Your Healthcare Community Interest Company

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Hollyfield House Surbiton Health Centre	1-727827222 1-727899272
Community health services for children, young people and families	Hollyfield House Surbiton Health Centre	1-727827222 1-727899272
Community End of life care	Hollyfield House	1-727827222
Community health Inpatients	The Cedars Unit	1-727827967

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Summary of findings

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Overall summary

Letter from the Chief Inspector of Hospitals

Your Healthcare Community Interest Company is a not for profit social enterprise, delivering health and social care community services for residents in Kingston and Richmond. Your Healthcare has around 620 staff in post. The organisation's healthcare services employ around 427 WTE staff.

Your Healthcare is commissioned to provide health services to all patients registered to a Kingston CCG GP (203,854 NHS Digital October 2016). This exceeds the resident population by 17.5%. Some patients resident in a surrounding borough are registered to a Kingston GP.

Our key findings were as follows:

Safe

- The duty of candour was understood and implemented by staff. The process was appropriately followed and actioned.
- The provider had up to date safeguarding policies and procedures. Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- There were effective policies and procedures to manage the storage and administration of medicines. Patients received their medicines on time and when they needed them. They knew if their medicines had been changed and could ask for pain relief when they needed it.
- Community nursing staff had no problems getting equipment such as standard pressure relieving cushions and hospital beds, pressure relieving mattresses and commodes in a timely manner. The provider maintained and safety checked equipment.
- Most staff washed their hands appropriately between patient contacts and adhered to the 'bare below the elbows' policy and had access to personal protective equipment (PPE). Staff were observed following infection control procedures and protocols in patients' own homes.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and home environments.
- Staff knew how to recognise incidents and mostly recorded and reported appropriately. However, due to lack of equipment or IT connectivity issues in the community, staff could not always access on-line reporting in the community, but had to return to a hub office to do so. This could cause delays in reporting incidents.
- The Cedars Unit had not reported any deaths within the last year; although five patients had died on the unit. Providers must report all deaths as a statutory notification to CQC and therefore this should have been completed.
- The Cedars Unit did not carry out mortality reviews and when we raised this with the provider, we were told that it wasn't required within the community setting. In the absence of any local mortality review process, it is difficult to understand how the provider would be assured that the death of the service user was attributed to the course of the illness or medical condition that treatment was being provided for.
- There were high vacancy rates especially for nurses and speech and language therapists across all services, which impacted on the delivery of care. Senior staff reported difficulties in recruiting nursing staff and recruitment was ongoing. Nurse staffing was listed on the directorate risk register as a high risk and was being looked at strategically.
- Extra space and storage was highlighted by staff as a concern on The Cedars Unit. Beds were close together in bays and there was no space, apart from manager's offices for speaking to patients and relatives in a private environment. The lack of communal areas meant that patients spent a large amount of the day sat by their beds.
- A number of staff reported that there were issues with the electronic records system and said that sometimes it crashed and did not save the data. The electronic system migration was recorded as a very high risk on the directorate risk register.
- All staff we spoke to said they were up to date in their mandatory training. Community staff in the different teams described good access to mandatory training. However, mandatory training was highlighted by

Summary of findings

senior staff as an area of risk of non-compliance due to lack of oversight and this was listed on the organisational risk register. Action being taken as result.
- Staff could access and book training through an online system, but there was no means for line managers to be able to check completion rates.

Effective

- There was no care plan and pathway widely in use that was specific to patients who were dying, during the inspection.
- Some staff working with end of life care patients were not confident about what process they should follow if patients did not have capacity. However, Mental Capacity Act processes were mostly followed and used appropriately when required. It was clear that when there were concerns about a person's ability to make specific decisions relating to hospital treatment and everyday decisions, mental capacity assessments were carried out. The patient's family and multidisciplinary team was involved.
- There were gaps in MUST nutritional assessments for patients receiving end of life care, either they were not available in patient records or not completed thoroughly.
- There were no personalised care plans on nutrition and hydration for patients receiving end of life care, to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- The number of young people attending drop in sessions at some schools were fewer than 10 in some schools, but there was no target.
- Community nursing staff told us the specialist palliative care team from the local hospice would measure patient's outcomes.
- The provider arrangements for end of life care services to achieve the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People, was in draft and being consulted upon. Timescales for implementation of the care plan were not provided.
- There was an audit programme, which was agreed by the audit and assurance board. The provider carried out internal audits such as 'bare below elbows' and anti-biotic prescribing. It also took part in external audits such as the sentinel stroke national audit programme.
- The Cedars Unit had taken part in the National Audit of Intermediate Care (NAIC) in 2015. This audit aimed to assess progress in services for older people aimed at maximising independence and reducing use of hospital admission and look at national trends.
- Policies and procedures were consistent with National Institute for Health and Care Excellence (NICE) guidance where appropriate such as NICE CG50 relating to responding to the deteriorating patient. Patient's needs were assessed and care and treatment was delivered in line with NICE quality standards relating to the assessment and prevention of pressure ulcers.
- The neuro gym service provided a range of specialised sessions to support patient rehabilitation as well as maintenance of movement, based on latest evidence. The service undertook action research on measuring a patient's arm recovery following their recovery programme. The results showed a good recovery for patients in terms of time and duration taken for recovery.
- The Barthel Activities for Daily Living (ADL) score was used to measure patient's performance in their rehabilitation
- Staff used outcome measures to monitor patient progress. Key outcome measures were Braden Assessment of pressure ulcer risk and nutrition scoring. However, in most of the records we reviewed, these assessments were not completed accurately, and there were no results provided to the inspection team.
- We found opportunities to participate in bench marking, peer review, accreditation and research were proactively pursued by the service provider. Information about the outcomes of people's care and treatment were routinely collected and monitored to improve patient care.
- There was no data on the number of children and young people achieving their treatment goals through speech and language therapy.

Summary of findings

- Multidisciplinary team (MDT) working was well established on The Cedars Unit and formed an integral part of the wards.
- All staff were very positive about the weekly MDT meetings in the community, which involved a full range of staff providing care and treatment including a GP, nurses, therapists and social workers.
- Patient's we spoke with told us staff always gained their consent prior to providing care or treatment. We observed nursing staff explained procedures to patients and gained verbal consent to carry out the procedures.

Caring

- Patients received compassionate care which was centred on them, whether inpatients or in the community.
- Patients were mostly positive about their care and treatment.
- The results from a service user engagement survey over the period January to October 2016 showed all of the respondents would be extremely likely or likely to recommend the unit. However, the response rate for both wards was extremely low, with only eight responses for Chestnut Ward and six for Elm Ward.
- Staff told us that the lack of therapeutic activities on the unit had been identified as an issue, and provision of an activity co-ordinator discussed, however funding was not available.
- On Elm ward at night, the Zimmer frames of each patient were put out of their reach, to prevent them using them and potentially falling. However, this did not encourage the patients to mobilise independently
- Call bells on The Cedar Unit were very loud and disturbing to patients.
- Community nurses delivered respectful and compassionate care with attention to their patient's privacy and dignity.
- The majority of families using the services that we spoke with were very happy with the services provided by Your Healthcare.
- Although there were only small numbers of mothers attending the feeding clinic, mothers at these clinics said staff were 'relaxed and friendly'.
- Staff involved patients in their care; they communicated well with them and provided them with simple information on how to manage their condition and options of treatments available.
- When patients asked questions, these were responded to appropriately and where further information needed to be obtained by a nurse patients were informed in advance.
- Relatives told us that they had been consulted about decisions and understood what was happening and why.
- Staff communicated with children and young people in an age appropriate way and involved them in decisions about their care.
- Staff in all services used written information to supplement verbal information, which was good practice.
- Staff met the emotional needs of patients by listening to them, by providing advice when required, and responding to their concerns.
- There was not a routine chaplain visit to The Cedars Unit; however senior nurses told us that they could contact a local chaplain if it was required.
- Patients and carers felt emotionally supported and reassured by the community nursing visits.
- Health visitors sensitively discussed mothers' feelings and emotional well-being during home visits.

Responsive

- Patients' needs were assessed and care planned accordingly. Where appropriate, care planning involved joint visits with staff from other specialties or GPs.
- Patients with complex needs including those who were housebound were discussed between services and a co-ordinated multi-disciplinary plan of care was agreed. Service users could access community nursing services directly and request visits and appointments.
- Staff worked closely with their local hospice to ensure end of life care needs of their patients were met.
- A Tongue Tie Release Clinic had been set up in January 2016, after midwives at the local hospital stopped doing this and instead referred cases to outpatient appointment at another hospital.
- There was a dementia nurse specialist to support patients living with dementia.

Summary of findings

- The Cedars Unit used a 'forget me not' sticker to identify patients living with dementia. There had been some effort to make the unit a dementia friendly environment such as the use of pictures and word signs on toilets.
- In the community, nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. The neurodevelopmental services assessed people attention deficit hyperactivity disorder and autism and worked closely the local acute and hospital social services. They provided learning disability awareness training to staff.
- We saw evidence of easy read documents and pictures for people living with a learning disability.
- People were generally seen in a timely manner, with some exceptions and had their individual needs met.
- The average wait for patients to access The Cedars Unit between October 2015 and August 2016 was three days for Chestnut Ward and four days for Elm Ward.
- There was a single point of access to the nursing service. Referrals were triaged immediately and the workload allocated accordingly.
- Waiting times were variable across the community services. Referrals for community nursing visits are often received in advance therefore representing a lead time for discharge home for example rather than a waiting period. Community nursing provides a daily priority based response and in consequence there is no waiting time to access this service. However, therapy services had a triage system in place to identify urgent and non-urgent appointments.
- The SALT service did not hold a traditional waiting list, but described a risk managed monitoring list. Different staff told us that the wait for routine assessment by a therapist was between six, eight or 10 months, so were not meeting the 18 week referral to treatment times.
- Face to face and telephone interpreting services were available. There were also a number of staff on The Cedars Unit that spoke a second language and would assist when it was suitable for them to do so. However, some staff reported that they would often use family if interpretation was needed which is poor practice. The unit had a menu that contained photographs of food choices that could be used for patients who may not be able to read English.
- Staff treated patients with respect regardless of their race, religion and sexual orientation. Relatives confirmed that they and their loved ones were shown dignity and compassion throughout their care.
- The SALT service produced leaflets for parents on the development of speech sounds, stammering and modelling correct speech which gave parents tips on how to help their child.
- There was a complaints policy and staff were trained on handling complaints.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.
- Our review of records found that there were no formal risk assessments for complaints that would determine how they should be dealt with and we did not see a record of how the learning would be shared. There was also inconsistent evidence on whether complainants were asked whether they were happy with the response.

Well led

- The managing director did not have a formal appraisal of her performance and was the only person in the organisation not required to have one. This was not good practice and must be addressed.
- There was a flowchart which described the governance structure and process. However, this was neither signed nor dated.
- It was clear that the governance process was understood internally, but the flowchart could be improved to demonstrate the overall governance framework. For example, there was no formal policy or procedure setting out the governance framework in narrative to back up the flowchart.
- The board lead for Foundation is on the membership of the Kingston CCG End of Life Care Steering Group, which acted as a forum for the commissioner to ensure collaborative working between their providers.
- Systems or processes were not sufficiently established or operated to effectively ensure the provider was able to assess, monitor and improve the quality and safety of end of life care services.
- There was no documented vision for the children and families service delivered by Your Healthcare.

Summary of findings

- The organisation was not clear about its risk tolerance, or had definitive SMART plans with clear milestones for managing risks.
- The provider had developed a manifesto to support their vision. There were clear priorities to help deliver the vision. The manifesto highlighted the status of the provider as a social enterprise with the freedom to use their resources to improve patient care.
- How the organisation is governed is outlined in its articles of association registered with Companies House.
- Risk registers were kept by separate departments and committees, which were amalgamated to inform to organisational risk register.
- The organisation took the health and well-being of its workforce seriously. It worked closely with the Public Health Department.
- Most staff told us they enjoyed working for the organisation.
- We saw an action plan which was agreed by the board, aimed at making progress against the WRES indicators. One desired outcome for the organisation in assessing its progress against the WRES indicators, was improving the percentage of BME staff in senior positions.
- There was active staff and public engagement.
- The multiple sclerosis support group generates income and run exercise classes for themselves. This came about as a result of the provider listening to the service users, to improve the service delivered.
- The Cedars Unit had recently bought a new piece of equipment called the 'Hover Jack'. This allowed the nursing staff to safely lift patients from the floor whilst keeping them flat so that they could then be transferred to a bed. This reduced manual handling for staff and a better patient experience.

We saw several areas of outstanding practice including:

- The multiple sclerosis support group was recognised as an example of good practice. This group generates income and run exercise classes for themselves.
- The provider re-invested surplus money in its services. This included the appointment of a tissue viability nurse, reduction of waiting times and purchasing of gym equipment.
- The Cedars Unit had a 'Hover Jack'. This allowed the nursing staff to safely lift patients from the floor whilst keeping them flat, so that they could then be transferred to a bed. This reduced manual handling for staff and a better patient experience.
- The Cedars Unit had a bariatric training suit for manual handling training. This allowed staff to better understand the problems of mobility and routine activity associated with bariatric patients.
- Schwartz Rounds were conducted in the organisation; this is a forum in which staff can openly and honestly discuss social and emotional issues that arise in caring for patients. The provider had supported staff to participate in the "Rounds".

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

Importantly, the provider must:

- Ensure the managing director receives a formal appraisal of her performance.

In addition, the trust should:

- Ensure there is a formal policy or procedure setting out the governance framework in narrative to back up the flowchart.
- Reduce the risk related to the electronic system migration.
- Correct the electronic data inaccuracy related mandatory training.
- Carry out formal risk assessments for complaints that would determine how they should be dealt with.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor Igbal Singh, consultant physician,

Team Leader: Roger James, Care Quality Commission

The team included CQC inspectors and a variety of specialists including district nurses; palliative care specialists; health visitors; pharmacist; school nurse; physiotherapist; occupational therapist, safeguarding specialists, and an expert by experience who have used health care services in community settings.

Why we carried out this inspection

We inspected Your Healthcare Community Interest Company as part of our comprehensive inspection programme.

How we carried out this inspection

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

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

We inspected the following community services provided:

• Community health services for adults

• Community health services for children, young people and families

• Community End of Life Care

• Community health Inpatients

We also inspected and rated Your Healthcare CIC at provider level. This is because it is one of 22 large independent community health providers that we inspect and rate and provider level.

The evidence contributing to this provider report is from the healthcare provision only.

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew.

During the visit, we held focus groups with a range of staff who worked within the service, such as nurses and, therapists. We talked with people who use services. We observed how people were being cared for and 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.

Information about the provider

Your Healthcare Community Interest Company is an independent not for profit social enterprise, which is asset locked, requiring all surpluses or profits to be reinvested back to the community services. It provides more than 40 health and social services across the Kingston upon Thames and Richmond localities. It formally became Your Healthcare Community Interest Company in August 2010.

Summary of findings

Your Healthcare Community Interest Company has three registered locations which provide community healthcare; Hollyfield House, Surbiton Health Centre and The Cedars Unit. We visited all three locations during this inspection.

Your Healthcare Community Interest Company provides services across Kingston and Richmond. The main clinical commissioning group (CCG) is the Royal Borough of Kingston, although it does have commission contracts with other local CCGs.

It provides the following core services:

- Community health services for adults
- Community health services for children, young people and families
- Community End of Life Care
- Community health Inpatients

This is the first inspection at provider level since registration of Your Healthcare Community Interest Company.

Your Healthcare Community Interest Company

Detailed findings

Good

Are services safe?

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

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

Summary of findings

We rated safe at provider level as good because:

- The duty of candour was understood and implemented by staff.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- Staff working with children had safeguarding training and access to regular safeguarding supervision.
- Staff knew how to recognise and report incidents on the provider's electronic recording system.
- There was a business continuity plan regarding major incidents which was reviewed annually.

However;

- There was a shortage of nursing staff which did have some impact in the community with some patients not having their visits as planned.
- The Cedars Unit had not reported any deaths within the last year; although five patients had died on the unit.
- The Cedars Unit did not carry out mortality reviews.

Our findings

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.
- The duty of candour was understood and implemented by staff. We were given a recent example of the incident review process and whether the duty of candour criteria was met. The duty of candour process was appropriately followed and actioned. A verbal apology and written letter signed by the board lead and the service manager were given to the patient.

Safeguarding

- Your Healthcare had up to date safeguarding policies and procedures. Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- Staff appropriately raised safeguarding alerts with the local authority.

Good

Are services safe?

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

- There were issues with the computer system that held the record of staff training and the training compliance data was only available for the whole organisation. Compliance for the organisation was 60% for safeguarding adults and for safeguarding children was 53%. However, senior managers said they could not confirm how accurate these figures were.
- Staff, including non-clinical staff were aware of what constituted abuse and the actions they would take to protect the safety of patients from abuse. Junior staff reported concerns to more senior colleagues.
- Staff working with children had safeguarding training and access to regular safeguarding supervision.
- The post of named nurse for safeguarding was vacant at the time of the inspection but an appointment had been made and the new post holder was due to start in January 2017. The safeguarding adviser was covering the named nurse post in the interim. She was accessible to staff and staff was able to give examples of when they had needed to speak with the team as well as the advice they received.
- Safeguarding adults and children was part of the mandatory training programme for staff. Different levels of training were provided according to their job role. Level 1 training was delivered to all staff on induction, and updated three yearly.
- Health visitors and school nurses knew what action they should take if children were not brought to appointments or if they were notified by the hospital's liaison health visitor that a child had attended an accident and emergency department. There was a flag on the electronic recording system for highlighting children where there were safeguarding concerns and we saw this in use.
- Health visitors told us they had good relationships with local authority safeguarding teams and social services. They felt that this enabled a rapid and joined up response in cases where they had safeguarding concerns. We saw evidence within electronic records of contacts with vulnerable children and families, as well as details of how they were being supported by other agencies such as social workers. Within the children's and families services, staff told us that if they had any concerns about children and young people, they would arrange home visits in order to assess the home environment and thus the level of risk.
- All the staff we spoke with had undergone training about female genital mutilation (FGM) and were aware of the action they should take if they identified a child or young person at risk.
- Safeguarding concerns were appropriately reported to the CQC.

Incidents

- Incidents were recorded and reported using the provider's electronic recording system which had changed to 'Datix' on 1 April 2016. Staff told us they understood the importance of reporting incidents.
- Staff knew how to recognise and report incidents on the provider's electronic recording system. They reported incidents and were able to discuss them with their line managers. They gave us examples of a range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. However, due to lack of equipment or IT connectivity issues in the community, staff could not always access on-line reporting in the community, but had to return to a hub office to do so.
- The Cedars Unit had not reported any deaths within the last year; although five patients had died on the unit. These were all expected deaths and we were told that these patients were receiving end of life care. Providers must report all deaths as a statutory notification to CQC and therefore this should have been completed.
- The unit did not carry out mortality reviews and when we raised this with the provider, we were told that it wasn't required within the community setting. However, the Serious Incident Framework applies to all NHS funded care and we would expect to see supporting decisions on management of deaths of service users and whether it should be reported as an incident. In the absence of any local mortality review process, it is difficult to understand how the provider would be assured that the death of the service user was attributed to the course of the illness or medical condition that treatment was being provided for.
- In the children, young people and families' service, no incidents were reported relating to staff shortage despite vacancies within the service, although we saw some impact on delivery, for example on one year old baby checks, and waiting times for speech therapy. We did not see evidence of learning and changing procedures as a result of incidents.

Good

Are services safe?

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

- In the community, staff used team meetings (where they occurred) or newsletters to share learning and trends from incidents; however, there were no team meetings held on The Cedars Unit. Incidents and learning from incidents were also discussed at handovers. Staff learned about incidents that had happened with a specific patient, such as a fall, at the handover. However; it was not clear how staff not present at the handover would be updated.
- Incidents were discussed at the sisters meetings held every month and this information was cascaded at handovers.
- When appropriate, route cause analyses were completed.
- Incidents were reviewed across the whole organisation by the audit and assurance board.

Staffing

- There was a shortage of nursing staff which did have some impact in the community with some patients not having their visits as planned.
- There were high vacancy rates especially for nurses and speech and language therapists across all services, which impacted on the delivery of care. Senior staff reported difficulties in recruiting nursing staff and recruitment was ongoing.
- Nurse staffing was listed on the directorate risk register as a high risk and was being looked at strategically.
- There were plans to hold an open day for recruitment of staff across Your Healthcare. Senior staff were looking at flexible options for example to invite newly qualified staff in to the team and upskill them so that they can become valuable members of the team.
- In addition, there was a high level of sickness recorded for the unit, with the most common reason being stress and back injuries; however it was not known whether these were always directly attributable to work.
- The Cedars Unit was not using staff acuity tools to determine or adjust staffing levels. The level of support individual patients required varied greatly and this was not considered in staffing numbers and the skills required. This meant the provider could not be assured that it was delivering safe care by sufficient staff with the appropriate skills.
- We were told that agency staff were very seldom used. The unit preferred to use staff from its bank register to cover vacant shifts. However, data provided to us showed that between June and August 2016, there were 75 nursing shifts that were left unfilled.
- Almost all staff we spoke to in community nursing and therapy teams told us that staffing was an issue. However, staff reported that they frequently worked over their hours to meet the needs of the service. Staff in the majority of teams told us that they regularly worked more than their contracted hours to ensure patients' visits were undertaken.
- The specialist palliative care was provided from the local hospice by clinical nurse specialist for end of life care.
- Caseload management for end of life care patients was undertaken by the nurse in charge of the service and was based solely on experience and judgements.
- Six doctors are employed by the organisation; two consultants and four trainees. The organisation sub-contracts for GPs to cover The Cedars Unit. Incidents relating to GPs are reported to their practice and to NHS England, because the provider has no managerial responsibility for them.

Major incident awareness and training

- There was a business continuity plan regarding major incidents which was reviewed annually. This identified the top priority as children and families at risk, and the next priority new birth visits. The plan also identified key contact details and a process for staff to follow. The plan covered electrical failure, telecommunications failure and IT failure. However, there had not been a simulation drill to test these.
- The organisation had protocols and standard operating procedures in place. An Emergency Planning Officer had been appointed. The organisation was awaiting confirmation of approval from NHS England Emergency Preparedness, Resilience and Response, following a review meeting in November 2016.
- There was also an up to date major incident plan which was reviewed annually.

Are services effective?

Requires improvement

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

Summary of findings

We rated effective at provider level as requires improvement because:

- The end of life care plan was not widely available to all staff in the community nursing team during the inspection, and had not yet been audited to determine if it was effective.
- Some staff working with end of life care patients, were not confident about what process they should follow if patients did not have capacity.
- There were gaps in MUST nutritional assessments for patients receiving end of life care, either they were not available in patient records or not completed thoroughly.
- There were no personalised care plans on nutrition and hydration for patients receiving end of life care, to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- There was no data on the number of children and young people achieving their treatment goals through speech and language therapy.

However:

- Policies and procedures were consistent with National Institute for Health and Care Excellence (NICE) guidance.
- There was an audit programme, which was agreed by the audit and assurance board.
- The Barthel Activities for Daily Living (ADL) score was used to measure patient's performance in their rehabilitation.
- Opportunities to participate in bench marking, peer review, accreditation and research were proactively pursued by the service provider.
- Multidisciplinary team working was well established.

Our findings

Evidence based care and treatment

- There was an audit programme, which was agreed by the audit and assurance board. The provider carried out internal audits such as 'bare below elbows' and anti-biotic prescribing. It also took part in external audits such as the sentinel stroke national audit programme.
- The managing director told us that staff were encouraged to audit everything.
- Staff told us about clinically driven local audits, which aimed to improve practice and patient care. For example staff told us an audit of pressure ulcers showed that the incidence of pressure ulcers had reduced. The community team were also auditing care plans, DNACPR and the use of MUST and Waterlow scores to maintain record keeping standards.
- The Cedars Unit had taken part in the National Audit of Intermediate Care (NAIC) in 2015. This audit aimed to assess progress in services for older people aimed at maximising independence and reducing use of hospital admission and look at national trends. Although some of the outcome recording had not been able to be submitted in time for the NAIC the team had still collated the results and used it as internal learning.
- Medication audits were regularly undertaken and outcomes monitored. If any issues were raised, then immediate training on medicines management and administration would be arranged for targeted staff and targeted where needed.
- Policies and procedures were consistent with National Institute for Health and Care Excellence (NICE) guidance where appropriate such as NICE CG50 relating to responding to the deteriorating patient. Patient's needs were assessed and care and treatment was delivered in line with NICE quality standards relating to the assessment and prevention of pressure ulcers. A newsletter was circulated to staff quarterly called 'Quality Matters', which highlighted new and revised policies for staff to be aware of. New relevant NICE guidance was also raised to senior staff during the adult services governance meeting.
- Discharge planning followed NICE CG27 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'.

Are services effective?

Requires improvement

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.

- Therapists were aware of the NICE guidelines for falls assessments and used evidence based tools including the Tinnetti balance assessment and the elderly mobility scale.
- Specialist teams across the community service including cardiac rehabilitation, neuro rehabilitation, speech and language therapy (SALT), tissue viability, all used best practice guidance to inform the care and services offered.
- The neuro gym service provided a range of specialised sessions to support patient rehabilitation as well as maintenance of movement, based on latest evidence. The service undertook action research on measuring a patient's arm recovery following their recovery programme. The results showed a good recovery for patients in terms of time and duration taken for recovery.
- NICE guidelines on ante natal and postnatal mental health have been in place since 2014 and were updated in 2016. However, health visitors told us they still used the Edinburgh Post-natal depression questionnaire (EPDS) and they had only recently had training on the now well established technique of using Whooley questions. i.e. open ended questions to assess maternal mood. Health visitors were not aware of a Your Healthcare protocol for assessing maternal mood and no data was collected on the percentage of mothers who received a maternal mood review by the time the baby was eight weeks old.
- Staff were aware of the Advanced Care Plan (ACP), but we did not see any evidence of its use. Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place in the manner of their choosing. ACP is a key part of the Gold Standards Framework Programmes.
- The provider arrangements for end of life care services to achieve the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People was in draft and being consulted upon. Timescales for implementation of the care plan were not provided.
- The service was piloting its own version of an end of life care plan. The care plan was not widely available to all staff in the community nursing team, and had not yet been audited to determine if it was effective.

Nutrition and hydration

- In end of life care, staff told us they used the MUST scale to help identify patients who may be at risk of malnutrition. However, the MUST charts in patient's records we saw were not completed at appropriate intervals and did not contain relevant information.
- In end of life care, there were no personalised care plans on nutrition and hydration to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.

Patient outcomes

- The organisation participated in the Sentinel Stroke National Audit Programme (SSNAP) for inpatients, early supported discharge and community rehabilitation team. In 2015, several items in the audit for the organisation were positive. Data was submitted for the period August 2015 to July 2016. Results are not yet known.
- The organisation has four inpatient stroke beds and in the 2015, the community rehabilitation team received 61 new stroke patient referrals service and the early supported discharge team received 54 referrals.
- The Barthel Activities for Daily Living (ADL) score was used to measure patient's performance in their rehabilitation. This has 10 variables describing ADL and mobility. A higher number is associated with a greater likelihood of being able to live at home with a degree of independence following discharge from hospital. On both wards on The Cedars Unit, this completed each week for every patient; however on Elm Ward it was collected on the electronic record and was harder to view patient progress.
- Physiotherapists recorded outcome measures for each patient on the advanced care notes system including goal setting, Goal Attainment Score and Patient Health Questionnaire (PHQ-9) and the occupational therapists used focus goals to increase patient's mobility. These were also only used to monitor an individual's progression and were not looked at collectively for analysis.
- Staff used outcome measures to monitor patient progress. Key outcome measures were Braden

Are services effective?

Requires improvement

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.

Assessment of pressure ulcer risk and nutrition scoring. However, in most of the records we reviewed, these assessments were not completed accurately, and there were no results provided to the inspection team.

- We found opportunities to participate in bench marking, peer review, accreditation and research were proactively pursued by the service provider. Information about the outcomes of people's care and treatment were routinely collected and monitored to improve patient care.
- For the mother and baby review visit carried out between six and eight weeks: 94% of mothers were visited by the time the baby was 8 weeks old, which was good. Health visitors achieved less good results for the timeliness of the 12 month review: only 53% of babies had a review by 12 months of age, although a further 17% were seen by 15 months. For the final health visiting review, for children aged between two and two and a half years of age, the service was seeing 85% of children.
- School nurses captured heights and weights of 99% of children as part of the school measurement programme which feeds into national data which is part of the Government's strategy to tackle obesity and provides a vehicle for engaging with children and families about healthy lifestyles and weight issues. The nurses could refer families of underweight or overweight children to other agencies for support if they were willing to participate.
- There was no data on the number of children and young people achieving their treatment goals through speech and language therapy.
- The number of young people attending drop in sessions at some schools were fewer than 10 in some schools, but there was no target.
- Attendance at adult contraception and sexual health clinics was close to target attendances from April to September 2016, although below target for dual chlamydia and gonorrhoea screening with an average 41% take up against a target of 80%. All those STI tested were notified of the result within 10 working days, but slightly below the 95% target for those testing positive for an STI treated within six weeks of test date.
- Community nursing staff told us the specialist palliative care team from the local hospice would measure patient's outcomes.
- Managers told us clinical outcomes on end of life care were not being measured by the provider, however they had plans to implement monitoring of patients outcomes in line with the Priorities of Care set out in One Chance to Get it Right (June 2014).

Multidisciplinary working

- Multidisciplinary team working was well established on The Cedars Unit and formed an integral part of the wards. Physiotherapy and occupational therapy attended the unit each weekday, a dietician and social worker on a part time basis and there was access to speech and language therapy.
- Community staff worked effectively with both secondary (the acute hospital services) and primary care (general practice and community staff).
- All staff were very positive about the weekly MDT meetings in the community, which involved a full range of staff providing care and treatment including a GP, nurses, therapists and social workers.
- Staff described good MDT working amongst colleagues. We found examples of effective multidisciplinary working both within and across teams. For example, specialist nurses in tissue viability, multiple sclerosis, motor neurone disease and palliative care were available for staff to consult for advice and support.
- Practitioners worked with other agencies as a team around the child so that information was shared across services where there were concerns about a child in vulnerable circumstances.
- We observed both internal and external multidisciplinary (MDT) working. For example, shared information between health visitor and school nurse teams, as well as work with GPs, school staff, social services, the police and the provider of integrated care.
- Speech and language therapists supported children in mainstream schools with special units for autism and hearing impairment, and in special schools.
- The community children's team worked collaboratively with the Educational Service for Sensory Impairment (ESSI) run by another local provider.
- Community nursing staff attended meetings at GP surgeries to discuss the ongoing needs of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act processes were followed and used appropriately by most staff when required. In most

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Requires improvement

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cases, when there were concerns about a person's ability to make specific decisions relating to hospital treatment and everyday decisions, mental capacity assessments were carried out. The patient's family and multidisciplinary team was involved. However, some staff working with end of life care patients, were not confident about what process they should follow if patients did not have capacity.

- Mental Capacity Act Training was included in the induction for all staff.
- We saw five records where service users had mental capacity assessment appropriately carried out.
- The provider's consent and mental capacity policy had been reviewed in October 2016 and was available to staff on the intranet.
- A bed rail audit was completed in March 2016, assessing the compliance of completing of the bed rail assessment tool and found that seven out of 15 patients had not had risk assessments completed for use of bed rails. Although a re-audit had not been carried out, all bed rail assessment forms for six patients that we reviewed had been completed appropriately.
- Staff had received training on the Mental Capacity Act (2005) (MCA) in relation to seeking patient consent prior to specific decisions. Data for the organisation showed that 68% of Your Healthcare staff had received MCA training; however there was no specific data for The Cedars Unit staff. Two therapy staff that we spoke with had limited knowledge of the MCA and stated that nurses would do a basic capacity assessment on admission. Nurses that we spoke with had more knowledge of the MCA principles.
- The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. It aims to make sure that people in care homes, hospitals and supported living were looked after in a way that does not inappropriately restrict their freedom. There were no patients on the unit at the time of our inspection that were under a Deprivation of Liberty Safeguards. However, they were able to explain the process that they would follow, such as a referral being made to the local authority for assessment.
- During the inspection, we found that staff on The Cedars Unit were not aware that there was a framework for discussion of "do not attempt cardio-pulmonary resuscitation" (DNACPR) instructions that was taken from the national best practice guidelines. However, following the inspection, the provider submitted a DNACPR policy which had been implemented in March 2016.
- Staff told us that if the patient was not for cardio-pulmonary resuscitation, the form was completed by the hospital and kept with the patient's notes. The information was then included on the daily bed state, so all staff were aware.
- Patient's we spoke with told us staff always gained their consent prior to providing care or treatment. We observed nursing staff explained procedures to patients and gained verbal consent to carry out the procedures.
- Staff had received mandatory training on Safeguarding Adults, Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards. Staff were confident about seeking consent from patients. However, there was no standard format or guidance on recording best interest decisions. Staff at all levels including managers were unclear how much information they needed to record on care notes and the format this should take when making best interest decisions for patients who could not consent during their last days in life.
- We observed staff discuss mental capacity assessments at community team multi-disciplinary meeting. They recognised the need to document assessments and decisions and said they documented these in case notes. However we did not see any evidence of this during our home visits with the clinicians.
- Service users told us health visitors, school nurses and therapists had explained the purpose and evidence for different clinical assessments and confirmed their consent before proceeding with any actions. Consent and Mental Capacity Act (MCA) training was mandatory for clinical staff but we were not given data on what proportion of CYP staff had this training.
- School nursing and sexual health staff had a good understanding of how to gain consent for children and young people and used Fraser guidelines and Gillick competences to make decisions about whether young people over 13 had the maturity, capacity and competence to give consent themselves. The service could not give advice to under 13s because a safeguarding referral was needed when a child of that age was engaged in sexual activity.

Good

Are services caring?

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

Summary of findings

We rated caring at provider level as good because:

- Patients received compassionate care which was centred on them, whether inpatients or in the community.
- Patients were mostly positive about their care and treatment.
- Staff were committed to the care and treatment they provided and we saw positive interaction with patients on both wards.
- Staff involved patients in their care and often provided them with simple information on how to manage their condition and options of treatments available.
- Staff communicated with children and young people in an age appropriate way and involved them in decisions about their care.
- Staff in all services used written information to supplement verbal information, which was good practice.
- Staff met the emotional needs of patients by listening to them, by providing advice when required, and responding to their concerns.

However;

- The proximity of the bays on The Cedars Unit meant that discussions of professionals with the patient could be heard by others within the bay.
- There were limited activities for patients to engage in on The Cedars Unit.
- On The Cedars Unit, patients walking frames were removed at night, because they were at risk of falling and staff wanted them to call if they wished to leave their beds. However, this meant that patient's independence was not being encouraged.
- Call bells on The Cedar Unit were very loud and disturbing to patients.

Our findings

Compassionate care

- We observed patients received compassionate care which was centred on them, whether inpatients or in the community. Patients were mostly positive about their care and treatment.
- Each bay on The Cedars Unit was single sex accommodation in accordance with national guidance.
- We saw staff closing curtains and doors when providing personal care to protect patient's privacy and dignity. However, the proximity of the bays on The Cedars Unit meant that discussions of professionals with the patient could be heard by others within the bay.
- The results from a service user engagement survey over the period January to October 2016 showed all of the respondents would be extremely likely or likely to recommend the unit. However, the response rate for both wards was extremely low, with only eight responses for Chestnut Ward and six for Elm Ward.
- In the Patient-Led Assessments of the Care Environment PLACE survey 2016 for The Cedars Unit, the average score for privacy, dignity and wellbeing was 84% which was the same as the national average.
- Staff were committed to the care and treatment they provided and we saw positive interaction with patients on both wards.
- Most patients said there were limited activities to engage in on the unit. There was a television in each bay, side room and also in the day room on Chestnut Ward. However one patient reported that it was kept on late in the night in one bay in Chestnut Ward and this was disturbing. Staff told us that the lack of therapeutic activities on the unit had been identified as an issue, and provision of an activity co-ordinator discussed, however funding was not available.
- The community nursing team reported they had received positive feedback from the patients' survey. We observed community nurses delivered respectful and compassionate care with attention to their patient's privacy and dignity. A good rapport existed between nurse and patient, and any carers or relatives.
- Staff spoke with patients in a reassuring, considerate and respectful manner.
- Staff had developed trusting relationships with patients, their relatives and loved ones.

Good

Are services caring?

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

- Out of 46 comment cards received from service users during the inspection, majority were positive about the care and support they had received from staff. Service users consistently told us they would recommend the service to their families and friends.
- The majority of families using the services that we spoke with were very happy with the services provided by Your Healthcare. Although there were only small numbers of mothers attending the feeding clinic, mothers at these clinics said staff were 'relaxed and friendly'.
- Friends and Family Test (FFT) results were consistently very good across CYP services and locations, with 93% recommendations for the three months prior to our inspection. However, the response rates were low as a proportion of users, for example there were only two comments on speech therapy.
- In a KISH survey of all age sexual health clinics, 32 were very likely to recommend and 13 likely to recommend out of a total of 39 responses.
- We observed that walking frames were removed from all patients' beds in Elm Ward and some in Chestnut during an evening visit. Staff told us that this was because they were at risk of falling and that they wanted patients to call if they wished to leave their beds. However, this meant that patient's independence was not being encouraged.
- Call bells on The Cedar Unit were very loud and disturbing to patients.

Understanding and involvement of patients and those close to them

- Most patients on The Cedars Unit were involved in their care and kept informed by staff.
- One relative reported that they and their family were being given advice and being included on options for change of a patient's residency after discharge, which included signposting to the relevant people.
- The service user survey results found that all of the respondents from Chestnut Ward felt sufficiently involved in planning their care and treatment, but two of the six respondents for Elm Ward did not. In addition, in answer to the question 'Did you understand everything the staff member told you, one respondent on each of the wards answered no, however the remainder stated they had.
- We were told network meetings would be organised for some patients with complex needs where required for discharge planning. The patient and their family would attend these meetings to set out what their aims and aspirations were. We saw records of two meetings that demonstrated this patient involvement.
- Staff told us about previous years, where a patient's spouse was at home alone on Christmas day, they would arrange for extra lunch to be provided so that couples could spend Christmas together.
- Community nurses involved patients in their care; they communicated well with them and provided them with simple information on how to manage their condition and options of treatments available.
- Patients were involved in planning of their treatment and nurses acted on patients wishes. When patients asked questions, these were responded to appropriately and where further information needed to be obtained by a nurse patients were informed in advance.
- A consultation between a patient and a speech and language therapist demonstrated that the therapist worked with the patient and encouraged the patient to set their own goals.
- Relatives told us that they had been consulted about decisions and understood what was happening and why. One family member had been invited to a multidisciplinary meeting with staff to discuss future care needs for their relative.
- Parents and carers told us they felt involved in discussions about care options and told us that they felt confident to ask questions and make decisions based on the information they received.
- Staff communicated with children and young people in an age appropriate way and involved them in decisions about their care.
- Staff in all services used written information to supplement verbal information, which was good practice.

Emotional support

- On The Cedars Unit, we observed that staff had developed strong therapeutic relationships. Psychological and psychiatric support was available, if a patient was referred for this by the GP. This could be done with a form or by phone for a more urgent referral.
- On both wards, we observed staff talking sensitively with patients, taking into account their emotional needs.
- There was not a routine chaplain visit to the unit; however senior nurses told us that they could contact a local chaplain if it was required.

Good

Are services caring?

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- Staff met the emotional needs of patients by listening to them, by providing advice when required, and responding to their concerns.
- Patients and carers felt emotionally supported and reassured by the community nursing visits.
- Community staff (including nurses, occupational therapists and physiotherapists) gave holistic care including support for close relatives. For example, we saw a community dementia nurse specialist checking the welfare and emotional wellbeing of a patient's spouse as well as the patient.
- Health visitors sensitively discussed mothers' feelings and emotional well-being during home visits. They asked about emotional support from families and if the mother needed any additional support, such as counselling. Health visitors worked with local maternity services to improve mothers' psychological support needs where midwives passed on this information.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive at provider level as good because:

- The provider had a wide range of services in place to meet the needs of its population.
- Patients' needs were assessed and care planned accordingly. Where appropriate, care planning involved joint visits with staff from other specialties or GPs.
- There was a rapid response team and impact team. Their services were either to facilitate early discharge or prevent hospital admission.
- The neurodevelopmental services assessed people attention deficit hyperactivity disorder and autism and worked closely the local acute and hospital social services. They provided learning disability awareness training to staff.
- The community matron and dementia nurse specialist offered support for patients with long term conditions and acted as specialist nursing support for the community teams.
- People were generally seen in a timely manner, with some exceptions and had their individual needs met.
- The average bed occupancy within The Cedars Unit was lower than the national average.
- Face to face and telephone interpreting services were available.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.

However;

- The 'activities for daily living' (ADL) specialist kitchen on The Cedars unit, was reported to not be used often as it was a long way from the unit and the environment was not similar to a patient's house and so it had limited benefit.
- A few children referred urgently to speech and language therapy could be seen quickly, but the delivery of this service was rated as a high risk on the risk register, because it could not deliver the service as commissioned.
- Some staff reported that they would often use family if interpretation was needed, which is poor practice.
- There were no formal risk assessments for complaints that would determine how they should be dealt with.

Our findings

Service planning and delivery to meet the needs of local people

- The provider had a wide range of services in place to meet the needs of its population. Services were provided at 26 GP locations in two localities (north and south localities).
- On The Cedars Unit, there was an 'activities for daily living' (ADL) specialist kitchen on the ground floor beneath the unit within the outpatients department that could be used by therapists while working with patients. However, this was reported to not be used often as it was a long way from the unit and the environment was not similar to a patient's house and so it had limited benefit.
- Four beds were allocated for patients who required neuro-rehabilitation. The care for these patients was led by the Community Neuro Rehabilitation Team (CNRT) and this was available between 8am and 4pm, six days per week.
- Patients' needs were assessed and care planned accordingly. Where appropriate, care planning involved joint visits with staff from other specialties or GPs.
- Patients with complex needs including those who were housebound were discussed between services and a co-ordinated multi-disciplinary plan of care was agreed. Service users could access community nursing services directly and request visits and appointments.
- Patients who were mobile travelled to clinics such as the MSK clinic, cardiac clinic and other clinics in Surbiton Health Centre and Hollyfield House to have their condition reviewed regularly.
- There was a rapid response team and impact team. Their services were either to facilitate early discharge or prevent hospital admission. The services were flexible and were seen as effective by the services user as mentioned in the patient survey results.
- Community nurses had a portfolio of GP practices. This allowed them to build up a relationship with patients

Good

Are services responsive to people's needs?

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

while supporting them in their own homes, build a good working relationship with their GP and have a greater understanding about the needs of the local population the practice served.

- Staff worked closely with their local hospice to ensure end of life care needs of their patients were met. Some of the nursing staff we spoke with told us they had received informal end of life training and advice from the local hospice. However, end of life care plans did not provide sufficient information about the personal wishes and preferences of patients and their families.
- Staff were encouraged to meet families' needs, without there being prescriptive direction from managers. The service had decided to absorb funding reductions and subsidise the health visitor service from income generated by other services.
- School nurses offered PSHE for pupils in primary schools: in Year 5 this covered relationships and in Year 6 contraception. At secondary school, schools could request a nurse to run confidential drop in sessions. Simple drop-ins were where young people could ask questions and enhanced drop in was for emergency contraception or chlamydia testing. Five out of 11 secondary schools and seven out of 18 primary schools used this service. School nurses adjusted the type of sex and relationships drop-ins according to the school's need. An example was adaptation for a catholic school who only wanted physical and mental health services information, and not contraception. Children were asked to complete evaluation forms, but these were not analysed in detail. School nurses reviewed responses at the end of each session to understand any gaps in information presented.
- Fewer than half children referred to speech and language therapy (SLT) were actively triaged by meeting a therapist face to face. Some of those waiting were referred to group dynamic assessment with a maximum of six children. Once assessed, children's interventions started immediately. The system allowed staff to prioritise the most urgent cases, but staff did not know how many parents sought assessment and treatment elsewhere rather than wait. About 10 new referrals were seen each month out of an average of 26 referrals in the period April to September 2016. There was a good deal of outcome data on children with special needs known to the special needs provider, but little information about other referrals. Parent feedback indicated waiting times to see a speech and language therapist were a concern.
- A Tongue Tie Release Clinic had been set up in January 2016, after midwives at the local hospital stopped doing this and instead referred cases to outpatient appointment at another hospital. The clinic ran one day a week for babies under 6 weeks old, with feeding problems. This had been well-received. It covered only those living within the Kingston area.
- A child enuresis clinic (night-time bed-wetting) had been started in the month of our inspection and had been running for a week. The clinic had formerly been part of the provider's adult incontinence service. The new service would supply incontinence products as well as training advice. It was thought it would take six to eight months to catch up with the referrals.

Meeting needs of people in vulnerable circumstances

- The neurodevelopmental services assessed people with attention deficit hyperactivity disorder and autism and worked closely the local acute and hospital social services. They provided learning disability awareness training to staff.
- We saw evidence of easy read documents and pictures for people living with a learning disability. These were developed by the neurodevelopment services and involved service users who were part of the 'Easy Info' group in their development. Examples included 'What is domestic abuse', 'Appointment letters' and the Friends and Family Test.
- There was a dementia lead for the organisation.
- The Cedars Unit used a 'forget me not' sticker to identify patients living with dementia. There had been some effort to make the unit a dementia friendly environment such as the use of pictures and word signs on toilets. In addition, there were clocks in order to orientate patients to the time. There was an activity box for patients living with dementia. This had puzzles and sensory balls that could be used by this group of patients while they were staying on the unit.
- In the community, nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties.

Good

Are services responsive to people's needs?

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- The community matron and dementia nurse specialist offered support for patients with long term conditions and acted as specialist nursing support for the community teams.
- The provider had employed a dementia nurse specialist to support patients living with dementia. However, this is only one person covering the whole geographical area and the population served by the provider.
- In the PLACE survey 2016 for The Cedars Unit, the average score for the care of patients living with dementia was 92% compared with the national average of 75% and for catering for patients with a disability was 86% compared to a national average of 79%.
- A red tray system was used to identify patients who needed help and support from staff with meals.
- The CYP service worked in partnership with other local organisations, including social services to support the needs of people in vulnerable circumstances.
- SALT practitioners working in schools advised teachers on how to modify the classroom and teaching methods so children with speech and language difficulties were able to engage in learning. Teachers told us that the SALT service was "producing excellent results" in helping to improve outcomes for their learners.

Access to right care at the right time

- People were generally seen in a timely manner, with some exceptions and had their individual needs met.
- The average wait for patients to access The Cedars Unit between October 2015 and August 2016 was three days for Chestnut Ward and four days for Elm Ward.
- Waiting times were variable across the community services. Referrals for community nursing visits are often received in advance therefore representing a lead time for discharge home for example rather than a waiting period. Community nursing provides a daily priority based response and in consequence there is no waiting time to access this service. However, therapy services had a triage system in place to identify urgent and non-urgent appointments.
- The average bed occupancy within the community inpatients between April and October 2016 was 79% which was lower than the national average of 89%. This was also lower than the level of 85% at which it was generally accepted that it could start to affect the quality of care provided to patients.
- At the time of our announced inspection, there had been 17 delayed discharges on The Cedars Unit between March 2016 and August 2016, all of which had been due to social issues, such as delays waiting for admission to residential care homes.
- Physiotherapists were only available on the unit between Monday and Friday. They did provide explanation sheets with pictures for patients of the exercises they were given. Patients were encouraged to do their exercises with care staff at weekends, although therapy staff said that 'this was not very successful.'
- Staff told us they responded to urgent referral requests the same day and could respond within two hours if required. Non urgent referrals would be followed up the next day. Triage arrangements were in place to ensure referrals were prioritised appropriately. The service received 766 more referrals in 2015/16 compared to the previous year (a 50% increase).
- Community nursing services were able to respond to urgent referrals within 24 hours; it included district nurses who were working day and night across the borough.
- There was a single point of access to the nursing service. Referrals were triaged immediately and the workload allocated accordingly.
- The tissue viability nurses provided care in community and hospital inpatient setting. This included supporting district nurses in wound care and management.
- The Rapid Response Team received 2,310 referrals in 2015/16; this represented a 50% increase from the previous year. Flexible appointment times were available for patients at a time to suit them. This meant that the service was responsive to the needs of the population it served.
- A few children referred urgently to speech and language therapy could be seen quickly, but the delivery of speech and language therapy was rated as a high risk on the risk register because the service could not deliver the service as commissioned.
- The SALT service did not hold a traditional waiting list, but described a risk managed monitoring list. Different staff told us that the wait for routine assessment by a therapist was between six, eight or 10 months, so were not meeting the 18 week referral to treatment times. Priority was given to those close to starting school, children with safeguarding concerns, those with a stammer and those identified with special needs.

Good

Are services responsive to people's needs?

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

- Staff told us they were unable to be proactive in picking up speech and language delays in children in nurseries borough-wide despite the recognised importance of intervention.
- The contraception and sexual health services provided walk-in clinics for women and men of all ages, at different times of day, so people could access provision at a time convenient to them.

Equality and diversity

- There is a high population of Koreans living in the Kingston. We saw that the provider catered for the potential language barrier by providing appointment letters in Korean for this group of service users.
- We were told that the provider had employed two service users with learning disabilities and made the reasonable adjustment accordingly.
- On The Cedars Unit, there were appropriate facilities including safe and level access for patients and visitors with limited mobility, although the lifts were somewhat dated. These included designated parking and toilet facilities to accommodate patients and visitors in wheelchairs. Community service buildings were easily accessible and adhered to the Disability Discrimination Act 1995.
- There was no multi-faith room within The Cedars Unit. Staff told us patients were able to use a room within another part of Tolworth Hospital if this was requested, however this room was in another accommodation block and patients would need support from staff to access this.
- Staff were aware of different dietary needs of patients and ensured they were provided. There were a number of menu choices available for patient's dietary preferences and nutritional needs including; halal, kosher, vegan and puree diet. Most patients reported that they were happy with the food options, however one patient stated that the food did not suit their needs as a diabetic and a comment card stated 'restricted food choices as on puree diet'.
- Face to face and telephone interpreting services were available. There were also a number of staff on the unit that spoke a second language and would assist when it was suitable for them to do so. However, some staff reported that they would often use family if interpretation was needed which is poor practice. The unit had a menu that contained photographs of food choices that could be used for patients who may not be able to read English.
- Mandatory training for all staff included equality and diversity awareness. Majority of staff had completed this and could demonstrate an understanding of equality and diversity.
- Staff treated patients with respect regardless of their race, religion and sexual orientation. Relatives confirmed that they and their loved ones were shown dignity and compassion throughout their care.
- The SALT service produced leaflets for parents on the development of speech sounds, stammering and modelling correct speech which gave parents tips on how to help their child.

Learning from complaints and concerns

- There was a complaints policy and staff were trained on handling complaints.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.
- Information on how to make a complaint is available on the provider's website, The Cedars Unit, team bases and clinics. Information leaflets on how to complain were also distributed by community staff to people's homes.
- Complaints were received via various routes including verbal, letter and email. The complaints manager investigated all complaints. The provider aimed to acknowledge complaints within three working days, which it met 95% of the time and respond within 24 working days, which it achieved 99% of the time.
- We reviewed the records of four persons who had made complaints in the past year. There were no formal risk assessments for complaints that would determine how they should be dealt with and we did not see a record of how the learning would be shared. However, following the inspection, the provider told us an informal risk assessment was made when a complaint arrived as to whether the complaint needed to be escalated. There was also inconsistent evidence on whether complainants were asked whether they were happy with the response.

Good

Are services responsive to people's needs?

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

- We were told that all complaints were discussed at the relevant governance group and then at the integrated governance committee. If relevant, complaints were taken to and discussed at part 1 of the audit and assurance committee.
- An example of a complaint that led to the change in practice was whereby school nurses changed the standard letter for parents.

Are services well-led?

Good

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

Summary of findings

We rated well-led at provider level as good because:

- There was a vision for the organisation and the provider had developed a manifesto to support it.
- There was a clear focus on patient care through the development and implementation of the provider's manifesto commitments.
- The organisation took the health and well-being of its workforce seriously
- Most staff told us they enjoyed working for the organisation.
- There was active staff engagement.
- The multiple sclerosis support group generates income and run exercise classes for themselves.
- Schwartz Rounds were conducted in the organisation; this is a forum in which staff can openly and honestly discuss social and emotional issues that arise in caring for patients.

However;

- There was no documented vision for the children and families service delivered by Your Healthcare.
- The governance flowchart was initially neither signed nor dated.
- There was no formal policy or procedure setting out the governance framework in narrative to back up the flowchart.
- The organisation was not clear about its risk tolerance, or had definitive SMART plans with clear milestones for managing risks.
- The managing director did not have a formal appraisal of her performance and was the only person in the organisation not required to have one.

Our findings

Leadership of the provider

- The managing director led the organisation and was also the registered manager for all the registered locations. We had mixed accounts of who she was accountable to. The managing director told us she was accountable to the organisation's members and the partnership board. However, a non-executive director told us that the managing director reported to the chair of the organisation, who held her to account. The managing director told us that she did not have a formal appraisal of her performance and was the only person in the organisation not required to have one.
- However, following the inspection, the provider told us that the managing director received 360 degree feedback from the executive directors, which was discussed in her meetings with the chair, but that these were not recorded formally.
- The medical lead was contracted to work two sessions per week in the organisation. He attended the integrated governance committee and completed the consultants' appraisals.
- A non-executive told us that the organisation was 'well run' and had a good level of rigour and robustness.
- We were told that the organisation was aiming to have a flat managerial structure with less band 8s and more frontline decision makers at local levels.
- Some staff at The Cedar Unit felt that their voices were not heard and senior managers were not visible to them.

Vision and strategy

- The vision of the organisation were to (1) look after people (2) work in partnership (3) be the employer of choice. Their aim was to deliver care that is safe, joined up, simple and easy to access, and based on the best available evidence.
- The provider had developed a manifesto to support their vision. There were clear priorities to help deliver the vision. The manifesto highlighted the status of the provider as a social enterprise with the freedom to use their resources to improve patient care.
- Staff were aware of the vision and values of the service in putting people first and took pride in what they did. There was a clear focus on patient care through the development and implementation of the provider's manifesto commitments.
- There were plans to relocate The Cedars Unit by 2019. The organisation had a vision for a new fit for purpose unit to be built, which would better accommodate the growing variety of patient's needs.
- There was no specific end of life care vision or strategy for the service. However the general vision of the community adult services, that was to provide safe and good quality support to every person dying at home every time.

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- There was no documented vision for the service for children and families delivered by Your Healthcare. Some previously commissioned services had been decommissioned in the past year. This made it difficult to set a long term strategic direction of the children and families service.

Governance, risk management and quality measurement

- As a community interest company, Your Healthcare has Members (Shareholders), affiliated members, a membership council and a board of directors. It also has a secretary.
- How the organisation is governed is outlined in its articles of association registered with Companies House.
- The governance structure was explained to us. The top decision making group was the audit and assurance board, which was two parts. Part 1 was chaired by a non-executive and functioned as an audit committee. Performance and finance reports are monitored in this part. Part 2 was chaired by an executive director, was the nearest thing to a trust board and dealt with strategic decision making and approvals. Reporting to this board was the integrated governance committee (IGC), which was chaired by the managing director. There were several governance groups which reported to the IGC and these included education and training, emergency planning, equality and diversity, infection prevention and control, information governance, safeguarding and medicines management.
- There was a flowchart which described the governance structure and process. However, this was neither signed nor dated. When this was pointed out the provider, the date of November 2016 was put on the document. It was clear that the governance process was understood internally, but the flowchart could be improved to demonstrate the overall governance framework. For example, there was no formal policy or procedure setting out the governance framework in narrative to back up the flowchart.
- There are five non-executives, but none were formal leads for services or clinical areas. We were told that they visited clinical areas as required.
- Risk registers were kept by separate departments and committees, which were amalgamated to inform to organisational risk register. The organisation was not clear about its risk tolerance, or had definitive SMART plans with clear milestones for managing risks. IT was on the organisation's risk register and the migration of records from Rio to Care Notes was considered high risk by management. Recruitment of staff was also on the risk register and the organisation was taking measures to address this. These included encouraging final year students on placements to take up positions, return to practice initiatives and developing new roles such as healthcare practitioners.
- We were told that there has been bespoke training on managing risks and route cause analysis, which all board members have attended.
- GP performance was monitored through quarterly meetings with GP lead.

Culture within the provider

- A non-executive director told us that the organisation was open and transparent and although the minutes of the audit and assurance board were not currently in the public domain, he would not have a problem doing so.
- The organisation took the health and well-being of its workforce seriously. It worked closely with the Public Health Department. There were a series of annual events in the organisation to promote health and well-being and these included, healthy eating, smoking cessation and exercising. The organisation also operated a credit union-like model, whereby staff were offered loans with an interest rate of 2%. We were told that 50% of staff were taking advantage of this scheme. Other initiatives to promote the health and well-being of staff included, use of notice boards that had guidelines on managing stress and the employee assistance programme.
- Most staff told us they enjoyed working for the organisation. One senior staff commented 'This was the best organisation I've worked for'. They said the organisation was open and transparent and they were able to ask questions and challenge colleagues.

Equality and diversity - including Workforce Race Equality Standards

- Compliance with the workforce race equality standard (WRES) is a mandatory requirement for all NHS organisations; and independent healthcare organisations that are commissioned over £200,000 per

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annum by the NHS. As such, WRES reports and associated action plans should be reviewed by, and approved by the board prior to submission and publication.

- There was a good breakdown of data by Your Healthcare in relation to the workforce race equality standard.
- Of the 620 staff employed by Your Healthcare, 23% were of a black or minority ethnicity (BME), with 95.9% self-reporting their ethnicity.
- The board lead for equality and diversity was the finance director.
- In terms of clinical staff (non-medical), BME staff were over-represented in band 2 (41.30%) and band 5 (43.18%). However, they were under-represented in band 6 (15.56%), band 7 (14.12%) and band 8a (9.52%). There were no BME clinical staff employed at bands 8b, 8c or 8d.
- In terms of non-clinical staff, BME staff were over-represented in band 4 (31.58%) and band 8a (33.33%). They were equally represented at band 6 (20%), band 7 (25%) and band 8d (25%). However, there were no BME staff employed at bands 8b or 8c.
- Medical and dental staff were on different terms and conditions from other staff and overall, 72% of the medical staff were from a BME background.
- In 2016, the organisation reported that the relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.45 times greater. This had fallen slightly from 1.5 times greater in 2015.
- BME staff were 0.58 times less likely to enter formal disciplinary processes as compared to white staff.
- The relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff was 1.02 times greater.
- The whole staff survey in 2016 had a response rate of 74% and addressed indicators 5 to 8 of the WRES. However, the survey was not broken down by BME and white groups and we were told that this would be amended for the 2017 survey.
- With regards to indicator 9, board voting membership had 16.46% more white than the white representation in the overall workforce, and 11.98% less BME than the representation in the overall workforce.
- We saw an action plan which was agreed by the board, aimed at making progress against the WRES indicators. One desired outcome for the organisation in assessing its progress against the WRES indicators, was improving the percentage of BME staff in senior positions.
- We held two BME staff focus groups (one managers; one staff) at the provider's headquarters on Wednesday 23 November 2016. We also interviewed the board executive lead who had responsibility for equality and diversity.
- The focus group for BME staff was attended by 13 members of staff, whilst only two members of staff attended the one for managers. There was a mixture of both positive and negative experiences of working for the organisation. Positive experiences included; good organisation to work for – opportunity to do well if you want, good support, access to courses and regular 1:1s. Negative experiences included; perception of inequality with regards promotional opportunities, poorly advertised race equality forum, and lack of support.
- There was a BME staff forum, which we were told that staff were encouraged to attend. However, when we asked about attendance in the BME focus group only two members of staff were aware of it. This was an informal meeting and no minutes were kept.
- We were told of actions to promote BME staff progression in the organisation, such as a leadership programme.
- We were told that the organisation was not currently using all the protected characteristics in service and workforce monitoring, but was hoping to do so next year.
- BME staff members told us about their negative experiences at the Hawks Road Clinic and as a result, they and several staff from BME backgrounds were leaving or had left the organisation. For example, it was alleged that BME staff were spoken to differently including being shouted at in front of other colleagues in the office and less frequent 121s with their line manager, compared to their white colleagues. We were told that concerns about the management practices against BME staff at Hawks Road clinic were reported to the RCN by one member of staff.

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Fit and proper persons

- The need for the organisation to meet the fit and proper persons requirement (FPPR), were outlined in the Code of Conduct for Members of Audit and Assurance Board (parts 1 and 2).
- We saw a record that the FPPR was discussed at the partnership board on 14 April 2015. It stated that the annual appraisal process for all directors should incorporate a formal review and confirmation that the individual complied with the criteria of being a 'fit and proper person'.
- We met with HR staff to check the provider's FPPR assurance process. We also reviewed the records of five directors. We were unable to locate all the FPPR checks in all five files we reviewed. There was a lack of clarity from the HR staff on the checks required.
- We found during the inspection that an FPPR checklist had been introduced and completed for a recently appointed NED, but not for directors previously in post. However, following the inspection, we were told that new directors go through the full FPPR checking process and that Disclosure and Barring Service checks had been carried out for all directors. Annually, directors confirm that they continue to meet FPPR requirements and these were filed on the provider's Electronic Staff Record System.

Staff engagement

- There was active staff engagement.
- Lunch time, show case events were held by services, through which, their work was promoted and good practice and learning was shared with staff. Information was also shared in the staff newsletter 'Quality Matters' and in staff team meetings.

Public engagement

- There was active patient engagement.
- Patient stories were presented at part two of the audit and assurance board, but they were not invited to attend. However, service users were invited to attend the partnership board, where they had a voice. The partnership board allowed for enquiry and challenge by service users of future and strategic direction.

Innovation, improvement and sustainability

- Your Healthcare had a financial surplus of £1.4 million in 2015/16 and is projected to have a surplus of £1 million this year. Some of that money was re-invested in its services, for example, appointment of a tissue viability nurse, reduction of waiting times and purchasing of gym equipment. Staff were also rewarded with £75 John Lewis's vouchers, dependent of their length of service and contracted hours in 2015. There were also opportunities for staff to propose ideas and initiatives.
- The multiple sclerosis support group generates income and run exercise classes for themselves. This came about as a result of the provider listening to the service users, to improve the service delivered.
- The Cedars Unit had recently bought a new piece of equipment called the 'Hover Jack'. This allowed the nursing staff to safely lift patients from the floor whilst keeping them flat so that they could then be transferred to a bed. This reduced manual handling for staff and a better patient experience.
- The Cedars Unit had recently invested in a bariatric training suit for manual handling training. This allowed staff to better understand the problems of mobility and routine activity associated with bariatric patients.
- Schwartz Rounds were conducted in the organisation; this is a forum in which staff can openly and honestly discuss social and emotional issues that arise in caring for patients. The provider had supported staff to participate in the "Rounds".
- During 2015, the Rapid Response team working in partnership with the London Ambulance Service and commissioned by Kingston CCG, delivered a six month pilot scheme which saw record numbers of people successfully treated at home rather than in A&E or hospital. However, we were not provided with the data of the pilot program to confirm its effectiveness.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that all persons employed, complied with this regulation because: 1. The managing director did not receive formal appraisals on her performance. Regulation 18 (2)(a)