HCRG Care Services Ltd

Sheppey Community Hospital

Inspection report

Plover Road
Minster On Sea
Sheerness
ME12 3LT
Tel: 01795879100

Date of inspection visit: 16 and 17 August 2022
Date of publication: 19/10/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated this location as good because:

- Staff assessed and managed patient risks well. The provider had a robust safeguarding process and we saw examples of collaborative working with other agencies such as the police and social services to safeguard people from harm. Staff managed safety incidents well and learned lessons from them.
- The service controlled infection risk well. There were hand hygiene stations across the hospital to enable all staff and visitors entering the ward to utilise this and reduce the risk of spreading COVID-19.
- Staff provided good care and treatment. Staff in the community wards ensured that patients had enough to eat and drink. The community adults team assessed patients to ensure their dietary and hydration needs were being met.
- Staff across the services ensured patients had pain relief when they needed it. Managers monitored the effectiveness of their services and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Patients were very positive about the care and treatment they received and praised staff highly.
- The provider planned care to meet the needs of local people and took account of patients' individual needs. It was easy for people to give feedback and the patients we spoke with told us they felt confident to raise concerns about the care received.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However;

- Staff did not always keep up to date with their mandatory training. Managers told us that they were reminding staff to complete their mandatory training, and some of the face to face training had been rescheduled due to lack of trainers.
- Managers and team leaders did not ensure that clinical supervision was always documented in line with policy. Some staff from the community inpatient service reported that they received one-to-one meetings with their managers on an ad-hoc basis.
- The ward environment on Harty ward did not provide enough space for the safe storage of large equipment, such as hoists, which were stored on a corridor within the ward and created both a trip and evacuation hazard for any patients located in the side room off this corridor.
- Staff did not ensure that patient records on Harty ward were stored securely. Patient notes were stored as paper files in trolleys on the ward. Staff told us that the trolleys were not locked due to a lack of keys. This meant that patient information were not secure.
- Harty ward was not entirely dementia friendly so patients could not always orientate themselves.
- The day room designed to provide a comfortable space for patients away from their bedside, was uninviting, and lacked any comfort or appeal.
- Staff did not ensure that patients' identifiable information were stored securely on Harty ward. Patient notes were stores as paper files in trolleys on the wards which were unlocked.
- Staff did not ensure that the maximum daily dosage for some medicines such as paracetamol was recorded in patients' medicines administration chart on Harty ward.

Summary of findings

- The continence team did not have a bladder scanner. Although staff informed us that there was a purchase order for a bladder scanner, the teams have been without a bladder scanner for over two months.
- Some services such as the podiatry service and speech and language therapy had a high waiting list, which meant that people might not always be able to access the services when they needed them.
- There was not always enough nursing and support staff on Harty ward to cover shifts. Staff, patients and their relatives told us that staffing was sometimes stretched.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Good 	We rated it as good because: • The community inpatient ward had enough staff to care for patients and keep them safe. Staff had training in most key skills and understood how to protect patients from abuse. • The service controlled infection risk well. Staff followed national guidance for the use of personal protective equipment (PPE) and the ward had a hand hygiene station at the entrance to enable all staff and visitors entering the ward to utilise this and reduce the risk of spreading COVID-19. • Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The patients and relatives that we spoke with were happy with the care received and some described it as “excellent” and “brilliant”. • The service planned care to meet the needs of local people and took account of patients’ individual needs. It was easy for people to give feedback and the patients we spoke with told us they felt confident to raise concerns about the care received. People could access the service when they needed it. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service’s vision and values and

Summary of findings

felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services.

However:

- Not all staff were fully compliant with all mandatory training. The service told us that access to IT systems was a contributing factor to this.
- The ward environment did not provide enough space for the safe storage of large equipment, such as hoists, which were stored on a corridor within the ward and created both a trip and evacuation hazard for any patients located in the side room off this corridor.
- The day room designed to provide a comfortable space for patients away from their bedside, was uninviting, and lacked any comfort or appeal.
- Patients notes were stored as paper files in trolleys on the ward. Although, these trolleys were not locked due to a lack of keys. This meant that patient information was not secure.
- The ward environment was not entirely dementia friendly so patients could not always orientate themselves.
- Staff told us they received one-to-one meetings with their managers on an ad-hoc basis, and clinical supervision was being carried out in groups, although managers did not routinely record when staff received clinical supervision.
- Staff did not ensure that the maximum daily dosage for some medicines such as paracetamol was recorded in patients' medicines administration chart
- The service did not always have enough nursing and support staff to cover shifts.

Community health services for adults

Good

We rated the service as good because:

- The service controlled infection risk well. The environments where staff cared for patients were clean and well maintained.

Summary of findings

- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Staff ensured that care plans were detailed and supported patient treatment and recovery. They ensured patients who were at the end of their lives received timely pain relief.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However;

- Staff did not always ensure they kept up to date with their mandatory training. Some teams such as the community nursing teams, and speech and language therapy teams were not keeping up to date with their basic life support and anaphylaxis training.
- The continence team did not have a bladder scanner. Although staff informed us that there was a purchase order for a bladder scanner, the teams have been without a bladder scanner for over two months.

Summary of findings

- Some services such as the podiatry service and speech and language therapy had a high waiting list, which meant that people might not always be able to access the services when they needed them.
- Patients reported that staff did not routinely collect feedback and the provider was not actively engaging with patients and carers to plan and deliver the services.
- Team leaders did not always record clinical supervisions with staff. Although all staff we spoke to said they met regularly with their clinical supervisors and training and development educators, and these met their needs.

Summary of findings

Contents

Summary of this inspection

Background to Sheppey Community Hospital

Sheppey Community Hospital is one of four locations within the North Kent business unit under HCRG Care Services Limited, who are an independent healthcare provider with over 5,000 staff nationally working in partnership with the NHS and local authorities.

Sheppey Community Hospital provides community adults services across the Swale boroughs in Kent, which align with the local Health and Care Partnership. After more than 10 years as part of the Virgin Group, Virgin Care rebranded as HCRG Care Services Limited in 2021 and was acquired by Twenty20 Capital.

The service registered with the Care Quality Commission in 2016. They are registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Nursing care

Sheppey Community Hospital provides the following core services:

- Community health services for adults
- Community inpatient service

The community health services for adults operated across the whole of Swale area. They provided care and treatment for patients in their own homes and in clinics.

The teams at Sheppey Community Hospital include:

- Speech and Language Therapy (SALT) teams worked virtually or in the community and clinics were held on demand. The service was available form 8.30am to 4.30pm Mondays to Fridays.
- Rapid response service that worked seven days a week 8am to 8pm.
- Intermediate care team that worked Monday to Friday 8am to 6pm. The rapid early therapist worked form the office from 8am.
- Community Nursing and Night Service that works 24 hours seven days a week. The Community nursing teams worked from 8am to 8pm and the night service worked from 8pm to 8am working in the community and responding to emergency calls.
- Other services such as community cardiology, community matron service, community diabetes service and community respiratory service provided day clinics on different days and times in the week.

The community inpatient service, Harty ward, is a 22-bed rehabilitation ward. At the time of the inspection the ward had 18 patients. The ward had beds for patients with progressive and non-progressive neurological conditions who need more rehabilitation following discharge from an acute hospital. This may be following a stroke.

Rehabilitation is also provided for patients who are medically stable but need support to improve their independence. The service provided therapy, education and support enabling patients and their carers to achieve the best possible quality of life.

Harty ward worked on improving mobility, strength, independence in personal and domestic care tasks, cognitive ability, communication and language.

Summary of this inspection

At the time of this inspection the service did not have a registered manager but they had submitted an application.

We had not inspected this location before.

What people who use the service say

Community health services for adults:

Patients told us the teams were very good and responsive. Patients told us they were very happy with the services they were receiving, and that staff were professional. Patients told us that staff took time to explain things to them and they never felt rushed. One patient told us that staff were very interested in their overall wellbeing. Another patient reported that staff provided the equipment they needed very promptly after assessment. Patients and carers told us that staff treated them with dignity and respect and addressed them appropriately.

Community inpatient service:

People who used the service were unanimously positive about the care they received and the staff. They told us that they felt safe, they felt they were being helping to get better, that they were always treated with dignity and respect and that they felt involved in their care. They told us that staff were very responsive, and that they were friendly and took the time to spend with them. They told us that the cleanliness level of the ward was always very high. Some felt frustrated at the delays in receiving packages of care which led to delays in their discharge.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. We announced this comprehensive inspection 24-hours prior to the inspection visit. Due to the service providing services throughout England, we announced the inspection so that the service could arrange interviews.

Community health services for adults:

During the inspection, the inspection team:

- Visited outpatient clinics where care and treatment were provided

Summary of this inspection

- Attended two home visits with staff
- Spoke with 15 members of staff including managers, service leads, community matrons, specialist nursing teams, therapist, allied health professionals and health care assistants onsite.
- Carried out virtual staff focus groups for staff we could not speak to onsite
- Spoke with 21 patients and two family members
- Reviewed five patient care and treatment records
- Observed a handover meeting
- Looked at a range of policies, procedures and other documents related to the running of the service.

Community inpatient service:

During the inspection, the inspection team:

- Had a tour of the ward and clinic/ treatment room
- Spoke with 13 staff including the ward manager, ward clerk, physiotherapist, occupational therapist, rehabilitation assistants, registered nurses, and healthcare assistants. These were carried out via onsite interviews as well as virtual staff focus groups where staff could join and give feedback on the service
- Spoke with eleven patients who were using services and eight of their relatives
- Reviewed two patient care and treatment records
- Reviewed four medication charts and observed a medication round
- Observed a staff handover meeting
- Observed staff providing care to patients on the ward
- Looked at a range of policies, procedures and other documents related to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The community nursing teams were sending bereavement cards and flowers to families and relatives following death of patients. This demonstrated compassion and kindness.
- There was a water crisis on the Isle of Sheppey in July 2022 where the whole of the island was without water due to burst mains water pipe leading to the island. Staff coordinated with the water company to ensure that all patients had access to water. Staff stayed long past their shifts into the night to deliver water bottles to patients around the island and also worked with people in the community to identify vulnerable families who needed water urgently.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Community health services for adults:

Summary of this inspection

- The provider must ensure that staff complete their mandatory and statutory training. [Regulation 18 (2)(a) Staffing].

Community inpatient service:

- The service must ensure that all equipment stored on the ward is stored safely to reduce environmental health and safety risks, particularly to prevent evacuation difficulties, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]
- The service must set a deadline to ensure that all staff are up to date with their mandatory training and ensure the appropriate IT access is in place to enable them to complete this. [Regulation 18 (2)(a) Staffing].

Action the service SHOULD take to improve:

Community health services for adults:

- The provider should ensure that the teams have access to specialist equipment to carry out their jobs effectively.
- The provider should continue its work towards reducing the waiting list across the services to ensure people are getting timely care and treatment.
- The provider should ensure that it is actively engaging with patients and carers in the planning and delivery of services. The provider should ensure that staff are routinely collecting feedback from patients about their care and treatment.
- The provider should ensure that team leaders are recording clinical supervision in line with the provider's policy.

Community inpatient service:

- The service should ensure that patient notes and information are stored securely.
- The service should ensure that staff have access to dementia training.
- The service should ensure that the environment is dementia friendly so that patients can orientate themselves.
- The service should consider improvements to the environment of the day room and the outdoor garden to increase comfort and rehabilitation for patients.
- The service should ensure that managers record when staff receive clinical supervision.
- The provider should ensure that staff consistently record the maximum daily dosage for each patient's medicine in line with best practice.
- The provider should ensure that there are enough staff to provide safe and consistent care for patients.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Community health inpatient services

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

Are Community health inpatient services safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff, however it did not always make sure everyone completed it.

At the time of the inspection, 80% of staff had completed their mandatory training across all the required training, which fell slightly below the service's target of 85%. However, there were specific safety modules which fell significantly below the service's target. These were basic life support and anaphylaxis (72%), moving and handling (75%), personal protective equipment (PPE) donning and doffing (75%), safeguarding adults level 3 (69%), fire awareness and evacuation (53%) and conflict resolution (64%). The impact of such low compliance meant that patients were likely being cared for by staff on shift who were not compliant in key safety modules. Managers informed us that the current compliance figures were mostly due to staff not being able to access the systems due to sickness, as well as others who were bank staff or new starters. There were also IT issues which affected staff's ability to complete these modules whilst on the ward.

Managers had access to a training matrix to identify when training was due, and they sent reminders out to staff.

The service had recently employed a Practice Development Nurse (PDN) who was focused on reviewing compliance and identifying gaps in staff training and learning. Staff told us that the PDN offered various training inputs which they could book onto including learning disability, autism and dementia. Although, these were not part of the mandatory training package for staff working on the wards. The ward had patients with dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had a dedicated safeguarding lead who staff could access for advice and support.

Staff completed the appropriate safeguarding training for their role with a current average compliance rate of 82.7% across all four safeguarding modules. Safeguarding adults level three had the lowest compliance at 68.75%. Although, staff said they felt confident raising safeguarding concerns and understood their role in the process. Staff could give examples of how they had taken action to protect vulnerable patients with safeguarding concerns.

Senior staff told us they discussed safeguarding incidents in monthly quality governance meetings and this was cascaded down to the team through their monthly team meetings and a safeguarding newsletter which was shared via email. Team meetings had safeguarding as a standing agenda item, so this meant that information was shared effectively to staff. The service also provided safeguarding supervision and followed a safeguarding policy.

At the time of the inspection, no children under the age of 16 could visit the ward. Managers told us that this had been in place since COVID-19. Although, they did give an example of a patient who had three small children and how they had made allowances by moving the patient into a separate bay to enable their children to visit.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date which demonstrated that all areas were cleaned regularly. Cleaning audits showed an average compliance rate of 97% for the recent period of May to July 2022.

Staff knew how to prevent infection and had received training in infection prevention and control (IPC). Staff followed national guidance for the use of personal protective equipment (PPE) and the ward had a hand hygiene station at the entrance to enable all staff and visitors entering the ward to utilise this and reduce the risk of spreading COVID-19.

At the time of our inspection, the ward had two patients being cared for in side rooms as they had infections that could spread. Due to the side rooms having their own bedrooms with en-suite facilities, staff were able to isolate the patients in these rooms appropriately and we observed strict IPC practices being used by staff when caring for this patient. We also observed that staff cleaned equipment after use with patients.

The service had an infection control lead responsible for ensuring audits were completed. The recent 2021 IPC audit showed 100% for general IPC questions and 75% for the environmental audit. Comments and actions plans were evidenced throughout which showed how the provider made clear where improvements could be made.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the ward environment did not always provide adequate space for storage, delivery of therapy and comfort away from patient's bedside.

The design of the environment followed national guidance. There were no mixed gender bays and some patients had their own rooms with en-suite facilities which maintained their privacy and dignity.

Patients could reach call bells and we observed staff responding quickly when called. We reviewed the call bell system and saw that all call bells had been responded to within two minutes which meant that patients were not left waiting for long when they needed staff. Patients also told us that call bells were always responded to although some told us that short staffing impacted the response they received.

The service had enough suitable equipment to help them safely care for patients, for example hoists, wheelchairs and pressure relieving mattresses. Patients also had access to specialist equipment to aid their rehabilitation and meet their needs including use of a dedicated patient kitchen and bathroom.

Staff carried out daily safety checks of specialist equipment. Staff had easy access to an emergency resuscitation trolley which had equipment including a defibrillator, oxygen and suction. All equipment was in date, calibrated and checked regularly.

Staff disposed of clinical waste safely.

There was a significant lack of storage on the ward for larger equipment. This equipment was stored along one of the corridor areas on the ward which led to one of the side rooms and a store cupboard. Managers told us that the room was not often used due to the inability to manoeuvre a bed out of the room efficiently in the event of a fire. If they were at capacity and needed to make use of this room, they informed us that it would be mobile patients that would be placed into this room. This risk was documented on their risk register and managers advised that staff knew to move the equipment in the event of an emergency evacuation.

The day room on the ward lacked comfort and appeal. It had a large table and dining chairs, as well as a lounge area which was tucked around a corner with a TV. Managers and staff told us that they were trying to encourage more patients to make use of this room although it was not inviting. There was also an outdoor space which previously was maintained and accessed by patients and staff on the ward. At the time of the inspection this was significantly overgrown and unmaintained, so it was not able to be used. It would be positive for patients to be able to make use of this space and its greenhouse as part of rehabilitation.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Care records we looked at showed appropriate use of risk assessment tools such as Waterlow scoring for pressure ulcer assessments and use of the National Early Warning Score (NEWS2) carried out three times a day. We saw evidence of one patient whose NEWS score flagged up concerns and where action was taken to increase observations. Another deteriorating patient with suspected septic arthritis was also transferred to the local acute hospital.

Staff completed risk assessments for each patient on admission and reviewed these regularly, including after incidents. Staff made assessments of whether patients could easily use call bells to call for staff assistance, the appropriate moving and handling needed for the patient, as well as whether patients were at risk of falls, including bed rail assessments, and kitchen assessments.

Patients at risk of slips, trips and falls were observed closely by staff. We observed patients who had been assessed as a falls risk wearing anti-slip socks and this was noted on the boards above the patients' beds.

Staff knew about and dealt with any specific risk issues. Staff checked skin daily for patients identified with a pressure ulcer or deteriorating health. We saw that the SSKIN (Surface, Skin, Keep Moving, Incontinence, Nutrition) care bundle was completed for patients at risk of pressure ulcers. This patient also had an air mattress in place and pressure areas were regularly checked.

Staff shared key information to keep patients safe when handing over their care to others. Shift change handovers included all necessary key information to keep patients safe, including infection risk, safeguarding concerns, ability to mobilise and falls risks, as well as updates on their discharges.

Staff referred patients for specialist mental health support and assessments if they were concerned about a patient's mental health, including emergency support where needed. Managers gave an example of a patient who became violent and following mental health support, was subsequently placed under sectioning.

Staff ensured that patients on Harty ward had a personal emergency evacuation plan (PEEPS) in place. A PEEP provides those who cannot get themselves out of a building unaided with the necessary information and assistance to be able to manage their escape to a place of safety and ensures that staff are aware and ensure that the correct level of assistance is always available. The hospital beds were fitted with ski sheets. A ski sheet is an evacuation aid used to transfer patients in an emergency."

The service did not have piped oxygen on the ward. This meant that patients who required oxygen were not able to receive this at their bedside immediately due to a need to retrieve a cylinder from the ward storage. This was on the service risk register and staff mitigated the risk of this by storing it next to the resus trolley. Staff also monitored and ensured checks to ensure available supplies.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service calculated the number and grade of staff needed for each shift in line with national guidance. Although, the service did not always have enough nursing and support staff to keep patients safe. To mitigate risk, the service used agency staff frequently to cover unfilled shifts and all bank and agency staff had a full ward induction. Managers told us that where possible they used bank and agency staff familiar with the service, yet they often struggled to fill the day shifts. Substantive staff, including the ward manager who stepped in clinically, and on occasions staff from other wards, also carried out additional shifts to ensure these shifts were covered. Staff, patients and their relatives told us that staffing was sometimes stretched and that there were not always enough staff to cover what was needed.

The service used an electronic system which automated the staff roster in advance to ensure the ward had an appropriate mix of skilled staff on shift and gave a RAG rating to identify where compliance was not met. These shifts went out to bank staff for them to select, and two weeks prior to the shifts, these then went out to agency staff.

At the time of our inspection there were five posts vacant including two full time equivalent (FTE) healthcare assistants and a band 5 nurse position. The data provided showed that they were recruiting to three of the five posts. Managers told us that they had three international nurses undergoing their objective structured clinical examination (OSCE) who were due to fill roles as band 5 nurses post-completion in October.

Staff sickness on the ward was at a total of 11.12% for the past 12-months. 8.94% of this was long term sickness and the most significant reasons for absence were COVID-19 and surgery (planned). The provider also separately recorded the number of stress related absences which was five.

Staff turnover rate for the ward was 7.14% for the past 12-months.

Medical staffing

The service had a vacancy for a ward doctor. Although, at the time of our inspection the ward had medical cover from a locum doctor who had been working on the ward for a few months. Staff and patients told us the doctor was responsive. Out of hours staff could access medical support via 111. In an emergency, staff contacted the emergency services.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care. However, these were not always stored securely.

Patient notes were comprehensive and all staff could access these easily. All records, including patient risk assessments, routine patient observations, food and fluid charts and pressure care assessments were paper based and stored in trolleys in the corridors opposite the nurse's station.

Although, these trolleys were not securely locked as managers and staff told us that the keys were not available for the locks. This did mean that records were not kept securely. The ward clerk had been informed of this.

Medicines

The service used systems and processes to safely prescribe and store medicines. Although, the medication records did not always provide indications of medication and the maximum dosage was not always stated on the charts.

Staff followed systems and processes to prescribe and administer medicines safely. Medication rounds took place three times a day on the ward. We observed a medication round and saw that that medication administration records (MAR) were not signed until the medication was taken by the patient. Medicines were supplied by a local independent community pharmacy. The service was supported by the organisation's lead pharmacist who worked across all four locations within the business unit and who visited the ward twice a week.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. We saw evidence that the pharmacist completed a drug reconciliation process on admission of all patients.

Staff completed accurate medicines records and kept them up-to-date. The service kept a log of controlled drugs prescribed for individual patients which was double signed, and the recording of stock for controlled drugs was accurate. We saw evidence that this process was audited twice weekly and on an ad-hoc basis by senior staff. Any discrepancies were reported via the incident reporting system. Managers gave a recent example of an internal

investigation that had taken place due to a discrepancy of liquid medicine. Upon investigation the discrepancy was not as significant as first thought, though staff reflections and learning were discussed at the team meeting as documentation had not been completed properly. The lead pharmacist was providing additional training to staff to improve practice around this.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Any medication omitted was documented and the reasons why recorded on a form within the MAR chart.

Although, some MAR charts did not always provide indications of medication and the maximum dosage was not always stated on the chart. For example, we saw that there had been no indication for paracetamol, which should have stated analgesia, or for two other medications on one patient record. For another patient, no maximum dosage was shown when they were prescribed paracetamol as a regular medicine four times a day.

Emergency drugs were stored in the clinic room and checked weekly. Clinic rooms were locked with a keycode and keys held by the staff nurses.

The fridge and room temperature were checked daily to ensure medicines required to be kept at a certain temperature remained intact.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Staff monitored and recorded an appropriate range of safety performance indicators. These included recognising patients at risk of physical health deterioration and using a routine physical health monitoring tool.

The service displayed a safety thermometer board on the ward, which showed visitors the number of falls and pressure ulcers during the month. At the time of inspection, there had been no falls, medication errors or acquired pressure ulcers recorded for the month.

Falls and pressure injuries were reported on and reviewed at specified harm reduction groups where staff could identify any themes or trends. This information was fed back during monthly quality governance meetings.

The service made appropriate changes to care for patients with complex needs after identifying potential safety concerns. For example, one-to-one nursing and observations when required to help mitigate the risk of falls.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff we spoke with knew what incidents to report and how to report them in line with the service's policy. Falls, pressure ulcers and medicines were the most commonly reported incidents although they also recorded moisture lesions and deteriorating patients.

Good

Community health inpatient services

Senior managers attended monthly incident review panel meetings with the three other wards where specific incidents were discussed and lessons learnt identified which were then shared with the team during team meetings, ward meetings and handovers.

There was evidence that changes had been made as a result of feedback from an incident. For example, they admitted a patient from the acute hospital who they were told had tested negative for COVID-19. The patient appeared confused on the ward so when the nurse in charge checked the bloods, they discovered the patient was found to be COVID-19 positive. As the patient had been placed in a bay this resulted in the entire bay needing to be isolated. From this, staff now ensure that they check the pathology system prior to the admission of patients. They also raised this with the acute trust to ensure that they are checking the systems prior to discharge to improve the information given at the point of transfer.

Staff received feedback from investigation of incidents across community services and met to discuss the feedback and look at improvements to patient care through monthly 'learning events' which all staff could attend.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff told us that managers debriefed and supported them after any serious incident.

Are Community health inpatient services effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff kept up to date with and followed relevant National Institute for Health and Care Excellence (NICE) guidelines to plan and deliver quality care according to best practice.

Staff had access to policies on the staff Intranet and knew where to find them. Leaders told us they checked to make sure staff followed guidance through individual supervision and team meetings.

The service discussed audit outcomes during monthly quality governance meetings. Identified risks featured on the local and corporate risk registers.

At the time of our inspection, the service had no patients subject to detention under the Mental Health Act 1983.

Good

Community health inpatient services

Staff protected the rights of patients in their care and worked with patients to develop rehabilitation goals. These included increasing independence, improving mobility and activities of daily living. Occupational therapists and physiotherapists produced joint rehabilitation plans for patients and care staff encouraged and assisted patients with these plans daily. Although, there was no group activity or activity timetable in place on the ward. Staff told us that they were hoping to reintroduce group activity sessions.

The therapy team also completed home visits to ensure that patients' home environments were suitable to meet their needs once discharged, such as providing extra equipment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Managers told us that they accommodated patients with percutaneous endoscopic gastrostomy (PEG) feeds.

Staff used the Malnutrition Universal Screening Tool (MUST) in line with professional guidance to assess and improve nutritional care.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded patients' dietary requirements, including allergies, on a white board in the patient kitchen and on the board above their beds. The ward also had a "red" system which meant that if a patient was given food on a red tray or if they had a red beaker, this alerted all staff not to remove the food or drink until what had been consumed by the patient had had been recorded. Specific food and fluid requirements and any changes to these were discussed during handovers.

Patients were referred to a dietitian or speech and language therapist if they needed support with their nutrition or hydration. We saw the involvement of these professionals documented in care plans of patients who needed this additional treatment. Managers told us that speech and language therapists attended the ward when referred to, and a dietician employed by a neighbouring community trust attended the ward once a week.

Staff provided patients with menus daily so that they could choose their meals in advance and alerted the catering team to any special needs as identified at initial assessment. For example, allergies, soft choice, energy dense, healthy eating, vegetarian, gluten free or diabetic menus. The food was supplied by canteen staff onsite and brought to the ward where care staff distributed this to patients. We observed staff checking patients' boards to ensure that they were given the appropriate meal requirement. We also saw a staff member going through the menu with a patient and checking their allergies.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed that staff showed patients the Wong-Baker faces pain rating scale which was a pain scale comprised of smiley and unhappy face cards which they could relate to and explain their pain based on these.

Staff prescribed, administered and recorded pain relief accurately. Trained nurses were able to administer paracetamol without a doctor's prescription for temporary pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included audits on safeguarding, record keeping, health and safety, medicines safety, pressure ulcer management and IPC environment.

Managers and staff used the results to improve patients' outcomes. For example, a previous audit had identified that on occasions patients' weight checks were being missed. As a result, the service implemented weekly weight monitoring with each bay having a specific weigh day to ensure that these were not being missed. We saw that for the day of inspection, the patients in the relevant bay had been weighed. They also attached the patients' weekly reviews on the same day as well. This enabled them to ensure that reviews and updates were being carried out to improve patient outcomes.

Managers made sure staff understood information from the audits and this was shared in local team meetings and on the staff Intranet.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Overall staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Although the service had recently employed a practice development nurse (PDN) to support the learning and development needs of staff as they recognised that there was a lack of full clinical competencies in place for both registered and unregistered staff. At the time of our inspection, the PDN was undergoing a review of the team's competencies to identify all outstanding clinical competency requirements. The service was also bringing in refresher training for relevant updates on use of medical devices, NEWS2, MUST, aseptic techniques, documentation and communication. Newer staff were now receiving a full induction programme which was spread over five weeks and included various training inputs and clinical competency sign off. Managers told us that every staff member was trained before they came onto the ward.

Staff reported feeling well supported and described that they received informal supervision with their manager who had a very "open door" policy. Managers told us that they tried to have a regular one to one session with staff at least once every other month, though if not, they were always available when on the ward. Staff were also supported in their clinical practice through clinical practice supervision groups which had been set up across the business unit and enabled constructive and reflective peer discussions. Some staff told us that they attended these approximately every two months. Although, managers did not always keep clear records of the attendance of these.

Good

Community health inpatient services

Staff had the opportunity to discuss training needs with their line manager and were supported to develop through yearly appraisals. At the time of our inspection 87.5% of staff had received constructive appraisals of their work. The service had three new starters in June who were due to have their half yearly appraisal in October. Appraisals gave staff and managers the opportunity to discuss any relevant concerns or issues with poor performance and put in place plans to support staff to improve. At the time of the inspection, managers told us that no staff members were subject to a performance plan.

Managers made sure staff attended monthly ward meetings or had access to full notes when they could not attend as these were emailed to staff and a hard copy was kept on the ward. Information was disseminated to the team via email, during daily shift handovers and posted on the Intranet.

Multidisciplinary working and coordinated care pathways

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

All staff we spoke with felt that they worked well together as part of a multidisciplinary team (MDT). Staff described good opportunities for joint working, learning from each other and working together to better the outcome for patients.

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. Information and actions were recorded on a multidisciplinary communication sheet which was kept in patients' care records.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw that patients had been referred on to other specialist teams as needed, including community nursing and dieticians.

Staff reported good working relationships with professionals visiting the ward and other community providers. Staff worked with colleagues in adult social care when planning a discharge package of care for patients. We saw evidence of joint home assessments carried out by professionals from different teams to plan patients' discharge and ensure appropriate equipment was in place to support them in the community.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the ward. Staff assessed each patient's health when admitted and identified who may need additional support due to frailty or cognitive issues. One patient told us how staff had supported them to give up smoking since being on the ward.

Staff gave advice about health conditions, treatment and outcomes. The service had relevant information promoting healthy lifestyles and support services. For example, there were information leaflets available for patients on food services (meals on wheels), pressure ulcer prevention, community care providers and advocacy support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Community health inpatient services

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent and knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was covered within the mandatory adult safeguarding training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering of their wishes, and recorded this in the patients' records. We saw individual capacity assessments carried out for specific decisions including consent to wearing continence pads, being on an air mattress, and taking prescribed medication, rather than one generalised capacity assessment.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. We observed discussion around patients' mental capacity during a daily handover meeting.

We found that 'do not attempt cardiopulmonary resuscitation' (DNACPR) records were marked on the patient board with a green tick or red 'x' so that staff could find them quickly in an emergency.

Are Community health inpatient services caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were passionate about delivering care and were discreet and responsive when caring for patients. We observed positive and compassionate interactions between staff and patients on the ward. For example, staff drew the curtain around the patient when attending to their personal care in order to maintain their dignity. Relatives also told us how they ensured that they shut windows or took them into side rooms when having private conversations about their loved ones' care.

We spoke with eleven patients and eight of their relatives during the inspection. All patients and relatives spoken to felt happy with the care they or their loved one had received and told us staff treated them well and with kindness. All patients told us that they felt safe on the ward. One patient told us that staff were "very friendly and helpful", and a relative told us the care provided by staff was "very good". Another patient told us that they were receiving a "remarkable service" and another relative told us that they were "overwhelmed" with the care that their relative was receiving. The ward had several thank you cards displayed at reception from patients and relatives thanking them for their kindness and compassion during their stay.

Good

Community health inpatient services

Staff took time to interact with patients and those close to them in a respectful and considerate way. Most patients told us that staff would have conversations with them when they could and promptly responded to their call bell when it was pressed. Two patients told us that when they were short staffed, sometimes this impacted the response time when they pressed their call bell.

Staff followed policy to keep patient care and treatment confidential. They understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Managers gave examples of how they supported families to bring in specific food for patients who wanted this for cultural reasons.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for and discussing patients. At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they took extra time to listen to patients to support with their emotional wellbeing and this was reflected in the patient feedback. Patients and relatives told us that their needs were being met.

Patients described staff as kind and caring and told us that they were always helpful. Both patients and relatives told us that staff made time to talk and have conversations with their loved one. One patient told us that they mostly spoke with healthcare assistants and would have liked to talk to a nurse, though they recognised that staff were "overworked".

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Most staff supported and involved patients and those close to them to understand their condition and make decisions about their care and treatment. Staff told us that they prioritised a person-centred approach and always made sure that they gave patients options and ensured the patient fully understood any information given to them. One relative told us how staff always took the time to explain and reassure their loved one to keep them at the centre of what was happening with their care. Although, one patient told us that staff had done a continuing care assessment and a diversity check sheet and had not involved them with either of these.

We saw that, where able, patients signed their care plans, which showed their involvement. Patients received a welcome booklet on admission which told patients what to expected from their stay on the ward. Although, some staff felt that this booklet could be made simpler.

Family members were also involved in developing care plans and preparing plans for discharge. Staff told us that following weekly multidisciplinary meetings, updates on patient care were fed back to relatives. The service had received a recent concern from a relative who felt that they were not involved and had not been clear on the information relating to their loved ones care and treatment. This was resolved through a family meeting with the patient

and MDT which gave the relative greater understanding. Managers told us that family meetings were arranged in order to discuss the patient's care and where consent is given by the patient, they involved relatives fully in these discussions. Therapists also involved families heavily in the preparation of necessary equipment and assessment of a home environment for a patient's discharge.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For example, some patients who had suffered a stroke were unable to communicate verbally and so staff used pictorial cards to communicate effectively.

Staff provided ward phones and a tablet to enable patients to keep in touch with their relatives when needed. The ward also had a quiet room which could be used by visitors who wanted privacy when visiting their relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a feedback box located at reception and posters advertising the ways in which patients and families could provide feedback. The service had also restarted 'tea with matron' which was being held monthly and gave patients the opportunity to discuss any concerns or share compliments informally with the ward matron.

Relatives were asked if they would like to complete the friends and family test (FFT) feedback form and patient reported outcome measures (PROMS) prior to discharge. The business unit received an average positive score of 96.29% in the last 12 months of FFT responses. All patients spoken to during our inspection gave positive feedback about the service, that they felt listened to, valued, supported and had their views considered.

Are Community health inpatient services responsive?

Good

Planning and delivering services that meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service kept open bed space specifically for community patients who were no longer safe to be independent at home in order to avoid their admission into acute hospitals.

The service had systems to help care for patients in need of additional support or specialist intervention.

Therapy staff tailored patients' therapy sessions to meet their individual needs and involved care staff in the delivery of recommendations, as they then motivated and supported patients daily to engage in activities as part of their rehabilitation, such as those of daily living. Staff also took into account the needs of patients and accommodated these where possible, for example, younger patients who preferred to be in side rooms rather than bays.

Staff discussed patients' progress at daily handover meetings. Discharge, pain management and therapy goals were discussed at weekly MDT meetings and we saw evidence of multi-agency working in patient care records, particularly around discharge planning.

Staff supported patients to attend any required follow-up appointments at the acute hospital and transport was arranged for this.

Meeting the needs of people in vulnerable circumstances

The service made reasonable adjustments to help patients access services and coordinated care with other services and providers.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, the service could use large print, braille or audio versions for those who had visual impairment.

Staff made sure that patients and their relatives could get help from interpreters or signers when needed. Staff used translators via telephone for patients whose first language was not English and information could be provided to patients in languages other than English.

Patients were supported with their cultural and religious preferences. They previously had a Catholic priest visit the ward once a week and enabled patients to access church if requested.

Staff facilitated contact with relatives for patients during COVID-19 outbreaks when visiting was restricted on the ward. Staff used mobile devices to set up video and telephone calls for patients and relatives.

Although, considering that the ward often had patients with dementia and cognitive impairments, we did not see any explicit aids in place within the environment to assist these patients in orientating themselves.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

Managers and staff worked to make sure patients did not stay longer than they needed to.The average length of stay for the last 3-months was 27 days. Managers monitored admissions and discharges, as well as patients that spent more than 25 days on the ward which they reported to the clinical governance group.

Managers told us they often felt pressure from the acute hospital to admit patients and be flexible with their criteria for patients outside normal parameters, including out of area patients and those with more complex needs than rehabilitation, although they felt supported by the senior leadership team to manage this pressure.

Some staff told us that the 18 day stay target for patients was not always an achievable time frame to deliver the rehabilitation that some patients required. This was especially the case for more complex patients whose needs were more complex than rehabilitation.

Staff planned patients' discharge carefully, particularly for those with complex health and social care needs. The service worked closely with adult social services for any required care packages which were sourced by an independent provider. Managers monitored the number of patients whose discharge was delayed and took action to reduce them. For example, we observed delayed discharges being discussed at the handover meeting and action was taken by the nurse in charge to update their discharge coordinator of the delay and to follow up with the external services. At the time of the inspection the service had three patients whose discharge was delayed. Two of these patients were awaiting appropriate care packages and another was waiting for a care placement.

Good

Community health inpatient services

The service moved patients only when there was a clear medical reason or in their best interest. For example, we saw that there were some instances where patients had been moved back to the acute hospital when their physical health had deteriorated.

Staff supported patients when they were referred or transferred between services. Although, some patients explained that there was a lack of communication and updates on the system between the services which was not always helpful in the continuation of their treatment and care.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them.

The service clearly displayed information about how to raise a concern in patient and visitor areas. We observed a feedback box located at the reception desk and staff told us patients were asked if they would like to fill in the friends and family test (FFT) form and patient reported experience measure (PREM), prior to discharge to give their feedback. The service also displayed a 'you said we did' poster on the ward to encourage ideas and feedback from patients and relatives.

Patients and relatives said they would complain to the matron in the first instance but did know there were other ways to complain although none wished to raise any concerns.

In the last 12 months, the service had one formal complaint. This complaint was a joint complaint with the local acute hospital and was from a family member who felt that the service had given contradictory information to what they had been given from the acute. This complaint was not upheld. The service logged any informal concerns in a similar way and identified themes. The recent ones had been around a lack of involvement with a relative, lack of communication to relatives around visitation hours, staff conduct and attitude, and food.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that feedback from complaints was routinely discussed as a standing agenda item during team meetings. Managers gave an example of a recent concern raised by a relative around the miscommunication of visiting times. This was resolved by placing signage on the doors and creating a visitor leaflet clearly identifying the visiting hours to avoid confusion. In addition, another concern was raised by a patient about their evening sandwiches always being soggy. Staff resolved this by asking the catering team to provide the salad separately.

The service also received compliments from patients and shared this with staff.

Are Community health inpatient services well-led?

Good

Leadership

Good

Community health inpatient services

Leaders had the skills and abilities to run the service and understood and managed the priorities and issues the service faced.

Staff described an accessible and approachable ward manager who supported them on the ward clinically with patient care as needed. The matron prioritised their time between two locations, and feedback from staff was that they were responsive and visible when on site.

Some staff we spoke to told us that it was not common to see members of the senior leadership team on site at Harty ward but knew who they were and would feel able to contact them if needed.

Staff told us that they were given the opportunities to develop. One member of staff was currently undertaking their level three diploma in adult nursing. The service supported this staff member with paid study leave and a workplace facilitator for additional clinical support. Another member of care staff was being supported to undertake her healthcare diploma.

Vision and Strategy

The provider had a clear vision which was to work collaboratively with health and care commissioners and communities to transform services with a focus on experience, efficiency and improved outcomes for service users.

The North Kent business unit had a vision for what it wanted to achieve under HCRG Care Services Limited following the rebranding from Virgin Care in 2021, and a strategy to turn it into action developed with all relevant stakeholders.

The business unit's vision was focused on sustainability of services and aligned to local plans within the wider health economy. The strategic plan for 2022 to 2025 identified priorities to be delivered including meeting the expectations of people accessing care; being a responsive provider by driving quality outcomes for patients; investing in their employees to develop, attract and retain a high performing and sustainable workforce; adding social value to the communities they serve; and maintaining financial sustainability.

Information on the services' values and purpose was shared with staff during onboarding, at induction and was revisited during the yearly appraisal process. A poster identifying these was displayed in the staff kitchen. Staff described how the rebranding and strategy had not changed the delivery of care, which they said still maintained the priority on delivering the best possible care for patients. Staff felt particularly proud of the care they delivered to patients.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff we interviewed both individually and in the focus groups felt respected, supported and valued within the team. Staff felt able to approach their line manager if they wanted to provide feedback. The service had an open culture where patients, their families and staff felt able to raise concerns without fear. The ward displayed information for staff on freedom to speak up and whistleblowing. Staff told us that they were aware of how to access this information and would not be concerned at raising whistleblowing concerns if needed.

Staff were supported to learn lessons when things went wrong without being made to feel blamed.

Good

Community health inpatient services

The service promoted equality and diversity in daily work. Managers and staff told us how staff were all treated the same and described a good culture within the team. They felt that they worked well together, including bank and agency staff who they said were part of the team and not viewed as separate.

Managers told us how motivation and morale on the ward had been low during the COVID-19 pandemic as staff were frightened. Staff explained how the organisation had supported them during these times and how the Chief Executive had emailed through to the ward to thank staff for their hard work. Staff were also able to access a wellbeing platform which a staff member had sought counselling through for personal circumstances.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations.

The service improved service quality with monthly quality governance meetings and monthly operational meetings attended by service managers. The service had action plans to address specific risks which were discussed during focused meetings, for example harm reduction meetings which monitored pressure ulcers and falls. The service held meetings twice weekly for clinical leads and service managers to share learning across teams and the senior leadership and quality team met weekly to discuss significant events.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, as well as to feedback into any changes on the ward. The service had regular team meetings which enabled sharing of information. These were recorded and sent out so that staff who were unable to attend received the same information.

Management of risk, issues and performance

The service identified and escalated relevant risks and issues.

The organisation had an overall corporate risk register which applied across the business unit and a separate risk register which outlined specific risks for Harty ward. Leaders logged actions to reduce their impact and improve the service for patients, and each risk was assigned to an individual staff member. We saw evidence that this was regularly reviewed and updated.

The service had plans to cope with unexpected events. The ward had recently experienced a water shortage within the local community following a burst water main. This was managed effectively as water tankers delivered water to the ward. The service also provided showering and washing facilities for staff at the local Sittingbourne unit.

Information Management

The service collected reliable data and analysed it.

Staff knew how to access key information such as policies on the Intranet. Managers made staff aware when policies had been updated.

The service submitted notifications to external bodies, such as the CQC, as required. Staff had submitted one notification to CQC in the six months prior to the inspection relating to the water shortage.

Good

Community health inpatient services

Engagement

Leaders actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. The service worked closely with colleagues from the local acute hospital as well as with wider system partners.

The service held regular formal and informal team meetings which demonstrated that line managers updated their staff with information such as but not limited to, service updates, incident reports, audits and outcomes, compliments and complaints and lessons learnt. Staff were encouraged to attend monthly learning events. The service sent out monthly newsletters to staff to share good news/good practice and any other relevant updates.

The service had a staff survey to provide staff the opportunity to give feedback. Managers told us that they also had "have your say", informal one to ones and appraisals as platforms to be able to feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving the service and help improve consistency amongst staff. The role of the practice development nurse was to help with this by focusing on inducting new starters, training, and reviewing competencies of staff.

Leaders encouraged innovation. As part of a healthcare diploma, a member of care staff had introduced a project onto the ward called "pyjama induced paralysis". There was a board in the corridor which described clearly how research suggested that patients who remained in pyjamas whilst on the ward could experience increased muscle wastage, reduced mobility, loss of strength, loss of independence and increased hospital stays. The aim was to encourage all patients to get out of their pyjamas and into their own clothes to reduce the negative impacts described above. Staff monitored the numbers that did this each day. At the time of the inspection we observed most patients were sat out in their own clothes.

The service delivered learning events for all staff to provide a venue to support shared learning across the business unit. Staff told us these events were time protected for wider sharing of learning to take place from events and incidents, promoting good practices and lessons learnt.

Good

Community health services for adults

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

Are Community health services for adults safe?

Requires Improvement

Mandatory Training

While the service provided mandatory training in key skills to all staff, we saw that some staff did not always complete their mandatory training.

The provider had a comprehensive mandatory training programme. Staff told us they felt the mandatory training was relevant to their role. The mandatory training included basic life support, moving and handling and fire safety training.

Teams such as the community matrons service kept up to date with their mandatory training. However, other teams such as speech and language therapists (SALT) and community nursing teams had not completed all of their mandatory training modules. For example, the training rates for basic life support and anaphylaxis were 40% and 65.2% respectively for SALT and Community nursing teams. This was below the provider's target of 90%.

While staff told us they were allowed protected time for training and development, we saw that staff were still not completing their mandatory training. Staff told us they could request specific training.

Some teams told us that their managers regularly asked them what their training needs were and supported them to access training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff ensured that safeguarding conversations were a key part of a patient's initial assessment and ongoing care.

Staff knew how to make safeguarding referrals and who to contact if they had concerns. The North Kent business unit had a designated safeguarding lead who was responsible for reviewing all safeguarding referrals and ensuring that appropriate actions were taken. The teams also had a safeguarding champion.

Staff told us there was safeguarding supervision for all staff which was facilitated by the safeguarding lead up to four times a year. The safeguarding audit showed that there had been four safeguarding referrals in the last 6 months.

Staff discussed safeguarding robustly during handovers and in team meetings. Staff ensured that safeguarding risks were identified as part of patients' initial assessment. If there were any safeguarding concerns, this was highlighted on the system so that everyone was aware. The team leads ensured that bank and agency staff were aware if there were any safeguarding concerns on allocation of patients.

Manager kept staff informed of the outcomes of safeguarding investigations. For example, we observed during handover the team lead providing an update on a safeguarding referral that was raised by a staff member.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Managers showed us examples of when they have worked collaboratively with other agencies such as the police and social services to protect people from harm.

The service provided safeguarding training as part of their mandatory training. Staff told us that all qualified staff and managers, were required to complete level three safeguarding training, while non-qualified staff were required to complete level two safeguarding training. However, we saw that some teams were not consistently completing their safeguarding training. For example, only 54% of the community nursing teams had completed their adult level 3 safeguarding training, and only 69% of these staff group had completed their self-neglect training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinics we visited were visibly clean and the furnishings were well maintained.

The service generally performed well for cleanliness. The cleaning audit for the Sheppey Community Hospital was consistently above the provider's target of 95% for the last three months.

Clinical waste was disposed of appropriately and sharps bins were not overfilled. There were hand sanitising stations around Sheppey Community Hospital.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

While we saw that staff followed infection control principles including the use of personal protective equipment (PPE) for all clinics we observed, records showed some staff were not up to date on their donning and doffing training. For example, only 56% of the community nursing teams had completed the donning and doffing training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had a good stock of equipment to care for patients. All equipment was monitored and restocked by the band three staff. Staff told us they could order deliveries for the same day or next day. However, the continence team did not have a bladder scanner, as the bladder scanner had been broken for some time. Staff reported that the provider was in process of procuring a new bladder scanner for the team.

Staff carried out daily safety checks of specialist equipment.

The provider carried out regular equipment audits. Managers informed us there was an ongoing programme to replace some of the old equipment in the next year.

The premises that the service used for outpatient clinics were safe and well maintained. The service had suitable facilities to meet the needs of patients' families.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient and reviewed patients' risks regularly. The community nursing teams completed assessments for patients using a Malnutrition Universal Screening tool (MUST). Staff completed a Waterlow risk assessment for patients. This assessed the risk of pressure ulcers developing.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The community nursing and rapid response staff told us they regularly assessed and monitored patients to ensure their health was not deteriorating using the National Early Warning Score 2 (NEWS2). One patient reported staff weighed them regularly to ensure they were maintaining a healthy weight which could have an impact on their condition.

Staff knew about and dealt with any specific risk issues. Staff ensured that patients who were at risk of falls had the right equipment in place such as a walking frame. The tissue viability nurses ensured that patients who were bed bound had a comprehensive care plan in place to manage patients' pressure areas. One patient told us that the speech and language therapists (SALT) had advised them of the food they should avoid which could lead to choking.

Staff could refer to the mental health liaison and specialist mental health teams, if they were concerned about a patient's mental health. Staff told us if they had concerns that a patient was at risk of self-harming or suicide, they would raise an urgent safeguarding and escalate this appropriately.

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover meeting with the community nursing teams and saw that staff discussed patients' risks and any changes to their risks. The handover meetings were held daily, and it included all key information to keep people safe.

Staffing

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Team leaders regularly reviewed staffing levels and skill mix, and prepared staff rotas three month months in advance to ensure all gaps were covered. For example, the diabetic team told us that they could get additional staff to manage increasing demand and that there were good cover arrangements if anything changed.

The service had a pool of bank of locum staff that they could call at short notice. Managers told us the community nursing teams in Swale had not used agency staff in the last six months. The only teams that used agency staff on a regular basis were the rapid response and out of hours services. Staff told us that the agency staff were regular agency staff, who knew the service and the patients well.

The service was reporting a number of vacancies across the teams. For example, there were six vacancies across all staff bands for the community nursing teams in Sittingbourne. There was one band five vacancy for a podiatrist and four

vacant positions for the wound management teams. While we saw that the provider was actively recruiting for these roles and some staff were onboarding, some of these positions had been vacant for a long time. For example, the podiatrist vacancy had been vacant for 530 days. The podiatry teams told us that they have a very busy workload and staffing was quite stretched.

The provider was reporting 19 vacancies for the rapid response team. Senior leaders informed us that the reason why the vacancy rates were high was because they have received extra funding from the commissioners to recruit more staff and increase care provisions, which meant an increase in the number of staff they were actively recruiting to. They have successfully recruited around nine staff to the vacant positions who were awaiting their pre-employment checks at the time of our inspection.

The turnover rate for all staff bands and teams was about 12% including voluntary and involuntary exit in the last 12 months. One staff member was dismissed, and four members of staff wanted a better work life balance. The provider collected feedback from all staff that left the service and analysed the information in order to improve recruitment and retention.

The sickness and absence rates were generally quite low across the teams.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. It was easy for agency and bank staff to access patient records in order to provide care and treatment.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. All staff had individual log in credentials to access patient records.

Medicines

The service did not prescribe any medicines. Two members of staff were currently on the non-medical prescriber course. All medicine prescriptions were supplied by the patient's GP.

Staff followed best practice to check that patients had the correct medicines when they were admitted. Staff told us they regularly did a stock check of patient's medication to ensure they were taking them as required, and any side effects they might have.

Staff had epinephrine kits which were all in date and the teams were required to carry them on visits. However, we saw that some staff had not completed their epinephrine administration training which was part of the basic life support training. We were concerned that staff may not know the side effects of epinephrine administration especially for patients with an underlying heart condition.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Community health services for adults

The service had an online incident reporting system. Staff knew what incidents to report and how to report them, using the online system and in line with the provider's policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff discussed recent incidents and lessons learned during team meetings, handover meetings and during learning and development training sessions. For example, staff told us that it was compulsory for them to report all pressure sores and they had been undertaking some pressure area awareness courses at the local hospices.

Staff understood the duty of candour. They told us it was about being open and honest and giving patients and their families a full explanation when things went wrong.

We reviewed four incident reports across the service and saw that incidents were thoroughly investigated. Staff were given feedback and lessons were learned following investigation of incidents.

Team leaders supported and debriefed staff after a serious incident.

Are Community health services for adults effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had practice development nurses who supported the nurses with training and development, ensuring that staff were up to date with current clinical practice.

Managers told us they checked to make sure staff followed national guidance through individual managerial supervision, peer group supervision and one to one session, and each patient's care and treatment was discussed during daily handover meetings.

Staff told us they always ensured they were up to date NICE guidelines, and they completed risk assessments and care plans in line with best practice. The community nurses completed care plans depending on individual assessed needs and adapted the plans as required. For example, the diabetic nurses told us they would always amend oral medication in line with British National Formulary (BNF) and NICE guidelines.

Patients told us that staff planned their care with them. For example, one patient told us that staff spent considerable amount of time caring for them and discussing their care and treatment plans with them. One patient who was getting support from the occupational therapists said staff took time to explain the therapies.

The service leaders told us they were relaunching the patient care plans with a more detailed, holistic and personalised plan with a focus on patients view of what they wanted to achieve. They told us that they were waiting for approval from senior leaders to implement the new care plan.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff told us they did a malnutrition assessment for all patients using the Malnutrition Universal Screening Tool.

Patients told us staff always asked if they would like a drink or something to eat when they visited. The community nursing teams told us they routinely asked about patient's food and fluid intake and swallowing, and if they had any concerns they would make appropriate referrals to other specialists such as a dietician, speech and language therapist or the patient's GP.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff told us they always monitored patients for pain using verbal and non-verbal techniques. For patients who could not verbalise, they monitored them for signs of pain or discomfort. Staff told us when a patient expressed pain or discomfort, they immediately contacted their GP for a pain relieving medication.

Staff ensured that patients who were at the end of their life and on syringe drivers for symptom control were seen daily.

The service had a system in place for monitoring and reporting pain medication for patients who were at the end of their life.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service carried out a number of audits including the number of patient attendances and discharges.

Staff told us that there had been increased numbers of referrals across the different specialisms since COVID-19 lockdown eased. Managers informed us that the service audits allowed them to plan and align their services to improve care and treatment outcomes for patients. For example, the service was carrying out falls, pressure sore and pressure ulcer audits. The audits allowed the provider to submit a business case to the commissioners to purchase new equipment and recruit more staff.

Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, the provider audited the number of safeguarding referrals and actions taken to ensure that people are protected from harm and abuse. Results from the last three months indicated that the teams were performing very highly in responding to safeguarding concerns.

Managers and staff used the results from audits to improve patients' outcomes. The Community Matrons and specialist nursing teams were developing key performance indicators for end of life and palliative patients.

Patients reported that they generally received good care and treatment outcomes from the service. One patient told us the treatment programme the physiotherapists put in place was very effective as it had helped stabilise their balance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

The service had a robust induction programme for all new staff. Managers told us that the induction programme was developed in collaboration with staff to ensure they were getting the best out of the induction. Staff told us that they found the induction very useful, and it had prepared them for their roles. The induction was a four week programme which included mandatory and statutory training, as well as staff reading and understanding the provider's policies and procedures.

Staff told us all new agency and bank staff normally go out on their initial visits with a regular member of staff. Managers told us the service had recently launched a buddy system to ensure that staff continue to improve and develop.

Staff across the specialisms were vastly experienced, and they had the right skills and knowledge to meet the needs of patients. The qualified staff told us they kept up to date with their clinical practice through continuous professional development (CPD), and with support from the clinical educators.

The clinical educators supported the learning and development needs of staff. Staff told us the teams had regular in-service training events. For example, the physiotherapy lead had recently carried out a specific neck collar (a device used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine/neck injury sustained) training for the team. The sessions resulted from gaps in knowledge identified by the team.

We saw another example of the community nursing teams undertaking workshops and training with the occupational therapy (OT) teams for National Early Warning Score 2 (NEWS2). The OTs now have the application on their work mobile phones. The rapid response nursing teams had also undertaken end of life training with the OTs.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had a six monthly performance review and annual appraisal. Managers discussed career progression with staff as part of their appraisal.

All staff we spoke to said they had regular one to one discussion with their line manager, and these met their needs. However, while we saw that senior managers undertook and recorded clinical supervision with the band seven staff, we saw that staff supervision was not always recorded for all staff below band six grade in line with the provider's policy.

Managers told us that they ensured staff received specialist training for their roles. For example, the community nursing teams had undertaken training on how to care for end of life and palliative care patients. Staff told us there was training available for them on how to deliver sensitive news for terminally ill patients. However, some staff reported that the provider could do more to support them to access other external specialist training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Good

Community health services for adults

Multidisciplinary working

The service consisted of teams across different specialisms who worked together to benefit patients. The teams worked with other healthcare professionals including GPs and mental health services to ensure people's holistic needs were being met.

Staff worked across health care disciplines and with other agencies when required to care for patients. Managers and staff reported they generally had a good working relationship with other healthcare professionals, social services and other specialist services. For example, the diabetic nurses received clinical support as well as worked in collaboration with other diabetic services including a transition service for 18 to 20 year olds. Staff from the respiratory teams told us they worked closely with the acute hospital to manage patients with respiratory conditions, including those who required oxygen daily.

Staff reported that some GPs were very responsive and supportive in ensuring patients received timely care and support such as medication reviews, while some GPs were not very responsive, resulting in delays in patient care. The MDT coordination teams were now working with GP practice nurses to identify and provide early intervention for frailty patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a monthly meeting across all specialisms. The MDT coordination teams met weekly to review patients on wards to facilitate discharge, ensuring that issues that could cause delayed discharge were addressed, including housing and packages of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

The rapid response teams and community nursing teams provided a 24 hour, 7 days a week service. The community matron service was also available on weekends, while the diabetic nurses provided training for patients on some Saturdays.

Staff told us they could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Where required, staff could admit patients to the inpatient wards.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support.

Staff offered training for patients on how they could manage their own health and condition. For example, one patient told us that they have recently undertaken a diabetic training course which they found very useful, with support from staff. The patient told us the training helped them to understand what they can and cannot eat and how to manage their dietary needs. Other patients we spoke to also told us that staff had recommended training courses to them to improve their health and wellbeing.

Good

Community health services for adults

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us that they would always presume a patient had capacity to make their own decisions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed that staff sought consent before undertaking care.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Staff gave us an example of a patient who was not complying with their treatment; however, the patient was assessed to have capacity. Staff ensured that all documentation was completed accurately, and the patient was required to sign that they understood the risks of not accepting treatment.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act.

Are Community health services for adults caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

All patients we spoke said staff were kind and caring. They said staff treated them well, cared of them kindly, reassured them and always ensured they were comfortable.

Patients said staff took time to interact with them in a kind, considerate and respectful way. Patients and their carers told us staff took time to address any concerns they had. Staff took time to care for patients and patients said they never felt rushed.

Patients described staff as thoughtful, understanding and professional in the way they carried out their duties. Two patients we spoke to said that when staff cancelled their visit at short notice, they were very understanding and accommodating, and they ensured they booked another visit as soon as possible.

Staff followed policy to keep patient care and treatment confidential.

Good

Community health services for adults

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, we saw that staff were considerate when they arranged appointments, to ensure conflict with people's schedule.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient reported they were anxious when they got a clinic appointment, but staff provided assurance and eased their anxiety. The patient described their clinic session as very relaxed and informative.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were screens in some clinics to protect people's privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us that staff involved them in decisions about their care and treatment. All patients we spoke to told us that staff provided them with information on their first visit and regularly gave them information leaflets about their condition, the service and how to get further help and support with their health.

Staff informed patients promptly about visits and clinic appointments. Patients told us that staff usually rang them to schedule an appointment or visit at a time that was convenient for them.

Patients told us staff asked them if they understood the information and discussed their options, giving patients the opportunity to make informed decisions about their care. One patient told us that the physiotherapists went over a list of things they wanted to achieve and put a programme in place which they adjusted when it felt too difficult, but they thought it was too hard. However, the patient felt they could have been more involved in the decisions.

While some patients and their families told us they have given feedback about the service, others told us that staff did not routinely ask them for feedback. Patients generally gave positive feedback about the service.

Staff supported patients to make advanced decisions about their care.

Are Community health services for adults responsive?

Good

Community health services for adults

Good

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. For example, there was a podiatry clinic in Isle of Sheppey and Sittingbourne Mondays to Fridays. Staff told us that the clinics were planned a month in advice and were flexible depending on where the demands were highest.

The service had a multidisciplinary coordination team that worked with other stakeholders such as GPs, the inpatient wards, care homes and social services to support patients with complex care and help prevent hospital admission. Every week the MDT met with the other teams to review up to 10 patients to identify any barriers to care including whether the patients have a package of care, housing, benefits and carer support.

The MDT also worked with local charities to provide mental health support to patients. There were frailty nurses attached to GP surgeries who carried out initial patient visits and assess their status and home environment. They fed back to the MDT, who then coordinated the patient care.

Facilities and premises that were used for the outpatient clinics were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia via the MDT coordination teams. The service also worked with a mental health charity to ensure that people who required mental health services got the required help and support they needed.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. All patients we spoke to said that their visit appointment was rarely cancelled. Some patients told us that when staff cancelled, they called them to explain the reason, for example due to staff shortage, and apologised. The community nurses told us all patients were red, amber, green (RAG) rated and before a visit was cancelled it was always risk assessed. Staff ensured that the patient visits missed were always scheduled for the next day.

Staff ensured that patients who did not attend clinic appointments were contacted. Patients told us that staff were always happy to rebook a time that was convenient for the patients.

The service relieved pressure on other departments when they could treat patients in a day. The rapid response team were required to see patients within two hours to avoid hospital admission.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Good

Community health services for adults

The services were accessible for patients with mobility problems. Staff told us that the outpatient clinics were designed to accommodate wheelchair users. Managers informed us there was a holistic approach to care to ensure all patients needs were met. For example, the podiatrists informed us that there was a weekly home visit to housebound patients to provide care and treatment to them.

The service supported other services to ensure people's care and treatment needs were met. For example, the diabetic nursing teams provided education to care homes. There was also training for GPs and practices nurses which was updated regularly.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were aware of the Accessible Information Standard (AIS). The Standard sets out a consistent approach to identifying, recording, flagging and sharing the communication needs of patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The service used a third party interpreting and translation service that was available 24 hours a day.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff showed us picture cards and signs which they used to communicate with patients who had communication difficulties.

Most patients we spoke to felt the service was inclusive and took account of their individual needs and preferences.

The provider had a range of information leaflets for patients about how they could access other services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff took account of patients' hydration and nutritional needs when they planned their care. The speech and language therapist informed us they always us that they took account of people's cultural and religious needs when they recommend certain foods.

Access and flow

People could generally access services when they needed it. However, some services such as the podiatrists were reporting high waiting times from referral to treatment.

The service had a clear criterion for who they would offer a service. The community nursing teams carried out home visits only for patients who were housebound. All patients that were ambulatory (able to mobilise and get into a car) were seen in an outpatient clinic which was held up to three times a week.

All referrals to the service came through a single point of contact known as the Care Coordination Centre. Referrals came from GPs, consultants, care homes, hospices, practice nurses and people could also self-refer.

The service used a red, amber, green (RAG) rating system to triage all referrals. Patients that needed to be seen urgently were rated red and referred to the rapid response team. The rapid response team were required to see patients who were referred to them as urgent within two hours of referral. Staff told us that if a referral was triaged and found to be inappropriate for the service, they would refer back to the referrer with a suggestion of care.

Some services had key performance targets which were set by the provider and reported to the commissioners. This included the waiting times for referral to treatment, serious incident reporting such as pressure ulcers and safeguarding. Most of the specialist services had an 18-week target for referral to treatment for routine patients.

The podiatry teams were reporting a high waiting list. Managers told us that Covid-19 had played a huge part in the increased numbers of patients on the waiting list compared to previous years, because some services were stopped at the peak Covid-19 pandemic in order to support more urgent referrals. Managers told us they have been working really hard to reduce the waiting list. There were about 800 patients on the waiting list in March 2022 and by July 2022 the numbers had reduced to less than 100. Managers told us they have taken time to review all of the referrals and ensured that patients who needed urgent treatment were seen promptly. Managers told us they also ensured that they followed safe discharge procedures for those that no longer required their services.

While most patients told us it was relatively easy for them to access services, and had a swift initial appointment, some reported that they were waiting a long time before they were seen. One patient who needed treatment for their mobility problems told us they were on the waiting list for about two years before they were seen. Another patient told us they had waited a year for their initial assessment by the speech and language therapists. The patient also told us that the service they had been receiving from the team was exceptional and was full praise for the team.

Managers monitored cancelled visits and clinics. Staff told us that visits and clinics were rarely cancelled. However, in the exceptional circumstance that planned visits or clinics were cancelled, patients were always informed and staff rescheduled the visits or clinics at a time that suits them.

Most of the clinics were easily accessible for patients.

Learning from complaints and concerns

People knew to raise concerns about the care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The number of patient complaints was very low across the teams. The podiatry service had not received a complaint in the last six months. Staff told us they would always try to deal with any concerns the patient had at first instance.

Patients we spoke to knew how to complain or raise concerns although they have not needed to because they have been receiving a good service.

Staff had patient information booklets that they handed out on initial visits which contained information about how to contact the service and also how to raise a concern or make a formal complaint.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would always try to resolve any concern with the patient or carers initially, and if they wanted to make a formal complaint, they would support them to do so.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Good

Community health services for adults

Managers shared feedback from complaints with staff and learning was used to improve the service.

Most patients we spoke to told us that staff had not asked them to give feedback about the service.

Are Community health services for adults well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff spoke very positively of the guidance and support they received from their managers. Staff reported that the training and support they received from their leaders gave them the confidence to do their jobs.

Leaders supported staff's professional and career development. We saw several examples where the leadership team had supported staff members professional development such as supporting staff through a nursing apprenticeship programme, creating more job roles so that staff members could move to a higher band with managerial opportunities and experience and also allowing study time and financial support to staff who were undertaking their prescribing courses.

The provider made reasonable adjustments for staff who needed them. Managers supported staff who had been off work for extended periods to slowly get back into work. Managers worked with staff to identify other job roles which would suit their situation or condition with opportunities to grow and develop.

Although some team leaders reported they had not received formal managerial training, they felt there was good opportunities to grow in their role and they were getting adequate support from senior leaders, including shadowing them.

Vision and Strategy

The provider had a clear vision which was to work collaboratively with health and care commissioners and communities to transform services with a focus on experience, efficiency and improved outcomes for service users.

Each service had a clear strategy of how they would achieve the provider's vision and we saw that they were patient and staff focused. Leaders and staff knew what the strategy was, how they would apply it and monitor progress. For example, we saw that some teams were collecting regular data to measure their performance via different matrices including referral to treatment times.

The provider had a programme to grow its own staff. Managers were supporting a staff member to undertake an apprenticeship programme with the open university. Staff told us there were career development opportunities. Two members of the nursing staff were training to become non-medical prescribers.

Good

Community health services for adults

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported that their managers made them feel valued. They could approach them with any concerns around work and wellbeing and they felt managers addressed them. For example, some staff reported that their workload was high due to the number of patients they saw daily. Managers told us they were reviewing caseload and staffing daily to ensure there was an adequate number of staff with the right skills to provide care and support for patients.

Staff said that they always pulled together as a team and supported one another. For example, we saw that due to the increased volume of referrals to the rapid response teams, the intermediate care team were offering support to see patients who needed to be seen urgently. Although some members of staff expressed concerns about the impact the increased workload was having on them.

The provider had a freedom to speak up guardian who staff could contact if they had any concerns, and staff knew how to contact them. Staff we spoke to said they have not needed to contact the freedom to speak up guardian because they felt they were getting adequate support from their line managers. Staff felt there was always someone to listen if they had concerns.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a clear reporting structure which fed into clinical governance.

The provider held monthly clinical governance meetings where service leads met to discuss and review performance. The team's performance was reported to the senior leadership team and monitored via a quality reporting dashboard.

The service had an annual schedule of audits in place which provided assurance to the board. HCRG North Kent business unit patient safety and quality committee carried out regular audits and oversaw six key areas including infection prevention and control, safeguarding, health and safety, information governance, regulations and maintenance.

The results for the last three months showed that the teams were performing well across all the matrices.

There were staff meetings and managers meetings where issues affecting staff and patients were discussed. This was escalated to the clinical governance meeting through the team leaders and service managers. Outcomes of governance meetings were fed back to the teams via their managers. Staff told us they could access the minutes of clinical governance meetings on the intranet, and they were also sent regular newsletters and updates.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Each team maintained a register of risks which fed into the overall risk register and this was monitored and reviewed at monthly clinical governance meetings.

The service RAG rated the risks for the likelihood and impact of risks occurring. For example, the speech and language therapists rated the risk of patients with swallowing difficulties developing chest infections as high. The service put controls in place to mitigate the risk which included prioritising patients most in need.

Leaders used a system of audits to monitor the service performance. The provider had just completed a NICE guidance audit to ensure that the service was working in line with current best practice and national guidelines.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities.

The service used electronic systems for managing patient care records. Patients also had a copy of their personal management plan in their own homes.

Incidents, safeguarding and complaints were reported via an incident management system which was monitored by managers.

All staff had individual laptops and mobile phones and they could access patient records on their laptops. Staff kept patient records up to date. Staff told us that there were usually no delays in updating patient records.

The service consistently submitted information and notifications to external organisations such as the CQC, Health and Safety Executive and the CCGs as required.

Engagement

Leaders and staff were working towards increasing patient engagement activities. Managers told us some patient engagement activities had been suspended temporarily due to pressures and demands resulting from the Covid-19 pandemic. Senior leaders told us that relaunching patient and carer engagement was one of the organisational objectives for the financial year.

The provider was engaging with staff via several platforms including staff surveys, “you said, we did” and “feel the difference programme” where staff could give feedback about the service. Senior leaders told us the extra funding for the new induction programme was as a result of staff feedback.

Managers and staff felt the provider treated them as partners in the planning and delivery of services. However, some teams felt they could have been consulted before the provider purchased new specialist equipment.

Good

Community health services for adults

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was providing an educational programme for type 1 and type 2 diabetes over a six week period including on weekends for patients and staff.

The community nursing teams told us they have introduced a new initiative of sending bereavement cards to relatives when they lose a dear one.

The provider had recently put in a business case with the commissioners to purchase a Hoverjack – a piece of moving and handling equipment that enabled the safe and transfer of patients who were receiving palliative or end of life care. The provider informed us that the equipment had led to reduced visits from clinical staff as hoist and sling assessment were no longer required. The provider also informed us that the use of the equipment had improved comfort and dignity for patients during transfers.

The service had a robust business continuity and contingency plans in place. We saw that the service had responded well to the recent water crisis on the Isle of Sheppey and were continuing to improve their emergency response plans as a result of learning from this event.

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
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Community inpatient service:** • The service must ensure that all equipment stored on the ward is stored safely to reduce environmental health and safety risks, particularly to prevent evacuation difficulties, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Community health services for adults:** • The provider must ensure that staff complete their mandatory and statutory training. [Regulation 18 (2)(a) Staffing] **Community inpatient service:** • The service must set a deadline to ensure that all staff are up to date with their mandatory training and ensure the appropriate IT access is in place to enable them to complete this. [Regulation 18 (2)(a) Staffing].