CareQuality Commission

Buckland Hospital

Inspection report

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Date of inspection visit: 29 January to 30 January 2019
Date of publication: 26/03/2019

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?	Good	●
Are services effective?	Good	●
Are services caring?	Good	●
Are services responsive?	Good	●
Are services well-led?	Good	●

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Buckland Hospital on 29 and 30 January 2019. This part of our planned inspection programme.

At this inspection we found:

- The service had effective systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.

- The service routinely reviewed the effectiveness and appropriateness of care. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The provider demonstrated innovative ways of working to support GP practices in the locality.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care.

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included two GP specialist advisers, a practice manager specialist advisor and a CQC inspector.

Background to Buckland Hosptial

The services are provided by Channel Health Alliance (CHA). CHA is a collaborative federation of 28 GP practices within South Kent Coast CCG. CHA provides five GP led minor illness centres (called hubs). The hubs see patients who are already registered with one of the GP practices who are part of the federation. The aim of the service is to increase capacity in primary care locally and to give patients more timely access to care for minor illness. The majority of care is 'see and treat' and completed in the hubs.

There is a physiotherapy service. This service is for people with no previous musculoskeletal history, with no comorbidities (people who also have one or more other diseases or conditions) or any indication of another illness.

There is a home visiting service. CHA took over this service from another provider on 14 August 2018. The service is led by experienced paramedic practitioners. The practitioners lead a team of trained nurses and healthcare assistants, responding to on the day home visit requests on behalf of the practices.

The services work as follows: Patients call their GP practice as they would normally when ill. The practice receptionists, with clinical support, make an appointment, using standardised and locally agreed protocols, for the patient with the appropriate professional in an appropriate hub.

This is not an urgent care service. There are no walk-in patients.

Services are provided from the following locations at the times shown. We visited all the locations

DOVER Buckland Hospital

Monday – Friday 8am to 8pm

Saturday 9am to 5pm

Sunday 10am to 2pm

DEAL Victoria Hospital

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed

FOLKESTONE Royal Victoria Hospital

Monday – Friday 8am to 8pm

Saturday 9am to 5pm

Sunday 10am to 2pm

HYTHE Oaklands Health Centre

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed

ROMNEY MARSH Day Centre

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed.

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.

- Channel Health Alliance Limited (CHA) were hosted by other registered providers at the locations they operated from. They took care to ensure that the places where their staff worked were fit for purpose. There were regular audits on the condition of the workplaces. The headquarters of CHA retained copies of significant documents such as legionella and fire safety certificates that related to each of the locations (hubs) where it provided services.

- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.

- There was an effective system to manage infection prevention and control. CHA had engaged an external consultant who had carried out an infection prevention and control review. The review identified various areas for improvement. For example, there was now an infection prevention control folder at each site with relevant information and contact details for staff who were responsible for infection prevention control.

- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. All the equipment was less than a year old so did not need testing. However staff were drawing up a register of equipment requiring testing and had already identified the company who would be carrying out the testing. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system for dealing with surges in demand.

- There was an effective induction system for temporary staff tailored to their role.

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Staff had received training in managing "the deteriorating patient" and patients with severe infections such as sepsis. This addressed a nationally identified lack of skills in responding to acute deterioration. Content included clinical observations, monitoring trends and early warning triggers.

- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

- When there were changes to services or staff the provider assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Are services safe?

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, emergency medicines and equipment, minimised risks. The service kept prescription stationery securely and monitored its use.
- The service carried out regular medicine audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The service had audited antimicrobial prescribing. There was evidence of action taken to support good antimicrobial stewardship. We saw audits of individuals' prescribing which had identified antibiotic prescribing which did not meet with best practice. The relevant staff had received feedback on their prescribing practice. There was a follow up audit and the prescriber's practices had changed. We spoke with a staff member who had received advice concerning a different prescribing issue. They felt that the advice was wholly constructive and they were grateful for it.
- There were processes for checking medicines and staff kept accurate records of medicines.
- Palliative care patients were excluded from the criteria of patients that CHA should see. However, occasionally such patients were referred. We saw that they received prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. For example, the right skill mix, CHA's reliance on short term contracts and the problems different software platforms were assessed and suitable measures taken to reduce the risks.

- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.

Lessons learned and improvements made

The service learned from and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. There had been five significant events reported by the Home Visiting Service (HVS) and 23 incidents reported by the five hubs. Incidents at the HVS included occasions when patients had not been seen as required because of confusion over areas of responsibility. In response CHA had enhanced protocols so that patient safety was improved.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. When the service was launched there were a number of inappropriate referrals, to the hubs, from reception staff at different practices. CHA nursing staff had provided training to reception staff to improve their skills in this area. Since delivering the training the number of these types of incidents had reduced. CHA was still monitoring this as it was felt to be critical to patient safety.

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

Channel Health Alliance Limited (CHA) had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. For example, we saw clinical staff had access to most recent NICE based sepsis identification and treatment guidance.

- Patients' needs were fully assessed. This included their clinical needs and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

There had been reviews of the quality of note keeping. There was a standard format which included a range of issues including, history, examination, treatment use of chaperone and any safeguarding issues identified. This had identified some staff whose notes were insufficiently clear. Their note taking was discussed with supervising clinicians and, when re-audited had showed improvement.

There had been audits of medicines that would not be associated with the treatment of minor illness for example, anti-depressants. These audits found that such medicines had been prescribed rarely. The prescribing had been appropriate.

There was an annual audit plan. Each month had a set range of audits. Some audits were annual such as the checking of oxygen cylinders and nebuliser filters. Some audits were six monthly such as clinical waste and two week wait referrals (for suspected cancer diagnosos).

Audits included:

- a chaperone audit examining the use and recording in patients' notes the use of chaperones.
- Infection prevention control including handwashing.
- Disposal of confidential waste and
- An audit of the effective use of NICE Guidance.

The service was also meeting its locally agreed targets as agreed with its Commissioner (South Kent Coast Clinical Commissioning Group SKCCCG)).

There was a range Key performance indicators (KPI) set by the Commissioners of the service. These encompassed:

- the staffing and provision of the hubs,
- the numbers of appointments available,
- the fairness of the availability of appointments across different GP practices,
- governance arrangements
- and the views of the public about the services (friends and family test) service.

These were discussed with the Commissioners in monthly contact meetings. We saw that the provider generally met these targets and there was flexibility within this. For example, each practice was allocated a "fair share", whether of home visiting service or hub appointments based on the size of the practice. A flexible approach allowed the service to provide more than the "fair share" where it was recognised that a practice might be under pressure, perhaps because of staff sickness.

The provider recognised and dealt with problems. The Home Visiting Service (HVS) had been taken over from a previous provider, fewer staff than anticipated had transferred to CHA on change over. Initially this had resulted in the use agency staff, we saw this was recorded on the provider's risk register. The register recorded the actions taken to militate the risk. At the time of the inspection the HVS was fully staffed with employees.

National best practice was observed in gathering data. For example, the HVS used the National Early Waring Score (NEWS2). This is a system that emphasises standardisation and the use of physiological parameters that are already

Are services effective?

routinely measured. Therefore the HVS could compare the vulnerability of its patients and judge whether the right clinical staff were going to the right patients. The HVS could also compare the total case load in a weighted way from month to month.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as: an introduction to the leaders, a walk around the environment, fire procedures, staff facilities, emergency protocols and access, via computer, to policies, procedures and clinical systems as appropriate.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- CHA provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The was evidence that clinicians' record keeping and other practices were regularly audited. We saw that, where the standard found was below that expected, senior staff talked with the individuals concerned. We spoke with two such individuals both said that the interview had been entirely constructive and they were grateful that the issues had been raised.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Staff communicated promptly with the patient's registered GP so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may need extra support.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this. We saw self-care advice leaflets so that patients could review their progress towards recovery and could assess whether they needed to get back into contact with CHA or their GP.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- All the 63 patient Care Quality Commission comment cards we received were positive about the service experienced. These cards had been collected from the five hubs where the provider delivered services. The patients' feedback was similar across all sites. The positive feedback was in line with the results of the NHS Friends and Family Test and other feedback received by the service for example, from local patient participation groups.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. Staff had access to a telephone interpretation service. Details had been circulated to all staff and the details were kept in the

information pack at each hub. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations.
- A private room was available if patients were distressed or wanted to discuss sensitive issues.
- Written guidance was available for staff to follow that helped to maintain patient confidentiality for example, the confidentiality policy.

Are services responsive to people's needs?

We rated the service as good for caring.

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Are services responsive to people's needs?

Good

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. Staff from Channel Health Alliance Limited (CHA) had attended meetings of patient participation groups (PPG). CHA asked the PPG to act as sounding board for changes that were contemplated such as to any alterations to opening and closing times of the hubs. The provider engaged with commissioners to secure improvements to services where these were identified. CHA was commissioned without the ability to order even simple diagnostic checks. This had led to patients being referred back to their own practice for very simple matters such as providing a urine sample. CHA had worked with the Commissioners and each local group of practices to change this. Staff from CHA were now able to undertake diagnostic checks within set protocols.
- The service had a system that alerted staff to any specific safety or clinical needs of a person using the service. Care pathways were appropriate for patients with specific needs, for example, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.

Are services responsive to people's needs?

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The scheduled operating times of the hubs were:

DOVER Buckland Hospital

Monday – Friday 8am to 8pm

Saturday 9am to 5pm

Sunday 10am to 2pm

DEAL Victoria Hospital

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed

FOLKESTONE Royal Victoria Hospital

Monday – Friday 8am to 8pm

Saturday 9am to 5pm

Sunday 10am to 2pm

HYTHE Oaklands Health Centre

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed

ROMNEY MARSH Day Centre

Monday – Friday 8am to 8pm

Saturday closed

Sunday closed.

The Home Visiting Service (HVS) operated from Monday to Friday from 9am to 7 pm.

- The service did not see walk-in patients and a there was a 'Walk-in' policy which clearly outlined what approach should be taken when patients arrived without having first made an appointment. For example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff we spoke with were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.

- Written information was available to help guide staff who booked patients' appointments with the CHA hub service or HVS. For example, the reception staff at the GP practices had a list of presenting conditions which clearly showed what could be referred to CHA services. There was also a list of presenting conditions which were not to be referred to CHA.

- CHA staff at hubs and at the HVS had guidance on the recognition and management of patients with severe infections such as sepsis and the symptoms that would prompt an urgent response. There had been training for all staff on identifying and dealing with a deteriorating patient.

- Waiting times, delays and cancellations were minimal and managed appropriately. Patients were booked into timed appointments. Staff at the referring practice used a shared clinical system so could see the availability of appointments. Patients therefore did not wait to be seen unless unforeseen circumstances disrupted the timing of the clinical staff.

- Where patients presented with urgent needs their care and treatment was prioritised.

- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

- Referrals and transfers to other services were undertaken in a timely way. Patients requiring standard referrals went back to their own GP. Two week wait referrals for suspected cancer patients were made by CHA staff and this was systematically monitored.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

- The complaint policy and procedures were in line with recognised guidance. The HVS had received one complaint since it started on 14 August 2018. The minor illness service had received six complaints during the past year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

Are services responsive to people's needs?

- Issues were investigated across relevant providers, and staff could feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints. The service analysed the information for trends. It acted as a result to improve the quality of care. For example, there had been a complaint about a patient experiencing bruising following the use of a certain physiotherapy device. The service had apologised. They had reviewed the use of the device. They had identified that the same device was available in plastic, as opposed to metal, and therefore was less likely to cause bruising. They had replaced the metal devices with plastic ones.

Good ●

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Recruitment of clinical staff was a major issue for GP practices in the area and for Channel Health Alliance (CHA). CHA recruitment process was framed so as not to impact on local pactices. They had a policy of not seeking to recruit staff who were already working at local practices. They had a policy of not offering a greater salary of that offered by GP practices locally. In this way they operated so as not to compete for the same staff. They accepted that they would have to find different incentives to recruit and retain staff. Their approach was to offer diverse opportunities and a rich learning experience. We saw nursing staff who were supported to work both at the hubs and in the home visiting service so as to provide work variation.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. Staff were actively mentored. For example, we saw staff who were performing management roles for some of their week in order to broaden their experience, retain their interest and prepare them for a role in management. CHA wanted these staff to develop within their own service but their support was never conditional on remaining with CHA.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The CHA mission statement was simple, to deliver high quality care through innovation and collaboration. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. Staff from CHA met with patient groups and shared their plans for developing services so patients could influence the decision making. The five hubs each serviced a set of GP practices termed the "locality". There were regular locality meetings between CHA and the GPs. These had led to developments in the service. For example, CHA staff had not been able to undertake simple diagnostic tests. Patients who needed the tests had been sent back to the practice. This wasted clinical time, left patients frustrated and led to delays in treatment. CHA and the localities removed this barrier by developing protocols and processes so it was clear who was responsible for which part of the various treatment pathways.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. In the appraisals we looked at staff had adopted some of CHA strategic objectives, such as to be patient-centred (strategic objective 1) and to provide high quality healthcare services to the population (strategic objective 4). We spoke with staff knew CHA strategic objectives, if not in total, in principle and where they were directly relevant to that staff member.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population. The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service. We spoke with staff who had travelled long distances to work at CHA. They told us that the motivation was the culture and team work they found a CHA. They told us they felt they belonged at CHA.
- The service focused on the needs of patients.

Are services well-led?

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Patients, who had raised concerns or complaints, were always contacted by telephone if possible. CHA apologised for the issue and kept the patient informed. We examined two complaints. One related to the process of examination and one to the use of a physiotherapy device. We saw that learning from the complaint was circulated to all staff. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. We saw instances where staff note taking and record keeping required improvement. CHA addressed these learning needs with the staff concerned. We spoke with staff who had been through this process. They said that the experience was not judgemental and was positive. They felt there was a genuine no blame culture.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the commissioners' requirements. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local Clinical Commissioning Group as part of contract monitoring arrangements.

Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. All clinical staff had had their consultations reviewed and remedial action taken where necessary.

The providers had plans for major incidents.

The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. There were nine clear key performance indicators. These were used to identify

Are services well-led?

areas of concern, such as the use of agency staff and cost overruns, early in the service's history. Steps were taken to address the issues and subsequent data showed that the risks from these issues had been reduced.

- This performance information was combined with the views of patients. Patients completing the NHS friends and family test (FFT) were asked if they were willing to be contacted by the CHA. If they agreed they left their telephone number on the FFT response. CHA telephoned about 10% of these patients each month to help identify any emerging issues. So far, the feedback had been completely positive.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. CHA staff met with members of local patient participation groups (PPG). They used these contacts as a sounding board for planned changes to the service, for example, to increasing the number of diagnostic checks that could be carried out at the hubs.
- Staff described how they gave feedback. There were staff meeting, regular appraisals and one to one or group clinical supervision. One of the issues raised by staff was the repetitive nature of some of the clinical

work. CHA had acted on this by giving staff the opportunity to work in different areas and different departments. Staff who worked remotely were engaged and able to provide feedback.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. CHA promoted learning and satisfaction amongst GPs through its "pioneer programme". This was open to all GPs. It offered medical professionals flexible working options and the opportunity for a more portfolio career. There were opportunities to work in the hubs, the home visiting service and at different GP practices. There was support for becoming a clinical supervisor, for achieving GP with a special interest status and access to regular post graduate education sessions.
- CHA had successfully bid for funding from Health Education England (HEE) to establish a new role for nursing staff "Diabetes Management Champions in Nursing Homes". Selected nurses would undertake a qualification in treatment of disbetes, recognised by the Royal College of General Practitioners, to provide a diabetes management champions in nursing homes. This project was scheduled to start in the sring of 2019. The initiative recognised a growing inequality of access to care across the area and was designed to alleviate this.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation evidenced by the number of pilot schemes in which the provider was involved. For example, CHA was piloting point of care c-reactive protein testing. The testing was reserved for occasions when the clinical examination was inconclusive and to distinguishing between viral and bacterial conditions. The aim was to reduce

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inappropriate prescribing of antibiotics and to reassure patients who might be anxious that they might need an antibiotic. CHA was working with Kent and Medway Sustainable Transformation Plan and the local authority to develop a mobile telephone app for carers, so that they could access multiple services from one platform, across the whole of Kent and Medway

• There was a focus on education. All the hubs were taking placements, from local universities, of nursing students and student paramedics including placements at the Home Visiting Service. Similarly CHA was working with the Kent, Surrey and Sussex Deanery and the East Kent Community Education Provider Network to provide placements for pre and post registration doctors. CHA believed that these two initiatives would increase the pool of available talent and help to alleviate future recruitments problems.