient's home, accessing where the entrances and exits were and any barriers blocking their exit.

Major incident awareness and training

- Each service we inspected had a business continuity plan to be used when events occurred which interrupted or compromised their service. Staff knew what these plans were and were able to give examples of when they had been used. For example, mobile workers recounted examples of how they maintained the service during adverse weather events such as snow affecting the local road transport system.
- At clinical and community hospital locations we saw firefighting equipment, safety signage and posters on notice boards about fire and other emergencies. We checked a random sample of fire extinguishers and saw labels indicating they were tested and serviced. We saw that fire safety was part of mandatory annual training. Fire training compliance varied between 88% and 100% all staff groups training compliance was better than the VCSL target of 85%. Managers told us that evacuation drills were practiced annually.

Good

Are services effective?

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

Summary

- Services were delivered in-line with Virgin Care Services corporate and local policies and Standard Operating Procedures. These had been developed with due consideration and reflection of the current national guidelines and monitored to ensure compliance.
- Patients had comprehensive assessments of their needs and those who support them were included in decision making and wellbeing.
- There was evidence across VCSL that the provider was improving patient outcomes.
- Regular appraisals and clinical supervision ensured staff had the skills needed to carry out their roles and were offered opportunities to further developing their professional skills and experience.
- We saw evidence of established and highly effective multidisciplinary working, teams worked collaboratively to understand and meet the range and complexity of people's needs.
- Patients moved between teams effectively and care records were shared between teams to ensure a smooth transition.
- Appropriate awareness and training in the Mental Capacity Act (2005) and consent was provided and staff understood their roles in relation to this.
- In Oldham, the service had developed a workforce education and training programme to improve the confidence of healthcare professionals to manage the complex level of patients seen, maximise the quality of outcomes, support the development of an appropriate structure that tailored training to the staff member and focus attention on quality improvement so that patients felt satisfied with the level of service they experienced.

However

- Not all Do Not Attempt Cardiopulmonary Resuscitation forms were fully completed in line with best practice guidance. The provider had not yet introduced the new Recommended Summary Plan for Emergency Care and Treatment.

Detailed findings

Evidence based care and treatment

- All Staff had access to up to date policies and documents through 'The Jam', which was the VCSL intranet. We spoke to staff who found this extremely useful and informative. Staff were also informed of up to date changes in guidance through weekly newsletters and team meetings.
- There was evidence of staff working to the Gold standard framework (GSF) an evidence-based approach to optimising care for patients approaching the end of life. There was evidence of early referral and introductory visits by one of the district nurses and we saw patient records that corroborated this.
- Any changes to national guidelines, for example National Institute for Care Excellence (NICE) guidelines, were discussed and disseminated to staff through the Clinical Audit Committee and Information Government (IG) meetings. We saw minutes from these meetings in which changes were documented. We also saw guideline changes were a regular item in the agenda.
- Central Alerting System (CAS) information was, cascaded through a Safety Alert Management system, which tracked responses to alerts. CAS is a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. There was an audit tracker, which captured all NICE guidance, quality standards and technical appraisals. NICE baseline audits and action plans were also embedded into the tracker.
- We reviewed 18 patient care records in Surrey community adult services and saw care goals had been identified and personalised care plans developed. This reflected best practice, which included using templates that followed national guidelines, for example for assessing patients for the risk of pressure ulcers and malnutrition.

- The physiotherapy and occupational therapy services used the 'Goal Attainment Scaling' with an extended tool which links to the World Health Organisation's (WHO) International classification of functioning, which measured the impact of these services.
- Procedures were reviewed against (2011) The Royal Marsden Hospital Manual of Clinical Nursing Procedures 8th Edition. We saw evidence of this in the Hypodermoclysis Guideline for Adults Policy (V7 March 2015). This showed the hospital used relevant guidelines to ensure the most up to date information was being used.

Pain relief

- We saw when pain was assessed as part of the initial consultation; a nationally recognised pain scale was used to determine how bad the pain was, with a rating of one for no pain and 10 for severe pain.
- The staff sometimes used the Abbey pain score is used to assess patient's pain and we saw this being used with at least two patients during home visits. The Abbey Pain Scale is used for people with dementia or who cannot verbalise.
- On one home visit to an end of life care patient, we saw evidence of the pain score being checked, analgesia being reviewed and a relative being involved in those discussions as she was the main carer for the patient.
- Pain was discussed as part of individualised patient care plans. However, pain was not routinely assessed as part of each visit. For example we saw a patient describing her pain during a home visit, but no formal pain score was used to determine at what level the pain was. This meant there was no indication between visits if the patient's pain had increased. We also observed a further three home visits where no pain scaling had occurred.
- Staff considered patients' pain when providing care. We observed staff checking comfort levels, for example, when changing wound dressings.
- Patients we spoke with described nurses warning them of any potential pain before treatment, for example the removal of dressings. We were told by patients they felt there pain was well managed.

Nutrition and hydration

- We reviewed patient care records and saw patients were assessed using the **Malnutrition Universal Screening Tool** (MUST); this is a nationally recognised and recommended tool to identify a patient's malnutrition risk.
- We saw evidence care was provided appropriately in response to these assessments. For example, we observed a nurse discussing a patient's weight loss and the introduction of a feeding tube, a device inserted into the stomach through the abdomen. It is used to supply nutrition when a patient is unable to receive nutrition orally.
- Patients and staff had access to dieticians if needed. We saw an information leaflet entitled 'How to improve your nutrition' which followed NHS Primary Care Guideline and MUST (2005) guidelines. We also saw a leaflet entitled 'How to improve your hydration'. These were given to every patient in their initial patient pack. We spoke to patients who were able to show us evidence they had received this and witnessed staff routinely checking patients eating and drinking habits.
- Dieticians had created a guidance document on malnutrition in care homes, which supported assessment of malnutrition and gave specific advice on hydration. There were sections on how to fortify meals and drinks to improve the nutritional content.

Technology and telemedicine

- Some community staff carried a handheld electronic device, which enabled them to update patient records, order medicines and track the location of staff. This meant that staff had information readily available and could use the devices for effective patient care. For example, staff were able to upload photographs of patients' wounds for an accurate record, aid specialist referral and monitor progress.
- The nurses could upload information about the patient that they wanted the GP to access and whilst the system was not fully integrated with the GP's IT system, the GP could access the information and therefore be informed promptly of changes in the patient's condition.
- A recent pilot for a sub-epidermal moisture scanner (SEMS) showed positive results and was planned to be used throughout community care. A SEMS is a non-invasive sensing technology, which promotes early detection of pressure ulcer (PU) damage including

identification of localised risk areas. The pilot showed a decrease from an average of three pressure ulcers a month, from May to October, to one in total, from November to January.

- Teledermatology involves the referring of an image of the skin of a patient together with a relevant history of the condition to a clinician for advice. The Oldham service was seeking to introduce teledermatology to enable faster diagnoses and reduce avoidable patient referrals from GPs. They had estimated that 50% of referrals could be seen by a telederm pathway in the future, so some patients would be triaged to an appropriate specialist appointment, whilst others would receive diagnostic and management advice to avoid the need for a face-to-face consultation.

Patient outcomes

- Virgin Care Services Limited (VCSL) could demonstrate through documented evidence that following acquisition of services, they had managed to bring about sustained, significant improvements to patient outcomes. The Clinical Governance RAG rating score for Wiltshire services, acquired in June 2016, had improved month on month from 45% to 85% in an eight month period. Similar patterns of improvement could be seen for other acquired services. Some more established services sustained scores of over 90% with North East Lincolnshire scoring 100% over the reporting year.
- A pilot mortality review had been undertaken between July 2016 and August 2017 in response to a national report into the deaths of people with learning difficulties or mental health difficulties in an NHS trust. Zero attributable harm was identified through the review but the provider is widening the pilot review and establishing a mortality reporting database.
- We saw evidence of a core audit programme, which included infection control, medicines management, safeguarding, hand hygiene, and health and safety. We saw that the audits were based on nationally recognised tools, for example, the clinical records audit was checked against the Healthcare Quality Improvement Partnership (HQIP) tool, the best practice recommended tool.
- In Luton, the effectiveness of the service was measured by the provider and by the local clinical commissioning group (CCG). The service had a number of commissioning for quality and innovation (CQUINs) such as screening for anxiety and depression (GAD7 and PHQ6), medicines' management risk assessment tool (Count Tool) and the rehabilitation self-management plan. We saw the service had achieved these CQUINs during the inspection period (between January 2016 and October 2016).
- The service recently undertook a piece of work to identify the highest hospital admissions from care homes. Once these had been identified, the community nurses went into the homes to offer training and make care home staff aware of the services they offered to try and reduce hospital admissions. After 500 hours of training was provided the provider could demonstrate a 57% fall in the incidence of pressure ulcers within care homes.
- The introduction of a new Pressure Ulcer pack and the use of a specialist SEM scanner to reduce the incidence of pressure damage in community hospitals resulted in a 95% reduction in pressure wounds during the test period.
- VCSL participated in five national clinical audits from 2015 to 2016. Within Adult Community services these included Healthcare Quality Improvement Partnership (HQIP) and Chronic obstructive pulmonary disease (COPD) audit. The COPD audit was supported by the Department of Health (DH) with the aim to improve the quality of services for people with COPD by measuring and reporting the delivery of care as defined by standards embedded in guidance.
- In rapid response and rehabilitation, hospital admissions data was entered onto the system and was reviewed on a monthly basis by a service manager and individual staff activity was monitored to ensure any unusual figures were investigated.
- Monthly information was collected on the preferred place of care (PPC) for end of life care patients and their preferred place of death (PPD) and then this is compared to the actual place of death. We saw evidence that Surrey VCSL patients achieved 96% to 100% of their PPC and PPD compared to the Surrey county average of 54%. The National End of Life Care Intelligence Network data showed that 76% of patients died in their preferred place of death.
- We saw audit being completed in conjunction with a local hospice on the use of sub cut fluids and whether this use of hydration was used appropriately. The results of this audit were not available at the time of the inspection visits.

Good

Are services effective?

- The benign lesions audits, undertaken in Oldham, had initially shown that 41% of benign lesions were of low clinical priority. Following the production of a policy and patient leaflet to manage patient expectation a further audit showed that there had been a reduction in low clinical priority procedures to 8%.
- Patients with Psoriasis completed a Psoriasis Area Severity Index (PASI). This was reported on a quarterly basis to commissioners. The measure is the percentage of patients that had their expectations met. In June 2016 the percentage was 90% and in October 93% of patients said their expectations had been met.

Competent staff

- Staff were recruited safely; we reviewed staff files and saw they contained references, photographic identification, copies of certificates, Nursing and Midwifery (NMC) registration validation and disclosure and barring service (DBS) checks.
- All Surrey District Nurse Teams had a "Book of Service Standards (BoSS) for community nursing. This was very detailed and covered information such as organisational structure, the Virgin Care vision and goals, common processes, standard operating procedures (SOP), information governance guidance and professional service standards.
- New starters to VCSL confirmed they had attended an in house orientation and a period of shadowing to ensure they were comfortable and confident. This shadowing period was determined on an individual basis. One new community nurse explained how they had first shadowed other community nurses, and then performed care under supervision before being allocated their own caseload. This had made them feel supported and helped build their confidence.
- The Human Resource (HR) department used an electronic staff record (ESR) that linked to the General Medical Council (GMC) and NMC registration sites. The provider produced a report from this, twice monthly, to identify when registrations were due to lapse. Staff were sent a reminder three weeks prior to the date and then a further two reminders if confirmation of re registration was not received. We were told in the event a registration had lapsed, staff were employed as health care assistants (HCAs) until they had renewed their registration.
- All staff we spoke with told us there were training opportunities available and they were supported to develop. They gave us examples of education and training they had recently completed. This varied from support to undertake non-medical prescribing courses and master's level study, to clinical education such as completing a diabetes module or training on dementia and implementing the butterfly scheme.
- There was evidence staff were assessed on competencies before being allowed to deliver care. For example, Hypodermoclysis (a technique used for the administration of large volumes of fluids in mildly dehydrated patients), within the Guideline for Adults Policy (V7 March 2015) recognised this would be a new area of practice for many staff, so obtaining appropriate training and completion of the hypodermoclysis competency framework was required before practicing. Following training, there was a formative section, which was completed by staff and further assessed by a qualified mentor.
- Staff were encouraged to attend a three-day course in end of life care including breaking bad news, communication, changing gear in the last year of life and advance care planning and assessment. Staff were very positive about this three-day course.
- We were told about and saw evidence of a Community Nurse Improvement Programme (CNIP) Surrey 2015, This non-accredited in house programme for band 6 and above nurses consisted of two half day and two full day sessions. We saw, 67% of district nurses and senior community nurses attended all four sessions. Qualitative feedback was used to build on and improve the following sessions and the development of the band five programmes. District Nurses self-rated their confidence, ability, knowledge against the learning outcomes before and after the programme, it showed before the training that they had rated managing relationships at 46% before compared to 90% afterwards, and awareness and capability and disciplinary procedures at 15% before and 92% afterwards.
- All the staff we spoke with said they had appraisals with their line manager that were meaningful and useful and had objectives set and training needs identified. We saw 98% of staff were up to date with their appraisals in community nursing and rapid response and all staff had received appraisals in wheelchair services.

Good

Are services effective?

- The majority of the staff we spoke with told us they had monthly one to one meetings with their line managers. We were told there was an open door policy if staff had any queries or needed extra support.
- The services encouraged staff to undertake clinical supervision. Clinical supervision is a formal process for professionals to review and reflect on the clinical practice.
- A clinical supervision audit took place in December 2015 and December 2016. In 2015, it was identified that the hospital was falling below targets for attendance at training for clinical supervisors, with a target of 80% and only 75% attending. This was identified as an action plan for improvement. In 2016, this had improved to 100%. This showed that the action plan after the 2015 audit had been successful. Staff we spoke with confirmed they had received clinical supervision and found it useful.
- From April 2016, all registered nurses are required to revalidate with the NMC in order to continue practising. Registered nurses told us they had received support from the organisation and could demonstrate a good understanding of the requirements needed. Minutes of team meetings showed it was regularly discussed.
- The VCSL Chief Nurse had met with the NMC and was a board member of the Royal College of Nursing and this had allowed an early understanding of the revalidation process.
- The registrant's revalidation status was checked as part of the annual appraisal.
- Competencies were checked by senior staff throughout all band levels. For example, band three Healthcare support workers had competencies checked by band six nurses and band six were monitored by band sevens.
- In 2015-16 the Oldham service was commissioned to develop a Workforce Education and Training programme as part of its Commissioning for Quality and Innovation (CQUIN) scheme. The aim of the programme was to improve the confidence of healthcare professionals to manage the complex level of patients seen, maximise the quality of outcomes, support the development of an appropriate structure that tailored training to the staff member and focus attention on quality improvement so that patients felt satisfied with the level of service they experienced. Staff undertook an advanced communication course as part of the programme. There was primary care engagement and training and supervision was given by the clinical lead. Details of courses were made available to staff in news bulletins.

Multi-disciplinary working and coordinated care pathways

- There were weekly multidisciplinary (MDT) meetings, which included, amongst others, social workers, mental health teams, GPs, community matrons, district nurses and also a representative from the volunteer services. We witnessed two of these meetings that were extremely effective and considered patient needs across many sectors. The teams worked well to ensure patients received care promptly in a holistic and joined up manner.
- We saw several examples where staff demonstrated good relationships with other team members with regards to patient care. For example, a mental health nurse asked for an opinion on a patient that needed an assessment for capacity, or a GP being consulted after a home visit identified patient's additional symptoms. Staff unanimously told us that the multi-disciplinary relationships within the area had a positive impact on patient care.
- The local ambulance service and community teams had an alert system in place for paramedics if a patient they were called out to was under the care of the community team. Where possible this was used to avoid patients being transferred to hospital. For example if a patient had had a fall the community rapid response would attend and care for the patient if appropriate.
- The weekly MDT meetings and the single point of access hubs ensured patients were transferred between teams in an effective way and ongoing treatment and care was ensured.
- The service provided an 'in-reach' service with a local acute hospital provider. The clinical navigators completed assessments of patients' need in the acute hospital, in both ward and emergency areas and identified the most appropriate setting in the community for the patient to be cared for.
- The service provided care home support teams who would visit the local care home weekly to review patients and proactively check for any potential problems.
- We attended a multidisciplinary meeting (MDT) and were shown a spreadsheet that included all patients

who were receiving care. If the patient was new they would be highlighted in red, this meant they were discussed first at the meeting to ensure sufficient time was allocated. Administration staff attended the MDT meeting, they documented all the relevant information and action required. This ensured important information was documented.

- Staff worked closely with the local hospice, to ensure that there was a collaborative and supportive working relationship. For example palliative care and end of life policies are developed jointly and they were working together to review the Verification of Death Policy.
- The clinical nurse specialist (CNS) from the hospice called into the surgery hub to discuss cases with the district nurse who was the case manager. We saw that the district nurse knew which CNS was available to support in her area and knew their contact number. For example following a patient's recent discharge, there was a need to get dressings to a patient and the district nurse was unable to do this immediately. The hospice nurse stepped in and was able to support the patient. This showed flexible working and good teamwork, supporting the patient in the home environment.
- We observed good multi-disciplinary working for one patient at home who required increased support with four services contributing to a package of care led by the district nurse. The Macmillan and Marie Curie nurses are available to give advice and support and we saw that their contact numbers were available to the district nurses
- There was good support from the GPs who were active in putting advance care planning in place.
- The Oldham service was initially unable to accept cancer referrals due to a lack of a multidisciplinary team (MDT) model. They had worked with local clinical leaders in dermatology and oncology to develop and implement a locally run Oldham Dermatology MDT that was unique across Greater Manchester and was noted as innovative by the Clinical Commissioning Group.
- As well as carrying out clinical audits and keeping up with medical advances, the Oldham MDT met on a bi-weekly basis to discuss a list of patients where cancer had been identified through histopathology and decide on the appropriate onward referral pathway for the patient. Patients were referred to local acute trusts, dependent on the type of cancer identified or to the Christie Specialist Cancer Hospital for skin lymphomas.
- The service had co-ordinated care pathways in place for booking and triage of patients. The triage pathway determined which clinical pathway the patient was assigned to. There were pathways in place for Community Dermatology; Secondary Care Chronic Skin Conditions; Secondary Care Paediatric Skin Conditions; Secondary Care Skin Lesions and two-week wait Cancer Referral Pathway. When patients were on the cancer referral pathway the MDT were responsible for agreeing and documenting the treatment planned for each individual. This was recorded on the Somerset Cancer Register, which supported the tracking of patients to ensure that treatment was actioned as planned. There were a number of sub-pathways for those patients who had been placed on the cancer referral pathway. These were clear and directed the clinician to next actions for example for those patients who did not attend for their first appointment; those removed after the first consultation or referred onward after first consultation and treatment procedures for non-cancer and cancer diagnoses

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, acute hospitals, nursing and residential homes. There were single points of access throughout the service including Surrey Heath and Farnham". These consisted of multidisciplinary team members all co-ordinating from one hub. This enabled quick discussion and referral within teams and allowed staff to get fast responses to questions about patient care if needed. This promoted communication and multidisciplinary working.
- Referrals were handled effectively with a clear criteria and a multi-agency approach ensured people got the right care in a timely way. Referrals were rated red (highest need), amber and green after initial assessment and allocation of visits calculated in response to this.
- Patients could self-refer to some services for example the continence team, podiatry and physiotherapy. We witnessed a patient requesting an ear syringe service and this was followed up during the daily handover meeting. The appropriate staff member was allocated the visit.
- The VCSL community nursing teams worked towards an estimated date of discharge for all patients. We saw

discharge was planned from caseload admission through assessment and reassessment of goals and in collaboration with the patient, carers and relevant co-providers.
- Patients were discharged when the agreed care outcomes were achieved. The patient was given details of how to contact the service again and an indication of when this may be needed.
- GPs were made aware of discharged patients in all cases. Appropriate referral to specialist services or admission to hospital/nursing home was indicated on the transfer of care document.

Access to information

- Information was available to staff in a timely and accessible way; all the localities we visited used an electronic patient record system. Some staff had access to the electronic records via computer terminals in offices, or some staff via the use of electronic tablets, which could be used in patients' homes.
- In areas where connectivity was poor, staff could still input information into the tablet, which would automatically be uploaded to the live system as soon as connectivity was established.
- Local GPs were linked to computer system that the district nurses used; this meant they could access patient records and information directly from the GP surgery. This ensured that if a community nurse had a question about a patient the GP could look at the records and advise the district nurse of any further actions to be taken. For example, looking at a photo of a pressure sore to see if the treatment needed a GP visit.
- We witnessed a patient asking about services and being advised by the district nurse as to the best course of action. District nurses were able to refer patients to services such as telemedicine if needed.
- Palliative care records were kept in houses for patients with end of life care needs. We saw patient records which had all relevant documentation including, Do Not Attempt **Cardiopulmonary Resuscitation (**DNCPAR) information. Patients also had any appropriate medication available.
- Staff that used the electronic records were positive about them, found them easy to use, and reported no issues with accessing notes and care plans.
- After a patients discharge from the service community nursing notes are stored as required in line with Information Governance guidance in place with the commissioners. We saw this was also guided by data protection legislation.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood their requirements of relevant legislation and guidance including the Mental Health Act 2005. Staff also demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS).
- We saw staff were up to date with Mental Capacity Act training. We were told this included minimal restraint guidance and focused on the patient's best interest, in-line with national guidance and legislation. Across Business unit four, 95% of staff had completed mandatory training for MCA in community nursing in February 2017. In rapid response and rehabilitation, the compliance ranged from 100% to 86% with an average of 95% having completed the training. All of these set against a target of 95% meaning the targets were being met.
- Staff told us they did not have much experience of completing the two stage capacity assessment but would seek advice and support from either a colleague in the mental health team of local GP in they felt it was needed.
- Patient records we reviewed showed the appropriate consent had been obtained and correct records were kept in-line with best practice. These were also audited to ensure compliance.
- We witnessed staff members gaining verbal consent from patients before and during treatments and ensuring the patient understood the care they were receiving.
- We observed a discussion around a patient's capacity in a MDT meeting, which involved community nurses, dietician, mental health team and social worker. It enabled a wide view on one patient's situation and enabled a quick decision to be made as to how the whole team were to proceed.
- We heard a recent example where the best interests of a patient had been assessed which allowed medication to be given whilst a patient was asleep to minimise the distress. Whilst the community team were involved in the process, several teams assessed the patient before the decision was made.

Good

Are services effective?

- In Oldham, we examined two consent forms for women who were receiving isotretinoin treatment for acne. Because of the dangers of the drug to unborn children the consent process had to be very thorough. We saw that all the risks were clearly discussed with the patients and pregnancy tests were carried out where appropriate before consent was sought. These were repeated at each patient review.
- One set of patient notes showed evidence of discussions held with family at the final stages of the patient's life. The patient had capacity and the Do Not Attempt cardio Pulmonary Resuscitation (DNACPR) form was completed appropriately. The DNACPR form was in keeping with the patient's wishes and best interest.
- However, we checked a further six DNACPR forms and found the standard of completion was variable. Three were fully complete, two lacked adequate information and rationale and one form had not been reviewed for five months. Therefore not all notes were in line with the guidance about decisions relating to cardiopulmonary resuscitation.

Good

Are services caring?

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

Summary

- Feedback from patients and their relatives/carers was continually positive. We witnessed staff giving time to patients to listen to their concerns and offering support where needed. Staff explained and ensured that patients and carers had a good understanding of procedures before undertaking them.
- Staff showed kindness and compassion with all patient contacts; they respected patients dignity at all times and were sensitive to patients' need.
- Staff exhibited a strong commitment to holistic and individualised care. This was firmly incorporated into the philosophy of the organisation.

Detailed findings

Compassionate care

- Results from the NHS Friends and Family test showed consistently positive results. Between April 2016 to September 2016, business unit four received 3876 responses, 73% of patients were extremely likely to recommend and 24% were likely to recommend services.
- The results for the Friends and Family Test (FFT) for the community services in Luton between July 2015 and September 2016 showed that patients had responded positively with 100% scored across the three month period from June 2016 to August 2016.
- We observed a wide range of staff from different services in patient's homes and in clinics. Their interactions were professional, friendly and kind.
- We spoke with 12 patients who used a variety of services provided by Virgin care Services limited (VCSL) all patients we spoke with felt staff were caring and compassionate.
- We saw staff took time talking to patients and explaining things to them and those people close to them.
- Staff treated patients with privacy, respect and dignity and this was seen when they protected patients from cold and exposure, using blankets to maintain dignity. In the clinics, the curtains were drawn and doors closed to ensure privacy. Staff knocked on doors before entering.
- One relative of an end of life patient was overwhelming positive about the community team that had supported them describing a caring and sensitive approach by all members of the team.
- Staff adapted their assessments and treatments to meet the individual needs of each patient. For example, there were times when certain standardised assessments might not be appropriate. We observed this during our inspection with an interaction between a member of staff and a patient living with dementia. The staff member treated the patient with empathy and went the extra mile to ensure the patient understood and gave them unlimited attention.
- All of the patients we spoke with were complimentary regarding the care and efficiency of the community staff. Comments such as "I look forward to seeing them"; "always smiling always happy", and "I don't know what I would do without them" were very common.
- VCSL used a dignity map to plot out the characteristics of a good service that respected dignity. The dignity map focused on change. The map helped view dignity through a holistic approach. The map was broken into four sections, focus on the person, dignified and respected, a better service and getting the basics right.
- All of the staff we spoke with took great pride in their work and were committed to providing the best care they could.
- One of the speech and language therapists told us one of the best things about their job was that she had the ability to spend as much time as needed with patients.
- One visit demonstrated that the breaking of bad news was done sensitively with care and compassion and visiting a bereaved family was done in a similar way with time taken to advise and support.
- The Motor Neurone Disease team from Farnham had been presented with the 'Extra Mile Award' by the MND association for their "Exceptional care of people with MND".
- Across VCSL, 97% of patients would recommend the services to family and Friends (FFT)

Understanding and involvement of patients and those close to them

Good

Are services caring?

- Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.
- We spoke to five relatives or carer's during our inspection all were very positive about the services provided. One relative said, "If you phone the contact number because you have a question they are always pleasant and friendly".
- All staff interactions we observed demonstrated good communication with patients and their carers and relatives. In the diagnostic and treatment centre, we observed nurses discussing the planned care with patients. In addition, the staff gave patients written information on their attendance to the clinic and what the next steps were for example any further investigations that were required.
- Staff did not use jargon when speaking to patients to ensure they understood what was happening and explained equipment and the process before carrying out procedures. Staff took time to explain what they were going to do and adopted this to a way the patient would understand.
- We saw staff involved patients and their families in planning care and treatment. Staff caring for patients with life limiting and long term conditions discussed the individual needs with patients and developed the best and most effective plans for addressing their needs in partnership with patients and their relatives. An example, of this was when a physiotherapist discussed different options of stair lifts with a patient and their relative, which would enable the patient to go into the kitchen. The physiotherapists provided information on different types of stair lifts and contact details of different companies.
- We observed a physiotherapist teaching a relative some exercises that they could do with the patient to improve their mobility. The physiotherapists took time to explain the exercises to ensure the relative understood and also provided written information that the relative could refer to.
- We saw individualised advance care plans in patients' homes, which reflected the choices and preferences of the patient. Advance care planning was the process of discussing and documenting the patient's wishes for future care, which enables health professionals to understand how the patient wishes to be cared for.

Emotional support

- Staff knew how to access different support groups and organisations for patients if required, for example the Alzheimer's society, Parkinson's society, and Age UK.
- There was information displayed in clinics regarding a variety of support groups for example prevention of falls, living with dementia, and counselling services.
- Personal, cultural, social and religious needs were addressed. Staff we spoke with were aware of their patient's specific needs such as those with religious beliefs.
- We saw a November 2016 leaflet, which detailed a description of the advocacy work the service provided and other advocacy services provided by VCSL.
- VCSL had a variety of resources available for carer's. For example, they could refer a patient to the local County Council for advice, information and support, or to request a Carer's Needs Assessment.
- VCSL had a website with advice for both carers and staff. It included a carer's guide, a carer's awareness workbook for staff and benefits for carers.

Good

Are services responsive to people's needs?

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

Summary

- Services were delivered in a timely way with flexibility and continuity of care. There was highly co-ordinated working between other services and teams.
- The needs of patients were considered and used to make changes to the service. Urgent needs were catered for and waiting times and delays were minimal.
- Staff were able to schedule appropriate time for each patient dependent on their needs, and understood that when more time was needed adjustments could be made to ensure appropriate care was given.
- Complaints were treated fairly and with compassion and taken seriously. We saw examples of changes to the service because of complaints made.

Detailed findings

Planning and delivering services which meet people's needs

- Corporately there was a clear business plan and model for how the provider wanted the service to grow and develop moving forward. At the time of the inspection there were significant changes to the contracts with CCGs taking place. Some services were being acquired and others were being transferred to other providers as contracts were split. There arrangements are outside the remit of this inspection.
- There was a 100 day plan for new services and a separate exit plan for those exiting the organisation.
- Some support services were centralised and benefitted from the resources of the wider Virgin Holdings parent company. There remained, however a view that some services were best kept at local level with national support. This included business unit based human resources staff and IT engineers and finance staff.
- All acquired services went through a robust assessment process to enable staff to work within the VCSL framework and to VCSL policies. Support and guidance was provided throughout the transfer period.
- Local staff were encouraged to have ownership and to be involved in service planning to meet the needs of their local community. Hastings MSK staff, for example, had been supported to offer a 'Multiple body part clinic' which reduced the need for several appointments and allowed the staff to consider the problem from a more holistic perspective.
- All community nursing services operated for 365 days per year and managed long-term conditions, provided support and education to individuals to self-care, technical care within the community setting and provided care at home to avoid unnecessary hospital admission.
- Throughout the care episode the community nurse acted as case manager to ensure service delivery was appropriately instigated and coordinated to meet the individual patient's needs.
- Patients in nursing homes were not treated by the service; however, patients in care homes with residential beds were treated by the community nursing service.
- The single point of access (SPA) for community health services operated seven days a week from 8am to 8pm in Surrey Heath and from 9am to 5pm in the other SPA in Surrey, staff told us that changes were planned to operating times in line with new service specifications from April 2017.
- Administration staff recorded initial information and then directed the call to the appropriate local SPA. All calls were answered and triaged by a clinical navigator, who was a band six clinician with the aid of a health care assistant (HCA) who referred the caller to the most appropriate service.
- The SPA enabled quick and accurate assessment of a patients needs and staff were able to get fast assessment and access care plans from one central place. Staff and patients we spoke with told us this meant there was no crossover of work, waiting for the correct referral or care plan to be completed.
- The community also had walk-in centres which combined with the 'hubs' provided a joined up care service for the frail, elderly and those with long term conditions.
- In Farnham we saw a similar integrated system in place, bringing together the Integrated Care Teams (ICT) and North East Hampshire and Farnham via the 'Happy, Healthy and at Home The care provided to patients was

planned and delivered with commissioners, stakeholders and other providers to ensure it was timely, appropriate and considered to needs of the local population.

- We were given several examples where the service had worked with the local commissioners to increase the service offered. The community matrons provided support to care homes across Surrey to reduce hospital admissions and improve the quality of care for people living in care homes. Systems in place included the assessment of unwell patients, advising on management of long-term conditions and training of staff in care homes. Homes had an identified matron who they could contact for advice and referrals to the integrated care team.Education provided included pressure care, catheter care, end of life care and malnutrition.
- Community matrons were available to co-ordinate the care of patients with long-term conditions who required advanced nursing care management, thereby improving quality of life and reducing unplanned use of services such as avoiding unplanned hospital admissions.
- Staff were able to schedule appropriate time for each patient dependent on their needs, and understood when more time was needed adjustments could be made to ensure appropriate care was given. For example, more time could be allocated to more complex patients, which allowed for any unexpected circumstances.
- We spoke with a specialist tissue viability nurse who was available to advise and assist patients. Community teams were able to refer to the specialist for assessment and advice.
- Patients and their families were involved in the planning of services they required. For example, we saw a patient who was able to decide when a treatment enabling him to receive nutrition was implemented, empowering him to make decisions at his own pace.
- The provider led rehabilitation unit pathway redesign in Luton Intermediate Care Rehabilitation Service. The provider ensured clear criteria were set and waiting times were reduced. Facilitating change resulted in reduced length of stay from 53 to 38 days. The enhanced Stroke pathway service redesign enabled the staff to see 129 patients in the year April 2015 to March 2016, which was much better than the CCG target of 45 patients.
- The organisation worked closely with Commissioners, local acute hospital trusts and other key services. The Oldham service had primarily been planned around the local population to avoid them having to travel some distance to an NHS trust in another borough to receive treatment. The service was situated in the Oldham Integrated Care Centre which is a building in the centre of Oldham and is easily accessible by car and public transport.

Equality and diversity

- Staff were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that staff could communicate effectively with all patients where English was not there first language.
- Staff had access to translation services on their electronic devices that could be used by patients.
- Staff could access information leaflets in other languages if needed and we saw information on the back of patient information leaflets signposting patients to these.
- A leaflet for people with Parkinson's disease was created to promote attendance at group therapy sessions for speech and language support. The leaflet had been translated into Nepalese, Hindi and Polish to reflect the linguistic culture of the local population.
- Breast screening leaflets had also been adapted and translated into Nepalese to encourage women from the local community to attend.
- Physiotherapy staff tailored exercise programmes to meet individual needs taking in to account age or disabilities. This meant, for example, that those patients who were wheelchair users could still participate in the recommended exercises or programme.
- There was a variety of equipment available to meet the needs of patients with a high body mass index (BMI).For example, specialist bariatric wheelchairs were available.
- During our inspection we observed a patient requesting a smaller Zimmer frame as their one did not fit into their bathroom, this was delivered to the patient the next day.
- At the fast track meeting we saw an example where, because of age, a patient had requirements that were considered and the package of care to support that patient was adjusted accordingly.
- Accommodation was seen to be made for patients that were outside of their normal place of residency to receive appropriate care.

Good

Are services responsive to people's needs?

- Equality and diversity training was in place for staff and 100% of community staff had completed this mandatory training.

Meeting the needs of people in vulnerable circumstances

- A recent Dementia Strategy was created from listening to stories of people affected by dementia, reviewing innovations in place with other providers nationally and staff consultation. The provider had set up a Dementia Community with people from across the services with a dedicated page on the intranet signposting staff to resources. The group had reviewed the screening tool and training programme and there was a current recruitment programme for dementia champions from within the staffing complement and an audit across services to ascertain how Dementia Friendly the services were.
- A team of knitters had been recruited to knit a type of sensory hand muff that provided a source of tactile and sensory stimulation for people living with dementia.
- Patient-led assessments of the care environment (PLACE) put patient views at the centre of the assessment process and areas included privacy and dignity, cleanliness, food and general building maintenance. In addition, the building's suitability for dementia sufferers who sometimes have difficulties with identifying contrasting colours such as doors and door frames unless these are clearly marked. Scores for dementia in Farnham, Milford were better than the national average of 75% with results of 80% and 76%.
- Staff were able to give us examples of caring for people living with dementia and the adjustments made, for example, taking time to talk to patients, using simpler language and involving carers.
- VCSL have committed to supporting John's Campaign, an initiative championed through the Carers Forum to allow family carers the right to stay with their relative who is living with dementia, when they are in hospital.
- There were plans in place to create an information pack to be given to all patients at the point of diagnosis. Three pilot projects were taking place including an Ageing Well Hub in partnership with Age UK, which provided a single point of access to staff at Virgin Care to access advice and support, links to community transport and continence services, an advice line and out of hour's service and an entertainment library.
- We heard and saw evidence about a new initiative that had been designed by a staff member who recognised that patients were often confused by the number of people who were caring for them and how to contact them if they needed help or advice. A simple document which outlined the roles of different services such as district nurses (DN), out of hours (OOHrs), Marie Curie, Hospice, palliative care teams and GPs and provided contact details for each service. Direct phone numbers could also be filled out by the district nurses as and when a patient was allocated.
- The provider was involved in implementing the 'Surrey Carers Prescription', which evolved from the Carers Pathway. Staff accessed a referral from the Surrey Carers Prescription Website and identified the needs of the carer. Services included benefits advice, a young carer's service, back care advice, breaks, and respite. The local authority also provided an 'Emergency Carers Card' via prescription so that additional emergency provision could be made. There were 536 referrals made during 2014 to 2015, showing this was a successful venture.
- Patient's carers were included in the visits we attended. We heard an example where an aromatherapy massage was given to a patient as well as his partner. We witnessed a community matron checking on a carer during a visit, ensuring they had support, and the possibility of respite care.
- The provider had a carers club with a website that signposted people to other resources. Tea parties, 'Raise a cuppa for carers', were also held.
- VCSL were part of the carers collaborative that won the HSJ Commissioning for Carers Award.
- Staff were able to ensure safe discharge to other services as more complex cases were discussed at the weekly MDT meetings. For example, a patient who no longer needed nursing care but still needed social workers to visit.
- Patients with long-term conditions were cared for by a multi-disciplinary team who worked together to provide appropriate care. We saw many examples where team working had helped patients and their carers to achieve flexibility and choice in the care they received. For example, nurses had arranged for a patient to receive respite care but with his regular home carers being able to continue to care for him in the respite setting. This aimed to help the patient and his partner feel most comfortable with the change of setting.

Good

Are services responsive to people's needs?

- At the time of our announced inspection of the Oldham site, there were no toys in the waiting area for children. We were told and observed that, where it was not appropriate for a child to accompany their parent into a clinic, that a Healthcare Assistant would look after the child in reception until their parent or carer was back from their appointment. There was little to occupy the child during this time. When we returned on our unannounced inspection, we saw that the service had purchased a selection of toys for the waiting area and there was a cleaning rota in place to minimise the risk of infection.

Access to the right care at the right time

- Patients had access to the right care at the right time. We saw the majority of patients using community services for adults were seen by a care of the elderly consultant within 10-15 days, which was better than the national target of 18 weeks. Wheelchair services aimed to assess patients within 18 weeks but were slightly below, with a 19 week average for the low risk patients.
- Patients using community services for adults were RAG (Red, Amber and Green) rated daily depending on the urgency of their care needs. They were rated red for the most urgent and seen that day, amber rated patients were seen within 24/48 hours and green rated patients seen as soon as possible. In Surrey Community Nursing Service there was a patient priority and demand escalation guide that was agreed with CCG's and was used by local community nursing teams.
- When appointments were cancelled, patients were phoned as soon as possible and told of the delay, and offered an appointment the next day if possible. If a patient was cancelled, the RAG rating was increased. For example, if they were green, they moved to amber, and if they were amber, they moved to red, to ensure they would be prioritised when allocation for the next day was considered.
- The rapid response and rehabilitation care team (RRARCT) in Surrey provided care to patients who required a social care package in order to prevent hospital admissions or to facilitate an earlier discharge from hospital. The team responded within two hours of receiving a referral and were available 8am to 10pm, seven days per week. The RRARCT provided support for patients until a care agency could be identified. The majority of patients remained with RRARCT for between 10-25 days.
- Records showed that the RRARCT had steadily been increasing the 'alternative to admission' rates from October 2016 to January 2017, with 2279 patients avoiding admission in October 2016 and 3572 in February 2017.
- Patients were offered six weeks of free telehealth after hospital discharge. Telehealth provide suitable equipment to patients so they are safe at home, for example, we saw a patient had rails put in the entrance to their home to assist mobility. We also witnessed a community matron refer a patient for bed rails to aid mobility. Staff told us that there were minimal delays with this service and that it worked well.
- In Oldham, all urgent referrals were offered an appointment with 14 days and routine appointments were offered an appointment within 28 days. The service had carried out two triage audits that showed that the patients were being seen on the correct pathways and avoided them receiving unnecessary appointments.
- The service was also monitoring rejected referrals so that they understood why referrals were being referred by GPs incorrectly, ensuring that patients did receive access to the right care and to support GPs with referral guidance.
- The Oldham Total Skin Service offered a seven day service to enable patients to access services at a time most convenient to them. There were early morning and evening clinics and clinics on a Saturday and Sunday and Bank Holidays. The service had introduced weekend minor surgery clinics to improve access for those patients who could not get to the clinics during the working week.
- For Oldham, Key Performance Indicators showed that the targets for scheduling a first appointment within two weeks for urgent scheduled referrals were 95%. Records showed that this was 100% met since the service started. However, not all patients chose to attend a first appointment within two weeks. The target for attendance was 93%. This target had not been met in May, July. September, October and November 2016 and in January and February 2017. The service had established that this was due to patients wishing to delay their first appointment and provided an exception report with a narrative on any missed two week wait appointments to the CCG on a monthly basis.

Good

Are services responsive to people's needs?

- Percentage of service users waiting no more than 31 days for cancer treatments where that treatment was surgery, anti-cancer drug regimen or a course of radiotherapy was shown to be 100%. Percentage of service users waiting no more than 62 days from referral to first definitive treatment was also shown to be 100% from the service start date.
- The target for patients receiving a first appointment within four weeks for routine scheduled referral was 95% or above. Key performance indicators showed that this target had not been met in May, June, July, September, October and November of 2016 but had been consistently met since then.
- The service used the Somerset Cancer Register to ensure that cancer patients were seen and treated as quickly as possible. Priority tracking lists were used to show patients in order of chronological breach and number of days on the pathway. This minimised the number of breaches of key performance indicators and was managed by the MDT Co-ordinator.

Learning from complaints and concerns

- The Complaints Policy stated complaints should be acknowledged within three working days and fully investigated. The complainant should be kept informed throughout the process and a time frame given.
- All complaints received were sent to the Customer Service Team (CST), who provided central support and sent an acknowledgement letter and confirmed a response date. The complaint was then forwarded to the service manager to begin any necessary investigation.
- An open and transparent response that addressed all the points raised was encouraged with staff being supported to offer face to face meetings whenever possible.
- The Clinical Lead for each service was responsible oversight of all complaints and telephoned complainants personally. The sign off for all complaint letters was the business unit head.
- The CST also monitored social media and feedback sites for any new comments and responded to these as they would more formal complaints and comments.
- The overall level of complaints was very low across all VCSL adult community services.
- The complainant was informed to take the complaint to the independent Parliamentary and Health Service Ombudsman if they were not satisfied with the way the complaint had been dealt with by VCSL.
- We saw there had been 14 formal complaints relating to adult community care from December 2015 to November 2016.
- We reviewed four complaints and all followed the company policy and had clear wording, were honest and open and adhered to the complaints policy. They also detailed any actions the provider had taken and discussed outcomes.
- We were told of a change in practice following a trend in complaints around specific appointment times not being given for home visits. As a result, the service now gave a three hour time frame for visits so the patient would know to expect the early morning, late morning, early afternoon or late afternoon.
- Staff told us they would always try to address complaints informally in the first instance. The clinical lead, for example, told us how they had visited a patient at home with another colleague to allay concerns and discuss problems early, before they escalated into a full formal complaint.
- Staff left information leaflets detailing how to raise a concern or complaint in patient homes. We asked patients if they were aware how to make a complaint if needed, and were told they had been provided with information in their welcome pack.
- We saw evidence from minutes that complaints were discussed at locality meetings and were mentioned in weekly newsletters. We were told that they were also discussed and updated in the handover meetings as and when appropriate.

Outstanding ☆

Are services well-led?

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

Summary

- The leadership, governance and staff culture were highly developed and used to drive and improve the delivery of high quality person-centred care.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a clear governance structure and assurance framework with effective and clear communication to and from the executive team.
- There were very robust systems in place for providing assurance to the Board about the safety and quality of the services provided. Data collated as part of the assurance and governance framework was used to drive service improvements. The governance structure was comprehensive but not unduly complex and encouraged operational staff to take responsibility for the services they delivered.
- Leaders exuded a strong sense of shared purpose, strove to deliver and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Staff felt supported by their line managers and felt confident to raise concerns with them. There was a strong visible local and national leadership who, together with the staff, were committed to improving patient care.
- We saw staff and managers shared the same vision and strategy. The organisation was pro-active in celebrating staff achievements.
- The leadership drove and supported continuous improvement and staff were accountable for delivering change. Safe innovation was encouraged and celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Staff felt empowered to make positive changes.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

Governance, risk management and quality measurement

- Virgin Care Services Limited (VCSL) had a very clear governance structure that fed up to Virgin Healthcare Holdings Limited, the parent company through their monthly meetings.
- The VCSL Executive team led the services provided and received assurance both from the Virgin Care Clinical Governance Committee and directly from the Health and Safety Committee and Information Governance Committee.
- At VCSL Clinical Governance Committee meetings, the executive team shared learning, monitored KPIs and the clinical strategy with each business unit (regional) director and clinical lead.
- The VCSL Clinical Governance meetings were chaired by the medical director.
- Reporting directly into the VCSL Clinical Governance Committee were four sub committees – Infection prevention and control, research governance, medicines management and safeguarding adults and children. The sub committees each had representation from each business unit and were multidisciplinary to enable concerns and ideas to be considered from a wider perspective.
- Sitting under the VCSL Clinical Governance Committee and with information passing in both directions were the Business Unit Clinical Governance Committees (Clinical Quality and Risk; Integrated Governance Committees).These business unit meetings were chaired by the business unit head.
- Providing arm's length, higher level challenge and assurance was a Quality Committee that provided additional organisational assurance on clinical governance, quality and safeguarding. This group received reports from the VCSL Clinical Governance Committee and also the Health and Safety and Information Governance Committees. The role of this group was to provide 'Blue Sky' thinking, to consider innovative ideas and to ask strategic questions that arose from the assurance reports.
- For each business unit, there was a monthly Business, Clinical Quality and Risk Meeting (BCQRM) where a

monthly clinical quality report was shared, which addressed all clinical quality & safety including safeguarding, complaints, compliments and friends and family test (FFT) data.

- The clinical quality report was comprehensive and we saw the minutes for September and October 2016. The July 2016 BCQRM showed concerns were addressed. In addition targets and actions identified in relation to risks to patients, staff and the organisation.
- Staff understood and felt involved in governance processes.
- Staff told us they knew how to escalate concerns relating to clinical governance, concerns would be raised with the clinical leads for each service.
- Quality outcomes were recorded in a clinical quality report, which was shared with leaders of the organisation at the BCQRM. This meant that there was a process in place for sharing information on quality outcomes with leaders of the organisation.
- We saw up-to-date copies of the corporate governance structure and local staff structure in all of the community bases and clinics we visited.
- Staff received a monthly Clinical Governance matters newsletter with updates and reminders about clinical governance.
- Services completed a RAG rated Clinical Governance Scorecard monthly. The individual scores were collated into a comprehensive dashboard that allowed trends over time and comparisons to be made.
- As part of the assurance framework the provider had introduced Internal Service Reviews, a comprehensive account of the way services were provided, completed by each team every six months. The web based tool used the CQC five key questions and Key Lines of Enquiry as a basis for assessing each area of care provided by VCSL. Staff were required to complete the very comprehensive assessments, with supporting evidence to the governance team for analysis and benchmarking against other services. Where services rated themselves as anything other than 'Good' based on the responses to the questions and using a scoring matrix, then a review of why the score was less than 'Good' was held and the team were supported to make improvements.
- The Board saw the ISR as both a monitoring tool and a development tool. Front line staff had worked with subject matter experts to create the review tool.
- Where services were new in scope, additional support and resources were made available to enable them to reach the benchmark of 'Good'.
- The provider had a Risk Register Policy that was used effectively locally and at Board level. Each service and business unit had its own Risk Register that it was responsible for. High scoring risks were escalated to the Virgin Care Clinical Governance Committee and upwards to the Virgin Care executive team. Significant corporate risks were escalated to the parent company.
- The risk register was discussed at each BCQRM and we saw evidence of this in meeting minutes. The register was up to date, identified the risk, the impact to the patient or service user, the controls in place, with a nominated lead for each risk.
- Individual executives, business unit directors and clinical leads were able to talk to us about the most serious risks within their remit. Examples were given of how the provider had responded and mitigated against risks.
- The provider had achieved the Cybersecurity Standards of the General Data Protection Regulation (GDPR). This legislation will apply in the UK from 25 May 2018. There were 22,000 data flows across the organisation that were mapped to check the provider was GDPR ready.
- The Caldicott Guardian was the clinical lead for the organisation.

Service vision and strategy

- VCSL had very clear strategies and an explicit service vision supported by Virgin Care

Values. There were clear shared goals that were known to staff. The Virgin Care Values were, "Think, Care, Do". The values formed part of every staff member's appraisal, were included in the welcome packs for staff and were on display throughout services.

- The provider had a Nursing Strategy that was under review at the time of the inspection visits. It had been identified that whilst nurses formed the majority of frontline professional staff, there were therapists and other staff groups who needed to be included. Going forward the Nursing Strategy was to become the Health and Care Strategy; the organisational values were being mapped to the professional Codes of Conduct which formed the basis of the strategy document.
- Each service also had their own Service Vision that was owned by staff. For example, following a Community

Are services well-led?

Nursing innovation Programme in 2015, the vision for community nursing in Surrey was agreed as, "To create a resilient, sustainable and innovative 21st century community nursing service that provides the best care and is highly respected by patients, carers, professional partners and the public".

- The Quality Strategy focussed on implementing and operating quality systems that supported a culture of empowerment, quality management, shared learning and continuous improvement.
- Within the strategy and assurance framework were clear accountabilities, structures and systems for reporting and monitoring. Clinical leaders worked alongside and in partnership with managers.
- There was an organisational belief that clinicians in operational roles were best placed to improve services and this led to there being a relatively small executive team and few central support roles.
- The new strategy going forward was created to allow for a 'Strategy on a page', a working tool rather than an exhaustive tome. There was a decision to keep it simple and to connect the strategy to the values and behaviours. "To attract the BEST practitioners, to have the BEST systems, and to deliver the BEST outcomes….providing the tools and creating the environment where quality flourishes, demonstrated through outcomes such that everyone feels the difference".
- VCSL had values which they believed helped them to 'Stand out from the crowd', they were unique to who VCSL were. They were said to be the moral compass of VCSL and defined the way VCSL were: Think-drive for better, challenge and learn, Care-heartfelt service, inspire, understand and communicate and Do-team spirit, accountability and resilience.
- We observed that staff reflected these values in their behaviour and their approach used when caring for patients.
- All staff we spoke to were aware of the VCSL values and were able to give examples of when they applied the values.
- All staff knew the direction their service was heading towards. One member of staff told us "It's not a guessing game on the direction." This meant the vision and strategy of the service was shared between the staff and managers.
- In Surrey the community service is currently working with the local hospice to establish a palliative care forum and working together on the strategy for the service. We saw evidence that this was in progress from the End of Life steering group and workshop minutes, which had an updated action plan. In Farnham it was noted that a five year strategy document was in place. We saw that the commissionaires of the end of life service were also involved in the work on the strategy.

Leadership of this service

- The executive team were approachable and accessible. Their contact details were known and staff were encouraged to raise concerns direct with members of the executive, if they felt they were not getting sufficient or appropriate responses at a local level.
- The executive team knew their services well and were able to describe examples of good practice, learning and incidents from across their services which were correlated with what operational staff told us. They talked about individual named members of staff, knew the buildings and could tell us about any particular challenges services and individual staff members were facing. They spoke with genuine warmth and respect for the staff and were clearly proud of the achievements of teams from across the country.
- The executive team made regular floor visits and all services had been visited over each year. Some executive members worked alongside teams where governance systems had raised concerns. The Chief Nurse had recently spent time with one team where an incident report raised concerns about the quality of pressure area care being provided. The Chief Pharmacist oversaw 'Deep Dives' where a potential cross service risk was identified.
- Business unit managers and clinical leads also spent time with the teams that reported to them. Over the year they visited all services and also provided a regular drop in session when they were available to meet with staff. Their mobile phone number was included on the business unit newsletter, so staff could call them directly.
- We heard about a management visit to a continence service that was described as 'eye opening'. The nurse manager had spent the afternoon helping with continence assessments and as a consequence they went away and consulted on the evidence base from subject matter experts and changed the process.
- Credit for all achievements was given to the front line staff. Good practice was recognised and celebrated.

Are services well-led?

There was support and opportunities for learning but limited tolerance of poor standards. One senior manager we spoke with talked about their staff having the freedom to act, and staff ownership of the care they provided. They also said, "People are encouraged to work to the top of their grade, 'just good enough' isn't really acceptable".

- All managers from business unit level upwards were required to obtain 360 feedback as part of their appraisal, annually. This allowed staff the opportunity to comment on their manager's performance and relationships.
- Managers we spoke with appeared knowledgeable about their service user's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. We saw that managers at all levels were visibly upset at losing their staff through transfer of the contracts to other providers. Senior managers specifically asked the inspection team to be mindful of the transfers that were happening and the impact this had on staff and their line managers.
- Senior leaders were supported to complete the Virgin Inspire leadership programme, after successful attendance at an assessment centre.
- VCSL had invested in developing the management skills of the senior district nurses as part of the Community Nurse Innovation Programme. In 2015, they introduced a nurse development programme for 56 senior community nurses where they were taught about managing teams effectively, customer service, 'The Virgin Way' and conducting Root Cause Analysis investigations. The lead for the programme was awarded the Nurse Leader of the Year award by the Royal College of Nursing Institute for their contribution to this programme.
- There was a Band 6 development programme available to staff who wanted to develop their leadership skills.
- Rapid response and rehabilitation, community nurses diagnostics and treatment, community rehabilitation and speech and language services were led by band seven team leaders. The band sevens reported to a variety of different managers depending on the service. Each service was led by a hospital matron, service manager or clinical lead. The director of operations had overall responsibility and was supported by Head of Community Care and Rehabilitation Services Farnham Hospital, Lead for Scheduled Care, Lead for Rapid Response and Rehabilitation Milford Hospital, Lead for Community Nursing Services and Surrey Wheelchair Services Manager.
- We saw strong leadership at a local level with staff praising their local managers regarding their support and communication. For example, one member of staff said, "they are the best manager I have ever had".
- We spoke with more than 40 members of staff about the leadership of the teams, all of them felt well supported by their line managers.
- The management team were visible to staff in the organisation and some had attended team meetings, and 'shadowed' staff in their daily work.
- Staff gave us examples of when their managers had provided extra support, for example when returning to work after ill health.
- Staff described managers as fair and flexible as willing to listen to concerns and tried to resolve issues. Staff felt valued, cared and empowered by their managers.
- The Chief Nurse led the nursing staff and was the chair of the Virgin Care Nursing Leadership Network. Membership of this group consisted of senior clinical nurses from each business unit, strategic and operational managers, nurses from all clinical specialities and representation from the Learning Enterprise. The remit of this group was to champion excellence and innovation in nursing, promoting the patient experience and patient safety.

Culture within this service

- The culture in the community teams encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned.
- We spoke with staff about the organisation culture and all of them reported that they enjoyed their jobs and felt valued.
- One staff member told us, "This is the best organisation I have worked for!" Another member of staff told us that there was a mutual respect between staff and all were passionate about working for VCSL.
- Staff were committed to making improvements for patients and felt they had been given the right tools to achieve this. Staff told us they felt empowered to make changes.

Outstanding ☆

Are services well-led?

- At the time of the inspection the provider was awaiting ratification of the Draft Diversity and Inclusion Strategy.
- There was a commitment to supporting staff from diverse backgrounds and to ensure equality for staff with protected characteristics. This included attendance at London Pride, a Diversity and Inclusion space on the VCSL intranet, a Mental Health Wellbeing toolkit, a Pledge for Parity and engagement with Stonewall.
- The provider had three 'Freedom to Speak up' Guardians, one whom was the legal counsel for the organisation. The guardians were supported by an anonymous online system. There is no requirement for providers of independent healthcare services to have Freedom to Speak Up Guardians but VCSL felt it was the right thing to do.
- Staff were also encouraged to make direct contact with Board members if they felt their concerns warranted senior intervention or they felt they were not getting an adequate local response
- The provider had invested £250, 000 training over 20% of the workforce in the People Flourish programme so that they can support colleagues to transform services, work better together and reduce sickness absence. Since the programme started there had been a 5% reduction in reported stress, increased staff retention and improved morale. The programme was credited with saving £160, 000 in recruitment costs as a result of lower staff turnover.

Fit and Proper Persons

- We reviewed nine staff files and saw all had relevant checks such as two references, photograph identification, disclosure and barring service (DBS) checks, medical checks, qualification checks and registration checks completed.
- We saw VCSL had a fit and proper persons' policy. We viewed the self-declaration form which contained declarations to be completed by directors or equivalent covering the following areas:
  - Good character
  - Qualifications
  - Competence, skills and experience
  - Health
  - Misconduct or mismanagement
  - Grounds of unfitness
  - Information required to be available for inspection by Care Quality Commission (CQC)
- The registered managers for the services we visited met the criteria for fit and proper person's regulation.

Public engagement

- VCSL had set up formal engagement with local GPs through their Engagement Strategy in the Guildford and Waverly area. Most of the GP practices were provided by a single GP led organisation, which provided commissioned services as an alliance rather than with individual practices. VCSL were working with the alliance to improve engagement with local GPs and to set up a GP centric service which included the formation of local multidisciplinary integrated care teams, a single 24 hour care co-ordination centre based at the local acute hospital and a joint management board for out of hospital care. As a result of the engagement there were now named nurses in GP practices and improved support to care homes.
- Business unit four held a Surrey Wheelchair Services user group forum in November 2016, this invited wheelchair users to give feedback on the service provided.
- VCSL invited service users to give feedback on the care they received 'you said we did' this could be left on the VCSL website or in writing. An example of changes made from 'you said we did' include service users complained that the diagnostic and treatment centre at Farnham hospital was difficult to find therefore the signage had been improved.
- We saw patient feedback and actions taken were displayed in clinics for patients and visitors to see. This demonstrated that the VSCL was listening to patients' feedback on how services could be improved.
- Patient satisfaction questionnaires were available in clinics patients were encouraged to complete these. This provided the opportunity for patients to give feedback on any areas they felt needed improvement.
- VCSL website provided information about the services provided. This meant the local population could use this to make decisions about where they received their care.
- We saw there was a variety of general information leaflets regarding flu advice and smoking cessation leaflets available for patients and visitors. In addition, there was information available for carers and relatives if they required additional financial or emotional support.
- VCSL in Surrey provided a carers club.

Outstanding ☆

Are services well-led?

Staff engagement

- VCSL had a yearly staff survey called 'Have your say' with a 'Pulse check' six months later. Four main themes were identified in the most recent business unit four (October 2016) 'Have your say' these included equipment and "tools to do the job", communication, morale and training. VCSL developed an action plan to address the issues identified within the 'Have your say' with a member of staff nominated, which ensured the action was taken.
- VCSL business unit four had a band 6 staff development programme this provided this staff group a dedicated programme, which explored the band six role, vision, values and expectations. This meant all band 6 staff shared the same vision and values and knew what was expected of them
- Staff were nominated for 'Star of the year awards', which were presented at the yearly 'Big Thanks' Christmas parties. One staff member told us she had won an award, other staff were aware of the awards and other staff had received nominations.
- Staff who won major awards had been taken out to dinner in a roof top restaurant in London.
- We saw there were Surrey wide newsletters, professional meetings and 'away days' held in many of the community services. VCSL produced a monthly 'Something for the weekend' newsletter which contained routine but important information, compliments 'shout outs' for staff, awards nominations and occupational health information. Staff we spoke with were positive about the newsletter as it was 'user friendly'.
- All staff had access to VCSL intranet through 'Jam' where policies, information and activities could be accessed.
- Staff had a VCSL 'tribe card' which offered discounts on many Virgin group products.
- Staff working at VCSL were able to access special deals and offers including reductions in admission fees to historic houses, restaurants and gym membership and media entertainment packages.
- As an independent provider VCSL were not required to employ a Freedom to Speak Out Guardian. However, the provider had appointed three guardians nationally. Data relating to staff seeking the support of the guardian (numbers and themes) were reported to the Executive via the Quality and risk meetings.
- The provider produced "Thank you" cards that allowed managers (and colleagues) to acknowledge specific positive contributions to patient care and service delivery. Staff talked positively about receiving these.

Innovation, improvement and sustainability

- Staff could apply to the 'Feel the difference' fund to help with ideas and innovations. Staff felt innovation was encouraged. This was a £100, 000 fund that seed funded local initiatives suggested by staff that focussed on patient experiences. The bids could be suggested by any staff and were approved by a peer panel. There was an option for very small bids to be fast tracked. Innovations so far have included standing desks, body blocks and a body mapping system.
- The rapid response and rehabilitation team undertook a pilot involving two local GP practices, which aimed to improve communication between GP's and the team. This resulted in an improved patient journey and reduced time spent establishing patient's whereabouts.
- The speech and language team purchased tablets with specific therapy applications these were used by patients to practice speech for relaxation and mindfulness.
- The role of the in reach GP had been developed to work based within the local trust accident and emergency department to support a rapid discharge approach and where appropriate to prevent admission of the frail elderly.
- The motor neurone disease (MND) multi-disciplinary team from Farnham has been presented with the extra mile award by the motor neurone disease association for their exceptional care for people with MND.
- VCSL were part of the carers collaborative that won the HSJ Commissioning for Carers Award.
- In Luton a member of staff was participating in the first cohort of the Chartered Society of Physiotherapists leadership development programme to start in 2017. This programme is a unique physiotherapy leadership development opportunity for band 6 physiotherapists or the equivalent who are working in a community setting. It will provide participants with the skills, knowledge and supportive networks, to lead service improvements.
- In Oldham, the sustainability of the service was a concern because of cost pressures in relation to the lack of a substantive consultant dermatologist on the team and also because the provision of a local multidisciplinary team was more costly than

anticipated. The service had been working with the CCG to implement a transformational plan that would introduce efficiencies whilst ensuring the best quality of care for patients. The plan included the training of nurses to deliver lower level interventions and the use of telehealth.

- The service had undertaken a review of service activity with the CCG to ensure that the correct levels of activity had been commissioned in each pathway and that any additional activity could be built into future contract negotiations. The review had highlighted that there had been a greater than expected number of cancer referrals. Referral numbers and inappropriate referrals were being monitored as a result.
- The provider was exploring a number of innovations to improve the service and overcome some operational barriers. They were being supported by the Virgin Care Futures Team to enable this.