

Anglesey House

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Anglesey House is operated by Virgin Care Services Limited. The service has a number of specialist services to support local people living with health conditions in the community. The teams are made up of a district nursing team who deliver a seven-day service and community matrons support people identified at high risk of admission to hospital due to their presenting health needs.

There is a rapid response service, including a rapid response palliative support team who offer acute nursing care and assessment in patients own homes.

The adult continence service is provided by a small team of specialist nurses. The learning disability primary care service provides support to people with learning disabilities. A community dietician provides support to patients with nutritional needs with a focus on the frail elderly population.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 15 May 2019. This was the service's first comprehensive inspection and they had not been previously rated.

To get to the heart of people's experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We have provided guidance for services that we rate and do not rate.

Services we rate

We rated it as **Good** overall.

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff had access to a training and competency programme to ensure they had the skills required to provide good quality care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit patients. District nurses and other allied healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. People who used the service told that staff went over and above what was expected of them. Staff displayed determination and creativity to overcome obstacles to delivering care.
- There was inclusive and effective leadership. There were up to date strategy, policies and standard operating procedures aligned with national guidance and the wider health economy. There was a demonstrated commitment to system-wide collaboration and leadership.

Summary of findings

- Staff we spoke with overwhelmingly felt positive and proud to work in the organisation. The culture centred on the needs and experience of people who used services. Staff told us that they felt pride in the organisation and the work they carried out to ensure patients received good quality care.

However:

- Staff highlighted continued issues with access to a network connection to support remote working and accessibility to patient records.
- Patient's care records did not always demonstrate that consent had been gained to provide care and treatment.
- Staff compliance with mandatory information governance training fell short of the service target. There were plans documented to improve the numbers for completion.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Community
health
services for
adults**

Rating

Good



Summary of each main service

We rated the service as good for safe, effective, caring, responsive and well led.

Summary of findings

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Good



Anglesey House

Services we looked at

Community health services for adults

Summary of this inspection

Background to Anglesey House

Anglesey House have a registered manager and the regulated activities are for personal care, nursing care and treatment of disease, disorder and injury.

We have inspected this location at provider level in 2017. This was the first inspection at location level.

The district nursing team deliver a seven -day service, providing holistic evidence-based care to housebound patients within East Staffordshire. The service support patients with complex needs in their own home to avoid unnecessary hospital admissions. This includes end of life care, wound care, continence care and support for patients with long term conditions. The service also provides ambulatory wound care and leg ulcer clinics in several locations.

The community matrons support patients identified at high risk of admission to hospital due to their presenting health needs. They take a multi-disciplinary approach, working with primary care, adult social care, mental health services, acute care and the third sector agencies who support older patients. The community matrons form part of the frailty team in accident and emergency at a local NHS trust team to support safe discharge of patients' home.

The rapid response service offers acute nursing care and assessment in peoples own homes. The service can carry out a variety of advanced acute nursing skills in the home and is designed to avoid admission to hospital and to support discharge. The service works closely with the community therapist and falls team and in close partnership with a local Hospital to support the safe transfer of care to the community. The service provides a range of nursing interventions and provides all out of hours community nursing during working hours.

The rapid response palliative support team are a team of support workers, supported by a registered nurse. These staff are skilled and experienced in supporting patients at the end of their life to prevent hospital admission. In addition, they support patients to return to their own home, if this is their choice, at end of life. The service has an 'in reach' element in a local Hospital to identify patients who can be transferred into community care.

The adult continence service is provided by a small team of specialist nurses. The team are available to patients with a bladder or bowel issue and are resident and registered with a GP practice in the East Staffordshire CCG area. This includes all residential/supported living care homes.

The learning disability primary care service provides support to primary care services to meet the needs of patients with learning disabilities in East Staffordshire. This includes advice, training and support to identify barriers to accessing health and identifying what reasonable adjustments are required to improve access to health and improve health outcomes.

A community dietician provides support to patients with nutritional needs in Burton and surrounds with a focus on the frail elderly.

Anglesey House is operated by Virgin Care Services Limited. The service opened in 2016. It is based in Burton upon Trent, Staffordshire. The service primarily serves the communities of the East Staffordshire.

The service has had a registered manager in post since 13 April 2017. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC on 16 April 2019.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in district nursing. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Summary of this inspection

Information about Anglesey House

The service is an independent community healthcare provider and is registered to provide the

following regulated activities:

- Nursing care
- Personal care
- Treatment of disease, disorder and injury

During the inspection, we visited Anglesey House which is the base for all staff and services. Staff worked in the community across 21 community sites offering a range of clinics. Clinics offered were leg ulcer clinics, musculoskeletal physiotherapy services, continence service, heart failure service, diabetes and podiatry service. Most of the community venues were health centre based. Staff also saw patients in their homes. We spoke with a number of staff including registered nurses, health care assistants, and senior managers. We spoke with one person in their home and one relative. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting most of the standards of quality and safety it was inspected against.

Activity (January 2018 to December 2018)

In the reporting period January 2018 to December 2018

All episodes of care recorded for the time specified relate to the delivery of NHS services. These are Community Nursing, Rapid Response, Community Matrons, Community Rehabilitation (incorporating stroke service, falls team, and Dietetics team), multiple sclerosis Intermediate physio, podiatry, adult ability, long term conditions (Diabetes and Heart Failure), continence service, and learning disability service.

All funding is NHS via the CCG.

The service employed 76 registered nurses, 16.6 care assistants and 4 receptionists.

Track record on safety:

- No Never events
- Clinical incidents 256 no harm, 908 low harm, 6 moderate harm, 0 severe harm, 0 death
- Six serious injuries – all of which were pressure ulcer related at category 3 or above and declared as a serious incident.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Nine complaints (three related to the continence service, one related to the podiatry service, four related to Burton Town Community Nursing and one related to Villages/Rural Community Nursing service)

Services accredited by a national body:

All registered staff are accredited via their professional bodies such as The Nursing and Midwifery Council.

The service lead and team lead in community nursing are Queen's Nurses accredited with the

Queen's Nursing Institute.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- Physiotherapy for Adults with a Developmental Disorder (PADD)
- Speech and language therapy for adults with learning disabilities
- Adult Enteral Feeds
- Infection Control
- Tissue Viability
- Care Navigation
- Pulmonary Rehabilitation
- Adult speech and language therapy for housebound patients
- Clinical Waste removal
- Maintenance of medical equipment
- Pharmacy

Summary of this inspection

- Dexa scanning
- IT support
- Cleaning






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Community health services for adults

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are community health services for adults safe?

Good 

We rated safe as **good**.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- All staff completed statutory and mandatory learning. Based on the last three months of figures, the overall compliance was 87%, this was above their set target of 85%. Service leads were responsible for monitoring and improving compliance. Plans were in place when targets were not met. The data we looked at highlighted two training programmes were not within target, we saw there were plans in place to improve compliance. For example, dates were added for face to face training and there were regular reviews to increase capacity within the courses.
- The training delivered ensured staff had the skills required to work with the patient group. For example, staff were trained in basic life support, manual handling and infection prevention control. There were ongoing mandatory training programmes where renewals and updates took place. Staff completed passport style booklets to evidence completion of their training.
- All staff, including bank staff, received an induction which included mandatory training. Mandatory training

was delivered using a range of methods, for example, eLearning and face to face training. All bank staff had their mandatory training competencies signed off before they could work unsupervised.

Safeguarding

- **Staff understood how to protect people from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff safeguarded people using systems, processes and practices which were communicated to staff. This happened from point of referral where patients received an assessment. Safeguarding issues were discussed at daily safety huddles. Staff worked alongside social care agencies and local authority safeguarding teams to share information and help manage concerns, referrals and incidents. Safeguarding champions met monthly and a safeguarding bulletin was generated and could be found in paper and electronic form.
- All staff had the necessary security checks at recruitment stage to ensure they were safe to work with patients. For example, up to date disclosure and barring checks (DBS) which were reviewed at appropriate intervals.
- All staff completed a safeguarding adults and children mandatory training module annually. We looked at three months of data and saw that staff training compliance was within target. For example, in May 2019 91% of staff achieved a Safeguarding adult level 1 certificate, 98% of staff received a safeguarding adult's level 2 certificate, 91% of staff achieved a safeguarding

Community health services for adults

children level 1, 97% achieved a safeguarding children level 2 and 87% achieved a safeguarding level 3.

Managers told us there were plans in place to get those who had not completed the training up to date.

- Vulnerable groups, including patients diagnosed with mental health conditions or patients with mobility issues were supported by assessing individuals care needs and where appropriate working jointly with other agencies. Staff gave us examples of when they worked together with local mental health teams and social services to help protect vulnerable patients. Safeguarding champions attended the safeguarding adults team network which was three monthly meeting.
- Staff reported safeguarding related incidents and the number of safeguarding adult referrals. We looked at three months of data. There had been a total of 23 safeguarding related incidents reported and from these 11 safeguarding referrals were made. Staff reported safeguarding incidents to the Care Quality Commission using the statutory notification system. This meant we were sighted on all referrals. Staff worked with social services using this system to support those patients identified as having a potential safeguarding concern.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.**
- Staff contributed to an infection prevention control activity report on a quarterly basis. We looked at the report for quarter two and quarter three. It highlighted the audit results of hand hygiene compliance across all teams. For quarter two, staff had achieved above the service target of 90% across all teams. This meant that all teams were observing hand hygiene principles to reduce the incidence of infection. Staff in one team had not achieved the 90% target in quarter three, however, this was recorded as a data matter, with plans to resolve the issue. It did not mean that staff were not observing good hand hygiene practice.
- Standards of cleanliness and hygiene were maintained. There were champions allocated across the service who met bi-monthly. They shared feedback from these meetings with teams. Feedback included findings from hand hygiene audits and any issues identified that required improvement. Information about infection

prevention control was advertised in the monthly staff bulletin. For example, the latest update for emerging infection monthly summaries and government publications.

- Staff managed infection control in patient homes by observing hand hygiene and using appropriate control measures, for example, the use of gloves and aprons. Staff shared good infection prevention practice with patients and those involved in their care to empower them while managing their own personal care and reduce the risk of infection.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept patients safe.** When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Safety and safeguarding systems, processes and practices were communicated to staff through training, competency checks and bulletins to provide key messages and updates.
- Staff ensured equipment was maintained to keep patients safe. For example, staff ensured calibrated and tested equipment was recorded and stickers were displayed for checking purposes.
- There were arrangements for managing waste and clinical specimens to keep patients safe. Staff managed clinical waste well. We saw clinical waste was stored, labelled, handled and disposed of appropriately at community locations we visited.
- Staff had access to storage space. There was a storage room with a recording system in place. This ensured items taken were signed out and replenished to ensure there were enough stock supplies.
- Specialist equipment needed to provide care and treatment to patients in their home, was appropriate and fit for purpose so that patients were safe. Companies who provided the equipment carried out training, audits and maintenance on equipment to ensure they were safe.
- Staff were trained and provided with the right equipment on safe manual handling practices in patient's homes. Staff reported equipment safety issues when these occurred and completed statutory notifications which were forwarded to the Care Quality Commission which outlined how they investigated and managed the issues.

Community health services for adults

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- Staff carried out risk assessments for patients. Risk management plans were developed in line with national guidance. Risks were reviewed and managed through daily team discussions and updated in patient records.
- Staff identified and responded appropriately to the changing risks to patients who used the service. This included deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Patients sometimes required an emergency or unplanned medical intervention or transfer to hospital. The process for this was via the 999 service. Staff were able to seek support from senior staff in these situations. This included patient GP's or senior clinical staff including those responsible for care co-ordination of patients.
- Staff managed the increased risks experienced by patients with lifelong conditions and at the end of life. All patients were risk assessed for skin integrity, pressure ulcers and falls using evidence-based tools. The information was used to form management plans which were stored in patient records. There were lead tissue viability nurses to support staff in reviews and ensuring good practice. Staff carried out wound care audits which reported on whether there were issues identified for learning and improvement.
- Assessments were carried out to ascertain whether patients needed urgent medical attention or referral for additional support/treatment including intermediate care. Staff carried out a range of appropriate assessments, such as, pressure ulcer risk assessments and Waterlow assessments (a pressure damage risk assessment). Those patients who had been referred and required intravenous antibiotics were referred to ambulatory care unit at the local hospital.
- Staff also assessed patients for risks of malnutrition and acted on these appropriately.
- There was evidence of a system for escalating concerns about deteriorating patients and that it was working. We were given examples of when nurses had escalated following assessment and observations using evidenced based tools. For example, a patient's partner was concerned following discharge from hospital and called the service for advice. A member of the team was nearby

and observed the person triggered for sepsis. The staff member called emergency services and the person was returned to hospital. This meant the person was safely assessed and managed. A serious incident was completed and raised with the discharging hospital as an incident.

- Staff carried out risk assessments at referral stage. Staff updated risk information on to the electronic system. All staff could access electronic records which supported real time updating whether on or off site. Staff could access alerts for key safety issues for patients, such as allergies. This shared electronic system helped to keep each patient safe.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**
- Staffing levels met the needs of the patients who used the service. There were 219 staff across the services. There were two whole time equivalent band 6 vacancies and three band 5 vacancies. There were two vacancies for physiotherapy staff and one band 3 care coordination centre staff vacancy. All vacancies were out to advert. There was a bank of staff to ensure there were enough staff. Where possible agency staff use was avoided.
- Staff sickness levels were low based on the figures we looked at which averaged around 4%. There were three whole time equivalent episodes of sickness across community nursing and one long term maternity leave. None of the sickness episodes were known to be work related.
- Staff attended a daily safety huddle to explore the needs of the patients and resources available; this included a review of safe staffing levels. We looked at daily capacity reports which were printed off and displayed on a white board in the staff room. The reports outlined the team leads, total staff numbers and skills levels. These were determined by planned dependencies then compared the difference between capacity and demand. Leaders used this method to ensure all patients received the right staff at the right level for their needs.

Community health services for adults

- The service pharmacist left in 2018. A recruitment process had been completed with no one suitable identified to take up post. The non-prescribing element was supported by a non-medical prescriber who linked in with local networks. The clinical governance lead continued to facilitate medicines meetings which we saw recorded. The non-medical prescribers could link in with Virgin Care pharmacist. There were annual medicines audits launched every September with all actions to be completed the following January. We saw this recorded with actions. For example, themes around housekeeping. The service had taken all mitigating actions they could in relation to this issue.

Records

- **Staff kept records of patient's care and treatment using an electronic records system.** Records containing patient information was stored securely and accessible to staff providing care if they had access to technology and network connections.
- Patient's individual care records, including clinical data, were written and managed with the intention to keep patients safe. There was evidence of assessments and care plans to meet the needs of individual patients. For example, six out of six of the care records we looked at were complete, accurate and stored securely. Patient's received a health records leaflet that told them about what information was held and who to contact about information governance.
- Patient information needed to deliver safe care and treatment was accessible including while working in patient's homes if there was a network connection. All clinical staff were provided with tablets to access all patient information. Each tablet had an application to help staff assess patients in a comprehensive way. The application was easy to use, and the information was immediately uploaded if there was a network connection. Some of the ongoing issues with the tablets were around connectivity.
- Staff recorded connectivity issues as incidents. Staff risk assessed connectivity issues in advance of home visits. This meant they might need to access to information to help them work with patients in the community before they attended. Technical support services were involved and there were plans to improve connectivity. Information that could not be immediately uploaded on to the shared system was uploaded as soon as staff were connected to a network.

- Patient records did not always demonstrate information needed for their ongoing care shared in line with relevant protocols. For example, one record did not have a discharge plan, which would have been a written record of that person's needs.
- If there were any gaps in incoming referrals staff at the service would chase up the missing information to ensure records were complete.
- Staff carried out regular care record audits. This was to check the quality and standard of patient's recorded care. Managers indicated all audits were on track and improvements were seen. The results were shared with staff and action taken to improve quality and standards.
- Staff from other services, for example, GPs had access to integrated care records. The electronic record system included a partner form which was completed to ensure partners received important patient information. The service had direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients, for example, details of their current medicine.
- Information governance training compliance was monitored by the information governance lead and reported at clinical governance meetings. We looked at minutes for the March 2019 clinical governance meeting. At that stage staff were not compliant in mandatory information governance training. 74% of staff had successfully completed the information governance training; the target was 95%. Managers were provided with a list of employees who were not compliant which would be monitored by the information governance lead. This meant that compliance would be reviewed at regular intervals to ensure completion.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff had access to an up to date medicines optimisation strategy. The strategy focussed on the delivery of high-quality care. An example of this was to ensure patients who used the service had access to non-medical prescribers to increase access to medicines. The strategy helped staff in their role to ensure safe use and handling of medicines. It also helped staff improve the reporting and learning from errors. The non-medical prescriber lead in the team was responsible for ensuring staff competencies.

Community health services for adults

- There was a medicines optimisation review panel meeting which met monthly to review the strategy outcomes and any necessary actions identified. Any medicines incidents which had been reported were reviewed and monitored, so that lessons could be learnt, and improvements made if necessary.
- Medicines and medicines related stationery were managed well. They were ordered, transported, stored, and disposed of safely and securely (including medical gases and emergency medicines and equipment). There was a system in place to ensure that medicines alerts or recalls were actioned appropriately.
- Policies were in place for the management of medical gases. A recent audit had identified some areas of risk and an action plan was in place and due to be completed by April 2019.
- Patient's received appropriate therapeutic drug and physical health monitoring with appropriate follow up in accordance with current national guidance or evidence base.

Incident reporting, learning and improvement

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.** Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate. There was a high number of incidents reported and staff told us that they were encouraged to report incidents when they were found. We were given examples of incidents raised, for example, a newly qualified registered nurse identified an out of date piece of medical equipment. They apologised to the patient, rectified the issue immediately and raised an incident. The staff member told us they were praised which meant they felt safe to raise future incidents and validated in being open and transparent with everyone involved.
- Staff we spoke with told us there were arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong. Where

possible, relevant staff, services, partner organisations and patients who used services were involved in reviews and investigations. For example, GP's, local authority health and social care staff and local NHS providers.

- Lessons learned, and themes were identified, and action taken because of investigations when things went wrong. There were root cause analysis panels who oversaw investigations. Staff were invited to attend investigations if appropriate. We saw correspondence shared with patients following root cause analysis and investigation and lessons learned as a result.
- Staff learned from lessons to make sure that action was taken to improve safety. Staff told us they learned from reviews and investigations by other services and organisations at joint meetings. Staff learned about incidents though bulletins on a monthly basis. We looked a range of bulletins. The monthly bulletins were accessible and easy to read. Information contained within was summarised and to the point.
- We looked at reports of eight pressure ulcers which had been appropriately recorded and investigated, including whether themes were emerging. Staff used the SBAR (Situation-Background-Assessment-Recommendation) tool to explore a patient's condition and make recommendations for improvement. We looked at documentation on serious incidents relating to pressure ulcers these contained appropriate actions. For example, training for staff to reduce or eliminate the incidence of further pressure ulcers. Where required staff would refer cases as safeguarding.
- Staff were trained in, knew and understood the principles of duty of candour. They could access an organisational policy to support duty of candour in practice. Clinical incidents were checked daily by managers for statutory reporting requirements. This included duty of candour. This was a statutory (legal) duty to be open and honest with patients, or their families, when something goes wrong.

Are community health services for adults effective?

(for example, treatment is effective)

Good 

We rated effective as **good**.

Community health services for adults

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff contributed to a clinical audit programme. The programme was documented with review information. Individual audits were aligned with National Institute for Health and Care Excellence guidelines. Guidelines were also used to develop standard operating procedures and policies. We looked at a wide range of this documentation. The information was accessible to all staff and kept in up to date, in well maintained folders to help with monitoring. The information was also available to patients in electronic form.
- Staff could access all up to date policies, standard operating procedures, and protocols on the intranet. The electronic system for policies was live. There were regular reviews of policies and standard operating procedures and team leaders were responsible for cascading updates to staff.
- Staff were committed to understanding their role in understanding equality and diversity. The leadership team included a diversity, inclusion and culture manager. This manager worked with the data team to develop an appropriate strategy. There was an annual report related to recognising the importance of ensuring services were fair and equitable to all and delivered with dignity and respect. There was an
- Staff used up to date technology and equipment to enhance the delivery of effective care and treatment and to support patient's independence. We saw this technology used by staff to deliver care at home which encouraged independence. Staff supported patients who used the service to use equipment at home. This included family members, carers and teaching care home staff to use equipment to try to avoid hospital admissions and promote independence.

Nutrition and hydration

- **Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.** They worked with other agencies to support patient who could not cook or feed themselves.
- Patient's nutrition and hydration needs were assessed. Where relevant, referrals were made to specialist support services, such as dieticians to support dietary and nutritional needs. This was documented in care records, care plans and discussed at daily meetings where staff discussed individual patient's needs.
- There was a team approach to ensuring patients nutritional needs and addressed these.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patient.
- All teams worked with patients who used the services to achieve good outcomes. For example, the frailty service supported the safe and timely discharge of frail patients who presented as an emergency admission. This helped avoid unnecessary admissions to hospital and enable patients to be cared for at home with the right support from community services.
- Staff at leadership level looked at quality data to inform actioning planning to make improvements. For example, wait times were recorded as 95% of patients being seen within 18 weeks. This was an improvement on previous wait times.
- Staff participated in relevant quality improvement initiatives. For example, local and national clinical audits and benchmarking and other quality improvement initiatives. All relevant staff were involved in activities to monitor and use information to improve outcomes.
- We saw recorded lists of audits completed. There were Medication Safety Audits. We saw five medication incidents were reported for January. These were reviewed by a medicine review group to look for themes, trends and learning lessons. We saw recorded audits of district nursing staff competency passports to ensure all staff were skilled and had the knowledge to deliver good quality person centred care. This was benchmarked against best practice. There were care of midlines audits with a benchmarking observation audit underway.

Competent staff

Community health services for adults

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
 - Patient's had their assessed needs, preferences and choices met by staff with the right skills and knowledge. Staff in the team were multi-professional with specialist teams who worked together to get the best outcomes for patients. For example, there were staff who specialised in the care of patients living with Parkinson's disease. They worked alongside district nurses to support patients with their specific needs.
 - Staff had their learning needs assessed through supervision and appraisal. Appropriate training to meet learning needs to cover the scope of their work was recorded in individual competency passports. The passports had clinical skills indicated with dates for training, refresher training periods and a signature section for both trainer and trainee.
 - Staff were encouraged and given opportunities to develop. Staff told us there was funding to complete additional qualifications, for example, extended prescribing courses.
 - Staff were supported and managed to deliver effective care and treatment. This was achieved through one-to-one meetings, appraisals, coaching and mentoring, and informal clinical supervision and revalidation. All qualified nursing staff achieved revalidation in the 12 months leading up to inspection. Staff told us they felt supported in their revalidation which was carried out with a more senior member of staff.
 - Staff could access a training and education page in the shared bulletin. Included within this was nurse education changes ahead. The bulletins advertised upcoming training events. The content was wide ranging and informative, for example, details about an Aseptic Non-Touch Technique Roadshow 2019. There were safeguarding references, including a safeguarding statement.
- Multidisciplinary working and coordinated care pathways**
- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**
 - All necessary staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. Staff from across other teams, met weekly to discuss patients. Staff were arranged in specialist teams and worked alongside each other to access the specific needs of the patients. For example, occupational therapy staff worked with other clinical staff to observe and educate on manual handling techniques to keep patients safe.
 - Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. All patients were allocated a care co-ordinator. Care co-ordinators would allocate and oversee the care and treatment needs of individual patients. Information about patients could be shared across services, for example, a shared electronic system with GP's and at regular joint meetings.
 - Staff worked jointly with external organisations to ensure consistent coordinated, person-centred care and support when they used, or moved between different services. For example, joint working with the local hospice to carry out joint palliative support worker. This meant there was a joined-up approach for coordinating care for patients at the end of life.
 - Staff worked in a multidisciplinary and multiagency way to support effective care planning and delivery for adults with long term conditions and complex needs. Staff carried out joint assessments with the local NHS trusts, local authorities and third sector organisations to manage care, treatment and risk.
 - Referrals to services were handled effectively with clear criteria by a central coordination centre and Single Point of Access system. This was where all referrals were triaged by a nurse and categorised depending on how quickly the needed to be seen. A rapid response team took those referrals when patients needed to be seen quickly by a team of clinical professionals who could meet their immediate needs.
 - Professionals from varying disciplines worked well together when someone's needs suddenly increased or they needed to be referred for more specialist services. There were clear referral protocols in place. Staff could very quickly access allied health professionals internally, for example, a physiotherapist or occupational therapist to support a persons' changing needs.

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- When patients were discharged there were clear mechanisms for sharing appropriate information with their GP and other relevant providers and professionals and to ensure that they fully understood what is happening and any next steps.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Patients were assessed to maximise the support needed to live well in the community. Staff worked with patients involved in services to live healthier. For example, they were encouraged in smoking cessation, with information relating to obesity and nutritional support service input where required.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. This was seen in care records and through discussions with staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff did not always record how they support patients to make informed decisions about their care and treatment.** They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff understood Deprivation of Liberty Safeguards. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff could access specialist services for those who lacked capacity, for example, advocacy services. This was important to ensure patients understood their rights and were treated equally and they were heard.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they followed the service policy and procedures when a patient could not give consent. We looked at patient's care records to see whether consent was indicated. Three of six entries relating to consent were not complete. This meant they did not have a record of consent.

Are community health services for adults caring?

Good 

We rated caring as **good**.

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We spoke with patients, looked at friends and family reports over a 12-month period from February 2018 to January 2019. There were testimonies from patients who used the service contained within the reports which were overwhelmingly positive. For example, describing kindness of staff. There was a 'You said, we did' section which described when patients had requested the service meet their individual needs. For example, a patient requested the podiatrist visit them in hospital to continue with their treatment while they had been on a ward.
- Staff were observed to be kind and compassionate when relating to patients in their homes. They engaged patients and those present in the process of receiving care and treatment.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.** They understood patient's personal needs.
- Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. We saw this in patient records, and in conversations with staff and through observations of the morning safety huddle.
- Staff recognised and supported the broader emotional wellbeing of patients with long term or complex conditions, their carers and those close to them. Staff worked alongside other agencies to support patients with these needs. For example, they worked closely with services who provided emotional support services for those who used services and others involved in their care.

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Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff communicated with patients so that they understand their care, treatment and condition and any advice given. Staff told us that they helped patients manage their own symptoms. They told us they carried out a lot of education. They did this by delivering newly diagnosed courses. These education groups were delivered across a range of sites, for examples, local clinics and the fire station. The aim was to get patients and those close to them empowered to manage themselves in addition to being supported by staff from the service.
- Staff understood accessible information standards (AIS). AIS applies to patients who used the service and have information or communication needs because of a disability or impairment. Patients' needs were assessed and recorded in records. Staff sought accessible ways to communicate with patients when their protected and other characteristics made this necessary to reduce or remove barriers. For example, if required staff could access information in large print or get support from services with the skills needed to aid communication.
- Staff made sure that patients who used services and those close to them were able to find further information, including community and advocacy services, or ask questions about their care and treatment.
- Staff involved patients who used services and those close to them (including carers and dependants) in planning and making shared decisions about care and treatment. We saw this communication between staff and patients who used the service.

Are community health services for adults responsive to people's needs? (for example, to feedback?)

Good



We rated responsive as **good**.

Planning and delivering services which meet people's needs

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Services were configured to reflect the needs of the population served. This meant flexibility, choice and continuity of care where possible was offered. The team were based in a hub where staff met at the daily safety huddle to discuss patient care, then dispersed to locations in the community or at the patient's own home. This meant that staff could discuss the needs of the service and those who used it daily. Workloads could be managed, and patient's individual needs could be met.
- Staff were recently located to a hub model. This means staff were based at a single location. Previously staff were based at GP surgeries or other community locations. Not all staff were happy with this change, however it was planned by leaders to ensure that all staff had a base to meet to discuss patient care and how they used the resources efficiently. Staff would then base themselves either at community locations close to those who used the service or visit patients in their own homes.
- The service worked with other health and social care providers (e.g. acute hospitals, local councils, social workers, GPs, housing agencies) to plan to meet the needs of patients in the area, particularly those with complex needs, long-term conditions, or life-limiting conditions. We saw documented references to joint meetings to discuss services and patient care. Patient records demonstrated joint working and staff told us about how they worked with other professionals to ensure good integrated care.

Meeting the needs of patients in vulnerable circumstances

- **The service was inclusive and took account of people's individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The service employed a learning disability nurse. The role was to meet the information and communication

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needs of patients with a disability or sensory loss.

Services were delivered, made accessible and coordinated to take account of the needs of different patients, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.

- Staff worked jointly with other health and social care organisations taking in to account patient complexities including those with progressive illnesses. The service employed a specialist palliative care nurse and worked alongside local hospices and hospitals to support patients at the end of life or with progressive illnesses.
- Patients who used the services were supported during referral, transfer between services and discharge. Staff used a care co-ordination model that involved patients in decision making. This included other organisations required to support patients while they were receiving care and treatment.
- Staff made reasonable adjustments so that patients with a disability could access and use services on an equal basis to others. Each person was assessed and planned for on an individual basis. Staff could see patients in their own homes if it was appropriate.
- Staff had access to services to help patients communicate effectively. Arrangements were in place to access translation services, and hearing loops in community venues. This meant when a communication barrier was identified there were resources available to help.
- Staff understood the principles of Accessible Information Standard (AIS). There was an implementation programme documented and shared with staff to help patients understand there was access to accessible communication methods to support their individual needs.

Access to the right care at the right time

- **Patients could access the service when they needed it and received the right care in a timely way.**
- There were systems in place to support patients to stay in the community if they wanted to. There was a rapid response team for those patients who required same day symptom management. This meant they could prevent hospital stays and ensure preferred place of care was achieved.

- Patient care and treatment was tailored to the individual their preference and need. Patients were offered a range of specialist services in the community. For example, they could be seen by a district nurse and a podiatrist on the same day to avoid multiple visits.
- Referrals were processed through the care co-ordination centre by qualified staff. Once triaged, patients were referred to the appropriate teams. Patient centred care plans were developed to manage symptoms. This ensured that the patient accessed the right service and intervention type for their needs thereby supporting effectiveness.
- Weekly multi-disciplinary meetings at the local hospital inpatient unit. Staff discussed patients and service provision to ensure that when appropriate, patients were discharged to their preferred place of care. There was an admission and discharge facilitator who practically and actively supported patient transition into and out of the inpatient unit back to the community.
- Staff carried out audits to monitor patients who did not attend appointments. They used the information to help them improve did not attend rates, look for themes and adapt the service where appropriate to improve outcomes.

Learning from complaints and concerns

- **It was easy for patients to give feedback and raise concerns about care received.** The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Patients we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints. Patients were encouraged to raise concerns in several ways. They could complain directly to staff, complete a complaint form or access complaints information on the website. Staff were expected to report and escalate concerns promptly. Complaints were dealt with to ensure openness and transparency, confidentially and regular updates for the complainant. Staff were mindful of a timely response and explanation of the outcome, and a formal record was kept. Records showed that there had been a total of ten complaints in the previous 12 months, none of which had been upheld.

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- Staff told us that concerns and complaints were used as an opportunity to learn and drive improvement. Managers provided us with examples themes from complaints and that they had introduced changes because of the learning from the theme.

Are community health services for adults well-led?

Good 

We rated well-led as **good**.

Leadership of services

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- Leaders demonstrated experience, capacity and capability needed to deliver sustainable care. The leadership team were made up of a managing director who was supported by a quality lead, lead nurses for community nursing, reactive care and specialist heart failure lead nurse. There was a head of therapies, and clinical governance lead. In addition, there was a corporate senior leadership team. There was a system of leadership development and contingency planning. We were told this in discussions with staff about their planning and achievements supported by the organisation.
- The leadership team told us they had an process for leaders. There were comprehensive and successful leadership strategies in place to ensure and sustain delivery and to develop the desired culture. Leaders understood challenges and priorities in their service.
- Leaders were visible and approachable. Staff we spoke with told us that they could access a member of the leadership team. Staff mostly told us they felt valued and could discuss issues or concerns which would lead to resolution.

Service vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action,**

developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff were clear about the vision and values of the organisation. Staff told us that the vision and values were in line with CQC vision and values. For example, providing care by being safe, effective, caring, responsive and well-led.
- The service had a strategy outlining local objectives and plans. The strategy and plans were aligned with the wider health economy. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.
- The leadership team monitored and reviewed progress against delivery of the strategy and local plans. The leadership team worked collaboratively with staff in achieving a three-year service plan that helped with business and financial planning. Teams had work plans, objectives and key performance indicators to allow systematic monitoring. Leaders met regularly to discuss outcomes.
- Leadership staff promoted a clear vision and a set of values, with quality and sustainability as the top priorities. Staff and volunteers took part in a consultation to agree the service values. It was agreed 'ask what matters, listen to what matters, do what matters'. The values were inspired by a dementia awareness guest speaker.
- Staff knew and understand the vision, values and strategy, and their role in achieving them. The vision and values were displayed throughout the building.

Culture within the service

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff we spoke with overall told us they felt supported, respected and valued. This was indicated in the annual staff 'Have Your Say' survey. Staff response rate was 64%

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in 2018 which was the most recent survey. This was the same as the previous year; 65% of staff would recommend the organisation as a place for care compared to 63% overall. In addition, 40% would recommend the organisation as a place to work compared to 38% overall. Another 12% of staff had their progress discussed with them.

- Managers acted to address behaviours and performance that was inconsistent with the vision and values, regardless of seniority. We were given examples of how staff would be supported in improving performance and steps that would be taken, following policy to take a more formal approach to behaviours and performance.
- The culture within the service encouraged openness and honesty in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. There was appropriate learning and action taken because of concerns raised. This was evidenced in the number of incidents reported, discussions with staff with examples of where learning had led to improvements.
- There were mechanisms for providing all staff at every level with development opportunities. Staff told us they received good quality appraisals and career development. All staff had received an appraisal within the previous 12 months. Staff gave us examples of when they had identified training needs during appraisals. For example, one staff member told us about training in verification of death.
- There was emphasis on the safety and well-being of staff. We saw this indicated in various ways. For example, the provider awarded staff and services for good work. Staff had access to a provider magazine. The magazine included details of staff achievements and awards. Staff could follow the provider on social media where recognition and wellbeing were further highlighted as a high priority.
- Measures were taken to protect the safety of staff who worked alone and as part of dispersed teams working in the community. Staff knew and understood the lone working policy. Staff could describe to us the process for lone working. This took the form of a group text which informed the team of the whereabouts of staff, particularly those worked remotely. There were administrative monitors who ensured staff checked in

and out. Staff also carried out risk assessments in advance and where there were risks, measures were put in place. For example, visits by two members of staff or they were seen in clinics.

- Processes and procedures were in place to ensure staff met the duty of candour principles.

Governance, risk management and quality measurement

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- Staff were represented at service level governance meetings. These meetings were where all the leads, including education and specialist nurses attended. We looked at minutes from these meetings and saw action plans which were to be fed to staff at all levels, including the corporate governance committee. There was a medicines optimisation group who helped increase awareness of what a medicine incident was and how to report it. There were medicines optimisation review panel meetings where staff learned from incidents.
- We looked at the governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There were various functions to oversee the effectiveness of the service. There were several committees to oversee quality assurance, for example, infection prevention control and safeguarding committees. Service teams fed in to these committees to review and monitor improvements.
- All levels of governance and management functioned effectively and interacted with each other appropriately. The leadership team attended governance meetings and information was fed in to local teams at team meetings, in the form of minutes and emails.
- Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom. There were clear lines of accountability with team leaders overseeing staff and helping them to achieve their objectives. This was evidenced in staffing structures and understanding of roles and responsibilities. Staff contributed to the identification, monitoring and management of risks. We saw risks

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documented in the risk registers. These risks were reviewed and shared at monthly meetings. The meant the leadership team were assured of monitoring and ownership.

- The leadership team monitored and reported on clinical governance scorecards. We saw this documented in monthly governance meetings. The scorecards helped monitor clinical performance and the workforce delivering it. The system helped managers keep up to date with anticipated increase in workload and how to deliver it in terms of workforce and the delivery of care.

Public engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture. Staff provided friends and family members with friends and family leaflets. We looked at the service friends and family report. During December and January, the overall score to recommend to friends and family was 97%.
- Patients who used the service provided feedback using the 'you said, we did' process. Patients who used the service asked for patient appointments to be scheduled together to avoid repeated clinician appointments. Staff listened and as a result agreed to schedule appointments together where possible. For example, a learning disability nurse and continence nurse to see a patient at a single appointment to reduce the number of appointments a patient had to attend.
- There were positive and collaborative relationships with external partners. The aim was to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Staff worked with other stakeholders across the health economy, for example, local hospices, social care services and GP's for the benefit of those who used the service.

Staff engagement

- Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Following the results of a staff survey, the senior management and leadership team

instigated additional opportunities for staff to engage with the team. This was in the form of chat sessions with the managing director, leadership forums, colleague bulletin (via email), team brief and an annual staff engagement event.

- The managing director offered informal drop-in sessions with staff. This gave an opportunity to share ideas, flag concerns or ask questions informally. The aim was to increase visibility of the managing director and to give staff an opportunity to be listened to at a senior level.
- The service leads operated an open-door policy. Staff could directly raise any concerns making the service leads visible to all staff. Staff we spoke with told us that they could approach service leads if they needed support.
- Staff attended bi-monthly leadership forums. The purpose of the forums was for staff to share feedback, work together to resolve concerns, cascade messages to teams and empower staff to deliver transformational services.

Innovation, improvement and sustainability

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**
- Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. This led to improvements and innovation. For example, we saw evidence of scheduled peer reviews to evaluate clinical performance.
- There were systems to support improvement including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Staff told and we saw documentation relating to staff being awarded for their contribution and efforts.

Information management

- Patients were assured that information about them was treated confidentially in a way that complied with the GDPR. There was an information governance policy and information sharing was explained and consented to by those using the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that all staff have access to a network connection to support remote working and accessibility to patient records.
- The provider should ensure patient's care records demonstrated that consent had been gained to provide care and treatment.
- The provider should ensure that staff comply with mandatory requirement to complete information governance training.
- The provider should ensure that care records are completed fully.