Kent Community Health NHS Trust

RYY

Community health services for adults

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Kent Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Kent Community Health NHS Trust and these are brought together to inform our overall judgement of Kent Community Health NHS Trust

Summary of findings

Ratings

Overall rating for Community Health Services for Adults	Good
Are Community Health Services for Adults safe?	Good
Are Community Health Services for Adults effective?	Requires Improvement
Are Community Health Services for Adults caring?	Good
Are Community Health Services for Adults responsive?	Good
Are Community Health Services for Adults well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall this core service was rated as Good. We rated it good for being safe, responsive, caring, and well led. However the service requires improvement in being effective.

Kent Community Health NHS Trust delivers community based services to adults across Kent and Medway and East Sussex. Services are provides in people's own homes, nursing homes, clinics and GP practices.

Our key findings were as follows;

- Kent Community Health NHS Trust had a detailed vision and strategy in place to meet the needs of the communities it served across Kent. This was communicated to staff and the public through the trust's website and in leaflets and brochures.
- The Trust had implemented a number of initiatives to improve experiences and health of patients with complex needs that included the chronic knee pain programme and a new integrated discharge pilot.
- Complaints were well handled in the Trust with the majority of concerns addressed at local level. Patients we spoke with told us that they had no problem in accessing the right service in a timely fashion and were happy with the service provided.
- The Trust had been through a sustained period of change and reorganisation leaving certain staff groups feeling disaffected. However the majority of staff we spoke with said they felt valued and supported by their managers and were proud to work for the Trust.
- Staff from some teams told us that the leadership didn't listen and 'imposed change' without listening. The trust was aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible.
- Patients were generally pleased with the care and treatment provided by Kent Community Health NHS Trust. Staff were caring, and supporting patients in their needs. Staff had made a difference, enabling patients to cope at home and generally improving the quality of their lives
- There are systems in place to report and record incidents, concerns, near misses and allegations of abuse. However we found that not all managers could access the computer systems and there was a degree of under reporting of safety incidents such as falls, pressure ulcers and missed visits.
- Learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings. Staff generally received feedback from any incidents however this feedback was variable across the organisation.
- Systems and processes were in place to ensure patients received appropriate evidence based personalised care and treatment. This included monitoring and audits of the service in order to inform priorities and service development. However we found that lack of staff in some areas and poor equipment services had an adverse effect on patient outcomes.
- Recruitment and retention of staff was variable across the organisation with some teams reporting vacancies for over a year. Low staffing numbers and inappropriate skill mix of some teams meant that patients did not always receive the care they needed. The Trust was aware of the staff shortages and had put recruitment strategies in place. Bank and agency staff were being used an interim measure. However where staffing levels had been low for a significant period of time this continued to have an adverse effect on patient outcomes and staff morale.
- The Trust was moving to an electronic system to record care and support teams. However where the paper based system currently in use was not always fully completed by staff and did not give assurance that risks were always identified, assessed or monitored.
- Patients did not always benefit from specific, measurable care planning starting from an initial comprehensive assessment which was updated periodically when needed and subject to effective quality assurance and robust performance management.
- Transcribing of information between computer systems, patients own care records, base records and those made by specialist teams such as out of hours or respiratory specialist nurses gave opportunities for error.

Summary of findings

- Although the Trust had provided training and development opportunities the distances to travel, the time required to undertake the training and the lack of resources in certain teams to cover meant that not all staff had undertaken the necessary training to enable them to carry out their job effectively.
- CQC had received concerns that certain groups of staff felt unable to raise concerns or whistle blow out of fear of losing their job and issues such as under reporting and poor record keeping hadn't been identified by the Trust as a risk.
- Although recruitment and retention challenges and equipment issues were identified as a risk and had action plans in place to address them, staff were still reporting instances where lack of staff or equipment were causing harm to patients and these risks were not being addressed in a timely fashion to protect patients.

We saw some good and outstanding practice including;

- There were robust safeguarding arrangements and the trust worked well with partner agencies to protect vulnerable people from abuse
- There was good multi-disciplinary and cross boundary working which meant that patients were assured of receiving the right care by the right team. The specialist services were especially praised for the support they gave not only to patients but the teams and wider health and social care community.
- Learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings
- The patients we spoke with were all happy with their nurses' and therapists' standards of hygiene. They told us how the nurses used sanitizing hand gel and/or used their own hand washing facilities during visits to their home.
- During our inspection we observed good hand hygiene and infection prevention practice within the district nursing clinics and by staff in patients own homes. We saw that staff throughout the Trust used personal protective equipment such as gloves and aprons and adhered to the 'Bare below the elbows' guidance to ensure that lower arms were kept clear of clothing and jewellery to help prevent cross infection.
- When we accompanied the district nurses and attended outpatient clinics we saw that patients were all asked their permission before any treatment or procedure took place and that where necessary consent forms were signed. Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.
- Qualified staff told us that there were lots of personal development opportunities available in the Trust. They told us about further training and qualifications they had gained such as foundation degrees, post graduate courses, individual modules and mentorship.

However, there were also areas where the Trust needs to make improvements.

Importantly the trust should

- Address the understaffing, the equipment failings and poor record keeping in order to ensure patients receive safe care and treatment.

Summary of findings

Background to the service

Kent Community Health NHS Trust is one of the largest providers of community care in England covering the whole of Kent extending into London and East Sussex. This includes 12 district councils, seven clinical commissioning groups (CCG) and four acute trusts.

The Trust was formed by a merger of two NHS community trusts in 2011 and has been subject to significant reorganisation of services since then, the most recent being a realignment and rationalisation of community services in 2013. The services provided in each area of the county are heavily dependent on the services and model of care commissioned by the CCGs. With each of the CCGs at a different developmental stage this has led to differences in the way care is provided for adults with long term conditions across Kent.

The Trust provides adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and following a hospital admission to support them at home. Services are provides in people's own homes, nursing homes, clinics and GP practices and include:

- Community nurses including out of hours services
- Dieticians
- Health visitors
- Dentists
- Podiatrists
- Occupational therapists
- Physiotherapists
- Family therapists
- Speech and language therapists
- Radiographers
- Pharmacists
- Cardiac rehabilitation
- Regalement and intermediate care
- Specialist support services for example Parkinson's disease and diabetes.
- Health and wellbeing services such as smoking cessation and sexual health services.

Our inspection team

Our inspection team was led by:

Chair: Carolyn White, Director of Quality/Chief Nurse

Derbyshire Community Health Services

Team Leader: Sheona Browne Inspection Manager Care Quality Commission

The team of 34 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, patients and public representatives, experts by experience and senior NHS managers.

Why we carried out this inspection

Kent Community Health NHS Trust was inspected as part part of our comprehensive community health services inspection programme we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

Summary of findings

How we carried out this inspection

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

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

The inspection team inspected the following four core services at the Kent Community Health NHS Trust:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- End of life care

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We carried out the announced inspection visit between 09 and 13 June 2014.

What people who use the provider say

We spoke with 46 patients or their carers across the trust from clinics and out patients to visiting patients in their homes or contacting them by telephone. We looked at patient feedback and the complaints the trust had received.

All the patients we spoke with, without exception, told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust. We were told about the kind and caring community nurses and therapists who were more 'like a friend coming'. Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, "All the staff are good, some are excellent".

Patients said that they were always treated with dignity and respect and gave examples where nurses had taken time to explain things to them, not making them feel silly or rushing them but treating them with respect and compassion. Patients were full of praise for the teams that saw them at home. 'First Class', 'A1'and 'the very best were among the words used, and the knowledge and experience of the team members was highlighted.

One patient, speaking of the Folkestone team, said, 'this must be the best team in which to learn to be a nurse', when saying that he had seen a student nurse. They told us they were partners in their care and felt information was shared that enabled them to make decisions about their own care and treatment. Carers we spoke to told us they felt involved and that they were listened to. The patients at the lymphoedema clinic stated how cared for they felt during their appointments, which could take one to one and a half hours. Patients without exception said that the staff made time for them and answered their questions 'or they found the answer for me'.

All the patients we spoke with were full of praise for the service they received. One person said, "No matter how busy they are they always have time to talk". Carers told us that they were always listened to and their opinion taken into consideration.

Good practice

We saw some good and outstanding practice including;

Summary of findings

- There were robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.
- The Trust's infection rates were low when compared with national benchmarks. This indicated good infection control practices were employed across the service.
- The patients we spoke with were all happy with their nurses' and therapists' standards of hygiene. They told us how the nurses used sanitizing hand gel and/or used their own hand washing facilities during visits to their home.
- During our inspection we observed good hand hygiene and infection prevention practice within the district nursing clinics and by staff in patients own homes. We saw that staff throughout the Trust used personal protective equipment such as gloves and aprons and adhered to the 'Bare below the elbows' guidance to ensure that lower arms were kept clear of clothing and jewellery to help prevent cross infection.
- The service was using technology to improve care. Cardio-respiratory nurses were using remote blood pressure monitoring equipment which enabled staff to check on patients observations in the own home whilst back at base. This was helping patients to stay independent in their own homes and self-manage their condition. Community nurses visiting patients at home using computer tablets which were being used to take pictures of wounds and then send them to the specialist tissue viability nurses for advice on treatment. Staff told us this improved the accuracy of patient's observations and reduced errors.
- Patients told us, and patient feedback received by the Trust, showed patients felt were treated with kindness, care and compassion and staff made time for them.
- The Community teams told us that accessing interpreters was not a problem and the Dover team had an interpreter permanently on the staff as they provided health care to a large Eastern European community. Patient information leaflets were available in a variety of languages, including Czech, Slovakian and Turkish.
- There was good multi-disciplinary and cross boundary working which meant that patients were assured of receiving the right care by the right team. The specialist services were especially praised for the support they gave not only to patients but the teams and wider health and social care community.
- Learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings
- When we accompanied the district nurses and attended outpatient clinics we saw that patients were all asked their permission before any treatment or procedure took place and that where necessary consent forms were signed. Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.
- Qualified staff told us that there were lots of personal development opportunities available in the Trust. They told us about further training and qualifications they had gained such as foundation degrees, post graduate courses, individual modules and mentorship.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Review the efficacy of the Trust recruitment
- In relation to care planning, provide further training on the principles of holistic, rather than task orientated, care planning.
- Regularly audit and review the quality of care planning to ensure patients always benefit from specific, measurable care interventions that commence with an initial comprehensive assessment, that meet all their

identified needs including those in relation psychological, emotional and social support takes account of their preferences and which is updated periodically.

- Ensure that all community matrons have skills and qualifications in prescribing to ensure patients in acute pain receive prompt medication.
- Review arrangements for the provision of equipment to ensure that appropriate equipment is available in a timely fashion to support patients and staff to prevent an adverse effect on patient outcomes.
- Review the timescales in relation to the roll-out of electronic systems that support and record care to ensure that there is assurance that risks are always identified, assessed or monitored using an effective system. They should take steps to introduce standardised record keeping across the service to improve standards of record keeping and to minimise the risks associated with records. They should review the systems and processes in use, including those for allocating visits, with the aim of minimising the transcription of information from one system to another to reduce the risk of transcription errors.

Kent Community Health NHS Trust

Community health services for adults

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Community Health Services for Adults safe?

By safe, we mean that people are protected from abuse

Summary

Services provided to adults in the community were safe.

The Trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. However we found that not all managers could access the systems and there was a degree of under reporting of safety incidents such as falls, pressure ulcers and missed visits. Learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings. Locally staff told us they usually received feedback from any incidents however there were differences across the county. Patients were kept safe through robust safeguarding arrangements and the trust worked well with partner agencies to protect vulnerable people from abuse.

Recruitment and retention of staff was a serious problem in some areas of the county with some teams reporting vacancies for over a year. The low staffing numbers and inappropriate skill mix in some teams meant that patients did not always receive the care they needed. The Trust was aware of the understaffing and had put recruitment strategies in place and were using bank and agency staff as an interim measure. However the situation continued to have an adverse effect on patient outcomes and staff morale

The Trust was moving to an electronic system to record care and support teams. However the paper based system currently in use was not always fully completed by staff and did not give assurance that risks were always identified; assessed or monitored Staff use a paper system when they cannot access systems. Patients did not always benefit from specific, measurable care planning starting from an initial comprehensive assessment which was updated periodically when needed and subject to effective quality assurance and robust performance management. We found there was transcribing of information between computer systems, patients own care records, base records and those made by specialist teams such as out of hours or

respiratory specialist nurses. Although records were managed differently between the various teams and divisions throughout the county the transcribing between records gave opportunities for error.

Detailed findings

Incidents, reporting and learning

- We found that the Trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. This included the on line reporting tools, policies, procedures and audits. The trust worked with partner agencies such as the Clinical Commissioning Groups (CCGs) and social services to investigate any concerns and develop actions plans.
- Information regarding incidents were fed through to the Quality Committee where safety and safeguarding concerns were reported, discussed and escalated to the Trust Board. This demonstrated that there were clearly defined systems in place for reporting safety incidents and allegations of abuse which were in line with national and statutory guidance.
- The incident reporting information available indicated that the Trust reported below the national average for pressure ulcers, venous thrombosis, falls and urinary tract infections. When we queried this with staff and managers we found that there was a degree of under reporting. For example, staff told us that incidents such as falls or missed visits were not consistently recorded on the electronic monitoring system. Although the trust's on-line reporting system was available for all staff to use, there were inconsistencies in the grades of staff using it. For example, band three staff members told us they used the system while some band 5 staff told us they reported incidents to senior staff who then completed the online report.
- On reviewing records we found instances where falls and pressure ulcers had not been reported. We spoke with managers about under reporting and asked how they monitored incident reporting and we asked various managers for their individual team's incident data. The response from managers across the county was inconsistent. Some managers were fully aware of their team's incident reporting rates and told us about their reporting figures, incidents and complaints. Others were less knowledgeable and told us that they did not have access to the system because they were recently appointed; one manager commenced in post in April 2014 and another manager commenced in post the week before our visit.
- We found that managers did not always have the tools to monitor incidents as they did not have the appropriate level of access to the IT systems. Not all incidents where patients came to harm or were at risk of coming to harm were reported through the Trusts electronic incident reporting systems. There were inconsistencies in the way managers across the county used data from the risk registers for the area they were responsible for.
- We saw that learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings. For example, in response to a series of insulin related incidents the Trust had undertaken an investigation and put an action plan in place help improve staff practice and to avoid any further errors in the administration of insulin.
- The action plan in the board minutes of February 2014 identified that where possible the day staff should administer insulin, a diabetic nurse consultant would be appointed, patient information would be updated and additional training would be put in place. This information was dispersed throughout the Trust at team meetings, in staff bulletins and through the Trusts intranet to help ensure all staff were updated and given the opportunity to learn from past issues.
- On speaking with front line staff they were aware of the incidents involving insulin and the actions needed to address the action plan. This demonstrated that there were systems in place to learn from incidents that had been escalated to the Trusts clinical governance teams.
- Locally staff told us they usually received feedback from any incidents however there were differences across the county. Some staff told us that although there were systems in place for learning, in their individual team learning was not embedded and gave examples where they had to chase and follow up for feedback.
- Other staff from different teams gave several examples where learning from incidents had been shared for example a patient with leg ulcers did not have a care plan in place and their skin condition deteriorated. The learning from the investigation identified a poor documentation by agency staff and a plan was put in place to monitor this and shared across the team.

Good

Are Community Health Services for Adults safe?

- The Trust demonstrated there were systems in place to learn from incidents in order to reduce the likelihood of the incident happening again although the process was not embedded in all teams.
- Most staff teams were knowledgeable about the process for gathering data as part of the NHS Safety Thermometer initiative. This tool monitored improvements in patients subjected to pressure ulcers; falls; venous thromboembolism (VTE's) and catheter acquired urinary tract infections with the aim of improving clinical care.
- We saw that the information gathered for the Safety Thermometer was fed back to senior managers and directors of the Trust who used the information to inform them of the current risks and plan strategic priorities. However we noted that in one area, the data collected for the safety thermometer for May did not correlate with the incidents recorded on the online reporting system.

Cleanliness, infection control and hygiene

- The Trust had up to date infection control policies and procedures in place. This included disposal of clinical waste and sharps. Staff told us that following incidents of needle stick injuries the teams had discussed safe waste disposal at their base meetings. This demonstrated that there was learning from incidents to improve infection control practice.
- We looked at infection control systems and practices and found that the trust's infection rates were low with new urinary tract infections among patients with a catheter below the England average for the year ending April 2014. The trust's infection rate of C. difficile reduced from 14 to 8 incidents in the previous year with zero MRSA bacteraemia rates for the second year running. This indicated good infection control practices across the Trust.
- The patients we spoke with were all happy with their nurses' and therapists' standards of hygiene. They told us how the nurses used sanitizing hand gel and/or used their own hand washing facilities during visits to their home.
- During our inspection we observed good hand hygiene and infection prevention practice within the district nursing clinics and by staff in patients own homes. We saw that staff throughout the Trust used personal protective equipment such as gloves and aprons and adhered to the 'Bare below the elbows' guidance to ensure that lower arms were kept clear of clothing and jewellery to help prevent cross infection.
- We heard how the infection control link nurses undertook monthly audits and kept 'Hand washing' competency data which all the staff had completed. We saw that hand washing and uniform audits were undertaken on a monthly basis and the March 2014 reached between 91 – 100% compliance. Infection control was included in the annual mandatory training for all staff. However not all staff were up to date with their mandatory infection control training.

Maintenance of environment and equipment

- Patients were seen in a wide variety of locations throughout the Trust ranging from GP surgeries, community hospitals, and clinics and in their own homes. There were no concerns raised about the maintenance of the environment and equipment although it was noted that some of the older locations looked tired and in need of refurbishment, others were new and looked easier to maintain.
- Staff told us about some of the difficulties that the design and layout of the buildings presented. For example, in the Westcliff Community hub the open plan nature of the building meant it was difficult to maintain confidential conversations. Although there were small side rooms available on a day to day basis having confidential conversations on the phone with patients or discussing issues within the team was difficult.

Medicines

- There were systems in place for the safe administration of medicine in the community including readily available policies and procedures. We noted that there had been four drug related incidents in the past year with three relating to insulin use. As a response to this the Trust had conducted a Root Cause Analysis (RCA) investigation and had an action plan in place to address the issues found. This included additional training in the management of diabetes medication however we found that the action to be taken was very overdue.
- We had concerns that the under reporting of incidents included drugs administration as during discussions with staff we found two medicines related incidents which had not been reported. One was where a patient had not taken their medication as the result of a missed

visit and the other was a patient admitted to hospital because the community matron visiting the patient was not a nurse prescriber and had been unable to arrange for the doctor to prescribe the medication in a timely fashion.

Safeguarding

- The Trust had in place policies and procedures to safeguard vulnerable adults together with key contact numbers. We saw terms of reference and minutes of meetings which demonstrated that through the Kent Safeguarding Vulnerable Adults Board (KSVAB), the trust worked in partnership with statutory agencies such as the local authorities and police to safeguard vulnerable adults. The trust had named safeguarding nurses and specialist safeguarding advisors within designated safeguarding teams.
- We noted that since registration 45 safeguarding incidents had been raised for the Trust. The majority of safeguarding concerns raised involved the trust not acting promptly on a patient's deteriorating condition. From the minutes of the Adults Operations Quality Meeting we noted that safeguarding was a standing item on the agenda and any issues were discussed together with action plans. We found the trust had robust arrangements in place to safeguard vulnerable adults.
- All the staff we spoke with knew how to recognise signs of abuse and were confident about reporting concerns. At the focus groups community staff described incidents where they had reported concerns and the action that was taken. Staff told us that safeguarding was well managed in the Trust. They told us that they usually received feedback following reporting an incident and any lessons learnt were disseminated through the team.
- Safeguarding vulnerable adults training was included in the Trusts mandatory training programme and all staff were expected to attend training relevant to their role and responsibility. However on reviewing training matrix we found that not all staff were up to date with this. Although not all training was up to date we found that staff understood the signs of abuse and were confident in escalating concerns and reporting through the trusts safeguarding processes.

Records

- The Trust told us that they were introducing an electronic system of care documentation. We spoke with nursing and therapy staff who told us about the move to electronic records. Some of the staff we spoke to had misgivings about the computer based records system as connectivity across Kent was problematical and many staff did not feel confident with the new technology. However other staff were looking forward to receiving the new IT equipment.
- One group of community staff told us how records sometimes went missing due to patients throwing them away or relatives taking them. They told us they were looking forward to the training to enable them to keep electronic records. We saw that the Trust had put in place training for staff before the system was to go live later in the year.
- During our inspection we reviewed 20 sets of care records at varying locations across the Trust. We found the Trust relied heavily on paper based systems to plan and assess patients' needs and then document the care given to meet those needs and monitor the outcomes. In the community, care records were kept both in the patient's home with summaries held back at base with hand written copies in both locations. We found that the summary records kept at base did not reflect the care given and many had not been updated for some time. Many base held records were simply equipment requests and correspondence.
- During our inspection we noted there was a lot of transcribing of information between computer systems, patients own care records, base records and those made by specialist teams such as out of hours or respiratory specialist nurses. For example observations taken and recorded in the patients' home were then transferred to a diary and later in the day put in the patient's base notes. Records were managed differently between the various teams and divisions throughout the county but in general there was much transcribing between records which gave opportunities for error.
- We found that the specialist, therapy and out of hours services kept separate records. Staff across the Trust told us there was good communication between all services such as when a patient was seen as an emergency out of hours or there was a change in treatment following a visit to a specialist service. They told us that the community nursing office would be telephoned to alert them to the changes with a note made either in the diary or in the patient's notes. We found that the use of multiple paper based record systems increased the opportunity for errors.

Good

Are Community Health Services for Adults safe?

- The community care records we reviewed documented the care given at the visits well, with the daily contemporaneous notes completed at each visit. However the care plans were task orientated and did not address the patient holistically. For example patients psychological, emotional and social support needs were not routinely assessed or included in the care plans.
- One team told us about the monthly records audits that were done and showed us how the risk assessments had improved as a result. We saw that this team were using electronic equipment to take photographic evidence. They demonstrated how they involved the patients in their care by discussing their care needs with them and encouraging them to sign the care plan.
- The Trust had started to introduce electronic systems to plan caseloads but these were not fully operational or embedded, with staff copying entries from computers into desk diaries and then again onto personal diaries. This meant there was a risk of transcribing errors when planning the day's work. For example, in one community nursing office we found the days allocations written on paper cards and held together with a bull dog clip. The cards were not standardised and each contained different information. Staff told us that they felt the system was effective but acknowledged that there was room for error.
- Some teams told us that there was usually one or two 'Missed visits' a week because they had been missed off the list when allocating or not copied into a diary. These were usually only discovered when the patient called to say no one had visited and were not recorded as incidents. The system for allocation was highly dependent on the nurses' individual knowledge of the patients with much room for error and loss of information. The system for allocating caseloads did not provide assurance that patients were always seen in a timely fashion according to their assessed need because of missed visits which were not recorded or monitored.

Lone and remote working

- The Trust had policies and procedures in place to protect staff when working alone or remotely. However we found that due to staffing pressures there were occasions when these policies had not been followed. For example, one of the out of hours teams we spoke with told us that there was often three nurses on a shift rather than five which meant that they sometimes had to work alone when visiting a patient for the first time.
- Staff raised concerns about the lack of security in some of the neighbourhood team hubs at night. They said that they phoned each other through their shifts to let each other know where they were.
- The Trust acknowledged that due to staffing constraints that best practice could not always be followed and had put in place guidelines to support staff when working without a qualified nurse in order to address staff safety concerns.

Assessing and responding to patient risk

- We looked at a wide variety of care records across the county in varying health settings and found that the majority of records were incomplete with risk assessments for falls, poor nutrition and the development of pressure sores not undertaken or updated on a regular basis. This meant that there was a risk that when a patient deteriorated this was not identified quickly and measures put in place to address the issues.
- We looked at the incident reports for the past year and found that there were incidents where pressure sores had developed or deteriorated due to changes to the patient not being identified promptly, communicated effectively or actions taken promptly. Poor risk assessments was an identified factor in many of the safeguarding alerts made involving pressure ulcers in the community. We found that the assessment of risks to patients was not always carried out in a timely or effective manner.

Staffing levels and caseload

- The Trust acknowledged that recruitment and retention of staff was identified on the trust's risk register. In December 2013 there were areas of the Trust which were working with a 13 - 20% vacancy rate and although this was improving there were still areas that had been chronically understaffed for some time. The situation was compounded by differing service provision and increasing demands with the seven CCGs. The Trust had a Nursing Recruitment Strategy Workforce Group with action plans in place to address the staffing issues.
- During our inspection we found that across the county the staffing situation varied from area to area and team

to team. There were areas and teams that were fully staffed, had low reliance on bank or agency staff and had manageable caseloads. Staff in these teams felt able to manage a heavy caseload as they were well supported by their team. However there were also teams which had been understaffed for many months. We heard of nursing posts that had been vacant for over a year. Staff in these teams told us they were exhausted and demoralised. They told us of incidents where they felt unsafe and pressured to deliver care outside of their area of competence. They told us that they did not take lunch breaks and that any non-urgent work would be 'Put off for another day'.

- Staff working in these understaffed teams told us of instances where patients' first visits were undertaken by health care assistants and it took several days for patients to have a care plan in place as the qualified nurses were so over stretched. They told us there were instances where patients were not seen by qualified staff every three visits according to trust guidelines.
- We were told of an out of hours team who sometimes had an agency band two health care assistant on duty with only telephone access to a qualified nurse working in another area. We were told of staff taking work home to do as there was not enough time to do the paper work during the day. Nurses told us, "We want to do a good job but we are so short staffed we only get time to do the basics".
- We found that all the understaffed services worked hard to ensure that staffing issues did not affect patient care but there were instances where insufficient numbers of suitably qualified staff had impacted on patient outcomes. For example missed calls, poor record keeping, delays in accessing intermediate care teams and deteriorating pressure ulcers.
- The Adult Operations Quality Meeting in May 2014 acknowledged the correlation between a higher incidence of pressure ulcers and high vacancy rates. We were told that all heads of service had recruitment plans in place to mitigate a shortage of staff. However staff turnover matched staff recruitment which meant that the vacancy levels stayed the same.
- In the absence of a tool appropriate for community nursing services the trust had undertaken an adapted version of the Safer Nursing Care Tool, which provided guidance on staffing levels aligned to the acuity and dependency of patients. The Trust was also working with national bodies in the development of a community staffing tool.
- At inspection we noted that different teams used different methods for calculating the community nurse staffing levels and caseload weighting. For example some teams used simple feedback from the nurses and others used a computer programme for capacity and demand which looked at skill mix, the number of staff available and the level of patient need to determine staff allocation.
- However, because of the staffing vacancies the majority of teams were working with high caseloads. This meant that there was often only time to do the basic nursing tasks with little time to address the patient's holistic needs. We noticed this on our visits our with the community nursing teams. Staff managed the tasks allocated in a timely fashion but there were occasions where nonverbal clues that the patient was uncomfortable were not picked up due to the nurse needing to move onto the next patient.
- Several patients in the East of the Trust commented on how many different nurses they had seen at home. They tended to stress that all the nurses were 'good' or 'excellent', but would prefer more continuity to establish a better rapport. Most understood that this was hard to avoid due to staffing pressures.

Deprivation of Liberty safeguards

- The Trust had policies, procedures, advice and guidance for staff relating to the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DOLs) and consent. These were readily available to staff on the Trust's intranet together with best interest guidance and relevant forms to conduct mental capacity assessments.
- Staff understanding of the act varied across the trust with some teams having full understanding with capacity and consent firmly embedded in practice and other teams were not so confident and told us they would need to look up the policies to make sure.
- When we accompanied the district nurses and attended outpatient clinics we saw that patients were all asked their permission before any treatment or procedure took place and that where necessary consent forms were signed. Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.

Good

Are Community Health Services for Adults safe?

- The Trust had in place robust policies and procedures in place to guide staff in complying with the MCA, DOLs and consent guidance although not all staff were confident to apply this in practice.

Managing anticipated risks

- The Trust maintained risk registers which were discussed at the monthly management meetings between the director and the head of service. We asked managers how they managed the risks within the team and we found this was managed differently through the trust. Although some managers had IT access and were managing the team risks effectively others told us that they did not know what was on the risk register and could not access the system.
- We spoke with managers who did not use IT or electronic spreadsheets but held paper based documents in lever arch files. We reviewed these files and found they were not always kept up to date, did not include risk assessments or action plans. One 'Risk Register' consisted of a list which included 'Missed visits' and 'Unsafe discharge' without any further information or action plan.
- We had concerns that staff with the direct responsibilities for managing risk did not have the information or tools to do so effectively. For example although 'Missed visits' were included on the risk register the manager was unable to tell us how many there had been in the last month and did not know the frequency. This was the same with complaints management which we were told was in a 'protected' area of the trust's shared drive which could only be accessed by the Head of Service.
- Not all managers with risk management responsibilities could access information about risks or complaints in order to manage them effectively.
- We spoke with senior managers and directors at the Trust and were told they had identified that recruitment and retention of suitably trained and experienced staff was a major anticipated risk to the organisation. The Trust reported that together with an ageing workforce, sickness levels and remote locations many of the teams were under staffed and were suffering with too many agency staff. They told us the Trust was aware of the staffing issues and had plans in place to address them such as recruiting from abroad and developing links with universities. However there were inherent difficulties due to the locations of some of the teams that made recruiting and retaining suitably trained and experienced staff difficult.
- The Trust had a programme to 'Grow their own' talent but this had led to problems with staff being promoted without having the necessary skills or experience for the post they were recruited to. An example of this was community matrons who did not have nurse prescribing qualifications which was acknowledged as being essential for the role. One community matron told us that they could not see themselves getting the qualification within the next four years due to work pressure and the time needed to study.
- We found that the Trust had systems in place to manage anticipated risks and develop action plans, however staff with direct line management for risk management did not always have the equipment, knowledge and skills to do so effectively.

Major incident awareness and training

- We were told that the Kent Community Health NHS Trust had several high profile locations where major incidents may occur such as the ports, international rail links, Channel Tunnel and airports. We were told how regular training took place on responding to major incidents alongside of other emergency services, health and social care providers. Managers told us how proud they were of the way staff always responded to requests for help during any major incident alert.
- Staff gave examples of how well the emergency planning worked following recent flooding in the area. One member of staff worked closely with social services in assessing patients and finding them alternative accommodation. The Trust had robust measures in place to deal with major incidents and maintain public safety.

Requires Improvement

Are Community Health Services for Adults effective?

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

Summary

The Trust had systems and processes in place to ensure patients received appropriate evidence based personalised care and treatment. This included monitoring and audits of the service in order to inform priorities and service development. However we found that lack of staff in some areas and poor equipment services had an adverse effect on patient outcomes

Although the trust had provided training and development opportunities the distances to travel, the time required to undertake the training and the lack of resources in certain teams meant that not all staff had undertaken the necessary training to enable them to carry out their job effectively.

There were good multi-disciplinary and cross boundary working which meant that patients were assured of receiving the right care by the right team. The specialist services were especially praised for the support they gave not only to patients but the teams and wider health and social care community.

Detailed findings

Evidence based care and treatment

- The Trust had a range of policies and clinical guidelines available for staff. These were held on the trust's intranet and readily accessible for staff in the community. The policies were up to date and based on current best practice guidelines such as NICE (National Institute for Health and Care Excellence). Staff told us about Best Practice Forums where staff met to discuss current guidelines and any new initiatives. We saw minutes of meetings where new guidelines were discussed and how to implement them in the community setting. This demonstrated that the trust was proactive in working to implementing new best practice guidelines.
- We were told that productive ward programme had been used in inpatient and community teams to increase patient facing time and was used in developing a staffing tool for the trust. However when we asked community teams across the trust there was little knowledge of the initiative or its implementation.
- The Trust employed lead and specialist nurses who supported education around best practice in their specialist areas. For example, respiratory specialist nurses were investigating streamlining the care pathway to improve the service to their patients and the heart failure team who were delivering heart failure competencies. We spoke with specialist teams across the trust such as the Falls Prevention Service, diabetes and heart failure teams. These teams used best practice guidance to inform their care and the service offered.
- From May 2013 the Trust had started to use FACE (Functional Analysis of Care Environments) a single assessment document used to provide integrated care for patients. This document included assessment and care planning tools. During our inspection we reviewed over 20 care records and found that the assessment and planning of care was inconsistently completed across the trust. For example we found basic assessments for nutrition, moving and handling and falls assessments had not been completed or updated where there was identified need such as a recent fall or development of a pressure ulcer. Staff told us that it took over an hour to complete the FACE document and felt it was too time consuming when they were so stretched for time. Managers told us that the document did not have to be fully completed and that some teams used an abridged 'Five visit' version which was more user friendly. However we found that basic information and risk assessments had not been completed in a number of the records we looked at across the trust.
- We found that the trust had appropriate guidance, policies and procedures in place but there were few monitoring systems in place to provide assurance that staff worked according to the evidence based guidance.

Pain relief

- The Trust supported patients with chronic pain through the Integrated Clinical Assessment and Treatment Services (ICATS) based in East Kent. The team consisted of a multi-disciplinary team of clinicians specialising in the treatment of long term chronic pain. The service was delivered through local outpatient clinics at locations

across East Kent and aimed to support patients in achieving self-management of their pain thereby reducing dependency on healthcare services. This service was not reviewed during our inspection.
- The lack of community matrons with prescribing meant that there was sometimes a delay in patients in acute pain receiving prompt medication.

Patient outcomes

- The care and treatment provided usually achieved positive outcomes for people who used the service. We spoke with 46 patients during our inspection and reviewed details of patient feedback including satisfaction surveys. We noted that much of the care delivered was task orientated and this was reflected in the care records kept.
- Staff told us that it was difficult to meet patients' expectations when time was a factor as clinical tasks took priority. Although when we accompanied community nurses on their visits we observed good care, staff did not always have time to deal with the patients holistically.
- Staff in the Out of Hours teams told us that there was sometimes a breakdown in communication which led to either missed or inappropriate calls. They gave the example of visiting a patient's home to find they had died earlier in the day.
- However all the patients we spoke with people talked positively about the care they had received and told us about the way the community services provided had helped to improve their lives. For example the patients of the Neuro-rehab Team in Gravesend told us how their lives had improved after receiving help from the team. One lady said, 'I'm now able to bake a cake', saying that before her hand function had been very poor and now she could use it to perform simple tasks. Another patient told us that they had changed their mind about giving up work following intervention from the team.
- We heard how the rapid response service as part of the intermediate care teams were improving patient outcomes and reducing hospital admissions amongst patients with complex conditions. The teams consisted of nurses, physiotherapists, occupational therapists and therapy assistants who worked with social services and other health providers to provide urgent support to patients in their own home including out of hours.
- The Trust provided details of audits such as the pressure ulcer and urinary catheter quality indicator which indicated that patient outcomes were improving. However due to under reporting of incidents the validity of some of this data was queried.
- Talking with staff we were not satisfied that all pressure ulcers were always correctly graded or reported as we found incidences of under reporting. We reviewed incident and safeguarding reporting data and noted that failure to act in a timely fashion had been a factor in deteriorating pressure ulcers. The care records we reviewed had not all been fully completed with risk assessments either not in place or not updated when a patient's condition changed.
- We found that in general patients were achieving positive outcomes for their conditions following intervention by the Trust.

Performance information

- Performance information across the trust was variable. The Trust used performance indicators to benchmark the outcomes for people using the service. However because of the change and transformation programme together with the rationalisation of services, we were told that the data collected previously did not always apply to the current configuration of services. The staffing situation in areas where there were few experienced managers in post meant that performance information was not always complete.
- We spoke with managers who told us about new initiatives to collect data and told us that the implementation of electronic records would improve data collection in the future.
- The Trust had an annual clinical audit programme which was made up from clinical audit projects undertaken within each of the trust's clinical directorates. Each directorate agreed its own clinical audit topics for example departmental records audits and national audits such as the stroke audit. We saw that some audits were undertaken in response to local concerns such as why patients did not attend outpatient appointments and others were in response to safety incidents.
- The Trust had systems in place to monitor its safety performance through the electronic incident reporting

system; for example there were 119 serious incidents reported by the Trust between December 2012 and March 2014 which occurred in the community care sector.

- The most common type of serious incidents reported were pressure ulcers (grades 3 and 4), which accounted for 58% of the incidents. We saw that the information was used to inform practice and prioritise resources. For example the trust had put in place a pressure ulcer sub group who looked at the data collected relating to pressure ulcers including the reporting, timing, severity, locations and cost implications. The findings from the sub group helped target resources to teams that were struggling and promote best practice from areas where there were positive outcomes.
- The Trust was collecting data to monitor performance; however a period of stability was needed to embed the process and benchmark the information both locally and nationally.

Competent staff

- The Trust provided training opportunities for staff from induction and mandatory training to funding for bespoke specialist training. The training was monitored by the team managers who used a computer based training matrix. We were told that although the Trust provided the training and managers oversaw their teams training needs, it was the individual's responsibility to attend the required training.
- Staff told us that their managers supported them in attending training but with the staffing shortages and distances involved it was hard to attend. In response to this managers were putting more training on locally and in house.
- Qualified staff told us that there were lots of personal development opportunities available in the Trust. They told us about further training and qualifications they had gained such as foundation degrees, post graduate courses, individual modules and mentorship. However the community matrons told us that although the role of nurse prescriber was essential for the role, many of them had had difficulties in accessing the prescribing course for either time or resource reasons. This meant that many of the community matrons could not fully undertake their role as they did not have the clinical competencies to do so.
- The training records across the trust showed that the majority of staff had undertaken their mandatory training although there were identified gaps managers were aware of them and were chasing them up.
- Staff told us that the training situation had improved recently and that new staff received a good induction to the Trust. There were concerns form staff raised about the induction and support that existing staff received when they were promoted. Several newly promoted managers and senior staff told us they had not received any induction or support when starting in their new role. One manager told us how they struggled as a result.
- We were told that a lot of training was 'E-learning' conducted remotely by computer. Staff told us they did not get protected time to undertake this training. The Out of Hours teams told us that some training was provided out of hours.
- The majority of staff had received annual appraisals although performance objectives were not always clear. We found that in those teams that were understaffed appraisals had not been done, there were few clinical supervision opportunities for staff and there were difficulties in signing off clinical competencies. Staff we spoke with told us that they found other ways to support each other such as informal learning sets and they used team meetings for support.
- Staff told us that when there was new equipment they had received relevant training and gave the example of syringe driver training which had been problematical.
- The Trust provided opportunities for staff induction, learning and development. However there were barriers to staff learning and development which meant that not all staff had received the training necessary for them to undertake their roles effectively.

Use of equipment and facilities

- Throughout the Trust we heard from staff and patients about difficulties in accessing the right equipment in a timely fashion. The provision of some equipment had been contracted out to a private provider and there were delays in providing patients with the equipment they needed.
- One team told us of delays of over 10 days in providing pressure relieving equipment. Another team told us that they routinely had to wait for several days and spend much time on the telephone chasing up the supplier. A carer told us how they had to wait three days for specialist pressure relieving equipment for their relative

who had a terminal condition. We heard that on occasion the delay in accessing equipment had led to the patient's condition deteriorating.

- Managers told us that interim arrangements had been put in place where the Trust provided 'Buffer' stores at various locations where staff could access equipment quickly if needed. However we were told that access to the emergency equipment was not easy, some staff not knowing about them or where they were kept, others telling us that access was restricted.
- The Trust acknowledged that there were problems for community staff in accessing correct equipment for patients in a timely fashion. This issue was included on the Trust's risk register and was being closely monitored with daily reports and weekly conference calls with the equipment provider.
- We were told that told that there were also problems with the availability equipment such as dressings, continence products and bladder scan equipment. The Trust was aware of these issues and had put measure in place to address them such as improved training for ordering.
- The delay in equipment availability was having an adverse effect on patient outcomes.

Tele medicine

- Community matrons and nurses from the specialist teams told us about the introduction of telehealth, in some areas of the community. For example, cardio-respiratory nurses were using remote blood pressure monitoring equipment which enabled staff to check on patients observations in the own home whilst back at base. This was helping patients to stay independent in their own homes and self-manage their condition.
- The Trust told us that they were rolling out the use of telemedicine with the community nurses visiting patients at home using computer tablets which were being used to take pictures of wounds and then send them to the specialist tissue viability nurses for advice on treatment. Staff using the new equipment were pleased with it saying it improved the accuracy of patient's observations and reduced errors.

Multi-disciplinary working and working with others

- Weekly multi-disciplinary team meetings (MDT) were held which were attended by a wide range of professionals. The care of each patient was discussed at these meetings on a case by case basis. The staff told us that it would be useful if a GP representative could always attend the meetings to ensure that the patients' medical needs were being met and considered alongside of their nursing, social and therapy needs.
- A pilot involving care homes was taking place aimed to reduce hospital admissions. This was a team looking into reducing hospital admissions from care homes. We heard that the team was successfully reducing admissions from a small band of care homes that were finding it difficult to cope with more complex patients. This service had not yet been audited. The team consisted of district nurses but did not include therapists.
- We found many examples of good multi-disciplinary working both within the Trust and with outside organisations. For example, staff told us that the long term conditions team attended meetings with the local acute trust to discuss safe discharge and integrating care, a representative from the local hospice attended the MDT meetings in Canterbury and there is always a representative from social services at the MDT meetings.
- Across the trust staff told us they had a good relationship with specialist teams who were a good resource for other health services.

Co-ordinated integrated care pathways

- Staff described the patient centred model of care and how they worked collaboratively with the health and social care coordinators. We saw that patients followed integrated care pathways where appropriate. This was a plan of care written and agreed by a multidisciplinary team and designed to help patients with a specific conditions move progressively through the clinical experience. These worked particularly well in the rehabilitation teams.
- The Trust used an electronic system working with GPs and ambulance service to reduce admissions to hospital. This system alerted the right team and GP surgery if a patient had received care from the ambulance service. They could then be quickly referred to the right team in the Trust. For example, if a patient had a fall at home and called the ambulance service they could quickly be referred to the falls team to reduce the chance of them having a recurrent fall.

Good

Are Community Health Services for Adults caring?

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

Summary

We spoke with 46 patients or their carers across the Trust from clinics and out patients to visiting patients in their homes or contacting them by telephone. All the patients we spoke with told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust and told us that the staff were kind and caring supporting them in their needs.

We heard from patients and carers how the staff had made a positive difference in their lives enabling them to cope at home and generally improving the quality of their lives.

Every patient that we spoke to spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, "All the staff are good, some are excellent".

Detailed findings

Compassionate care

- We spoke with 46 patients or their carers across the Trust from clinics and out patients to visiting patients in their homes or contacting them by telephone. We looked at patient feedback and the complaints the Trust had received. The information provided indicated that staff in the Trust treated patients with care and compassion. We did see a few complaints in which staffing attitude was a factor but these issues had been dealt with promptly and appropriately.
- All the patients we spoke with without exception told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust. We were told about the kind and caring community nurses and therapists who were more 'like a friend coming'. Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, "All the staff are good, some are excellent".

Dignity and respect

- Patients said that they were always treated with dignity and respect and gave examples where nurses had taken time to explain things to them, not making them feel silly or rushing them but treating them with respect and compassion.

Patient understanding and involvement

- Patients were full of praise for the teams that saw them at home. 'First Class', 'A1'and 'the very best were among the words used, and the knowledge and experience of the team members was highlighted.
- One patient of the Folkestone team said, 'This must be the best team in which to learn to be a nurse', when saying that he had seen a student nurse. They told us they were partners in their care and felt information was shared that enabled them to make decisions about their own care and treatment. Carers we spoke to told us they felt involved and that they were listened to.
- We saw that throughout the Trust there were information leaflets available on various conditions, accessing services and they types of support available. The leaflets were available in other languages, including Czech, Slovakian and Turkish. When we spoke with the community teams they told us that accessing interpreters was not a problem and the Dover team told us they had an interpreter permanently on staff.
- Staff in the specialist teams told us how they had developed an educational package for patients to help them understand their condition and that this had been very well received. The trust provided information that supported people to make decisions about their care and treatment.

Emotional support

- The patients at the lymphedema clinic stated how cared for they felt during their appointments, which could take one to one and a half hours. Without exception patients said that the staff made time for them and answered their questions 'or they found the answer for me'.
- All the patients we spoke with were full of praise for the service they received. One person said, "No matter how busy they are they always have time to talk". Carers told us that they were always listened to and their opinion taken into consideration.
- The records we looked at did not include assessing patient's emotional needs or include care plans that addressed this. However in practice we found that the community teams supported patients emotionally although this was not documented.

Good

Are Community Health Services for Adults caring?

Promotion of self-care

- There were systems in place to support patients to manage their own health and care and where possible to maintain independence. We saw that the specialist clinics undertook remote observations by telemedicine to help give patients confidence in managing their conditions. We saw that therapists visited people in their homes offering advice on lifestyle, diet, exercise and equipment.
- Patients told us about the improvements that had been made in their lives due to attending specialist clinics. For example patients of the Neuro Rehabilitation Team in Gravesend spoke enthusiastically about how through the support of the team they could now undertake simple tasks and gave us examples of how much they had improved since attending the clinic.

Good

Are Community Health Services for Adults responsive to people's needs?

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

Summary

The Trust was responsive in meeting the complex needs of the people of Kent and the commissioners of services. The Trust was forward looking to improve the health of patients and improve their experience of healthcare through various initiatives such as the chronic knee pain programme and a new integrated discharge pilot. These programmes of work demonstrated that the Trust was proactive in working to improve patients' experience of healthcare and implementing new best practice initiatives.

We found that complaints were well handled in the Trust with the majority of concerns addressed at local level. Patients we spoke with told us that they had no problem in accessing the right service in a timely fashion and were happy with the service provided.

Detailed findings

Service planning and delivery to meet the needs of different people

- We found that service planning in the Trust was complex due to the differing demands of the seven CCGs. For example, the Trust was moving toward centralised community nursing hubs in order to provide better support to the district nurses and community therapists. However this was supported by some CCGs and not others who preferred to have district nurses attached to their GP practices. The Trust worked to accommodate this and supported the district nurses by bringing them into the central hub on a daily basis.
- We heard how the Trust was looking to improve the health of patients and improve their experience of healthcare through various initiatives such as the chronic knee pain programme and a new integrated discharge pilot. These programmes of work demonstrated that the trust was proactive in working to improve patients' experience of healthcare and implementing new best practice initiatives.
- Staff told us that there was an expansion of specialist services due to identified need in the community. We found that care and treatment was planned and delivered to meet the needs of patients' individual needs and the requirements of the commissioners.

Access to the right care at the right time

- We spoke with patients who told us that generally they were received the right care at the right time. One patient told us how they had to take analgesia before the nurses came to change their dressing so it was important for them to be seen promptly. They told us that it was working well and the district nurses visited three times a week at 10am. We were told that they had had a lot of different nurses visit in the past and that was when things went wrong with the dressings and timings. Now they had regular staff it was going really well.
- Another patient, with a spinal injury, in the East part of the Trust, told us how they were seeing the team daily for bowel care. He really wanted this to happen at 6.30 am, with the Out Of Hours Service (OOHs), but it had been happening later in the morning, with the DN Team. He was hopeful that the OOHs Team would soon be able to accommodate him.
- We spoke with staff in the various specialist clinics and most were able to see patients within the target times for the service. For example, new stroke patients were seen within 24 hours and two weeks for people discharged from hospital. However we were told of other services where non urgent patients were pushed further down the list by urgent cases until they 'Fell off the end' of the list and no longer required the service.
- We found that in general patients could access appropriate care and treatment in a timely fashion.

Meeting the needs of individuals

- There were a range of information leaflets available in the locations we visited from the GP clinics to community nursing hubs and community hospitals. We saw that leaflets were available in a variety of languages including Czech, Slovakian and Turkish.
- When we spoke with the community teams they told us that accessing interpreters was not a problem and the Dover team told us they had an interpreter permanently on staff as they provided health care to a large Eastern European community.
- The patients we spoke with all confirmed that their needs were being met and were full of praise for the service they received.

Good

Are Community Health Services for Adults responsive to people's needs?

- Most patients we spoke with knew how to contact their teams if they needed to. Some said it would be good to know at what time of day a nurse would visit, but in cases where this was crucial, such as the administration of medication the team clearly did stick to the same time of day.
- Staff told us that they were proud of the fact they usually were able to meet the needs of their patients even when working under pressure and under staffed. However they told us that it was 'very stressful because you are unable to provide the patient with all they need when you are spread so thinly'.
- The Out of Hours teams gave examples of ensuring patients' needs were met by visiting patients in the evening when the day nurses had been unable to visit.

Moving between services

- The Trust looked for ways to ensure that patients were safety transferred and discharged into the community. For example discharge from an acute hospital was seen to be complex resulting in delays of transfer. The Trust analysed the process and identified areas of duplication and improved the discharge process. Staff told us about the hospital integrated discharge team which worked together with the acute trusts to ensure safe discharge.
- Patients we spoke with told us about their experience of transfer between services and in general no problems were highlighted. One lady told us she was visited in her nursing home by the same team who would be seeing her once she went home. She appreciated seeing the same therapists.

Complaints handling (for this service) and learning from feedback

- We saw that leaflets and posters giving details on how to complain about community services was available in all of the locations we visited, from GP surgeries and specialist clinics to the community services hubs and hospitals. The leaflets contained contact information for the Customer Care Team and gave advice on how to access help and support.
- The Trust had policies and procedures available on the StaffZone (the trust's staff intranet) to support staff when dealing with complaints and included such guidance as staff resources when dealing with complaints and 'A guide to staff when saying sorry'. This demonstrated that the Trust had mechanisms in place to inform patients and guide staff when dealing with complaints about services.
- The Trust produced a monthly patient experience report for the board which detailed complaints, patient satisfaction scores and details of the NHS Friends and Families Tests undertaken together with feedback from other sources such as the NHS Choices website.
- We saw that the report detailed the actions taken as a result of patient feedback. For January 2014 the actions included a presentation to staff on the importance of customer care following comments about staff attitude; extending the timing for the automatic door on the Sapphire Unit; offering alternative brand of nicotine gum in the smoking cessation clinics and introducing a newsletter to keep patients up to date in the Food Champion Programme. This demonstrated that the Trust had mechanisms to listen to patients' concerns, bring them to the Board's attention and where possible took action to address them.
- We spoke to managers across the service and found that not all managers had access to their team's complaints. We spoke with one manager and queried how they could address issues if they were not aware of the details and were told that complaints were dealt with corporately. We found that managers' access to complaints varied across the county.

Good

Are Community Health Services for Adults well-led?

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

Summary

Kent Community Health NHS Trust had a detailed vision and strategy in place to meet the needs of the communities it served across Kent. This was communicated to staff and the public through the Trust's website and in leaflets and brochures.

The Trust had been through a sustained period of change and reorganisation leaving certain staff groups feeling disaffected. However the majority of staff we spoke with said they felt valued and supported by their managers and were proud of to work for the Trust. Staff from affected teams told us that the leadership did not listen and 'imposed change' without listening. The Trust was aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible.

We had concerns that some groups of staff felt unable to raise concerns or whistle blow out of fear of losing their job and that issues such as under reporting and poor record keeping had not been identified by the trust as a risk. However this was in isolated cases.

We noted that although the recruitment and retention and equipment challenges had been identified as a risk and had action plans in place to address them, staff were still reporting instances where lack of staff or equipment sometimes affected the care to patients.

Detailed findings

Vision and strategy for this service

- Kent Community Health NHS Trust had a detailed vision and strategy in place to meet the needs of the communities it served across Kent. This was communicated to staff and the public through the Trust's website and in leaflets and brochures.
- The Trust covered wide and disparate communities from busy cities and ports to isolated rural settlements and we noted the difficulties in providing parity of services across the county.
- We spoke with senior members of the Trust who told us that because of the recent restructuring and the complex relationships with the seven CCGs it was a challenge to deliver consistently good care across the county. They discussed the pressures and barriers and told us that the Trust was on a journey with five strategic goals to deliver. These were;

To prevent people from dying prematurely

Enhancing the quality of life for people with long term conditions.

Helping people to recover following ill health or injury.

Ensuring people have a positive experience of care.

Ensuring people receive safe care.

- All the staff we spoke with were working towards these goals whether or not they knew of the Trust's strategic vision.
- From discussions with staff and patients, observation of practice and review of documentation we found that the Trust board was aware of the areas which presented the most significant challenges and had plans in place to address them. For example, understaffing in some of the community teams and the introduction of new technology to improve record keeping and data collection across the county.

Guidance, risk management and quality measurement

- The Trust had available a full range of policies, procedures and guidance for staff available on the trust's 'StaffZone'. These were readily available for staff working in the community to access and those seen were in date and met with current best practice guidance.
- Risk management and quality measurement of services was monitored through the nursing and quality directorate. Information was fed into this group who then reported directly to the trust board. We saw that the trust responded to urgent initiatives through the formation of sub groups to review issues and actions taken such as the pressure ulcer sub group formed in response to concerns about the number of pressure ulcers in certain community teams. However we noted that although the recruitment and retention and

Good

Are Community Health Services for Adults well-led?

equipment challenges had been identified as a risk and had action plans in place to address them, staff were still reporting instances where lack of staff or equipment was causing harm to patients.

- The Trust gathered information and data which enabled them to benchmark their performance against other similar trusts and the different areas within the trust. The performance information included CQUIN's (Commissioning for Quality and Innovation) targets which linked payments to local quality improvement goals.

Leadership of this service

- Staff told us that the Trust's Board were now more visible, holding walkabouts in locations across the trust and that several all staff leadership events had been held although it was difficult to find time to release staff for these.
- Individual teams told us that they were well lead by their immediate line manager and felt that there was a strong leadership team above that. They all told us that they got good support from their team members. Other staff told us that the Trust offered excellent clinical leadership and support with learning about patients' conditions.

Culture within this service

- The Trust had been through a sustained period of change and this had affected staff morale in some of the more affected teams. Staff from these teams told us that the leadership did not listen and 'imposed change' without listening. However the majority of staff told us that although the past year had been difficult, they felt things were improving.
- The Trust told us that they were aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible. We heard about the various methods the Trust was using to change the culture of the organisation which included the leadership and management development programme, staff audits and action plans to address staff health and wellbeing. In particular the Trust was investing in the middle management tier to enable them to lead and develop their teams more effectively.
- Staff across the Trust told us that they would have no problem in reporting concerns, complaints and whistleblowing if needed, especially where this affected patients. Many staff told us that their managers had an 'Open door' policy and they felt able to raise issues with them. However this was not the case in all teams. For example, one group of staff told us they would be reluctant to whistle blow in case they lost their job and a manager told us that they might have a problem in whistleblowing as they were not sure that the organisation would support them. This indicated that the culture and ethos the Trust was promoting was not fully embedded and had not reached some teams.
- Across the Trust staff told us they were proud of their teams and the work they did to support patients and their families. We heard stories about individual supportive managers and the 'Can do' workforce. Managers told us how proud they were of their teams who 'Did a good job everyday'.

Public and staff engagement

- The Trust engaged with the public through patient surveys which were collected using hand held devices and feedback through the trust website and comments made via the Patients Advice and Liaison Service (PALS). We saw that the devices offered real time patient feedback across all services although the uptake could be improved, We noted high levels of patient satisfaction for those services surveyed.
- Patients and carers were encouraged to contact the customer care team to share their experience of the services they had received. We were told that the trust received a low volume of complaints and this was confirmed by the patients we spoke with and the complaints information available.
- There were multiple forums for staff to engage with the trust from raising concerns to consultation on the service reconfiguration. These included incident reporting, "See something say something" campaign, whistleblowing policy, the StaffZone, bulletins, social media, patient safety walkabouts and web based feedback.
- Some staff told us that they had not been consulted about the recent changes and felt that the Trust had not listened when concerns were raised about the reconfiguration. They did not know why the reorganisation was necessary and felt it had been imposed upon them with the 'Shop floor' staff not involved or consulted.

Good

Are Community Health Services for Adults well-led?

- Staff told us about the Schwartz Rounds which were a forum for staff to meet once a month and explore the impact that their job had on their feelings and emotions. These were part of the clinical governance multi-disciplinary meetings to which all staff were invited to attend.
- We saw that the Trust maintained action plans following the CQC annual staff survey. The survey for 2011/2012 indicated areas where the trust scored below the national average; for example, staff working extra hours or pressured to attend work when unwell. Action plans were in place to address the worst scoring areas.

Innovation, improvement and sustainability

- Since the Trust was formed in 2011 there had been constant change and uncertainty for staff. The changes although necessary to amalgamate and consolidate the services offered by the Trust, had led to pockets of staff feeling undervalued and demoralised. We were told, "There's been too much change done too quickly" although we were told that the picture was slowly improving, certain teams felt "bruised and battered".
- The Trust was financially stable with systems in place to enable growth and development of services depending on the needs of the commissioning groups. We saw examples of the Trust developing services for long term care such as the integrated discharge team and the rapid response pilot.