Provide Community Interest Company

1-168055209

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)
1-283687220	Braintree Community Ward		
1-223517978	St Peter's Community Ward		

This report describes our judgement of the quality of care provided within this core service by Provide Community Interest Company. 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 Provide Community Interest Company and these are brought together to inform our overall judgement of Provide Community Interest Company

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

We rated the services as good overall because:

- Systems and processes were in place to protect people from harm. Staff reported and investigated incidents and managers shared learning across the organisation.
- Staff understood their role in safeguarding patients and robust policies and procedures were in place to support them.
- Premises and facilities were visibly clean and managers/staff implemented infection prevention and control measures in the areas we inspected.
- The organisation had clear business continuity plans in place to avoid disruption to services and we found staffing levels to be adequate to deliver safe services.
- Evidence based practice was implemented across the services we inspected and patient outcomes were measured benchmarked and contributed to improvements in patient care.
- Multidisciplinary teams worked well together, all staff had the skills and expertise to deliver effective care and treatment. Referrals were managed effectively through central point of access systems.
- Systems were in place for transferring care to other services and providers and discharges were planned with the patient carer and members of the multi-disciplinary team.
- Staff had access to the information they needed to deliver effective care and understood the Mental Capacity Act and Deprivation of Liberty standards.
- We found patients were cared for with compassion, dignity and respect. We observed staff interactions were caring, kind and respectful. Patients and carers all spoke positively about staff.
- Staff supported patients to manage their own health and wellbeing and carers were involved in decision making when appropriate.
- The organisation planned and delivered services to meet the needs of people. Systems were in place to ensure people were treated equally and could communicate effectively.
- The care of the most vulnerable and complex patients was managed by community matron. Patients could access services easily. Appointments and visiting were flexible to suit the needs of patients and carers.
- Care and treatment was prioritised according to need with the most urgent cases being seen within four hours.
- Staff managed complaints effectively and staff and patients knew about the complaints process.
- Staff shared and understood the organisation's vision and values. Staff felt involved in the decision-making and development of services.
- Comprehensive governance structures were in place. Risk registers reflected current risks and the board received assurance on the quality and performance of services through regular, accurate and up to date reports.
- Leaders demonstrated capability and had capacity to perform effectively; they valued staff and staff felt supported.
- The organisation had a caring culture and could be open and honest and raise concerns easily. The organisation was attentive to the health and well-being of staff and systems were in place to keep staff safe at work.
- Public and patient engagement was important to the organisation and methods were in place to gather people's opinions.
- Staff were invited to complete a survey annually and the results were discussed at board level. The organisation was innovative and continually looked for ways of improving the service.

However we also found:

- Some medication administration records did not have patient allergy/sensitivity status recorded.
- We found medication and stock items were out of date in one location, which staff immediately removed.
- The integrated care team service specification was out of date and the central point of access service did not have a voice recording system in place.
- The organisation did not routinely monitor restraint or consent processes.
- Where 'did not attend' appointments were raised, we did not see action plans to reduce these.

Summary of findings

Background to the service

Information about the service

Provide Community Interest Company (CIC) community health services for adults' services comprise of integrated nursing teams, physiotherapy, occupational therapy, speech and language therapy and a wide range of specialist services such as diabetes, tissue viability, podiatry, respiratory and continence services. In addition, Provide delivers prevention services such as Carecall (an alarm system for people living in their own home to call for emergency help) and falls prevention services and manages the wheelchair service.

Provide CIC delivers services to a population of approximately 1.9 million across Essex, Cambridge, Peterborough and the London boroughs of Waltham forest and Redbridge.

Community adult services are delivered from community hospitals, GP practices, clinics and in patients homes.

Community adult services comprise of integrated nursing teams, physiotherapy, occupational therapy, speech and language therapy and a wide range of specialist services such as diabetes, tissue viability, podiatry, respiratory and continence services. In addition, it delivers prevention services such as the Carecall and falls prevention services and manages wheelchair services.

During our inspection, we visited Braintree community Hospital, St peters Community Hospital, integrated nursing teams, tissue viability service, lymphodoema service, diabetes service, central point of access, wheelchair service.

We spoke with 10 therapists' 27 nursing staff including nurse managers and team leaders, 40 patients, three carers, six wheelchair users, one podiatrist, one doctor, two call handlers and observed care in nine patients homes.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

Team Leader: Simon Brown, Interim inspection manager, Care Quality Commission

The team included CQC inspectors, inspection managers, an inspection planner and a variety of specialists including: paediatrics and child health professionals, specialist nurses, community matron, safeguarding lead, director of nursing, physiotherapist and a strategic lead for equality and diversity.

The team also included three experts called Experts by Experience. These were people who had experience as patients or users of some of the types of services provided by the organisation

Why we carried out this inspection

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

How we carried out this inspection

We inspected this service in December 2016 as part of the comprehensive inspection programme.

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

Summary of findings

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced between 12 to 15 December 2016. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During our inspection we spoke with 46 patients and three carers. All spoke positively about the services they received and told us how kind and caring staff were.

Good practice

- The organisation used an electronic caseload analysis tool (eCAT) for workforce planning. Patient dependencies were scored based on both nursing and patient criteria. The tool was able to identify both planned and unplanned workload and the skill mix of the nursing teams
- The Carecall control room exceeded its response time targets on all but two occasions between April 2016 and December 2016.
- The central point of access team response times consistently met or exceeded targets.
- The early supported discharge (stroke) team worked closely with the local hospital and attended board rounds three times a week to identify suitable patients, according to the referral criteria, for discharge.
- Lone working devices, which looked like a car fob, had a panic button and Global Positioning System (GPS) tracker, had been introduced, which improved the safety of staff working alone in the community. The devices were monitored by Carecall.
- The speech and language therapy team utilised skype and facetime for patient consultations, which was more convenient for the patients and meant speech and language therapy staff saved travel time.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider should take to improve

- The provider should ensure staff have attended mandatory training in line with the organisations target.
- The provider should ensure staff complete the allergy status on all patient records.
- The provider should consider reviewing the integrated care team service specification.
- The provider should consider introducing routine monitoring of restraint and consent processes.

Summary of findings

- The provider should consider developing action plans to address did not attends for appointments.

Provide Community Interest Company

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 the safety of community adults services as good because:

- There was a robust incident reporting process, where incidents were investigated fully and learning from incidents shared. Being open and honest with relatives was an integral part of the incident reporting process.
- Safeguarding was given sufficient priority. Staff understood how to identify and protect patients from abuse and avoidable harm.
- Staff followed good infection and prevention control practices and the community outpatient clinics were visibly clean.
- Effective business contingency arrangements were in place to ensure patients continued to receive essential care during periods of adverse weather or major incidents.
- Staffing levels were sufficient to provide safe care for patients.

However we also found:

- Some medication administration records did not have patient allergy/sensitivity status recorded.
- We found medication and stock items were out of date in one location, which staff immediately removed.

Detailed findings

Safety performance

- Community integrated care teams (ICT) participated in the NHS Safety Thermometer, which is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter related urinary tract infections (CAUTI), venous thromboembolism (VTE) (blood clots in veins).
- We reviewed Safety Thermometer data for the period November 2015 to November 2016. Not all of the ICTs submitted data every month during this period. Halstead, Maldon, Witham and Chelmsford City submitted data for the whole period, except for September 2016. Braintree team submitted data in

August and November 2016, Chelmsford submitted data for May to November 2016 and Dengie submitted data for February to November 2016, with the exception of March and September.

- For the range of data submitted, the rate of harm free care averaged 94.6% for the community teams, which was better than the national average for community services of 93.3%. The rates of new pressure ulcers, CAUTI, VTE and falls with harm for this period were all better than the national average for community services during this period.

Incident reporting, learning and improvement

- Between October 2015 and August 2016, there were no never events reported for the organisation.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff reported incidents through the organisation's electronic reporting system. All staff understood their responsibilities to raise concerns and report incidents and near misses. Staff said they were encouraged to report incidents, although some staff told us they did not always receive feedback. Staff we spoke with could describe the details of incidents reported by staff, for example those relating to medication errors.
- Data provided by the organisation for the 12 months preceding our inspection showed staff within community adults had reported 1513 incidents, of which 1202 (79%) were minor or no harm incidents. A further 300 (20%) incidents were reported as moderate harm, ten incidents (less than one percent) were major/ tragic harm and there was one incident classified as death.
- The organisation reported 16 serious incidents requiring investigation (SI) between October 2015 and August 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Nine SI's related to the integrated care teams within the community adults service. Eight occurred within patient's own homes, of which four involved administration of insulin. The organisation had changed practices following a series of insulin incidents. The remaining four incidents included information governance, medication error, catheterisation error and peripherally inserted central catheter (PICC line) flushing error. (A PICC line is a tube inserted into a vein in the arm and is used to give medication such as chemotherapy.) Root cause analysis (RCA) was carried out for all SIs to try to determine the cause and help prevent re-occurrence.
- We saw evidence that learning from incident investigation was shared with staff, for example team meeting minutes. This information was also included in the 'Clinical Matters' newsletter, which was circulated to staff. Staff we spoke with confirmed managers shared this learning with them.
- Staff told us they received information about patient safety alerts through email. Staff provided an example of an alert about safer administration of insulin circulated to staff and the Standard Operating Procedures (SOP) had been changed following the alert.
- Staff working within tissue viability told us they had noticed the adhesive on one type of dressing they were using was causing a reaction on some patient's skin. Staff told us the organisation reacted quickly and sent a blanket email to all staff to advise not to use the product and notified the manufacturer.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires the organisation to notifying the relevant person an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff we spoke with knew of the terminology and could describe the need to be open and honest with patients. Service leads gave an example and we saw where duty of candour had been applied following an incident investigation.

Safeguarding

- The organisation had a safeguarding policy in place, which was available to all staff on the organisation's intranet. Staff we spoke with had a good understanding of their role and responsibilities to safeguard patients

and could describe the actions they would take if they had concerns. Staff also understood their safeguarding responsibilities for others for example, carers and children of patients they visited.

- Staff gave us specific examples of safeguarding concerns they had raised. For example, nurses within the tissue viability service could describe a safeguarding concern raised in relation to a primary carer of a patient within their care.
- Safeguarding training was mandatory for all staff working within the organisation. All staff we spoke with told us they had completed their mandatory safeguarding training and could describe the content of the training. This included awareness of Prevent (the Government counter-terrorism strategy), female genital mutilation (FGM), child sexual exploitation (CSE) and modern day slavery. Female genital mutilation is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- As of December 2016, 98% of staff within the Integrated Care Teams (ICT) had completed level two adult safeguarding training

Medicines

- The organisation had a medicines management policy, which provided the procedure for the prescribing and administration of medicines. This was accessible to staff on the organisations intranet.
- Some specialist nurses and community matrons were non-medical prescribers. Non-medical prescribers are health professionals who have undergone additional training and are qualified to prescribe medication. This meant patients did not have to wait to see their GP to have changes to existing prescriptions or new medication prescribed. The organisation maintained a register of all non-medical prescribers, which we reviewed.
- All of the community nursing staff we spoke with were consistent in their management of patient medicines. Nursing staff did not routinely transport patient medicines, patient's families were asked to collect medicines or local pharmacies delivered them to the patient's home. Nursing staff routinely carried adrenaline and saline used to flush intravenous or peripherally inserted central catheter (PICC) lines. In addition, nurses worked with GP surgeries to offer flu vaccinations for their patients. The vaccinations would be stored in a fridge at the GP surgery and transported by the nurse in cool boxes.
- The organisation had recognised a trend of incidents in 2015 relating to the administration of insulin and introduced a revised community nursing prescription chart in September 2015. In addition, staff received additional training and patients in residential care were provided with individual insulin boxes for their medication. We reviewed an audit from April 2016, comparing incidents relating to insulin administration before and after the interventions. Audit findings showed a 10% reduction in insulin administration incidents and an increase in the number of incidents reported, which demonstrates an improving safety culture. Staff we spoke with we aware of the incidents and the changes to procedures and prescription charts.
- We reviewed 11 medication administration records for patients cared for by community nurses. The records were legible however, three of the records did not have the allergies or sensitives section completed. The medication charts stated medication should not be given if the allergy/sensitivity section not completed and we saw medication had been administered in these cases. This meant patients could receive medication that may be harmful to them and staff were not adhering to the organisations policy. We saw actions in place to address this issue.
- Patient group directives (PGDs) provide a legal framework that allows some registered health professionals to supply and administer specified medicines to a pre-defined group of patients, without them having to see a doctor. We observed a physiotherapist administering an injection for the treatment of a muscular-skeletal condition in line with the PGD.
- We observed prescription (FP10) forms in community settings were managed and stored in accordance with NHS Protect guidance 2013. This guidance covered the security of prescription forms including ordering, storage and use of prescription forms.
- We found six boxes of out of date local anaesthetic in the drugs cupboard of the physiotherapy outpatients department at Braintree Community Hospital. We also found skin cleaning wipes within the same area that had expired. This was escalated to the physiotherapy

outpatients lead, who immediately removed and destroyed the items. We were told this medication had been used in the past for a procedure that was no longer carried out.

Environment and equipment

- We visited three community outpatient clinics where patients attended, which were owned by another provider. We checked 11 items of equipment within these localities and found the equipment was serviced and electrical safety testing had been completed.
- We checked the availability of resuscitation equipment at Braintree Community Hospital and St Peter's Hospital, Maldon and found it was, well-stocked and weekly checks were completed and recorded. This meant emergency equipment was safe and ready to use in an emergency. However, we also found some additional resuscitation equipment in the tissue viability clinic at Braintree Community Hospital, which had not been checked and the oxygen cylinder was empty. We escalated this to the manager of the area. The tissue viability nurses had moved to this location the week before and the equipment was no longer required. We returned to this location on another day and saw the equipment had been removed.
- Equipment for use in patients' homes was provided through a contract with an external equipment provider; staff confirmed equipment was readily available. If required urgently, equipment could be available the same day if ordered before noon. Staff told us community nurses visited patients who had received equipment at least every 12 weeks to ensure it was still required, in good working order and appropriate for the patient's needs.
- Staff told us they had access to appropriate equipment, and service leads considered requests for additional equipment if a need was identified. For example, physiotherapy staff told us they requested specialist therapy equipment, which the organisation supplied.

Quality of records

- Community nursing staff used an electronic system to access patient records. This was the same system used by some GPs. With patient consent, records could be shared between different teams within the organisation. For example, we saw where community nurses and podiatrists were involved in a patient's care, the system was used to message the teams about ongoing care and treatments.
- We saw staff update electronic records immediately after the visit if possible or the same day. This meant an accurate record of the patient visit was documented.
- We reviewed a sample of 18 care records. Plans of care and patients' progress were documented and updated. Records were stored and accessed on a secure site.
- Paper records were held at the patient's home, and we saw these were updated following visits. These records contained a copy of the most recent care plan and ensured all staff, including agency staff, knew of the care required during the visit. Notes were removed from the patient's home when the visits were no longer required.
- The organisation undertook a yearly audit of records. The latest audit compiled in January 2016 showed a total of 1364 records were reviewed across the organisation as a whole, of which 94% were electronic records. Although this information was not detailed enough to provide results for the individual community teams, the data showed an overall improvement in the quality of record keeping across the organisation for the period 2015/16 compared with a similar audit in 2014/15. For example there was an improvement in the recording of allergies/sensitivities within the electronic record, however, the organisation acknowledged these results were lower than required at 35.9% (compared with 11.47% in 2014/15). The organisation planned to continue with training and repeat the audit.

Cleanliness, infection control and hygiene

- There were infection prevention and control policies and procedures in place, which were readily available to staff on the organisation's intranet. Infection prevention and control was included in the mandatory training programme and 90% of staff were up to date with this training.
- Throughout community services for adults we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff used hand washing facilities in outpatient clinics and a supply of personal protective equipment, which included gloves and aprons, was available both in clinical areas and during home visits. We observed staff

washing their hands or using hand sanitising gel between patients and wearing gloves and aprons during home visits. All staff were observed to be adhering to the dress code, which was to be 'bare below elbows'.

- We reviewed 28 patient feedback cards, five of which specifically commented the environment was very clean. No patients we spoke with had concerns about cleanliness.
- We saw records of regular infection prevention and control audits that took place in order to ensure all staff were compliant with the hospital's policies such as hand hygiene and equipment cleaning. For example, we saw hand hygiene audits compliance from June 2016 to November 2016 for the outpatient clinics and ICT teams were consistently 100%.
- We saw clinical waste and contaminated sharps were appropriately managed in accordance with the organisation's healthcare waste policy September 2016 which also covered the disposal of waste generated in patients homes.

Mandatory training

- Mandatory training compliance was monitored and was mostly completed using an on-line electronic system, although some modules were provided as face to face sessions.
- Mandatory training included information governance, infection prevention and control, safeguarding adults and children, health and safety including manual handling, fire safety, basic life support, continuing health care assessor and awareness, dementia and learning disability awareness and Mental Capacity Act training.
- The organisation provided mandatory training data prior to our inspection. Compliance rates for all mandatory training for the ICT were above 85% for all categories apart from continuing health care awareness, which was 81%. The organisation's target for mandatory training was 95%. We saw 'failure to meet overall organisational mandatory training compliance of 95%' recorded as a new risk in the July 2016 risk report to the board. Staff we spoke with told us they were given sufficient time to complete their mandatory training.

Assessing and responding to patient risk

- Patients could access community health services through the central point of access service (CPA). This was a call centre and was available from 8.00am to 11.00pm every day including weekends and bank holidays. Providing a single point of contact enabled a consistent approach to triage calls and respond to patients' needs. Call centre staff assessed the level of urgency against documented criteria. There were four levels of response; urgent (within four hours), non-urgent/same day (within 24 hours), next day (within 48 hours) and after 48 hours. Call centre staff signposted patients to other agencies if more appropriate, for example GPs, NHS Accident and Emergency services or ambulance services. Staff within the integrated care teams worked an on-call rota in order to respond to urgent calls
- Risk assessments were completed for each patient as part of the initial visit or appointment. Recognised assessment tools were used to inform care plans and treatment. Assessment tools included pressure area assessment, nutrition status and frailty assessment tools. Where patients' needs changed, these were identified on subsequent visits and changes made to the plan of care.
- Patients with current, or a history of, pressure ulcers were assessed weekly. All other patients were assessed monthly. Staff submitted Incident reports for all patients with new pressure ulcers grade two and above. Patients in receipt of equipment were visited by community nursing staff 12 weekly to ensure the equipment was still needed and appropriate and to reassess pressure areas and nutrition status.
- Community staff took photos of any pressure area damage with patient's consent, using the phones supplied by the organisation. The pictures enabled specialist advice from senior staff or tissue viability nurses to be obtained and treatment to be started earlier. These records also allowed staff to monitor healing. Staff uploaded the photos onto the electronic record system and then subsequently deleted from the phones.
- Staff told us referrals to the tissue viability specialist team were triaged and classified as either category one or two. This ensured patients are higher risk were prioritised and seen within five days.
- Staff told us they were using catheter and peripherally inserted central catheter (PICC line) 'passports'. These passports were kept by the patient, and provided information for the patient and health professionals,

who also detailed any care given relating to the catheter or PICC line on the passport. This passport reduced the risk of complications associated with catheters and PICC lines.

- We saw staff at the community outpatient clinics performed risk assessments for the control of substances hazardous to health (COSHH) and procedures in place for cleaning spillages of body fluids.
- Community staff told us they carried equipment to monitor observations including blood sugars, if there was a concern about a patient at home.

Staffing levels and caseload

- The organisation used an electronic caseload analysis tool (eCAT) for workforce planning. Patient dependencies were scored based on both nursing and patient criteria. The tool was able to identify both planned and unplanned workload and the skill mix of the nursing teams. This tool was used to provide evidence of staffing requirement to the commissioners of the service. It also allowed staff to close caseloads where visits were no longer required, enabling staff to prioritise care.
- Community staffing was organised into integrated care teams (ICT) and included community matrons, nurses, physiotherapists, occupational therapists and nursing support workers. ICTs provided care for patients who were house bound and unable to access care by visiting the GP surgery. The ICTs were split into North and South localities. Teams within the North were based at Halstead, Braintree and Witham. Teams in the South were based at Dengie, Chelmsford, Chelmsford City, Maldon and Woodham Ferrers.
- Data provided by the organisation for October 2016 showed a caseload split across the teams of 61% in the South and 39% in the North. There was 115.25 whole time equivalent (WTE) staff working within the ICT teams of which 56.75 WTE were in the North and 58.5 WTE were in the South. Service leads used nursing and patient dependency data from the eCAT tool to demonstrate caseloads were approximately balanced across the teams. Service leads told us plans for recruitment for community teams and the early supported discharge, admission avoidance and repatriation (ESDAAR) team early in 2017.
- The central point of access call centre (CPA) had minimum staffing of three call takers (non-registered) on weekdays, two on weekends and bank holidays. The ESDAAR team comprised three band six nurses with a band seven lead and were based within the CPA. ESDAAR nurses provided clinical support to the call handlers as well as urgent home visits to patients. We saw minimum staffing levels were met during our inspection.
- Bank and agency staff were used to cover shifts, which were not filled by permanent staff. Staff told us regular agency staff were used, who knew the caseload well. Data provided by the organisation for the North team for the period May to July 2016 showed the number of shifts filled by bank and agency staff was 108 with no shifts unfilled. For the South team for the period June to August 2016 the number of shifts filled by bank and agency staff was 1164 with 89 shifts left unfilled.
- We saw clinical staff made referrals to non-clinical staff, called health navigators for patients whose clinical needs had been met but who would benefit from other support for example help with shopping or maintaining social networks. This meant clinical staff could prioritise patients with clinical needs. The organisation employed two WTE health navigators.
- Community physiotherapy outpatient managers said they had staffing challenges due to maternity leave. Staff were trialling longer clinic appointment times in order to maintain referral to treatment times. For example, staff offered a one-hour session for assessment, treatment and discharge if appropriate rather than the usual half hour sessions. This trial was still being evaluated at the time of our inspection.

Managing anticipated risks

- The organisation had provided business continuity plans for each of the community teams. We reviewed the service business continuity plan together with the winter contingency arrangements for one of the integrated care teams. These plans gave clear direction for staff in the event of loss of services such as telephones and IT, and also in the event of adverse weather.
- Staff told us, in the event of severe weather, they would contact patients by phone to assess their needs. The service had access to local volunteer drivers with “four by four” vehicles, who were willing to assist with the transportation of staff to essential visits during episodes of severe weather.

Good

Are services safe?

- We reviewed the CPA business continuity plan. Alternative office premises had been identified in the event of the office becoming unavailable for any reason. Service leads told us staff had recently worked from the alternative office to test the arrangements. The organisation had contingency plans for loss of telephony and IT. However, staff we spoke with within the CPA were not familiar with the contingency arrangements. Service leads acknowledged the inadequacy of the current IT infrastructure and the lack of out of hours IT support, which had been added to the organisation's risk register.
- We reviewed the standard operating procedure (SOP) for managing the allocation of work and associated risks within the ICT caseloads. This system ensured staff reviewed visits and allocated staffing for the next working week by the Wednesday of the week before. Service leads could plan ahead by moving staff or booking agency staff. A daily situation report (SITREP) status of green, amber, red and black was allocated for each team based on the number of patients, sickness, weather etc. Daily SITREP meetings were held with commissioners and the acute NHS trusts.

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 community health services for adults as good for effective because:

- Care and treatment was in line with current evidence based guidelines and standards.
- Audit and patient outcome measures contributed to service developments.
- Staff had the knowledge skills and experience to deliver effective care and treatment.
- Staff worked within multidisciplinary teams to meet the needs of patients.
- A central point of access referral system was in place, referral and exclusion criteria existed and patients were prioritised according to their need.
- Transfer to other services could be arranged easily and discharges were planned with the patient and carers and other members of the multi-disciplinary team.
- Staff had access to the information they needed to provide effective care.
- Staff understood the Mental Capacity act and Deprivation of Liberty standards.

However:

- The organisation did not routinely audit restraint or consent processes.

Detailed findings

Evidence based care and treatment

- Protocols and procedures we reviewed contained reference to evidence based care and treatment. The diabetes service incorporated the National Institute for Health and Care Excellence (NICE) clinical guidelines in their treatment protocols.
- The early supported discharge (stroke) team adhered to the Royal College of Physicians guidance, which recommended multi-disciplinary care planning and 45 minutes per day of therapy services tapering off at the end of six weeks.
- Speech and language therapy services adhered to the Royal College of Speech and Language Therapy - communicating quality guidance, which is a reference for best practice in speech and language therapy.
- The tissue viability and lymphodoema service incorporated NICE clinical guidelines in their treatment protocols and adhered to guidance such as the Royal College of Nursing guidance on leg ulcers. Tissue viability is a specialism covering skin and soft tissue wounds, lyn**plymphodoema is a long-term (chronic) condition causing swelling in the body's tissues. It can affect any part of the body, but usually develops in the arms or legs.**
- The organisations Guidelines for the Diagnosis and Management of Urinary Tract Infection (UTI) in Adults in the Community September 2016 contained reference to NICE clinical guidelines.
- The integrated care team and unscheduled therapy service specifications were based on evidence based best practice and NICE guidelines.
- We reviewed eleven care plans including patients requiring complex care and rehabilitation. All were legible and up to date and contained clear personalised goals for care and treatment. The records had been reviewed regularly with reassessments taking place where required. Evidence based assessments were completed in key areas such as the malnutrition universal screening tool and the Waterlow score for pressure ulcers.

Pain relief

- Patient care records included assessments for pain. We saw these completed in the records we reviewed including the Abbey Pain Scale, which was specifically for the measurement of pain in people living with dementia who cannot verbalise when they are in pain.
- We observed staff asking patients about their pain and comfort levels. Patients were offered pain relief prior to uncomfortable treatments such as leg ulcer dressings.
- Patients told us staff always checked to make sure they were comfortable and pain free during treatments.

Nutrition and hydration

Good

Are services effective?

- Patient care records included nutrition and hydration assessments. Nutrition was assessed using the malnutrition universal screening tool (MUST). MUST is a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines, which can be used to develop a care and identifies when patients need to be referred to a dietician.
- Staff told us, and we saw in patient care records, patients were weighed monthly and reassessed using MUST.
- An adult nutrition and hydration policy November 2016 was also available to staff based on NICE clinical guidelines

Technology and telemedicine

- The organisation provided a service called Carecall, which was an alarm system for people living in their own home to call for emergency help. It consisted of an alarm button, which when pressed sent an alarm to a control centre. The control centre was manned 24 hours per day. The alarm button activated a microphone enabling the patient to talk directly with control room staff and could automatically identify the address of the call.
- We saw the Carecall alarm buttons in patients' homes and patients told us they would not be without it and had received a prompt response when they had used it. There was a charge for the Carecall service.
- The Carecall control room was accredited by the telecare services association and produced monthly reports on response times. Between April 2016 and December 2016 the service exceeded its targets in call answering and response times in all but four occasions, 32 out of 36 targets exceeded. On the four occasions the target was not achieved two were due to factors beyond the organisations control and two were by a very small percent. The telecare service association is a recognised organisation that sets standards to drive improvements for telecare services.

Patient outcomes

- A comprehensive audit plan was in place including contractual clinical audits, local audits and audits to measure compliance with NICE guidelines.
- Outcome measures were used across adult community services although not so evident for patients receiving care from the integrated care team. A range of patient outcome measures were used across therapy services. For example EQ-5D questionnaire for measuring generic health status, ICIQ questionnaire to assess the impact of symptoms of incontinence on quality of life, Oswestry Disability Index to quantify disability for low back pain.
- The organisation also contributed to the Sentinel Stroke National Audit Programme (SNAPP). SSNAP measures the quality of care stroke patients receive throughout the whole care pathway up to 6 months post admission to hospital.However, leaders within the stroke service felt there were errors in the way the acute hospital were inputting the data, which then in turn reflected poor results. Senior leaders with in the stroke team were meeting with staff from the acute trust in order to address this. The stroke service therefore monitored outcomes at a local level as well. The results from April to July 2016 showed that out of 81 patients, 30 patients had improved and 51 had stayed the same.
- Outcome measures were monitored by the provider and the commissioner and included in key performance indicator measures.
- We saw evidence of patient outcomes and audit resulting in the review of services for example the start back programme resulted in a review of the low back pain service.
- The tissue viability service had audited its wound management processes for effectiveness. The report showed positive results in wound healing and patient reported levels of pain and comfort.
- The organisation did not take part in the 2015 National Intermediate Care Audit which meant they were not able to benchmark their care against other organisations.

Competent staff

- Staff had the skills and competencies to deliver holistic, effective patient care. Specialist nurses had attended relevant specialist training in their subject.
- Learning needs were identified through staff appraisal, organisational requirements, national requirements and learning from incidents. Staff in adult community services gave examples of where learning needs had been supported by the organisation and appropriate training delivered to meet the learning needs.

Good

Are services effective?

- Specialist staff delivered training on topics such as continence, pressure ulcers and diabetes. All staff attended a leg ulcer training course after they had been in post for one year. Dedicated time was allocated for staff to complete e learning.
- Therapy staff received practice updates at staff meetings in the form of a presentation. For example we saw a presentation on shockwave therapy for plantar fasciitis incorporating NICE clinical guidance.
- The respiratory team received practice updates in their team meetings; the last update was called 'Inhaler Bingo' to raise awareness of the variety of respiratory inhalers prescribed to patients.
- As part of their induction programme central point of access staff completed training on the electronic patient record system.
- Managers encouraged staff to develop within their roles, two members of staff we spoke with were completing post graduate courses fully supported by the organisation.
- The organisations intranet contained a section for learning and development, which included information for staff on the care certificate and apprenticeship opportunities. All healthcare support workers had had achieved the care certificate.
- Staff had access to clinical supervision. A clinical supervision toolkit was available to staff, which enabled them to make the best of the supervision session by focusing on challenges and achievements. A clinical supervision survey completed in June 2016 showed 98% of clinical staff had attended at least one clinical supervision session in the previous 12 months.
- Staff told us they had an annual appraisal, mid-year review and regular one to one meetings with line managers. The organisations target for staff appraisal was 90% and between April 2016 and November 2016 the rate was 90%.
- Registered nursing staff knew of the nursing and midwifery council revalidation process and we were shown evidence portfolios of two staff preparing for revalidation.

Multi-disciplinary working and coordinated care pathways

- Most referrals to the integrated nursing teams were made through the central point of access team but some were direct from the doctors of the general practices they were attached to. Other teams such as therapists had single point of access systems in place for referrals.
- Referral criteria had been agreed with the commissioner for referrals to the integrated nursing teams, therapy services and early supported discharge (stroke) teams. This meant the teams only received appropriate referrals to their services.
- Patients were attached to caseloads and a named nurse was responsible for each caseload.
- The integrated care teams held short weekly multi-disciplinary meetings to discuss the most complex and vulnerable patients on the caseload. This ensured everyone was aware of their role in the patients care, changes and discharge plans.
- Community nursing staff held weekly frailty meetings with GPs to proactively identify and plan preventative care for frail patients.
- The palliative care link nurse attended team meetings at the local hospice and shared information with integrated care teams.
- We observed a one stop multi-disciplinary diabetic clinic attended by a doctor, dietician and specialist nurse, this meant the patient only had to make one visit to hospital for a full review of their condition.
- Specialist nurses could refer directly to other medical services such as urology, gynaecology and colorectal, this meant the patient could move easily between services without needing a referral from the general practitioner.
- Staff could refer patients to specialist community services. The integrated nursing teams and GP's referred patient to the tissue viability and lymphodoema service and in turn the specialist services could refer directly to hospital consultants if necessary.
- The early supported discharge (stroke) team worked closely with the local hospital and attended board rounds three times a week to identify suitable patients, according to the referral criteria, for discharge. The early supported discharge team comprised of physiotherapists, occupational therapists, speech and language therapists and therapy assistants.
- Social care service representatives were involved in care planning and invited to multi-disciplinary team meetings when necessary.

Referral, transfer, discharge and transition

Good

Are services effective?

- Referrals to the integrated care teams were made through the organisations central point of access team, which operated from 8am to 11pm seven days a week. After 11pm urgent calls from patients were managed by the GP out of hours service. The integrated care team and GP out of hours service verbally hand over any outstanding patient issues at 11pm and 8am. Information could also be communicated through the electronic patient record system, which was also used by the GP out of hours service.
- An integrated care team service specification (April 2011 to March 2016) was in place, which described referral criteria, exclusion criteria, referral pathways, expected care, response times and performance standards. The document was out of date in places for example no mention of the electronic patient record system or electronic caseload analysis tool.
- Integrated care team contact information was displayed on the front of the patient held records we saw in the patients' homes.
- The central point of access was a small contact centre for managing referrals from other health professionals and the public. Callers were signposted to the correct service. A safety net for call centres is voice recording so if a call goes wrong it can be retrieved from the voice recording system and reviewed for investigation purposes and to identify learning. The central point of access contact centre did not record calls.
- Referrals for the integrated nursing teams were sent electronically from the central point of access team to the locality triage nurses. The triage nurse would then decide on the urgency of the call and allocate the visit to a member of the team. The central point of access team also contact the locality triage nurse by phone to make sure they knew of the call.
- We observed one triage nurse respond immediately to a distress call from a patient's relative. She told us she would be with the patient within 30 minutes.
- The central point of access team also included nurses who provided the early supported discharge, admission avoidance and repatriation (ESDAAR). They also supported the central point of access call handlers with clinical queries.
- Health care navigators worked within the ESDAAR team and supported integrated care teams by focusing on the social needs of patients such as referral to voluntary agencies, social interactions, and domestic issues. This meant the staff in the integrated care teams could focus on clinical patient care.
- Both the ESDAAR nurses and health care navigators worked across primary, secondary and acute care in order to anticipate and plan for the needs of patients to support early discharge or avoid admission to hospital.
- Therapy services received referrals to dedicated e-mail addresses or in writing from other health care professionals to a single point of access where the referrals were prioritised. This meant patients with the most urgent needs were seen first.
- We saw referral criteria and exclusion criteria for all the therapy services developed in partnership with the clinical commissioning groups.
- When patients went on holiday we observed staff transferring care to the local community services in a timely way to enable continuity of care.
- Staff told us and we saw evidence of this in the patient records we reviewed, that patient care was reassessed if there were any changes either an improvement or deterioration in condition. Care plans and level of care would then be adjusted accordingly and information shared with the multidisciplinary team.
- Discharge planning was discussed within the multidisciplinary teams and with patients from initial referral. Integrated care teams and therapists worked with hospital staff to ensure robust discharge plans were in place in order that the patient could be cared for safely at home.

Access to information

- Staff had access to paper and electronic versions of patient records, which were up to date.
- At the beginning of each shift, staff printed a record of their daily caseload, which contained summarised care instructions for each patient. The printed record was shredded at the end of their shift and we observed this taking place.
- A paper care record and medication sheet were kept in the patients home and district nursing staff had portable electronic devices, which meant they had access to up to date patient information.
- All staff had access to electronic patient records at the office bases.
- The records we reviewed contained all the information necessary to deliver effective care.

Good

Are services effective?

- All staff had mobile telephones and could contact other members of staff for advice or any changes in planned caseload.
- Any patient contact activity made in the out of hours period i.e. 11pm to 8am was communicated through the electronic patient record system shared by the GP out of hours service or verbal hand over. This meant the integrated care team were alert to any problems patients suffered overnight.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent for care was obtained at all the interactions we observed between staff and patients in line with the organisations policy for consent to examination or treatment.
- Patients were given information on treatment choices and were encouraged to make informed decisions about their own care.
- When consent was obtained prior to significant procedures for example invasive procedure such as urinary catheterisation, consent was recorded in the patient's record. We saw evidence of this in two of the patient records we reviewed. The organisation could not provide evidence of how the consent process was monitored.
- Staff knew of the Mental Capacity Act and deprivation of liberty standards and how this related to their patients. Nursing assessments included a mini mental test and we saw a flowchart for staff use to support them when assessing mental capacity. We observed one patient refusing care and the member of staff described how they would assess the capacity of the patient and record it in the electronic patient record.
- Carers were involved in decision making about patient care and best interest decisions were made when patients lacked capacity.
- We saw the Use of Restraint when Working with Patients policy, which was reviewed April 2016 to incorporate the most recent safety alert on the topic. It included lawful and unlawful restraint practices and DOLs. Awareness of the policy was included in conflict resolution training, mandatory for all staff.
- The adult safeguarding and learning disability lead monitored all episodes of restraint which were reported in the electronic incident reporting system.

Good

Are services caring?

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

Summary

We rated the care provided by community adults services as good because:

- All patients we spoke with were positive about the care they received.
- Patients and carers told us they were treated with compassion, dignity and respect and were included in the planning and delivery of their care.
- The interactions we observed between patients and staff were consistently respectful and compassionate, with staff taking time to support, listen and reassure patients.
- Staff supported patients to manage their own health and wellbeing and maximise their independence.

Detailed findings

Compassionate care

- We observed care being delivered to nine patients, either in their own homes or within clinics. In every case, we saw staff providing kind and compassionate care.
- We spoke to a further 26 patients either in person or by phone, who told us the staff were friendly, polite and caring. Without exception, the patients we spoke with were very complementary about the care and treatment they had received. In addition, we reviewed 28 patient feedback cards, the majority of which commented staff were kind and caring.
- Patient dignity was maintained by the way services were delivered. Clinic doors were closed, staff knocked before entering clinic rooms and waited to be invited in. We observed community nurses asking patients permission to draw curtains in patient's homes to ensure examinations were carried out in private. We also observed nursing staff covering patient's with towels to preserve their dignity.
- The organisation used the NHS Friends and Family test (FFT) to obtain feedback from patients. The FFT is a single question survey, which asks patients whether they would recommend the NHS service to their friends and family. For October 2016, results of the FFT were 96% for this service, which is above the England average of 95%.
- We saw staff were gentle when delivering care that could be uncomfortable for patients, taking time to remove dressings slowly and keeping them informed of what to expect.
- We observed an interaction between a respiratory nurse and a patient. The patient had walked to the appointment and was breathless and the nurse offered to drop a bag of equipment to his home so he would not have to carry it.

Understanding and involvement of patients and those close to them

- With the patient's consent carers and relatives were often present whilst care was delivered. This enabled them to be informed and involved in the patient's care and to provide support for the patient.
- When further appointments were being booked we observed staff had a good understanding of patient's and relative's personal commitments and we saw appointments made on specific days or times to accommodate these.
- Staff were observed to take time to speak to patients and their relatives in a way they would understand. The terminology that was used was understandable and checks were made to make sure patients and their relatives understood their care. We saw staff giving information leaflets to patients when required to ensure they add additional information to patients understanding.
- Patients we spoke with told us they felt included in the planning of their care. On one of the contact cards we reviewed, a patient had written " I especially like that they explain and consult about treatments"
- We saw staff supporting patients to manage their own health and wellbeing and maximise their independence. For example, we observed a community nurse explaining to a patient following surgery the importance of support stockings to avoid blood clots in the legs and signs of infection. The patient was also given advice about diet and exercise to aid recovery.
- We spoke to patients using the physiotherapy service who told us their condition was explained properly and they were given advice how to continue to keep fit.

Emotional support

Good

Are services caring?

- We observed a home visit where the community nurse provided support as the partner of a patient was also unwell and the patient was worried about the partner. The nurse was able to describe a holistic approach to the care of this family, which was beneficial to both patient and partner.

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 community health services for adults as good for responsive because:

- Services were planned and delivered to meet the needs of people.
- Systems were in place to ensure people were treated equally and could communicate effectively.
- Community matrons led on the care and treatment of the most vulnerable patients.
- Services could be accessed easily and were flexible to meet the needs of patients and their carers.
- Care and treatment was prioritised according to need with the most urgent cases being seen within four hours.
- Staff managed complaints effectively and patients understood the complaints process.

However:

- We did not see actions plans to reduce 'did not attend' appointments.

Detailed findings

Planning and delivering services which meet people's needs

- Service specifications were in place for key elements of community adult services. We reviewed eight service specifications, which were developed in partnership with commissioners these included performance measures for monitoring the effectiveness of the service.
- Integrated care pathways were in place, which incorporated primary, secondary and acute care, integrated care teams worked closely with other providers such as acute and social care services to ensure the most appropriate care package was in place for patients.
- The organisation used a specialised software package, which gave a greater insight into its population and service users based on their demographic characteristics, lifestyles and behaviour. This information was used to tailor health education programmes to the population needs.
- The organisation was responsive to feedback where services were not meeting needs. For example feedback about wheelchair services prompted engagement events with patients in vulnerable groups to gain insight into what was important for them in relation to wheelchair services.

Equality and diversity

- An equality and diversity working group was in place and a single equality scheme document, which covered staff and patients. Staff told us they attended equality and diversity training.
- The organisation used a recognised commercial translation service, which was accessed by telephone. Translators could be arranged to attend patient consultations if necessary.
- Between April 2016 and November 2016 translation services were used 66 times with Polish being the most requested language (21).
- British sign language interpreters could be arranged and information could be converted to Braille for blind or partially sighted patients.
- An audio loop was installed at Braintree Community Hospital but not in St Peters Community Hospital. An audio loop is a special type of sound system for use by people with hearing aids.

Meeting the needs of people in vulnerable circumstances

- Community matrons led on managing care of patients with long-term conditions, frailty and those with complex care needs. They made sure care was planned and co-ordinated across the multi-disciplinary team.
- We observed staff demonstrating enhanced communication skills when caring for vulnerable patients. Conversations about treatments were paced to suit the understanding of the patient. Treatments and products were demonstrated with sensitivity and patience to enable the patients to care for themselves/ independence.
- Specialist nurses did not routinely make home visits but would make exceptions for vulnerable patients particularly those nearing the end of life.
- Raising awareness of dementia was a priority for the organisation and dementia training was included in the organisations mandatory training plan. We observed

staff caring for patients living with dementia, which involved patience, taking time to talk and explain care to patients and involving carers so a familiar person was nearby.

Access to the right care at the right time

- The central point of access team had a screening process in place in order to prioritise calls. Categories were urgent - within four hours, non-urgent/same day - contact within 24 hours and visit within 48 hours if required. If staff were concerned about a call there was always a clinical member of staff available for advice and support and a clear emergency escalation process. The reported response times for November 2016 were 99% for a four hour response, 99% for a 24 hour response and 93% for a 48 hour response. We reviewed previous month's reports from April 2016 to October 2016 and all the response time percentages were consistently above 99%.
- We saw several examples of where care was delivered at a place and time to suit the patient. For example specialist nurses making home visits for patients with limited mobility and appointments being changed to meet the patient's needs.
- Patients told us if there were any changes to the nurses' visits they would receive a phone call informing them of the change and the reason for it.
- The tissue viability clinic offered flexible appointment times for patients who worked so they could see the nurse before they started work or after they finished.
- Patients attending outpatient services were given follow up appointments on the day and were sent a reminder letter and message to their mobile phone. In addition, information leaflets were given, which explained how to change or cancel appointments. Patients we spoke with were happy with the appointments system and told us it was easy to change an appointment if necessary.
- Patients told us their appointments generally ran to time and if there was a delay reception staff would explain the reason.
- The organisation monitored 'did not attend' (DNA's) appointments. We reviewed monthly reports between November 2015 and October 2016. DNA's were generally low with raised levels in the chronic obstructive pulmonary disease (COPD) service, diabetes service, oxygen service, Essex Lifestyle service and the Waltham Forest wheelchair service. The organisation did not provide an action plan for reducing the DNA's in these areas. Essex Lifestyle was the health education service delivered by the organisation and includes stop smoking support, guidance on diet and classes to support people suffering from long term conditions. We did not see an action plan in pace to address this.
- We spoke with patients who had been contacted with a last minute appointment due to a cancellation therefore facilitating timely patient access to services.
- The early supported discharge (stroke) team visited patients at home within 24 hours of discharge and then daily for up to six weeks in line with National Institute of Care Excellence guidance.

Learning from complaints and concerns

- Complaints were managed effectively within the organisation. A complaints and compliments policy July 2016 was in place and included information about duty of candour, staff understood their responsibilities in relation to complaints and the meaning of duty of candour.
- How to complain information and leaflets were clearly displayed and patients we spoke with said they knew how to complain if necessary. Leaflets also included information about the parliamentary and health service ombudsman and the NHS advocacy service.
- Actions arising from complaints were shared through team briefings and team meetings, staff described to us changes that had been made to care delivery following a complaint. For example therapy services had reminded staff not to use abbreviations in patient documentation following a complaint that too many abbreviations were used in a patient discharge report.
- We reviewed the actions from 73 complaints made between June 2016 and November 2016, explanations and apologies were given to the complainants following the principles of honesty and transparency.

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 community health services for adults as good for well-led because:

- There was effective leadership, leaders were visible, valued their staff and staff felt supported.
- Staff demonstrated a caring culture within the service and could be open and honest and raise concerns easily.
- There was a clear vision and strategy for the service, which staff understood and shared.
- Comprehensive governance structures were in place. Risk registers reflected current risks and the board received assurance on the quality and performance of the service through regular, accurate and up to date reports.
- The organisation was attentive to the health and well-being of staff.
- Multiple methods were in place to engage with the public and we saw examples of where the public had contributed to the development of services.
- The organisation consulted with staff annually and the results were converted in to actions.
- The organisation was innovative and continually looked for ways of improving services.

However we found:

- The integrated care teams' service specification was out of date in places.

Detailed findings

Service vision and strategy

- The organisation had clear vision and values. Staff understood the vision and values and we observed staff demonstrated them in the care they gave. For example, discussing self-care with the patient in an effort to achieve independence. Staff told us performance appraisals included measures against the vision and values.
- The vision and values were developed and reviewed by elected staff representatives and the board of governors.
- We saw the operational services strategy 2016/2017. It described clear realistic goals for all services including community adults. In addition, the clinical strategy 2016/2019 described objectives based on the vision and values and incorporated quality and safety. During our inspection we saw examples of where strategy objectives had being implemented such as competent staff and the roll out of the electronic caseload analysis tool (eCAT) system.
- The organisations 2015/2016 Quality Accounts document reported the organisation was on target to achieve all its objectives set out in the clinical and operational strategies.

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.
- The organisation reviewed its governance processes regularly and we saw evidence of this in the Quality accounts 2016/2017.
- We reviewed the terms of reference of the Harm Free group, which sat monthly and was a sub-committee of the Quality and Safety Committee. The group reviewed all grades three and four pressure ulcers acquired in the care of the community nursing teams. This included a review of resources and training required and ensured learning was shared with staff. In addition, the group monitored trends for example we were told additional training had been provided when a cluster of similar incidents from community nurses had been identified. The group was chaired by the head of quality and safety

and included an assistant director and representatives from safeguarding and tissue viability. The member of staff who reported the incident was also invited together with the community matron, to ensure learning was shared.

- The risk register identified organisational risks, which were red (high risk), amber or green rated (low risk). The register was reviewed regularly and included mitigating actions. A risk management report was submitted to the board every other month. We saw evidence of risk being discussed in the minutes of the board meeting May 2016.
- Staff knew of departmental risks and risks were relevant to staff concerns, for example the increased demand on the diabetes service had been mitigated by providing extra educational sessions for district nursing staff.
- An audit committee was in place to oversee the clinical audit programme. Results from clinical audit were used to improve service delivery.
- Team meetings were scheduled monthly and well attended. Minutes contained relevant information for staff and demonstrated clear cascade of information up and down the management structure including information from the board.

Leadership of this service

- Leaders and managers we spoke with spoke confidently and knowledgably about their role. Managers were undertaking a programme of 360-degree feedback at the time of our inspection. 360-degree feedback is a process in which employees receive confidential, anonymous feedback from the people who work around them. This includes the employee's manager, peers and direct reports. It provides useful feedback to managers to improve team and organisational culture.
- We observed managers working within the departments we visited, liaising with staff and communicating with patients. Staff told us managers were approachable and members of the board visited departments occasionally. In particular, staff told us the chief executive was very approachable and accessible.
- Leaders spoke positively about staff they managed. Staff told us they were supported well by their managers. Compliments were always fed back to relevant staff and we observed staff being praised for their work.
- Staff described to us how they liaised and communicated with other teams in the organisation and how they supported each other when services were under pressure. Staff came together at locality meetings and other events such as the organisations clinical summit and conference.

Culture within this service

- All staff we spoke with during focus groups and during our inspection felt they were respected and valued by the organisation. They knew how to raise concerns and felt at ease doing so. Staff were supported in raising concerns by a comprehensive whistle blowing policy.
- We observed staff working within teams. Conversations were open and challenges encouraged, which meant alternative opinions were considered contributing to effective decision making.
- Staff felt involved with proposed developments to services. Incontinence service staff told us they were involved in the review of continence products following an increased demand on products within a limited budget.
- Staff performance and behaviour was discussed at one to one meetings, and annual appraisals. A capability policy and procedure was available to support staff and mangers with performance not in line with the vision and values of the organisation. The policy was based on the NHS Litigation Authority policy and described performance management from informal capability to the final outcome, which could be dismissal.
- The organisation took account of the health and wellbeing of staff and between 2015 and 2016 had engaged 23% of employees in working well activities. Working well activities included the provision of picnic benches at two locations so staff could take lunch outside, table tennis kits, back massage and static exercise bikes. There were designated health and well-being champions.
- We saw and were told of several examples where the organisation had made changes to improve staff well-being and safety such as the procurement of specialist chairs for the tissue viability and lymphodoema service, which enabled the nurses to carry out treatments without having to stoop or bend for lengthy periods.
- Lone working guidance was available to those staff working in the community. Staff we spoke with knew of the guidance and we saw systems were in place to keep staff safe.
- Lone working devices, which looked like a car fob, had a panic button and Global Positioning System (GPS)

tracker, had been introduced, which improved the safety of staff working alone in the community. In areas where the devices did not work so well due to poor GPS signal, two members of staff worked together. The devices were monitored by Carecall.
- The organisation lone working policy clearly outlined staff responsibilities, use of lone working devices, risk assessment, procedures to follow and safety guidance. We saw completed risk assessments in the electronic patient record.

Public engagement

- The organisation told us it gathered information on people's views and opinions through a variety of ways such as in writing, by telephone, by e mail, the internet, social media, questionnaires, focus groups and surveys. All feedback was collated in an electronic system and reported to the board.
- The customer experience team also monitored patient feedback through complaints, compliments and the friends and family test.
- The organisation told us they took part in the patient participation groups linked to GP practices, the Stroke association and Essex multicultural activities network (EMAN).
- The survey programme detailed in the Quality Accounts document 2015/2016 indicated patient surveys had been carried out in 17 different services and the board received specialist reports on patient experience and engagement. We reviewed two of the survey reports each had accompanying action plans. For example tissue viability patients commented on the cramped environment and lack of space in the clinic. An action was to look for more suitable premises, which was completed.
- The wheelchair service engaged with the speak out council's high support needs group. This is a group of young adults with multiple and complex needs dependent on their wheelchairs. The speak out council identified their members had very specific views on the provision of wheelchairs. As a result the organisations wheelchair service signed up to a number of objectives arising from the engagement event.
- Staff told us information from patient engagement events was disseminated through the team brief and discussed at team meetings.

Staff engagement

- The organisation surveyed staff annually. We saw the annual staff survey for 2015 showed out of the 25 questions asked; 22 showed an improved position, two showed no significant change and one showed deterioration. Actions were in place to address the deterioration.
- The results of the staff survey were shared with staff through the team brief paper produced by the organisation and we saw this reflected in the minutes of locality and integrated care team meetings.
- Staff survey results were used by the board to inform projects such as the working well group.
- Staff we spoke with told us they felt involved in decision making this usually took place in discussions at team meetings or through staff representatives on the board of governors.
- The organisation held an annual award ceremony for staff in recognition of outstanding achievements. The award ceremony also included long service awards and the presentation of certificates to staff who had completed learning programmes.

Innovation, improvement and sustainability

- The organisation worked with the local university and provided placements for nursing and therapy students. This meant new staff rotated within the organisation sharing best practice and experience from the university.
- Following the introduction of the eCAT system it was identified that integrated nursing teams were not performing effectively and the efficiency of the teams could be improved by introducing dedicated equipment caseload management and a phlebotomy service. These two services were introduced therefore freeing up the time of the integrated care teams to deliver more patient focused care.
- The respiratory team were working with the local university to develop a formal assessment of pulmonary rehabilitation. This meant in the future they would be able to measure the effectiveness of the service.
- The speech and language therapy team utilised skype and facetime for patient consultations, which was more convenient for the patients and meant speech and language therapy staff saved travel time.
- Specialist equipment was commissioned as a result of research carried out by physiotherapists, which showed shockwave therapy was effective in the treatment of plantar fasciitis. Plantar fasciitis is a cause of heel pain.