Anglian Community Enterprise Community Interest Company (ACE CIC)

1-165291700

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)
1-289608590	Clacton Hospital	unit	CO15 1LH
1-289640064	Kennedy House	team	CO15 4AB
	Mill Road Therapy Centre	unit	CO4 5LJ
1-165291700	The Crescent, Colchester Business Park	team	CO4 9YQ

This report describes our judgement of the quality of care provided within this core service by Anglian Community Enterprise Community Interest Company (ACE CIC). 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 Anglian Community Enterprise Community Interest Company (ACE CIC) and these are brought together to inform our overall judgement of Anglian Community Enterprise Community Interest Company (ACE CIC)

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated Adult Community Services as good because;

- There were robust processes in place for reporting and learning from incidents. All members of staff we spoke with were aware of incident reporting and their responsibilities in relation to incident reporting. We saw evidence of managers discussing incidents at staff meetings.
- There was awareness and a pro-active approach to following safeguarding procedures. Staff knew how to raise a safeguarding concern and could give examples of what they would report.
- Care that was delivered took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff had received an annual appraisal, and had opportunities for their personal development. The average target for appraisals was set at 75% and community adult services had exceeded this target. Staff we spoke with provided examples of training and development that they had accessed.
- We saw good examples of multidisciplinary team working and coordinated care pathways.
- Staff treated patients with kindness and respect and always protected their privacy and dignity when delivering care.
- Relationships between patients, their relatives and staff were caring and supportive. Staff recognised and considered the personal, cultural, emotional and social needs of the patient.
- Patients were involved in making decisions around care planning.
- Patients were given information about how to make complaints. Complaints were investigated and patients were informed of the outcome.
- Staff had access to interpretation services.
- There was a well-embedded governance structure in place, this fed from locality teams upwards into the executive board.
- Staff valued the support and dedication of their immediate managers.
- We saw good examples of innovative practice.
- All staff we spoke to told us that there was a patient centred culture.
- The organisation was pro-active in celebrating staff achievements with several members of the adult community teams receiving awards recently.

However;

- Equipment was not always fit for purpose. We found items in use that were either out of date or had no date for maintenance testing.
- Vacancies impacted on services provided by some of the community teams, for example the respiratory service.
- Some specialist teams within the community adult service expressed 'feeling isolated'. The absence of clinical lead in the respiratory service also made staff feel losing a link with the wider service.

Summary of findings

Background to the service

Anglian Community Enterprise (ACE) Community Interest Company (CIC) provides a range of adult community services predominantly to the population of North East Essex (Colchester and Tendring Districts). In June 2015 ACE was awarded the Care Closer to Home Contract commissioned through the North East Essex Clinical Commissioning Group (NEECCG). This meant from April 2016 the nursing and therapy community services have been delivered in an integrated model, closely aligned to the GP practices.

Community Adult services are provided by four integrated care teams; Colchester North, Colchester South, Tendring North and Tendring South, from a wide range of community locations including hospitals, clinics and health centres. Services we visited included:

- Community Nursing - Integrated Care Team
- Community Rehabilitation - Integrated Care Team
- Early Support Discharge Service for Stroke (ESD)
- Respiratory service
- Continence & Urology
- Epilepsy
- Cardiac Services
- Transfusions
- Cardiology
- Continence/Urology
- Lymphedema
- Pain Clinic

During the inspection, we spoke with 54 members of staff including assistant director of clinical development, integrated care managers, community matrons, district nurses, community nurses, healthcare assistants, physiotherapists, occupational therapists, associate practitioners and student nurses, and 21 patients and relatives. We observed episodes of care and reviewed 10 patient care records and three medication records.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should ensure equipment is fit for purpose and ensure maintenance and servicing is completed in line with provider policy at all times.
- The provider should ensure compliance rate for mandatory training courses is in line with the provider's compliance target.

Anglian Community Enterprise Community Interest Company (ACE CIC)

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There were processes in place for reporting and learning from incidents. All members of staff we spoke with were aware of incident reporting and their responsibilities in relation to incident reporting. We saw evidence of managers discussing incidents at staff meetings.
- Staff we spoke with were aware of the Duty of Candour and their responsibilities to be open and honest following incidents that had caused moderate or severe harm to a patient. 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 used comprehensive holistic patient risk and care assessments to identify and respond to risks to the safety, health and wellbeing of patients in the community within their care.
- Staff were up to date with mandatory safeguarding training and there was awareness and a pro-active approach to following safeguarding procedures. Staff knew how to raise a safeguarding concern and could give examples of what they would report

However:

- Equipment was not always fit for purpose, we found items in use that were either out of date or had no date for maintenance testing.
- Vacancies impacted on services provided by some of the community teams for example the respiratory service.
- The compliance rate for some mandatory training courses was overall below the compliance target of 95%. For example, compliance rates for information governance and basic life support training ranged between 75 – 90%.

Good

Are services safe?

Safety performance

- The provider participated in the NHS safety thermometer programme, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Data is collected on a specific day each month to indicate performance in four key safety areas - new pressure ulcers, catheter related urinary tract infections (CAUTI), venous thromboembolism (VTE) and falls.
- Between October 2015 and October 2016 the rate of harm free care averaged 98.6% for community nursing. This was higher than the national average for harm free care, which was 94.3% in December 2016.
- Staff we spoke to were knowledgeable about this initiative, and results of the safety thermometer were displayed and shared locally through the monthly 'Quality Matters' newsletter to improve practices.

Incident reporting, learning and improvement

- The provider had systems in place to report and record safety incidents, near misses and allegation of abuse. There was an incident reporting policy in place which provided guidance for staff on how and when to report incidents in the service
- Between 1 April to 31 October 2016 the service reported 1136 incidents. The most reported incidents in October were pressure ulcers and slips, trips and falls. The majority of these occurred in patients own homes and were attributed to pressure damage.
- Between 1 July 2015 to 31 July 2016 11serious incidents were reported by the service. The majority of these were Grade 2 or Grade 3 pressure ulcers, with one incident reported as Grade 4 pressure ulcer. 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 or serious harm.
- Staff we spoke with knew how to recognise and report incidents on the electronic recording system, and were able to give examples of reportable incidents such as pressure ulcers and medication errors.
- We saw evidence of lessons learned through investigations. For example, following an incident it was identified that there was a need around sepsis training. As a result community nursing teams had additional sepsis training and a sepsis recognition toolkit was introduced.
- We reviewed the Root Cause Analysis (RCA) of four serious incidents. These were comprehensive in content and included a chronology of events, why the event occurred, reflection and actions taken to mitigate the risks.
- The RCAs we reviewed related to pressure area damage. A pressure ulcer determination panel tool and learning from experience had been completed to identify any learning and put actions in place to improve the care of patients at risk of developing pressure ulcers. For example, better documentation and referral to the tissue viability team to assist in grading the pressure ulcer.
- Integrated care managers used regular staff meetings and newsletters to share learning and trends from incidents with staff. Minutes from staff meeting in Tendring South and Colchester North held in August 2016 noted discussions around the investigation of incidents, action taken and lessons learnt.
- The provider produced a monthly integrated incident report for the board which highlighted concerns across the services. In October 2016, community nursing reported the most incidents, reporting 126 incidents. Of these 29 were classified as no harm, or near misses, 57 minor harm, 39 moderate harm and one catastrophic harm. At the time of our inspection the incident that was classified as catastrophic was still under investigation.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities to be open and honest following incidents that had caused moderate or severe harm to a patient. This was documented in the electronic records and the RCA forms
- The duty of candour was part of mandatory staff training and had been incorporated into the relevant reporting policies, to provide guidance to staff.
- Monitoring of the compliance of duty of candour took place during any investigation of serious incident process by the risk management team.

Good

Are services safe?

Safeguarding

- The provider had a safeguarding policy in place and safeguarding training was included in the mandatory training. Safeguarding level two, children and adults, were undertaken on a three yearly basis.
- Compliance rates for safeguarding adults level two as of 31 August 2016 was above or in line with the provider's compliance rate target of 95%, apart from one locality that had 94%.
- Staff we spoke with had a good understanding of safeguarding and were able to explain the actions they would take if they had concerns about a patient.
- Information about the safeguarding lead, contact details and safeguarding flow charts were on notice boards in the team bases we visited. The flow chart demonstrated the local safeguarding process for staff to follow in the event of a safeguarding concern.

Medicines

- The provider had a medicines policy and a controlled drug policy that detailed specific arrangements for medication administration in people's homes.
- All clinical staff were required to complete training in medicine administration and had to repeat this every two years to support safe medication administration practice.
- Many of the community matrons had undergone additional training in order to become non-medical prescribers. Non-medical prescribing is the prescribing of medicines and dressings by health professionals who are not doctors. This meant that potential delays in patients receiving their medication were avoided and patients did not need to attend unnecessary appointments with the GP.
- Patient group directions (PGDs) were adopted by the service to allow nurses to administer medicines in line with legislation. PGDs allow some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.
- The community nursing teams provided day-to-day management of syringe drivers (a small, battery-operated pump that deliver continuous medication) in patients' homes. Syringe driver training is role specific and data provided by the service showed that, at the time of our inspection 70% of the community nursing staff had an up to date training. The remaining 30% were scheduled for refresher training.
- Medicines stored in the infusion clinic at the Jubilee Unit in Clacton were all in date. The treatment room had a keypad, with access only to authorised staff. A daily checklist was completed by nurses.
- A daily temperature log was completed for the fridge where chemotherapy drugs were stored. We checked the records for the month of November 2016, there were no gaps in the log. The temperature was within the acceptable range on the day we inspected and staff informed us what they would do if it was outside of this. For example, rechecking the temperature, reporting to line manager and recording actions taken on the temperature log book.
- The fridge was kept locked at all times. Drugs in the fridge were checked and in date.
- Unwanted or expired medicines were disposed of in yellow bins and chemotherapy drugs were placed in a purple box, and kept in a locked room for final disposal.
- The community respiratory service worked with patients who used oxygen at home. The service used an external organisation to manage the equipment provided to patients at home.
- The provider monitored the NHS Medication Safety Thermometer, whereby data was collected on one day each month from the community nursing teams. The Medication Safety Thermometer identifies harm occurring from medication errors. Data for August and October 2016 showed that 0.5% of patients seen by the community nursing teams had an omitted dose of medication in the past 24 hours. In October there were no patients with an omitted dose.
- In August 2016 data showed that medicine allergy status was documented in 96.3% of patients. This percentage had increased to 99% in October 2016.

Environment and equipment

- Equipment supplied for use in patients' homes was contracted through an external equipment provider. For example pressure relieving cushions and mattresses. Equipment decontamination and maintenance was the responsibility of the private contractor.
- Staff informed us that they were able to order equipment for patients when required. For example,

beds, mattresses, mobility aids, and moving and handling equipment. These were prioritised as either urgent or routine and they usually did not experience delays with deliveries.

- We visited four locations where patients attended clinics or the community nursing teams were based, all equipment and dressings were stored in well-organised storage cupboard. We checked a range of dated disposable items and found that all items were stored correctly and within the expiry date.
- Syringe drivers were serviced and kept locked at the integrated care teams' base. Systems were in place to sign out syringe drivers to patients in the community. It was completed showing time and date that a syringe driver was logged out, patient details and the date that it was returned. We checked the syringe drivers that were on site at the time of our visit. All were within date for calibration and electrical safety testing.
- There was a service level agreement with the local acute trust for the maintenance and safety testing of medical devices.
- We reviewed the equipment service logs at Mill Road Therapy Centre, where the cardiology service was held. The lead told us that the local equipment log was being updated with the list of equipment held by the team and the corresponding service and maintenance dates.
- The equipment log at Mill Road listed six out of 17 manual blood pressure recorders were past their calibration date. We brought this to the attention of the cardiology lead who told us that the list might be outdated as most staff have been issued with new manual blood pressure recorders recently. We were also informed the provider was in the process of introducing an equipment mapping tool to ensure calibration and service checks were carried out.
- We checked the availability of resuscitation equipment at the infusion clinic and the Mill Road therapy centre. We inspected the resuscitation equipment at both locations, and found that regular checks were recorded and all of the consumable items and medicines were in date. However, at the Mill Road therapy centre we found the service and maintenance date for the defibrillator was overdue. This was raised during the inspection with the manager of the unit and we were told that they would escalate with the maintenance team.

Quality of records

- Community nursing records were recorded on an electronic system. The records contained risk assessments, screening tools, care plans, mental test scores, therapy outcome measures, falls histories, contact notes, and consent.
- We observed staff completing electronic records and updating plans of care. We reviewed 13 electronic patient records and found detailed assessment and care planning with up-to-date risk assessments such as Braden scoring, MUST assessment (a nutritional screening tool), falls, manual handling, mental health assessment and mobility assessment. We saw evidence that there were goals agreed with patients, which meant that patients were active partners in making decisions about their care and treatment.
- Record audits were completed on a quarterly basis to ensure staff met and maintained standards. Community nursing team based in Tendring south told us that the results of the records audit from October 2016 were discussed at the team meeting. Overall the audit showed that there was good compliance apart from the use of acronyms and the consent box not always being ticked.
- Paper nursing records were used for patients attending the infusion clinic at the Jubilee centre. These were placed in trolleys behind the nursing station, which was always manned. At the end of clinic and overnight, we were told that the trolleys were locked. The clinic only held one week's of medical notes in a locked store room.

Cleanliness, infection control and hygiene

- The target for infection control training was 95%. Across the community services compliance ranged from 91% to 97% for the month of August 2016.
- Staff adhered to the 'bare below the elbows' policy and wore gloves and aprons when providing care in clinics and home environment to prevent the spread of infection.
- We observed staff washing their hands and using alcohol gel prior to and post procedures in clinics and in clients' homes.
- Monthly audits were completed using the "essential steps" tool which audited infection control compliance

with hand hygiene, personal protective equipment, and catheter care. Results showed that in November and December 2016 there was 100% compliance in community nursing teams.
- The outcome of the audits were discussed with clinical teams to improve training and monitor techniques and standards of hand hygiene performed by staff.
- All locations we visited were tidy and visibly clean. Clinical and domestic waste was segregated and sharps boxes were available and used appropriately.
- We observed that cleaning of chairs and trolleys took place between patient treatments in the infusion and lymphoedema clinics.
- Hand washing facilities and alcohol hand gel were available throughout the clinic areas. Staff we observed followed good infection prevention and control procedures when working in the community.
- Water quality at a therapy centre had been identified as a concern due to contaminants found when routine tests of water outlets had been carried out. Precautions had been put in place with filters being fitted to taps, bottled water for drinking supplied and on-going water testing and monitoring .This had been recorded on the providers risk register.

Mandatory training

- Mandatory training covered a range of topics, which included fire safety, health and safety, basic life support, safeguarding, manual handling, infection control, information governance and conflict resolution.
- Mandatory training was delivered through classroom sessions and e-learning. Staff also had the option of printing the workbooks for the e-learning courses and completing the workbook instead of doing it online.
- Team leads received notification when mandatory training was due for their team members.
- The organisation compliance target for mandatory training was 95%. Data showed that in August 2016 the compliance rate for some mandatory training courses was overall below the compliance target. For example, compliance rates for information governance and basic life support training ranged between 75 – 90%.

Assessing and responding to patient risk

- A comprehensive holistic patient risk and care assessment was completed electronically by staff in the adult community services. This meant staff were always able to access the risk information relating to patients that they were treating.
- Staff caring for patients with allergies were reminded of these by an alert on the electronic record and we observed staff checking with patients about any allergies, for example prior to using a new wound dressing.
- During the first meeting with new patients staff completed a full assessment of care needs. This took place whether the patient was in a clinic or in their own home. We observed this in both settings; the process identified potential risks so these could be addressed and plans of care made.
- Pressure area risk (Braden) scores and malnutrition universal screening tool (MUST) assessment were completed monthly or more frequently if there was a change in the patient's condition.
- Patient risk assessments were part of the electronic care record. We reviewed 10 care records and saw staff had completed a range of risk assessments, such as malnutrition and falls. We found where a risk had been identified; appropriate care had been planned and implemented.
- The chronic obstructive pulmonary disease (COPD) team offered an 'SOS' service whereby even after discharge from the team's care, patients could contact the team at any time, without having to contact their GP for a new referral.
- The community nursing team used a sepsis tool kit, which was put in place to support the identification and appropriate management of patients with sepsis.
- The 'Community Gateway' was the central single point of access for community health services. Administration staff would record initial information and then direct the call to the appropriate team. All calls would then be answered and triaged by a band 6 clinician who referred the caller to the most appropriate service; ensuring patients received timely and appropriate care.

Staffing levels and caseload

- As of the 31 July 2016, the percentage of total vacancies across the adult community services was 22%. The total

number of vacancies for registered nurses across all community nursing teams was 24.3 whole time equivalents (WTE) and for the nursing assistants was 1.9 WTE.

- Within the nursing teams, a caseload-rating tool was used to help plan workload. This tool 'weighted' nursing tasks, with tasks being allocated 20, 40 or 60 minute time slots depending on the complexity. Additionally severity of the patient's illness was rated as red, amber or green, with 'red' patients being given a higher priority for care.
- The vacancies across the localities varied. The community respiratory team is a small team, which sits under the Tendring north integrated care, has a total establishment level of 9.1 WTE. At the time of our inspection visit, the total number of vacancies was 3.5 WTE, which included a vacancy for the respiratory lead. There was also long term sickness within the team.
- Bank or casual nursing staff were used to cover any nursing staffing shortage. The data showed between 1 May and 31 July 2016, bank nurses had filled approximately 159.5 hours of vacant shifts to cover staff sickness, vacancies or absence.
- Staff in the respiratory service described how low staffing and high workload led them to frequently working over their contracted hours to deliver patient care but had not logged the hours, so there was no evidence to prove how many. This included completing admin work at home in their own time.
- There were vacancies for therapists across the service, which at the time of our inspection were being filled by agency therapist. The therapy lead for the service told us recruiting into the vacancies was challenging and discussion were taking place with an agency to secure permanent placements through them.

Managing anticipated risks

- There was a 'lone working policy' which staff were encouraged to follow, as well as a tracking system which could locate the member of staff. Some community teams had local arrangements in place where they would text or call a nominated colleague at the start and finish of their shift. This was a deviation from the lone working policy and we raised with the managers at the time of our inspection.
- Staff were able to use the electronic records system to flag alerts if a patient had specific risk or had a history of being abusive to staff. If they had concerns regarding any of the areas they were visiting, staff would visit in pairs and night duty staff always worked in pairs to ensure their safety.
- Locally, community nursing teams had access to the organisational 'cold weather' plan. This included identifying which staff were in walking distance of patients homes and clinic bases. The more vulnerable and highly dependent patients would be identified and these patients would be prioritised using a RAG rating (red, amber, green traffic light system). Those patients identified as 'red' such as those who required time critical medication such as insulin received visits first.

Major incident awareness and training

- There were policies and procedures in place for dealing with major incidents. We found that local plans were in place and staff were aware of the emergency plans within their teams. For example, the single point of contact team had clear plans to continue the service in the event of a major incident or incident affecting service delivery, such as information technology failure.
- Health and safety training, and fire safety training was part of the mandatory training programme. Data from 31 August 2016 showed that 97% of staff in the community adults service had completed both health and safety training and fire safety training against a target of 95%.

Good

Are services effective?

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

Summary

We rated effective as good, because:

- Care was delivered that took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff had received an annual appraisal, and had opportunities for their personal development. The average target for appraisals was set at 75% and community adult services had exceeded this target. Staff we spoke with told us of numerous examples of training and development that were available.
- There were many examples of integrated multidisciplinary teams working well together. These often included team members from other organisations such as the local acute trusts, hospice and other voluntary sector organisations.
- Throughout the inspection, we observed that the patients consented appropriately and correctly.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Evidence based care and treatment

- Care was being delivered that took account of national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. We saw reference to national guidelines in patients 'health care notes
- The community nursing teams used recognised tools such as the Braden Score (a screening tool used to assess patients' risk of developing a pressure ulcer) and MUST (a malnutrition universal screening tool) in assessments for patients. The care planning, that we observed was based on individual patient needs, was appropriate and relevant.
- Patients' assessments were completed using templates that followed national guidelines, for example for assessing patients for the risk of pressure ulcers and malnutrition.
- Patients followed rehabilitation pathways. For example community staff in cardiac services, stroke rehab and pain clinic agreed goals and care pathways with patients and relatives at the start of treatment programmes, and regularly monitored and reviewed them. This was evidenced in the patient's electronic record.
- In the cardiac rehab clinic staff provided a range of specialised exercise sessions to support patient rehabilitation as well as maintenance of movement, based on latest standards from the British Association for Cardiovascular Prevention and Rehabilitation (BACPR).
- Staff followed national guidance on the prevention of pressure ulcers. All skin damage from grade 1 to grade 4 was reported as an incident. All grade 3 and 4 ulcers required further investigation.
- The pain clinic used methods that were fully compliant with NICE guidelines for pain management in supporting patients to self-manage pain and reduce their dependency on invasive interventions.
- The early support discharge for stroke (ESD) team provided specialist person-centred intensive rehabilitation for patients following a stroke and were based on NICE guidance.
- The lymphoedema team conducted initial assessments and decided on a care plan with the patient. The care plan was regularly reviewed and the patient was given an information booklet that encourages self-management.

Pain relief

- We reviewed patient care records and saw that patients' pain was assessed and care plans developed if patients were experiencing pain.
- Staff considered patients' pain when providing care. We observed staff checking out comfort levels for example for example, when changing wound dressings, and therapy staff identifying what factors aggravated and eased patient's pain.
- We observed the Early Support Discharge Service for Stroke (ESD) team checking patient's comfort levels when supporting the patient to carry out their exercise

and stopping if it was causing distress. We also saw staff monitoring patients closely whilst taking part in the exercise class in the cardiac clinic to prevent possible pain and distress.

- Patients could be referred to the pain team for the management of long term and chronic pain. The organisation's pain team, accepted referrals for patients with long term and chronic pain, and were available for advice and support for individual patients

Nutrition and hydration

- Patients' nutrition and hydration status was assessed using the 'Malnutrition Universal Screening Tool' (MUST) by the community teams and recorded in the patients care plans we reviewed.
- Staff told us that for those patients identified as nutritionally at risk, an action plan was put in place and recorded on the electronic care record.

Technology and telemedicine

- The provider has recently rolled out the use of smart phones to all staff in the integrated care teams which would help to support effective patient care, for example by making it easier to take photographs of patients' wounds, which could easily be uploaded onto the care record to aid referral for specialist input and to monitor progress.
- Tendring south community nursing team recently piloted wound photography, where they were able to photograph wounds to assess progress or deterioration of wound healing. It also allowed them to discuss treatment options with colleagues to ensure best care and/or make referrals to tissue viability specialist nurses.
- The musculoskeletal physiotherapy service allowed patients to self-refer to physiotherapy via telephone. Staff would then call patients back and triage their needs, before providing appropriate advice or clinic appointments to further their care.
- The pain clinic team offered patients a pain toolkit app, which provided extra support for patients to increase their awareness of pain self-management.

Patient outcomes

- The provider was in the process of rolling out standardised patient reported outcome measures (PROMs) across the service, which was due to be completed by January 2017. This would mean a consistent approach to monitoring and auditing the quality of the service or outcome measures for patients in order to improve the quality of the service
- The service will be using 'Wellbeing star' to measure patient outcomes within the ESD, Adult SLT and Long term conditions. However we were told that the service will be using 'EQ-5D', standardised instrument for measuring generic health status, as the main PROMs in the services.
- The services had participated in all national audits for which they were eligible. These included National Audit of Intermediate Care, Chronic Obstructive Pulmonary Disease (COPD) National Audit, National Diabetes Audit, National Diabetes Foot Care Audit, Sentinel Stroke National Audit Programme (SSNAP) Post-Acute Organisational Audit and UK Parkinson's Audit.
- At the time of our inspection the reports for the National Audit of Intermediate Care, COPD Audit and National Diabetes Audits had not been received from the National Teams and therefore we were not able to consider the providers results in line with national benchmarks.
- SSNAP audit data submitted between April and July 2016 showed the proportion of days in which therapy was received was better than the national average at 55 minutes for occupational therapy (48 minutes national average), Physiotherapy 50 minutes (42 minutes national average) and Speech and Language 38 minutes (20 minutes national average).
- The audit showed that patients were being seen within one day of referral to the ESD team, in line with the national average. The length of stay with the ESD team was greater at 41 days compared with the national average of 37.
- The pain service used the Pain Self-Efficacy Questionnaire (PSEQ) to measure patient outcomes. Outcome tools based on measuring anxiety and depression were also used in the pain service. However at the time of our inspection the outcome results for these measures had not been audited and we were unable to see the reports.

Competent staff

- All new staff had corporate induction within the first two months of employment as well as local induction and welcome pack. Induction included various mandatory

training sessions including Safeguarding children and adults, Infection prevention and control, care and compassion, basic life support and Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLs).
- Staff new to the organisation remained supernumerary until they completed their competencies. Staff confirmed that they were not expected to attend visits alone until not only had they completed competencies, but that they felt comfortable doing so.
- The target appraisal rate was 70%. Appraisal rates for September 2016 were above the target for adult community services. Compliance rates for Colchester north were 80.6%, Colchester south 83.5%, Tendring north 85.5% and Tendring south 70.1%.
- Staff described the appraisal process as useful and that they were able to input into goal and objective setting.
- Healthcare assistants (HCAs) working within the integrated care teams were given competency workbooks on starting with the organisation. The workbooks had to be completed by the HCAs and signed off by a senior member of staff as part of the HCAs' induction training. This ensured that all new HCAs had a minimum level of knowledge on completion of their induction. We saw the competencies work book and it ensured staff were regularly checked to maintain their competencies.
- Staff told us that they were encouraged and put forward by their leads for additional training. For example one of the band 7 community nurses said that they would be starting their district nursing qualification next year.
- One of the integrated care team managers told us that they were taking part in the Assistant Director Development Programme as part of the organisations successions plan.
- Staff had access to specific training to ensure they were able to meet the needs of their patients and their professional objectives. Staff from the stroke rehab team had various opportunities to attend external conferences and other courses.
- The community matrons assessed the training needs of junior members of staff and provide training. Staff found this to be a valuable learning experience.

Multi-disciplinary working and coordinated care pathways

- Patients with complex needs under the care of the integrated care teams were discussed at the MDT meetings, which were held in different locations including GP surgeries. Meetings were attended by community matrons, community nurses, specialist nurses, and therapists. This meant that all staff had the opportunity to discuss patients' care with other members of the multidisciplinary team.
- The early support discharge Service for Stroke (ESD) team conducted joint nursing and therapy visits. This helped to speed up patient reviews as well as getting equipment in place.
- The Lymphoedema team liaised closely with the leg ulcer team and tissue viability specialities. They also plan combined appointments, on the same day, for patients who attend the infusion clinic to avoid patients coming to the clinic twice.
- The Lymphoedema team also had MDT meetings with the breast care and head and neck teams in the local acute hospital.
- Staff in the community nursing teams attended monthly Gold Standards Framework meetings at local GP surgeries. Staff told us these meetings involved multidisciplinary discussions of patients on the palliative care register. This meant that all staff involved in end of life care had an opportunity to discuss patients' care with other members of the multidisciplinary team
- Community nurses attended the local hospice for a weekly MDT meeting to discuss palliative patients on their case load. This MDT meeting was in its pilot phase and was being developed to improve relationships between the different services and provide a good patient experience.
- The ESD team had weekly MDT meetings to discuss their caseload and was attended by the stroke consultant from the local acute trust and representatives from the local voluntary stroke services.

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, acute hospitals, nursing and residential homes.
- Patients were referred into the adult community services via the 'Community Gateway' which is a single point of access for all services provided by ACE. This allowed new patients to be referred electronically into a centralised system and then for these referrals to be passed to the relevant team.

Good

Are services effective?

- Referrals could then be 'tasked' to teams under the organisation electronic patient record system. This allowed teams to track incoming work and prioritise their caseload.
- The musculoskeletal physiotherapy service offered direct referral for patients via telemedicine service through a third party contractor.

Access to information

- The provider used an electronic record system throughout the community services. This allowed a single point of access to records for staff.
- All community staff were issued with laptops and were able to access and update patient records remotely.
- Staff were able to access the electronic records when visiting patients in their home and were able to review and update records contemporaneously.
- Staff could use the electronic record system to access care information from other services when patients had indicated that they were happy for this to be shared. This allowed instant access to staff to see the range of care delivered to a patient.
- Staff could access a range of policies and guidance via the provider's intranet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions and seeking consent before providing care or treatment appropriately. For example, the early supported discharge service for stroke gained consent at the patient's first assessment and recorded it. The team sought verbal consent prior to each intervention. The consent was captured on the electronic patient record.
- The Mental Capacity Act (MCA) 2005 was part of mandatory training. Data from 31 August 2016 showed compliance was in line with the organisation target of 95% across adult community teams.
- Staff we spoke with had good understanding of the MCA and gave practical examples of how this would be assessed, or any concerns that required to be escalated.
- The organisation had an up to date MCA and Deprivation of liberty Safeguards (DoLS) policy in place to provide staff with guidance.
- Chemotherapy patients carried a consent chart with them, which they brought to every appointment in the infusion clinic. Consent was recorded at each treatment.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

- Patients and their relatives were consistently positive about the treatment they received from the nursing staff
- Staff treated patients with kindness and respect and always protected their privacy and dignity when delivering care.
- Relationships between patients, their relatives and staff were caring and supportive.
- Staff recognised and considered the personal, cultural, emotional and social needs of the patient.
- Patients were involved in making decisions around care planning. Patients understood their treatment and condition and were well informed.
- Patients' individual preferences and needs were reflected in how nursing staff delivered care.

Compassionate care

- Throughout our inspection, we saw staff speaking to patients and their relatives courteously and respectfully.
- Staff treated patients with dignity and respect and always introduced themselves with "hello my name is" even to patients who they saw regularly.
- Staff were aware of patients' personal situations, their families, pets, home lives and enquired about them. We saw this on home visits and in the Jubilee Clinic.
- Staff closed curtains around patients to protect their privacy and dignity before delivering care.
- Staff maintained patient confidentiality by locking computer screens when they moved away from them so that patient information was not visible.
- Nursing staff used chaperones, according to hospital policy, when patients were having intimate procedures or if a patient requested one.
- All of the 18 patients and three relatives we spoke with were consistently positive about the treatment they received from nursing staff. Patients told us the staff were professional and caring. One patient told us "I have been looked after well, I could not ask for better treatment". Another told us "I cannot fault anything, the staff are excellent" and another said "I cannot wish for nicer people…they are very good, very helpful".
- Results from the NHS friends and family test showed consistently positive results. The adult community services scored 98% and 99% for quarter one and two of 2016/17. All the patients we spoke with said they would recommend the service to family and friends. One patient told us "it is the best service I have ever experienced" and another said "I think they provide an excellent service".
- Nursing teams provided a holistic approach to patient care. An example of this was an end of life patient who lived with his elderly mother and was anxious to spend time with her and that she was not alone. The patient was nursed at home with additional nursing visits provided to enable this. One patient told us "the nurses make me feel very comfortable".
- Administration staff provided a caring service to patients. An example of this was a continence clinic patient had run out of continence pads and was unable to get a GP appointment. The patient telephoned the 'Community Gateway' single point of contact and administration staff liaised with the GP to have a referral sent to the clinic so the patient could be supplied with pads quickly.
- Staff liaised with a local animal support service to ensure patient's animals were taken care of while they were in hospital.
- Nursing staff had liaised with the Fire and Rescue service to help clear a patients garden area to enable them to mobilize in a safe environment.
- A therapist described how a patient had wanted to go to the hairdresser. Walking to the hairdressers was set as the care plan goal. When the patient was deemed able, one therapist walked them to the hairdresser and a second therapist walked them home after their appointment.
- A nurse described how they had changed a care plan to meet the personal preference of a leg ulcer patient. The patient wished to wear a particular pair of shoes for a special occasion. The care plan was altered so that different leg ulcer dressings were used enabling the patient to wear the shoes. We spoke to the patient concerned who told us this change had been very much appreciated.

Outstanding ☆

Are services caring?

Understanding and involvement of patients and those close to them

- All of the 18 patients we spoke with told us they were involved in making decisions around their care and treatment planning. Patients and their relatives were involved as partners in their care.
- On all visits we observed patients being included in discussions about their care and treatment, where applicable relatives and carers were also involved. Patients told us that they felt they were always empowered to make decisions about their care. They said they felt fully included and their opinions respected. One patient told us "(staff) they communicate very well".
- We saw clear evidence that patients were active partners in their care. Patients were supported to manage their illness whenever possible; for example a patient informed us on how they had started to self-manage their own wound care needs, through the support and guidance of the nurses. This had enabled the patient to develop a greater understanding of their condition.
- One patient told us they could change their own wound dressings which meant they did not need to stay in and wait for the nurses as often and could see their wound was improving.
- During the inspection we observed four specialist clinic appointments. Staff consistently provided patients with information about the care they were receiving. All patients' observed were asked if they had any questions by the staff who were treating them. We observed strong professional/patient relationships that were supportive of the patient's needs.

Emotional support

- Staff created "Community Walls" in the office bases. These were notice boards of information and leaflets relating to local services such as bereavement counselling, isolation befriending services and social services. Staff could inform patients of the support available to them in their area. We saw the Community Wall in Tendring South office.
- Nursing staff provided patients with information regarding relevant local support groups. For example, the leg ulcer support group and the lymphoedema group which were patient run with the support of nursing staff.
- Nursing staff described how they changed their shift pattern so they could attend bereavement visits with families of patients they had cared for.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Staff in the adult community services were aware of the needs of differing communities, within its area.
- Urgent referrals to the rapid assessments through the 'Community Gateway' (single point of access referral hub) were monitored. The data for quarter 2 2016 showed that 99% of patients were seen within the two hours of the urgent referral.
- Patients were given information about how to make complaints and when complaints were raised they were investigated and patients were informed of the outcome.
- Staff had access to interpretation services.

Planning and delivering services which meet people's needs

- Adult community services were provided through the integrated care teams from four geographical locations. Staff told us that being together in one base allowed staff and patients easy access to professionals within community nursing and therapy services.
- The pain team delivered services in a range of community locations and bases, including the local hospice. This allowed patients a choice of where to attend. The team also supported a bimonthly coffee morning for patients in the local community which was run by volunteers.
- The cardiology service had introduced a one stop cardiology clinic, whereby patients could see a heart failure nurse specialist who performed an echocardiogram (ECG), a specialist nurse would discuss the diagnosis with the patient and refer to a nurse prescriber to review medication if needed. The team works closely with a GP with specialist interest in heart failure and angina. This has positively impacted patient care as they are seen quicker and enter the care pathway quicker. Patients are given phone numbers for support and follow up once they have attended the clinic. Staff told us that this has increased the stabilisation of patients' heart failure and reducing the need for hospital admission.
- The provider employed clinical nurse specialists who were available to support patients living with leg ulcers, lymphoedema and cancer.
- We saw patients were encouraged to self-manage and nursing staff provided information regarding relevant local support groups.
- Palliative patients that required nerve block for acute pain had to travel to a neighbouring acute trust as the service could not be provided locally. However senior managers told us that they were trying to offer this service through a third party contract with a private hospital and discussions were underway.

Equality and diversity

- During our inspection, we saw staff providing individualised high quality care to all patients. Patients' cultural and religious needs were included in the individualised care plans following an ongoing assessment of needs.
- The organisation compliance rate for equality and diversity training was 96%, which was above the target of 95%,
- There was an interpreter service available. Staff we spoke with were aware of how to access the services and provided examples of doing so.
- The electronic referral system into the service contained a prompt to indicate if an interpreter service was required for the patient, meaning staff can book for an interpreter in advance.

Meeting the needs of people in vulnerable circumstances

- Staff told us that they would allocate longer appointments for patients with learning disability or special needs. In clinics, staff told us that they would try and arrange the first or last clinic appointment.
- Staff at the lymphoedema clinic told us that they would see patients with learning disability in the presence of their carer.

Access to the right care at the right time

- The adult community service had procedures in place for urgent referrals or rapid response to be assessed and processed within a maximum of two hours. The service

conducted a quarterly audit by reviewing 100 care plans; 25 from each locality. The data for quarter 2 2016 showed that 99% of patients were seen within the two hours of the urgent referral.

- We were told by managers that the waiting time to see a psychologist for pain management was less than two weeks, however we were not able to confirm this as data was not routinely collected. For patients that were on the waiting list for a medical review by the pain team, where appropriate, would be offered the option of going on two self-management sessions while they wait for a medical review.

Learning from complaints and concerns

- There were processes in place for dealing with and learning from complaints. Between August 2015 and July 2016, the community health service for adults received 45 complaints with eight upheld.
- Patients we spoke with were aware of the complaint process and how they could raise concerns with the complaints team.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. We saw information leaflets displayed in clinic areas setting out the complaint process and explaining to patients how they could raise concerns. The information was also available to patients on the provider's website.
- We saw examples of local learning from complaints. For example, a complaint was received regarding transport issues at the lymphedema clinic. Following the complaint the clinic staff ensured that patients requiring transport were booked into early appointments and the transport service was called to confirm collection time, when the patients' treatment had been completed.
- Complaints and learning from complaints were discussed at team meetings. We saw the meeting minutes for Tendring south intermediate care team from August 2016, which evidenced a complaints discussion.

Good

Are services well-led?

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

Summary

We rated well led as good because:

- The provider had a strategy to provide safe care.
- There was a well-embedded governance structure in place, this fed from locality teams upwards into the executive board.
- Staff valued the support and dedication of their immediate managers.
- We saw good examples of innovative practice.
- All staff we spoke to told us that there was a patient centred culture.
- The organisation was pro-active in celebrating staff achievements with several members of the adult community teams receiving awards recently.

However:

- Some specialist teams expressed 'feeling isolated'. The absence of clinical lead in the respiratory service also made staff feel they had lost a link with the wider service.

Leadership of this service

- Clear leadership structures were in place within teams with identified service leads. Each community nursing team were led by band 7 nurse lead and the therapy team was led by therapy lead, who both reported to an integrated care manager. The assistant director of operations had overall leadership of the adult community services, who reported into the director of operations and quality.
- The executive team and other board members were visible to staff in the organisation and some had attended team meetings. For example when staff were being transferred from the acute trust into the organisation members of the executive team went to the meetings and answered their questions.
- Leadership team meetings took place and that information from these meetings was cascaded to staff via team meetings and newsletters. For example the Colchester south integrated care team newsletter for November 2016 showed information that was discussed in the board meeting such has the improvement in the meeting the mandatory training targets .
- There was no respiratory clinical lead for the service and staff felt that this was impacting on service development and improving patient and service outcomes.
- The organisation had invested in band 6 and band 7 managerial leadership training, for team leaders. In addition they have supported leadership training for two band 8a through the assistant director development programme
- The majority of staff we spoke with spoke highly of their immediate line management and they felt supported within their teams by their managers.
- Local team leadership was effective. Staff we spoke with said they were supported by their line managers and that local leaders were visible and approachable.
- However, there was a small localised group of specialists within the community adult services who expressed concerns about the local leadership and felt unsupported.

Service vision and strategy

- The organisation had clear vision and values. The vision and values were developed and reviewed by staff
- The vision and values were displayed on posters in staff areas we visited. The staff we spoke with were aware of the principles of the organisation's vision and values.
- The vision and strategy for community services for adults was aligned to integrated working by providing a range of responsive services closer to home, avoiding inappropriate admission and facilitating early discharge from hospital

Governance, risk management and quality measurement

- There was a clear governance structure in place with committees for relevant aspects of governance such as quality, safety, audit and risk management. We saw

evidence the board received regular reports from each committee. Reports from the committees were detailed enough to give the board assurances and raise awareness of risk.

- A comprehensive range of policies and procedures was in place each describing the roles and responsibilities of staff within the organisation. Staff had good access to policies and procedures for reference and to support decision making. All the documents we reviewed were up to date and relevant to service delivery.
- We reviewed the terms of reference of the Quality, Safety and Assurance (QSA) group, which sat monthly. The group reviewed, analysed and discussed the details of Learning from Experience Action Plans (LEAPs), complaints and incidents. In addition the group monitored trends for example we were told there had been a trend in medicines errors in particular insulin errors in residential homes. Minutes from 14 November 2016 showed that the group discussed the investigation and further work that had been conducted surrounding this and the actions that have been suggested to be put in place such as introducing photo ID in residential homes.
- The provider kept a corporate risk register and all local risks were monitored on the one register. We reviewed the risk register from July 2016. It included information about the risk, how the risk was being managed, evidence that the management plan was effective, and evidence that actions put in place to reduce the risk. This showed that risks to the service were recorded, assessed and reviewed and plans were made to mitigate risk.
- Meeting minutes showed that the risk register was regularly discussed at divisional and Board meetings. For example the minutes from the November 2016 board meeting showed that the water quality at the Mill road therapy centre was identified as a risk and was added to the risk register.
- A Quality, Safety and Assurance Group was in place to oversee the clinical audit programme. Results from clinical audit were discussed by the group and used to improve service delivery.
- Team meetings were scheduled monthly and we saw evidence of this in staff newsletters. Minutes contained relevant information for staff and demonstrated clear cascade of information up and down the management structure.

Culture within this service

- All the staff we spoke with demonstrated a culture of providing high quality patient care with an emphasis on respecting patients' dignity and encouraging and maintaining their independence.
- Staff described a supportive culture within their immediate teams. In some parts of the service staff told us that they were working beyond their planned hours on occasion to complete work tasks. Staff described the need to do this to ensure patient care remained at an appropriate level.
- Some teams within the adult community services had a number of sickness absence and staff vacancies. Staff told us that they felt under pressure due to increasing workloads and a lack of staff. The organisation target for sickness absence was set at 4%. Overall sickness absence rate for the organisation was 5.29%, higher than the target rate.
- Since April 2016, the adult community services had been provided from four locality based integrated care teams. Both nursing and therapy staff in the teams said that this had brought about a supportive and joined up culture of working. However some community adult specialist services which were not part of the integrated teams told us that they 'feel adrift from the organisation'.

Public engagement

- The organisation sent out friends and family (FFT) questionnaires following episodes of care. The figures for adult community services for quarter one and two 2016 scored 98% and 99%, respectively.
- The organisation regularly received compliments from patients. During 1 April to 31 October 2016 the organisation received 94 compliments overall.

Staff engagement

- The provider is an employee-owned social enterprise, meaning staff were stakeholders in the organisation. All staff were given the option of being a shareholder. New staff enrolled automatically with the option for opting out. Over 50% of staff were shareholders. Shareholders sat on the Staff Shareholder Council and were involved in appointing non-executive board members. This demonstrated staff were engaged.

Good

Are services well-led?

- The executive team told us that there were formal and informal processes in place to listen and respond to staff. The staff council meets regularly with the joint union and management team regularly.
- Most staff we spoke with were aware of who the members of the staff council representatives were and we saw posters were displayed in staff office, with the names and contact details of the local staff council representative. A member of staff told us that they did bring up an issue with their local representative however they never heard anything back regarding the issue they raised.
- The executive team used a weekly e-newsletter to share information with staff. Staff we spoke with told us of Cascade-7, a weekly e-newsletter where managers had to share the information with all staff.
- Most staff said the executive team were visible; they had visited Mill road therapy centre Health Centre to speak to staff when the concerns around estates and water quality were raised. Some staff members told us that in the run up to the implementation of care closer to home there was increased visibility from the senior management team.
- The organisation conducts annual staff survey. Although the response rate is very low, 37% in 2016, there has been an improvement year on year both on response rate and overall score.
- The organisation recently celebrated the ACE Star awards 2016 where colleagues nominated staff, and winners were invited to a ceremony. The integrated care managers and several adult community individuals all won awards in several categories. Staff were very proud of their nominations and awards and which fostered a sense of recognition for their work.

Innovation, improvement and sustainability

- The ESD team won ‘an Excellence in Stroke Care’ Award from the Stroke Association's East of England Forum. In addition the Lead for ESD was shortlisted for awards that recognised the project and initiatives that team provide. This included a transitional two weeks input to stroke patients who are discharged from acute hospital into residential homes. ESD also run a stroke exercise group in Clacton and Harwich together with the Tendring Specialist Stroke Services and an upper limb therapy group in Clacton Hospital. Tai Chi clinics were also provided for stroke patients at a local community centre in Colchester.
- The organisation recently celebrated the ACE Star awards 2016 where colleagues nominated staff, and winners were invited to a ceremony. The integrated care managers and several adult community individuals all won awards in several categories. Staff were very proud of their nominations and awards, which fostered a sense of recognition for their work.
- Community adult services work closely with local council to provide falls prevention education programmes to the residents of sheltered housing.