Medway Community Healthcare C.I.C

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We found the following areas of good practice:

The staff culture of overwhelming pride in their work and desire to provide a service with children, young people and their families at the centre.

The organisation had systems and processes in place to keep patients free from harm. Patients were protected from the risk of abuse and avoidable harm.

Infection prevention and control practices were in line with national guidelines. Staff kept clinical records accurately and securely in line with the Data Protection Act 1998. Medicines were stored appropriately and administration was in line with relevant legislation.

There was good demonstration of multidisciplinary working within the organisation and with external agencies such as local acute care providers and adult social care.

Staff treated patients with kindness, compassion and respected patients' dignity at all times. We saw staff involving patients and their families in decision making about their care and providing emotional support with great depth of understanding.

We saw good local leadership with an open and transparent culture. There was clear vision and focus on the delivery of excellent quality of care. Staff were positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values. The senior management were visible and regularly engaged with staff and patients.

However, we also found the following issues that the service provider needs to improve:

The organisation should review the Healthy Child Programme to identify the improvements required in order to ensure targets are met.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good 	•The organisation had systems and processes in place to keep patients free from harm. Patients were protected from the risk of abuse and avoidable harm. A range of risk assessments were utilised by the various clinical teams to assess and manage risk and staff would escalate risks which could affect patient safety. We saw systems in place for reporting, investigating and learning from incidents. •Infection prevention and control practices were in line with national guidelines. Clinics we visited were visibly clean, tidy and fit for purpose. Staff providing patient care in clinics and patients' home environment wore personal protective equipment and were bare below the elbow. Staff demonstrated an appropriate hand washing technique. •Staff kept medical records accurately and securely in line with the Data Protection Act 1998. •Medicines were stored appropriately and administration was in line with relevant legislation. •Staff had the appropriate skills and knowledge for their roles and received regular mandatory training and supervision. The organisation actively supported staff to develop and extend their knowledge and competencies, and supported staff with external training and secondments. •Staff had a good awareness of policies and procedures based on national guidelines and standards. We saw evidence of local and national audits undertaken to monitor the quality, safety and effectiveness of care. •There was good demonstration of multidisciplinary working within the organisation and with external agencies such as local acute care providers and adult social care. •Staff treated patients with kindness, compassion and respected patients dignity at all times. We saw staff involving patients and their families in decision making about their care and providing emotional support with great depth of understanding. •People's concerns and complaints were listened and responded to and feedback was used to improve the

Summary of findings

		quality of care. There was a system in place for capturing learning from complaints and incidents and there was good local ownership of any problems with teams working closely together to resolve any issues that arose. •We saw good local leadership with an open and transparent culture. There was clear vision and focus on the delivery of excellent quality of care. Staff were positive about their experience of working in the organisation and showed commitment to achieving the providers strategic aims and demonstrating their stated values. •The governance framework ensured employee responsibilities were clear and quality performance and risks were all understood. The senior management were visible and regularly engaged with staff and patients. •The organisation was proactive in celebrating staff achievements with several teams receiving awards recently.
Community health services for children, young people and families	**Good**	• Services delivered by the location were safe. There were procedures in place to protect vulnerable service users. Record keeping was safe and secure. There were good infection control procedures in place and the service had the right number of appropriately trained staff to provide the service. • Services were effective, evidence based and focussed on the needs of children and young people. We saw examples of good multidisciplinary work. Care and treatment was evidence based, and there were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently. Parents told us that staff displayed compassion, kindness and respect. • Children, young people and families who used the service were overwhelmingly positive about the way staff treated them. Service users were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Service users and staff worked together to plan care and there was shared decision-making about care and treatment. • We found the service was responsive to needs of children and families. Multidisciplinary team working, including external partners, ensured children and young people were provided with care that met their needs. • The services for children, young people and their families were well led. The board and senior managers

Summary of findings

		had oversight of the reported risks and had measures in place to manage these risks. Staff felt well supported by their local managers and felt they were valuable members of the organisation.

Summary of findings

Contents

Overall rating:

Good

MCH House

Services we looked at

Community health services for adults; Community health services for children, young people and families

Summary of this inspection

Background to MCH House

MCH House is part of Medway Community Healthcare (MCH), which is an independent Community Interest Company, co-owned and has 1,359 staff. As a social enterprise they are a for-better-profit organisation and reinvest any surplus back into health and care services and the local community. MCH provides community services and social care services in Medway and the surrounding areas for a population of around 280,000 people.

MCH House is registered for the following regulatory activities:

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Nursing care

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

There were three registered manager.

MCH community health services for adults and community health services for children, young people and families are based in MCH House the registered location. We also inspected intermediate care at the registered Amherst Court and this inspection report is a separate location report. Primary care services and adult care services are provided from various other registered locations and these have been inspected by other CQC directorate inspection departments.

This was the first inspection.

MCH community health services for adults are provided from eight separate locations and some clinics are provided at smaller locations throughout the area.

Services include community nursing, rapid response therapy and care management (intermediate care), physiotherapy and clinical assessment service. Specialist teams provide support and expertise for learning disabilities, dementia, continence, nutrition and dietetics, speech and language and long term conditions (cardiology, diabetes and respiratory). Dedicated clinics are provided for cardiology (diagnostics, arrhythmia, rehabilitation and heart failure), dermatology, respiratory, diabetes, nutrition and dietetics, wound therapy, leg ulcer, anticoagulation, falls and musculoskeletal physiotherapy (patients who experience problems with muscles or joints).

The community nursing service is the largest proportion of the community health services for adults workforce. The community nurses provide nursing care in people's homes and are divided into five teams to cover specific geographical areas. The community nurses for Chatham and Rochester are based at Lordswood Healthy Living Centre and Rochester Healthy Living Centre; Gillingham and Rainham teams are based at Unit 7 in Gillingham and the Strood team at Keystone Centre for Health and Social Services.

Community health services for children, young people and families provide services for the areas of Medway, Swale. Services are provided from numerous locations across these areas and include health visiting and children's therapies.

Children and young people can be seen in school, health clinics, and community centres or at home.

The children's therapy team is a multi-professional team providing services for children with disabilities and complex needs aged 0-18 years in Medway and Swale. This includes a paediatric musculoskeletal and podiatry service. The team consists of physiotherapists, speech and language therapists, occupational therapists, podiatrists, dieticians and a continence advisor.

The health visiting team provides a range of universal, preventative and targeted services from the antenatal period until children start school. The team also offers support around maternal mental health. The team

Summary of this inspection

consists of health visitors who visit new parents at home to offer initial advice, with on-going support available up to school age through further home visits or at a local clinic.

Our inspection team

Team leaders: Elaine Biddle and Sheona Keeler

The team that inspected the service comprised four CQC inspectors and a variety of specialists: community nurse, board level director and a community matron.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before our inspection, we reviewed a range of information we hold about the organisation and asked other organisations to share what they knew.

- We reviewed 38 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection.
- During the visit, we held focus groups with a range of staff who worked within the service. We spoke with 56 staff across the service including administrators, health visitors, speech and language therapists, technical assistants, physiotherapists, occupational therapists and nurses. We interviewed the executive and non-executive leads.
- We spoke with parents and saw babies and children receive treatment with their parents' consent.
- We talked with people and carers who use services. We observed how people were being cared for and reviewed care or treatment records of people who use services.
- We visited, with permission, nine patients at home to observe assessments and care provided. We looked at a range of documents, including audit results, action plans, policies and management information reports.
- We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the organisation.

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

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

We carried out an announced visit on 6 and 7 March 2017.

What people who use the service say

All patients we spoke with were overwhelmingly positive about the care they received.

Summary of this inspection

We received 38 comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection. Comments were overwhelmingly positive about the care patients received, cleanliness of the clinics and praise for the staff.

From April to December 2016, the friends and family test for children's therapy service indicated on average 98% of patients would recommend the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good.

- The organisation provided us with the incidents reported with evidence of learning achieved and the resulting changes in practice that took place. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation.
- Staff understood and fulfilled their responsibility to raise concerns and report incidents and near misses. Incidents were investigated and staff were aware of the Duty of Candour regulation.
- The organisation monitored the services' safety record locally, organisationally and in line with national guidance.
- The provider gave safeguarding sufficient priority and staff knew how to escalate safeguarding concerns. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.
- There were systems, processes and standard operating procedures in infection control that were reliable and kept patients safe. There were arrangements to prevent the spread of infection and compliance with these was monitored.
- There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.
- Staff demonstrated good medicines storage, management and administration. There were systems that ensured patients' medicines were given safely, on-time and according to the prescription.
- We found patients' records were complete and accurate and there were systems to identify patients whose condition may be deteriorating to allow early intervention.
- The organisation had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the provider's mandatory training programme.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. There was a clear pathway for reporting and dealing with child protection and safeguarding concerns.

Summary of this inspection

- Staff used an electronic record system. It was secure and easy to navigate. We reviewed five electronic records and found they were detailed, up to date and included all clear information to indicate outcomes of assessments and treatment plans.
- The service for children, young people and their families had effective infection prevention and control procedures in place. Clinic areas we visited during the inspection were visibly clean and there was evidence of good waste segregation. We observed staff using alcohol hand sanitiser between patients and we saw them cleaning equipment with disinfectant wipes.

Are services effective?

Good

We rated effective as good.

- Staff were competent to perform their roles and were encouraged to develop their skills further. Staff received a comprehensive induction to the organisation as well as regular clinical supervision and appraisals.
- Policies and procedures reflected best practice, such as National Institute for Clinical Excellence (NICE) and other guidelines. The care delivered was evidenced based and there was participation in national audit programmes.
- The organisation had policies and procedures to ensure multidisciplinary and multi-agency work took place. Additionally, there were arrangements to support young people who were transitioning to school and to adult services.
- MCH had an on-going, comprehensive audit programme, which monitored areas for quality and improvement regularly.
- Staff had a good knowledge of the law relating to consenting children to treatment and involved parents and carers in treatment planning and goals.
- Care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.
- Staff worked with other health professionals in and out of the organisation to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.
- Patients' pain, nutrition and hydration needs were assessed and addressed in line with national guidance.
- There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day.

Summary of this inspection

- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.

However:

- Not all locations used by MCH staff had computer terminals at which staff could access patient records.

Are services caring?

Good

We rated caring as good.

- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.
- Patients felt well informed and involved in their procedures and care, including their care after discharge.
- Patients' surveys and assessments reflected the friendly, kind and caring patient centred ethos. Our observations of care confirmed this.

Are services responsive?

Good

We rated responsive to be good.

- Services operated at times that allowed patients to access care and treatment when they needed it.
- There were a variety of mechanisms to provide psychological support to patients and their supporters. For example those with spiritual needs, requiring bariatric equipment, patients whose first language was not English, or support for people living with dementia or learning disabilities. This range of services meant that each patient could access a service that was relevant to their particular needs.
- There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment care and the experience of patients and their supporters.

Are services well-led?

Good

We rated well-led to be good.

- All the staff we spoke with knew the MCH values. Staff felt people lived by them.

Summary of this inspection

- There were clear lines of governance and all the staff we spoke with told us they felt valued and supported by their local managers, the managing director was visible and attended meetings on an ad hoc basis.
- All the staff we spoke with told us the service had an open and honest culture and staff were passionate about providing the best service possible for the people they supported.
- The service proactively engaged and involved all staff as shareholders and ensured that the voices of all staff were heard and acted on. The leadership actively promoted staff empowerment through shareholder involvement.
- There was a process in place to identify, understand, monitor and address current and future risks and the executive leaders were knowledgeable about risks faced by the service.
- Children's therapy and health visiting staff reported to Heads of service and the Heads of service reported to the associate director of therapies and children. The associate director of therapies and children reported to the managing director.
- The health visiting teams were divided into 'hubs' based at different locations and there was a lead at each hub.
- Staff were clear about the lines of accountability and staff we spoke with expressed confidence in the leadership of the organisation.
- The senior leadership team 'signed up' to a set of leadership behaviours and were confident they would be held to account, as would others, if they did not reflect those behaviours.
- Feedback from staff about local leadership was positive and complimentary.
- MCH had developed its own leadership development programme 'LEAD' which was designed to support staff to develop the skills, knowledge and behaviours to be successful leaders.
- We saw good local leadership with an open and transparent culture. There was a clear vision and focus on the delivery of good quality care.
- Staff were positive about their experience of working in the organisation and showed commitment to achieving the provider's strategic aims and demonstrating their stated values.
- Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole organisation.

Summary of this inspection

- Governance processes were evident at departmental, organisation and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.
- The organisation was proactive in celebrating staff achievements with several teams receiving awards recently.

Good

Community health services for adults

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

Information about the service

Medway Community Healthcare (MCH) services for adults are provided from eight separate locations and some clinics are provided at smaller locations throughout the area.

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Are community health services for adults safe?

Good

Safety performance

- NHS England defines and publishes a list of never events, reviewed annually in consultation with healthcare providers and stakeholders. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.
- MCH had no never events related to community health services for adults between November 2015 and November 2016.
- The provider reported 2,922 patient deaths during 2016 across the organisation. Of this figure 1,224 patients were under the care of the community nurses at the time of death. These deaths were expected and patients were under the care of an appropriate pathway.
- Five serious incidents requiring investigation (SIRI) occurred in community health services for adults between November 2015 and September 2016. SIRIs are any incidents that caused unexpected or avoidable death or severe harm to one or more patients, staff, or members of the public or where the outcome requires life-saving intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm. Two of the incidents were pressure ulcers received by patients being nursed in their own home. The incidents were investigated and found to be avoidable. The remaining incidents were found to be unavoidable. No SIRIs were reported in October and November 2016 as none had occurred.

- MCH monitored patient safety to enable them to measure, assess and analyse any incidents of harm. The data was collected for the Commissioning for Quality and Innovation (CQUINs) framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. We saw the data was documented in the patient safety incident report which was published every three months. The Preventing Harm Oversight Group (PHOG) that met monthly monitored the data and reported to individual teams and key committees.
- Staff captured data to look at harm from falls (inpatients), medicine incidents, transfer of care incidents and pressure ulcers. Medicine incidents related to medicines omitted or delayed administration. Transfer of care incidents included patients discharged to MCH with an uninformed inherited pressure ulcer or an inappropriate discharge, for example no equipment.
- Data showed between April 2016 and October 2016, there were 44 medicines incidents, 255 transfer of care incidents and 379 pressure ulcer incidents. Of these 678 incidents, 243 were rated as moderate harm, 231 low harm and 204 no harm.

Incident reporting, learning and improvement

- The organisation had an incident reporting policy which encouraged openness, the reporting of all incidents and descriptions of the levels of incidents. An electronic incident reporting system was used and staff demonstrated a good understanding of how to use the system.
- The dissemination of information regarding incidents and lessons learned was through electronic communications and staff attendance at meetings. We saw that reported incidents were a standard agenda item on team meetings. This meant there was a process for the monitoring, investigation and learning outcomes of clinical incidents.
- Staff were able to give us examples of incidents that had been reported in the past.
- We saw that 1,469 incidents were reported between March 2016 and February 2017 across the organisation. The high numbers of incidents reported suggested a good reporting culture.
- Incidents were investigated by the managers to establish the cause and monitored by PHOG. The majority of incidents related to pressure ulcers and these were reported as inherited, acquired or deteriorated while in the care of the organisation. Learning from the incidents had resulted in the tissue viability team sourcing a pressure mapping device for use with patients and for staff training. The results of the investigations were reported locally to departmental teams, the organisation's executive team, the local clinical commissioning group and other relevant organisations as required. The electronic incident reporting system had a facility for staff to complete lessons learned. Staff demonstrated this to us.

Duty of Candour

- The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days.
- Duty of candour was included in the serious incident policy and was available on the organisations intranet. Staff were able to describe the basis and process of duty of candour. We saw operational staff understood their responsibilities with regard to the legislation and we found the responsible manager ensured the duty was considered and met when investigating safety incidents. We reviewed a sample of service wide clinical incidents, patient notes and root cause analysis and saw evidence staff had applied the duty of candour appropriately.

Safeguarding

- As of 19 December 2016, CQC received no safeguarding concerns or safeguarding alerts in relation to MCH.
- We saw the policies for safeguarding vulnerable adults and children which were in date and referenced national guidance.
- MCH had a lead for safeguarding adults and children. The lead provided strategic safeguarding leadership and expertise across the organisation. Staff knew who the lead was. Each team had an allocated link person for safeguarding who were central to disseminating education and support to their local multidisciplinary team.
- Staff had attended safeguarding training at the appropriate levels for their roles and were alert to any potential issues with adults or children. Safeguarding training was delivered as part of the annual mandatory training programme and embedded into staff induction.

- Staff we spoke with had a good understanding of what a safeguarding concern might be. They were knowledgeable about the policies and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse and received training to recognise religious radicalisation.
- We saw information about the safeguarding lead with contact details and safeguarding flow charts on notice boards in all of the community localities we visited. The flow chart demonstrated the local safeguarding process for staff to follow in the event of a safeguarding concern.
- Checks had been made to assure staff suitability to work with vulnerable people and a summary record showed staff had disclosure and barring checks (DBS). This meant the provider had taken necessary steps to help ensure they only employed people suitable to work with vulnerable adults or children.

Medicines

- Storerooms where community nursing teams stored items related to people's treatment such as dressings and catheter bags were found to be in date, neatly arranged and labelled for ease of access and identification.
- Prescribed items, for example medicines, dressings and catheters were not stored or transported by community nursing teams. Patients or their relatives arranged the storage and delivery of repeat prescriptions. A less mobile patient explained the local pharmacies had a home delivery service.
- All prescribed medicines and dressings were returned to the pharmacies when no longer required by the patient.
- Controlled drugs (CDs) are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration. CDs were not stored at localities or transported by staff, as the organisation was not licensed to do so.
- Community nurses were allocated specific bags for the carrying of vaccinations, for example influenza. This meant the organisation was ensuring vaccines were stored, transported and administered in accordance with the manufacturer's instructions.
- All records were electronic except for the recording of medicines (for example insulin) and these were kept in the patient's home. We saw these records showed the name of the medicine, the dose to be administered and the route. The nurses recorded the batch number and expiry date of the medicine and point of administration. Before administering insulin the patient's blood sugar reading was obtained and recorded. This was in line with national guidance.
- The physiotherapy department in MCH House had a diagnostic ultrasound machine used to administer guided injections in line with evidence base and best practice. Medicines administered included steroids in combination with a local anaesthetic which are injected into a painful joint or used to treat inflammation in soft tissues.
- Where appropriate medicines were stored securely to minimise unauthorised access. We saw the doors of medicine cupboards were secure and locked. Medicines cupboards were clean and tidy. All the items stored were within date and there was a system of expiry date checks.

Environment and equipment

- Security of access to buildings was achieved where necessary by entry phone and keyless door locks. All staff wore identity badges that clearly stated their name and role. We saw that visitors were provided with temporary badges where appropriate. We were asked to show our identification when we entered buildings and visited patients in their homes. This meant staff controlled the access of unauthorised people and access to patients to ensure their safety.
- There was access to emergency equipment. First aid kits were mounted on walls in clinic offices and posters explaining who to call and where they were located in the building. Staff checked the contents against a checklist. This meant all items were ready for immediate use should an emergency occur. In some cases another provider managed the emergency items, for example the resuscitation trolley in MCH House was provide by Medway Doctors On Call service. We saw the trolley contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. The trolley was secure and fully stocked and ready for immediate use. All equipment needed was available, as indicated by an equipment list and all consumables were in date. There was a system for checking these daily and we saw the fully completed records of checks.
- There were processes in place for regular equipment checks both from internal and external maintenance sources and a clear preventative maintenance process.

We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use.

- We saw records showed equipment used for patient testing and observation were calibrated (check the instrument's accuracy) annually. This included blood pressure equipment, thermometers, blood glucose machines and pulse oximeters for testing oxygen saturation levels.
- Managers assessed staff to ensure competency before staff used any medical devices, for example the glucometer, a medical device used for determining the approximate concentration of glucose in the blood. We saw examples of competency assessments in staff records, which were kept by managers.
- We saw the community nurses calibrated blood glucose machines weekly and documented the results according to manufacturer's instructions. The machines are required to be calibrated periodically because there are variances in the test strips used which can make the results different between batches.
- Staff reported no problems with equipment and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients, for example pressure relieving mattresses and physiotherapy equipment. The mattresses used by the organisation were fit for purpose and provided protection from infection and pressure damage.
- The gymnasium in MCH House was a spacious area with a variety of equipment available, for example treadmills and exercise bikes. This meant the organisation had the appropriate equipment to enable physiotherapists to assist patients in their rehabilitation.
- Syringe drivers were available across the organisation and were stored at the Wisdom Hospice. The syringe driver is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. The organisation used an appropriate syringe driver which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010).

Quality of records

- A secure electronic system was used for recording consultations, assessments and visits. Staff had access to information that was relevant to their role, for example the rapid response team (intermediate care) had access to the social services system to assist in their allocation of care agencies.
- We looked at 10 patient records and found they were multi-disciplinary and all departments in community health services for adults contributed. The records were well maintained and easy to navigate. They were compliant with guidance issued by professional regulatory bodies. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received.
- The electronic system could be accessed from office localities or remotely through the use of mobile computers when in the community. Community nurses used a computer tablet which showed the previous five consultations, last set of observations and date of the patient's last catheter change if appropriate. The tablet was used to document when nurses were en route to a patient, when they arrived and when they left the patient. The nurses completed electronic records either in the patient's house or immediately when they returned to their car. This meant the records were updated while the information was still current, for example the measurements of wounds.
- The only paper records used by community nurses were for recording administration of medicines and those records remained in patients' homes. When pages were complete or if there was a change in the medicine prescribed the old paper notes were returned to the office and scanned onto the computer system.
- Each service audited a random selection of a defined number of patient notes each month, for example the physiotherapists audited 10 sets. The audit monitored the appropriate completion of assessments for the patients' individual clinical needs. The results of the audits between April 2016 and March 2017 showed that: The score for the whole organisation was 85% and community health services for adults scored an average 86% during the same period.
- The results of the audits were collated on the organisation's 'preventing harm dashboard'. This was rated using the Red, Amber, and Green (RAG) system to show how areas were performing. Areas highlighted as green and complete included 'have the appropriate assessment windows been completed for the patient's relevant clinical needs?', 'Has a Braden score been completed?' and 'Has the patient's drug chart been

completed appropriately?' Areas consistently rated red and showing where staff were underperforming were 'Has a body map been completed if appropriate?' and 'Is the infection status window completed on the patient's record?' The results of the audits were also collated in a 'personalised care planning and consent dashboard'. Generally the results showed services were green across the board. However, the dashboard showed a personalised plan had not been completed for the majority of patients. Areas highlighted requiring improvement were monitored by PHOG with a defined action plan in place.

Cleanliness, infection control and hygiene

- Infection control was part of mandatory training for all staff. Sessions were tailored to the specific service and were delivered using a mixture of face to face and e-learning throughout the year. Data showed 92% of community health services for adults had attended the training by December 2016. The compliance for all services was 94%.
- All the clinical areas and buildings we visited were visibly clean and tidy and we saw there were good infection control practices in place. There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the 'five moments for hand hygiene' near hand washing sinks. Sanitising hand gel was readily available throughout all areas.
- During the inspection we saw staff providing patient care were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organization (WHO) guidelines on hand hygiene in health care. In addition mobile workers carried portable containers of sanitising hand gel. We saw these used during home visits.
- We saw personal protective equipment (gloves and aprons) were available for all staff and observed staff used them appropriately. Staff visiting patients in their homes carried small stocks with them for use.
- We observed staff following best practice in line with the Royal College of Nursing essential practice for infection prevention and control, guidance for nursing staff. We observed staff undertaking aseptic techniques such as inserting catheters and administering intravenous therapy.
- In line with Department of Health (DH) guidance 'Saving Lives' the organisation used a system of care bundles to guide and manage the use of indwelling devices such as intravenous cannula. The use of these bundles ensured that such devices were cared for using a best-practice approach and that the risk of serious infection was minimised. The records we saw showed the relevant care bundles were used and completed at the specified times.
- All the equipment we looked at was visibly clean. Staff had access to disinfectant wipes to ensure equipment which was shared between patients was cleaned between each patient use, for example glucometers and blood pressure machines. We observed staff doing this both in clinics and in patient homes. Larger pieces of equipment, for example the electrocardiogram (ECG) used by the cardiology team, we saw an 'I'm clean' label was attached. This indicated the equipment was clean and ready for use.
- We saw disposable curtains were used in clinics and these had recent dates on them. This indicated they had been changed within six months in accordance with industry standards and organisational policy.
- Waste in the clinics was separated in different coloured bags to identify the different categories of waste. This was in accordance with the DH Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in clinics where sharps may be used and in patients homes where appropriate. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container. Used bins were returned to the main offices and buildings and stored securely in locked cupboards. We saw the caretaker removed full bins from the nurses' store room in Lordswood Healthy Living Centre and placed them in the main disposal unit, checking they were marked with the correct code.

Good

Community health services for adults

- During the inspection we saw all seating used within clinics and the patient waiting areas was covered in a material that was impermeable, easy to clean and compatible with detergents and disinfectants. This was in line with HBN 00-09 section 3.133 for furnishings.
- All flooring in the clinics and waiting areas was in line with HBN 00-09: Infection control in the built environment, 3.109. The flooring was seamless and smooth, slip resistant, easily cleaned and appropriately wear-resistant.
- We saw the organisation's Infection Prevention and Control (IPC) programme 2016/17. The aim of the programme was for the prevention and control of healthcare associated and other infections and to ensure patients received the correct care reducing risk to patients, staff and the public. The programme listed 18 areas with actions required, lead person, priority, timescale to be completed and risk rating. For example, number 16 was to ensure healthcare waste in the community met statutory compliance HTM 01-07. The action required was to develop arrangements for community staff to remove waste from patients homes. The lead was the senior IPC nurse and head of estates. The priority was rated as '2' (to be completed within 12 months) and was rated as 'A' (plan in place/initially implemented/some progress). Comments recorded included outstanding actions as estates had set up actions for MCH properties only and did not include waste in patients' homes. Community nursing teams disposed of clinical waste in patients' household rubbish.
- We saw the IPC annual audit plan 2016-17. This listed who was to perform the audit, compliance (target), frequency, who reported to who and who was responsible for monitoring action plans. For example hand hygiene audits were to be completed monthly with 100% compliance. Results of audits were reported to teams, service managers, quality team and business team. We saw the audits for community nursing teams and they were compliant with hand washing.
- The cleanliness of sites was monitored through audits and was undertaken every three months by the infection prevention and control subcommittee who reviewed results and compiled actions plans. Data showed the overall score achieved for community sites was 86% (target 87%). Actions for site issues were requested from the estates team.

Mandatory training

- We saw the training records for staff for mandatory training. We spoke with managers who monitored the completion of mandatory training for their teams. We saw they had electronic systems, which recorded the training that was required, and its completion dates. Managers described how they used the system to ensure staff remained up to date.
- The training programme was comprehensive and contained all the training subjects that would be expected. For example, safeguarding adults and children, conflict resolution, informed consent, diversity awareness, information governance, moving and handling, infection control and fire safety, health and safety. The training was available as face to face and on-line learning packages. No staff we spoke with described difficulties accessing these electronic training packages.
- We saw the latest (January 2017) training compliance figures for all departments providing community health services for adults. Overall, all areas were 91% compliant. The falls service, physiotherapists, adult learning disabilities team, care home team and the continence service were all 100% compliant. The community nursing teams were 93% compliant.

Assessing and responding to patient risk

- Patients received a full nursing assessment on the first contact appointment. All the records we saw showed this.
- We saw in the 10 patient records we reviewed there were risk assessments in key safety areas using nationally validated tools. For example staff assessed the risk of falls, deep vein thrombosis (DVT), malnutrition and pressure damage. We noted when risks were identified relevant care plans (which included control measures) were generated. We checked a sample of these control measures and found them to be in place. We saw risk assessments were reviewed and repeated within appropriate and recommended timescales. Where risks were identified, staff had access to support, guidance and equipment to help manage these risks.

Good

Community health services for adults

- Staff described examples of identifying and responding effectively to changing risks in home locations such as deteriorating patients and medical emergencies. Staff contacted GP's or the emergency services depending on the circumstances.
- All staff received training in basic life support and anaphylaxis. This face to face training was part of induction and staff attended an update every year. We saw mandatory training records which showed us all appropriate staff had completed the training.
- The organisation had responded to guidance from the National Institute for Health and Care Excellence (NICE) NG51: sepsis: recognition, diagnosis and early management. Sepsis arises when the body's response to an infection damages its own tissues and organs. It can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly. Clinical staff received training for sepsis awareness by the means of an e-learning package. The sepsis pathway was available for community nurses through the computer tablet. Staff showed us how they accessed this.

Staffing levels and caseload

- The teams used a staffing tool to assess caseload management and staffing requirements. Managers collated information relating to referrals, contacts and attendances to their services in a dashboard. Referrals for the community nursing teams were based on geographical locations. Staff for all teams told us the caseloads were variable and were manageable.
- MCH reported 265.93 whole time equivalent (WTE) qualified nurses and121.98 WTE nursing assistants were employed across the organisation in October 2016. The vacancy rate for qualified nurses was 15.04 WTE and 16.42 WTE nursing assistants. During the same period 11 lots of 12 hours shifts (two qualified nurse shifts and nine nursing assistant shifts) were filled by bank or agency staff. The community nurses' clinical lead told us they did not use external agencies and shifts were filled either by bank staff or staff were paid overtime.
- The majority of agency use throughout the organisation was for health care assistants in the enablement team with intermediate care. MCH did not centrally hold the information on the number of bank and agency shifts for thier community teams. They told us they monitored bank and agency usage by overall spend.
- We saw the organisation received assurances from agencies used for staff. This included training, qualifications, disclosure and barring service disclosure and barring checks (DBS), immigration status, professional registration and details of induction.
- MCH had six community nursing teams based in four different localities and had a head of service and a clinical lead. The service provided was a standardised approach across the whole organisation. The teams covered geographical areas and mirrored local care teams. Two community nursing teams were paired together to provide support. Each base had a band 7 lead, each community nursing team had a band 6 team leader and team consisted of band 5's, band 3's and band 2's.
- We saw the off duty for nursing staff for March 2017. The actual number of staff working matched with the agreed number recorded on the off duty.
- The physiotherapy department employed one clinical lead (band 8a) and four band 7's. The team was made up of band 6 physiotherapists, band 5 physiotherapists, assistants and band 3 support workers. At the time of inspection a healthcare apprentice was part of the team and we were told they were guaranteed a permanent position in the organisation when they had completed their apprenticeship.
- The rapid response team (intermediate care) was made up of three full time managers, two full time and one part time care manager assistants and one full time administrator.
- The continence team for MCH consisted of one part time clinical lead (band 7), one part time continence advisor and three band 5 community continence nurses based over the three localities.
- The cardiology team consisted of 23 staff, a mixture of full time and part time qualified specialists and administrators. The cardiology lead nurse spent half of their time as a clinician and the remainder managerial and clerical work.
- The dementia support team consisted of one team lead, two band 6, three support workers and one administrator.
- The diabetes team had one vacancy at the time of inspection. The team was made up two full time band 7 specialist nurses, 2.6 WTE band 6 dieticians and 1.72 WTE band 4 educators.
- The learning disability team had a full quota of staff with no vacancies. The team was made up of a team leader

who was the lead nurse, one full time nurse, one full time physiotherapist, one part time physiotherapy assistant, one full time and one part time speech and language therapists (SLT) and one part time SLT assistant.

Managing anticipated risks

- We saw an alert system could be quickly cascaded through the organisation to ensure they were working within the national framework for the Medicines and Healthcare Products Regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are safe.
- We saw the organisation had adverse weather policies in place and these were accessible to staff. Mobile workers recounted examples of how they maintained the service during adverse weather events such as snow affecting the local road transport system. A 'snow plan' was displayed in community nurse localities which explained to staff the process to be implemented to ensure diabetic patients still received their insulin in the event of adverse weather conditions.
- Patients' electronic records showed completed risk assessments for individual risks to staff, for example patients who were smokers or those with dogs. In addition staff told us in a focus group, if a patient lived in an area in the community which had been assessed as unsafe, staff attended in pairs.
- MCH had a lone workers policy. Staff were aware of the policy and they told us it was effective and embedded into practice. All staff working in the community were provided with phones or electronic diaries which showed where staff were located. In addition, staff had the option of carrying a lone worker's device which could relay the wearer's location in an emergency or if the worker felt under threat. There were several 'local' systems in place dependant on the team and area. For example, the dementia support team employed a buddy system where they would text or call a nominated colleague when they finished for the day. If the buddy had not heard from their colleague by 6pm they would follow protocol and contact managers.
- A director for the whole organisation was on call at all times. A band 7 community nurse was on call at all times including weekends and bank holidays. Out of hours cover always included a senior nurse to provide extra clinical support.
- We saw at Lordswood Healthy Living Centre, the community nursing team were able to contact the administration team in an emergency by using a separate phone. The team had a specific code name to use in the event of emergency, for example if assistance was required as a nurse felt they were in a compromising situation. An agreed code phrase 'red folder' was used. Staff we spoke with were aware of this system but they had not needed to use it.

Major incident awareness and training (only include at service level if variation or specific concerns)

- Overall we found MCH had effective systems and processes to help ensure major incidents were managed effectively. We saw the organisation had major incident policies in place and these were accessible to staff.
- Clinics and centres had an allocated fire warden and first aider. We saw firefighting equipment, safety signage and posters on notice boards about fire and other emergencies. Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.
- We saw mandatory training records which showed us by January 2017, 92% adult community services had completed fire safety training.

Are community health services for adults effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

- Overall, we found relevant National Institute for Health and Care Excellence (NICE) guidelines, quality standards, service frameworks and other good practice guidance was available and followed by staff. We saw examples in use such as pressure ulcer assessment and treatment guidelines as well as diabetes and heart disease management pathways.
- We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework. Staff were able to access national and local guidelines through the internal computer system. This was readily

available to all staff who demonstrated how they could access the system to look for current guidelines. We noted there were appropriate links in place to access national guidelines if needed.

- Care was supported by local and national audits which included clinical topics such as the sentinel stroke national audit programme (SSNAP) as well as environmental, handwashing and infection control checks. The results of these were shared among staff. We observed examples shared in team meeting notes and displayed on notice boards.
- Patients approaching the end of life were identified through the use of the Gold Standards Framework (GSF). This is a framework for identifying patients with end of life care needs, irrespective of diagnosis. Staff in the community nursing teams told us they attended monthly GSF meetings, at local GP surgeries, where patients on the framework were discussed. This meant staff had an effective system for identifying patients with end of life care needs.
- Individual care plans were clear, up to date and in line with relevant guidance. For example physiotherapy treatment plans included clear outcome goals, which were personalised and monitored using nationally recognised measurements such as patient reported outcome measures (PROMs). PROMs are a method of capturing the patient's opinion on the impact of their disease or disorder and the effect of the treatment.
- Medway Community Healthcare (MCH) was part of the Medway Collaborative Venous Thromboembolism (VTE) Group. VTE is the formation of blood clots in the vein. The VTE group was established to create a collaborative approach with community and independent providers in Medway. The group worked together to ensure an integrated approach was present for the provision of services for the delivery of high quality care to patients in preventing and managing VTE in line with NICE Quality and Standards guidelines (June 2010). We saw this was delivered through a collaborative health economy steering group with a defined action plan.

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- We found a recognised pain assessment tool available for use, which reflected national guidance. None of the patients we spoke with required pain relief at the time of our inspection.
- We saw staff discussing pain relief and symptom management with patients. For example, we saw a nurse discussing symptoms such as sickness, pain and breathlessness with a patient.
- The organisation had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance on opioids (a strong pain killer) for palliative care.
- Effective pain control was an integral part of the delivery of effective end of life care and was supported by the palliative care team at the hospice. For appropriate patients GPs prescribed anticipatory medicines. The prescribing of anticipatory medicines is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. The community nurses told us they prioritised the visit requests for pain relief and for palliative care patients. This meant patients were not delayed in receiving pain control.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- Patients had access to dieticians if needed. We saw an information leaflet entitled 'How to improve your nutrition' which followed NHS Primary Care Guideline and Malnutrition Universal Screening Tool (MUST) guidelines. We also saw a leaflet entitled 'How to improve your hydration'. These were given to every patient in their initial patient pack. We spoke to patients who were able to show us evidence they had received this and witnessed staff routinely checking patients' eating and drinking habits.
- Nurses assessed patients' nutrition needs using a nutritional screen assessment tool MUST which identified patients who were at risk of poor nutrition or dehydration. It included actions to be taken following the nutrition assessment scoring and weight recording. If a patient scored two due to a low BMI, 10% weight loss in six months or had little or no food in the previous five days or more, they were referred to the dietician. We saw staff reassessed patients every month or more frequently if concerns were highlighted.
- Community nurses had access to weighing scales which were kept at each office base.
- Staff discussed nutrition and hydration with patients. For example, we saw a nurse having a discussion with a

patient about their lack of appetite. The nurse asked the patient if they had considered using the 'meals on wheels' service and explained how the service could be contacted.
- Staff were able to refer to the speech and language team for those patients who had swallowing difficulties.

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- MCH used a confidential electronic system to record and store patient information, which allowed therapists and practitioners to access care records. This resulted in improved continuity of care and multidisciplinary communications for patients visiting clinics.
- We saw office based staff contacting patients on the telephone to check current symptoms and make recommendations until a nurse could visit them.
- Staff took photographs of wounds using their work electronic devices and these were uploaded to the patient's record. This meant an accurate record of the wound was kept and enabled to staff to monitor the healing process.
- We asked the clinical lead for community nurses about the use of telemedicine (the remote diagnosis and treatment of patients by means of telecommunications technology). We were told a system which was used by the council was in the trial stage and not in use by the organisation at the time of inspection.

Patient outcomes

- The organisation reviewed patient satisfaction feedback, incidents and complaints, activity data and staff surveys. This enabled them to monitor patient outcomes to benchmark against similar services and improve people's outcomes.
- We saw the organisation monitored patient outcomes for patients seen by the rapid response team (intermediate care). Data was collated on the Adult Social Care Outcomes Framework (ASCOF) which demonstrated the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. The framework formed the basis for integrated teams working locally and supported local partners to identify shared responsibilities, pursue shared goals and improve outcomes for their communities. Data was reviewed on a monthly basis by a service manager and individual colleague activity was monitored to ensure any unusual figures were investigated. We saw the service was on target for users who achieved an improvement in independence, reduction in length of stay in hospital, increase in hours of community enablement and service was in place within 24 hours of first contact.
- The organisation worked in partnership with Medway Clinical Commissioning Group (CCG) to develop a mutually agreed programme of appropriate outcome measures for services measured through the Commissioning for Quality and Innovation (CQUINs) programme. This encourages care providers to share, continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.CQUIN in isolation will not address these issues, but if aligned with the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, it can be a strong lever to help bring about changes, to deliver improved quality of care to patients through clinical and service transformation. Data collected for CQUINs included pressure ulcers, reduction in hospital and community venous thromboembolism (VTE) and reducing the risk of dehydration.
- We saw the CQUIN Pressure Ulcer Collaborative 2016/17 action plan. The overall aim was to evidence a reduction in, or sustained number of pressure ulcers for Medway patients by evaluating the effect of collaborative working and education across the whole health and social care economy. It included the implementation of a Pressure Ulcer Passport (PUP), a specific care plan for care of and prevention of pressure ulcers, nursing home audit (prevalence of pressure ulcers) and target input, work with the emergency department at the local acute NHS trust for patients seen with pressure ulcers, staff education, and work on reduction of transfer of care concerns relating to pressure ulcers across the organisations. The agreed target was to sustain or reduce the pressure ulcers acquired in MCH care and avoidable pressure ulcers with a maximum of 20 in 2016/17. Data showed up to October 2016, 11 acquired pressure ulcers were reported. Following investigation and root cause analysis it was deemed four of these were true avoidable pressure ulcers obtained within MCH care.
- The main outcomes reported from the collaborative VTE project were sharing of data between primary, secondary and private care providers in the Medway

area. It was ascertained that the initial assumption that high numbers of patients were developing lower limb VTE post 90 day discharge was not proven. Areas suggested for further exploration by the CCG included public health involvement to raise awareness among the general public and the inclusion of community services for the provision of follow-up services post hospital discharge and to reduce the incidence of both physical and psychological post-thrombotic syndrome.

- The outcomes reported from the collaborative for reducing the risk of dehydration, highlighted there were no validated assessment tools available to identify patients at risk. However we saw services within MCH had clear assessments and care plans available where a patient at risk could be identified, symptoms reported and were able to put an early intervention into place.
- The organisation had an effective audit programme and we saw the audit schedule for 2016. According to data provided by the organisation, audits in progress included NICE quality standards, medicines management, pulmonary rehabilitation and patient reported outcome measures (PROMs). We saw good examples of good local outcome measurement, such as a series of audits of physiotherapy pre-assessments for patients undergoing elective knee replacement surgery (PROM-EQ 5D) in line with professional guidance.
- Key data captured in relation to patient outcomes assisted the organisation to define audits to measure efficacy of care. We saw audits were completed and reported to the clinical quality team who reported to the board. Trends were identified and action plans created to improve the service to patients. This was communicated back to the clinical departments for their action.

Competent staff

- Staff had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff's professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- Data showed 97% staff had received an appraisal in the year January to December 2016. All staff we spoke with told us they had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining their professional registration.
- The organisation encouraged and supported staff to attend training courses to promote career and personal development. This included clinical skills, diploma and degree modules, National Vocational Qualification (NVQ) training and management skills. Nursing staff told us they had access to local and national training. This contributed to maintaining their professional registration.
- The community nursing teams were encouraged to attend additional training including mentorship and individualised modules (for example, management of leg ulcers). We saw three community nurses were seconded each year to complete the district nursing pathway degree. The information board in Lordswood Healthy Living Centre advertised additional courses for clinical staff. These included a dermatology study afternoon on 03/04/2017 and a serious case review training workshop on 03/05/2017.
- Data showed community nurses had attended training for verification of death and 'do not attempt cardio-pulmonary resuscitation' (DNACPR). Physiotherapists had attended training for injection therapy and independent prescribers.
- The diabetes team provided support and a specialised education programme for other health care professionals. The team had an educator who was specifically trained in Dose Adjustment For Normal Eating (DAFNE) and provided one session every month. This is a way of managing type 1 diabetes and provides people with the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin. Other courses provided by the team included the 'X-PERT' course which was run in blocks of six weeks (the service was commissioned to run 25 sessions every year) and the 'X-PERT insulin' course. This course was commissioned to run 19 sessions every year; however the service was only able to provide 12 at time of inspection due to staff shortages.
- Newly qualified staff showed us the six month preceptorship programme for newly qualified nurses. We saw there was a good induction for staff and the practice nurse educator supported staff. The induction for staff was multidisciplinary, for example the learning disabilities team leader attended the induction courses for community nurses, long term conditions and

dentistry. We saw the competency and training folders for staff and noted the part of the induction for community nurses included end of life care, catheters and documentation.

- Each service had 'link' persons who were central to disseminating education and support to their local multidisciplinary team. We spoke with the end of life care 'link' for the dementia team who explained the team leader for the team provided the training for the dementia 'links'. The six community nursing teams had link persons for tissue viability, infection control, intravenous (IV) therapy, students and preceptorship, safeguarding, documentation, end of life care, information governance, continence, dementia and diabetes care.
- The community nurses notice board in Lordswood Healthy Living Centre displayed the names of staff who were competent in certain clinical skills. These included taking bloods, intravenous antibiotics, catheters, syringe drivers, Doppler ultrasound, ear irrigation, compression therapy and bowel care. This meant work could be allocated to the appropriate person and these competencies could be accessed to assist the staff in the team.
- We asked the clinical lead for community nursing teams about the arrangements for structured handovers. We were told there was not a standardised approach across the organisation as each team had separate arrangements. The aim of the service was for handovers to be operated daily, however this was not fully embedded and some teams did a weekly overview. Staff told us this was not a concern as they received adequate information about patients through the informal process.

Multi-disciplinary working and coordinated care pathways

- We saw good examples of multi-disciplinary working within the organisation. Staff described instances of how they worked with other members of the multidisciplinary team to meet the needs of service users and we observed practical instances of this when we watched care provided in both clinics and people's homes. For example, the learning disability team had a good working relationship with the community nurses and long term conditions specialists. In addition, the dementia support services worked closely with social services and all services within the organisation in particular the community nurses.
- Good relationships existed with GPs, neighbouring hospital trusts and other agencies such as local councils and emergency services. For example, the dementia support team worked closely with social services and the wound care team worked with the emergency department at the local acute NHS trust to monitor patients who attended with an existing pressure ulcer. In addition, the continence team attended the urology team meeting at the local NHS acute trust every three months. They told us this was "valuable" as it provided continuity of care for patients.
- We saw from care notes and assessment sheets referrals to services were handled effectively with clear criteria and a multi-agency approach to ensure people got access to the right care.
- The sample of patient records we reviewed demonstrated good multi-disciplinary working. Information was readily shared between the different therapy and care groups. This indicated a coordinated approach was achieved for people with complex needs.
- Our observations were supported by remarks from service users.

Referral, transfer, discharge and transition

- At the time of inspection, data showed 23,183 active patients were seen by community health services for adults. Of these community nurses saw 6,513 active patients, physiotherapy 5,646, dementia services 116 and adult learning disability team 107.
- In 2016 the community nursing team recorded 21,558 face to face visits and 2,053 of these were for patients on an end of life care pathway.
- The majority of contacts and referrals went through Medway On Call Care (MedOCC) telephone exchange system and were distributed electronically to the appropriate service or team. For urgent referrals, the MedOCC team contacted the appropriate team directly to ensure patient requests were expedited as soon as possible. The organisation's business team ran reports of referrals received and these were accumulated onto a dashboard (a management tool used to collate an

overview of services). This enabled the organisation to monitor the number of contacts received, patients who did not attend appointments (DNAs) and any service cancellations.

- Referrals were handled effectively with a clear criteria and a multi-agency approach ensured people got the right care in a timely way. Referrals were rated using the RAG system identified by the use of colours. Those with the highest need were rated red followed by amber and green after initial assessment and visits were allocated in response to this.
- In addition, referrals were actively scrutinised by managers to improve their appropriateness. For example, a referral received for a patient who required a daily anticoagulant injection was assessed as to whether they were housebound and eligible for a visit by the community nurses or if the patient could attend the clinic at MCH House.
- The three localities which housed the community nursing teams had a community nurse who was allocated as a 'triage nurse' on the off duty on a daily basis. This was usually a band 6 who would review all incoming referrals, book visits, monitor teams and allocate any urgent visits. They would also allocate the planned visits for the following day. At weekends a 'triage nurse' was allocated and would also assist with the morning medicines. A patient told us the triage system worked as they had contacted the team four weeks ago with a concern and the nurse visited within 2 hours.
- Staff told us they could refer patients to other internal services. The community nurses could refer patients using their computer tablet for services such as the dietician, continence and dementia team.
- The physiotherapy team triaged referrals within 24 hours and these were separated into urgent and non-urgent. The team contacted patients with a telephone triage to determine their urgency. Urgent referrals were seen within three days and non-urgent referrals within a week.
- The learning disabilities team only saw adult patients and children were seen by the local acute NHS trust. We were told the team received between 220 and 230 referrals every year and at least half of these were from the social service team. Referrals received consisted of dysphagia (difficulty in swallowing) assessments, physical health (diet and sexual) and health facilitation (accessing mainstream services).
- The dementia support service provided a short term service for patients based on eight to 12 weeks. The majority of referrals received were for a 'crisis' due to carer stress. If required the team could access respite beds in local care home but staff told us these were like 'gold dust'. The service was commissioned to receive 30 referrals each month and staff told us they received between 14 and 20 referrals a week. The referrals were triaged and RAG rated. Red referrals were seen within 4 hours; amber within the same week and green often required emotional support or signposting to other agencies.
- The rapid response team provided intermediate care. The team consisted of a social team and a therapy team and provided short term care and support for patients to prevent unnecessary admission to hospital or long-term residential care for up to six weeks. The team assisted a smooth discharge home from hospital and their focus was returning the patient to independent living. Referrals were received from several sources including the patient, GPs, community nurses and social care teams. The team told us they received on average 25 referrals a week. Referrals were triaged within four hours and depending on the severity of the referrals the patient was visited the same day or the day after.
- There were protocols in place for occasions when a patient's needs suddenly increased. Staff we spoke with were clear on the circumstances and procedures for referral to the rapid response team, hospital, GP or the emergency services.
- Patients were discharged when the agreed care outcomes were achieved. The patient was given details of how to contact the service again and an indication of when this may be needed. We saw examples of clinic discharge letters sent to GPs which were sent on completion of therapy.

Access to information

- Information was available to staff in a timely and accessible way, all the localities we visited used an electronic patient record system. Some staff had access to the electronic records by the use of computer terminals in offices, or some staff used electronic tablets, which could be used in patients' homes. In areas where connectivity was poor, staff could still input information into the tablet, which would automatically be uploaded to the live system as soon as connectivity was established.

- We saw staff could access current guidelines, policies and procedures on the internal computer system. Those who saw patients in people's homes had time allocated at their 'base' on each shift to update electronic records and review documents. This indicated staff could access advice and up to date guidance easily.
- We saw examples of care and risk assessments, care plans, case notes and test results were held on the electronic system. All the community staff had access to the same information and could see the most recent activity in a patient record.
- Staff that used the electronic records were positive about them, found them easy to use, and reported no issues with accessing notes and care plans.
- We witnessed a patient asking about services and was advised by the community nurse as to the best course of action. Community nurses were able to refer patients to services such as the occupational therapists if needed.
- The community nurses provided patients with an information wallet when visiting for first assessments. This contained a welcome letter from the team manager which explained the role of the team, storage of records and contact information. Additional information provided included a feedback form, preventing dehydration and pressure damage and additional information relevant to the individual patient (urinary catheter passport and pressure ulcer passport).
- The tissue viability nursing team designed and produced a 'My pressure ulcer passport'. All patients were provided with a passport which explained information to assess, avoid and the treatments provided for pressure damage. The passport was used to keep a record of treatment received for pressure areas and patients were advised to take the passport to appointments and hospital visits. The team worked with emergency department at the local acute NHS trust to report incidents when a patient attended with a pressure ulcer and recorded if the patient had a passport. All incidents were reviewed and checked if there were recurring themes. Care homes were supplied with the passports and the tissue viability team, in collaboration with the acute trust, provided training. Each residential home had also been provided with 'Stop boxes' which included appropriate pressure care dressings if staff identified an affected area. This meant the nursing homes had the resources to provide appropriate preventative care until the wound care team or community nurses could visit.
- We saw patients who had a urinary catheter inserted were provided with an individualised catheter passport. The urinary catheter passport was developed to ensure catheterised service users received the optimum standard of care by improving communication between hospital, community and the service user. The booklet keeps a record of size of catheter, frequency of change and documentation of when last changed. This meant patients received continuity of care.
- Palliative care records were kept in houses for patients with end of life care needs. We saw patient records had all relevant documentation including DNACPR information. Patients also had any appropriate medication available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Patient records we reviewed showed the appropriate consent had been obtained and correct records were kept in-line with best practice. We witnessed staff members gaining verbal consent from patients before and during treatments and ensuring the patient understood the care they were receiving.
- Staff understood their requirements of relevant legislation and guidance including the Mental Capacity Act (MCA), 2005. Staff also demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS).
- We saw staff were up to date with Mental Capacity Act training, we were told this included minimal restraint guidance and focused on the patient's best interest, in-line with national guidance and legislation.
- The organisation had guidance for staff on the implementation of DoLS which directed staff on the practice and procedures that should be followed when an individual who lacked mental capacity in their best interest, may have to be temporarily or permanently deprived of their liberty. This was to ensure staff were at all times able to work within the parameters of the MCA. We spoke with staff about their understanding of the appropriate assessment and documentation for DoLS. Staff were able to explain the process and had an understanding of the rationale. At the time of inspection CQC had not received any notifications of DoLS applications as none had been requested by the organisation.

Good

Community health services for adults

- Staff told us they did not have much experience of completing the two stage capacity assessment or DoLS applications but would seek advice and support from either a manger, colleague in the mental health team or local GP in they felt it was needed.

Are community health services for adults caring?

Good

Compassionate care

- The organisation took part in the friends and family test (FFT), a survey which asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care. According to published data the average score for all services in Medway Community Healthcare (MCH) for October 2016 was 98%. This is the percentage of respondents saying they would be 'likely' or 'extremely likely' to recommend the organisation. The score was better than the national average of 95%.
- All of the staff we spoke with took great pride in their work and were committed to providing the best care they could. We saw staff treating patients in a kind and considerate manner. Patients and their friends and family told us staff always treated them with dignity and respect. We spoke with nine patients and two of their friends and family who felt staff were caring and compassionate. A patient told us the community nurses "are all very kind".
- We saw staff took time talking to patients and explaining things to them and those people close to them. We observed a community nurse who was allocated as the 'triage nurse' compassionately assist a distressed patient over the phone and reassure them.
- Staff treated patients with privacy, respect and dignity and this was seen when they protected patients from cold and exposure, using blankets to maintain dignity. In the clinics, the curtains were drawn and doors closed to ensure privacy. Staff knocked on doors before entering.
- During the inspection we asked patients to complete feedback forms to describe their experience of the service provided. We collected 38 completed cards which were overwhelmingly positive about the care received. Comments included 'All the care and service provided has been excellent quality'.
- We saw staff collected compliments and were shown three emails received by the rapid response team (intermediate care). Comments included: "I am delighted my mother has fallen under your charge", "you are wonderful, you listened, actioned and told me what was happening and for that I am immensely grateful", "thank you so much for your concerning care" and "I really appreciate your speedy communication".

Understanding and involvement of patients and those close to them

- Individualised care was delivered and the records we reviewed evidenced this. The organisation had a strong person-centred culture and we saw staff placed a high value on positive relationships with patients and their families and supported them in a way that ensured they felt understood and valued.
- We observed staff discussed treatments with patients in a kind and considerate manner. The patients and their friends and family we spoke with told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and their questions were answered in a way they could understand.
- Staff did not use 'jargon' when speaking with patients to ensure they understood what was happening. Staff took time to explain what they were going to do and adapted this to a way the patient would understand. We saw staff explained equipment and the process before carrying out procedures.
- We observed staff introducing themselves to patients and their relatives. The organisation championed the 'hello my name is' campaign to promote compassionate, person-centred care.
- Staff wore identification badges at all times. We saw the photographs and names of staff were displayed on the waiting room walls in clinics we visited, which helped visitors identify who was responsible for the services delivered in those localities.
- Staff told us they encouraged their patients and friends and family to be involved in the planning of care as

much as possible. This was confirmed by family members we spoke with who said they felt involved in discussions about treatment options and could ask questions about the care they were receiving.

Emotional support

- Throughout our inspection we observed staff giving reassurance to patients both over the telephone and in person.
- Staff knew how to access different support groups and organisations for patients if required, for example the Alzheimer's society, Parkinson's society, and Age UK.
- There was information displayed in clinics regarding a variety of support groups, for example the prevention of falls, living with dementia, and counselling services.
- Personal, cultural, social and religious needs were addressed. Staff we spoke with were aware of patient's specific needs such as those with religious beliefs. Staff showed us how they could access counselling services and other psychological support for a patient if it was needed.
- The organisation had a variety of resources available for carers. For example, they could refer a patient to the local County Council for advice, information and support, or to request a Carer's Needs Assessment.

Are community health services for adults responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

- The organisation adapted to meet the needs of the local community through a variety of services purchased by the local clinical commissioning group (CCG). Through this process, we saw examples of when the organisation engaged with local GP surgeries, stakeholders and other NHS providers to ensure services provided met the needs of the local community.
- Staff were able to schedule appropriate time for each patient dependent on their needs and understood that when more time was needed,adjustments could be made to ensure appropriate care was given. For example, more time could be allocated to more complex patients, which allowed for any unexpected circumstances.
- Clinic environments we saw were appropriate for the services planned, with comfortable and sufficient seating, toilets and in some cases refreshment facilities.
- Patients and their families were involved in the planning of services they required. For example, we saw a patient who was able to decide when a treatment enabling them to receive nutrition was implemented, empowering them to make decisions at their own pace.
- Clinics and specialist nursing services operated during normal business hours (9am to 5pm) Monday to Friday. The learning disabilities team told us out of hours advice regarding accommodation and welfare issues were referred to the duty social services team and health issues to the out of hours GP service.
- The physiotherapy department was open 7am to 8pm Monday to Friday and 7:30am to 4pm on Saturdays. The community physiotherapists saw patients in their homes if they were housebound.
- The physiotherapy service provided exercise classes and worked in partnership with the local leisure centres to provide hydrotherapy classes to assist with patients' therapy and encouraged patients to be empowered to practice the exercises individually.
- The physiotherapy service tailored services to meet individual needs. For example they provided leaflets with clear photos demonstrating exercises appropriate for the patient. In addition therapists told us they, with consent and using the patients phone, filmed patients doing the exercises shown so the patient could remember how to do the exercise when they returned home.
- All community nursing services operated 24 hours a day seven days a week. Each of the six teams provided cover with separate shifts between 7am and 7pm. A service wide out of hours service was provided between 7pm and 7am. The out of hours service consisted of a band 6 (7pm to 7am), one band 5 (6pm to 2am), two band fives (7pm to 11pm) and two health care assistants (7pm to 11pm). The band 6 nurse was buddied with a band 6 who worked the day shift to enable them to gain consistency and have access to information shared, for example team meetings.
- Throughout the care episode the community nurse acted as case manager to ensure service delivery was

appropriately instigated and coordinated to meet the individual patient's needs. We saw community nurses arranged visits for patients requiring administration of medicines around individual needs. The morning insulins were administered between 7am and 10am, and a patient who was late rising from bed would be visited between 9am and 10am to accommodate their needs. This coincided with carers visiting who assisted with breakfast and personal care.

- The community nursing team predominantly saw patients who were housebound and were unable to get to a clinic environment or location. The service provided a medication clinic every day at MCH House for patients who were not housebound, for example the removal of chemotherapy pumps and daily anticoagulant medicines.
- The organisation provided a night sitting service for any adult patient who required constant support from family and carers. For example, patients living with dementia, end of life patients and those with an infection which was causing confusion. The night sitters were experienced health care assistants who would stay with the patient from 10pm to 6am up to a maximum two nights a week, depending on availability. Referrals were accepted from GP's, community nurses, care managers and health professionals and were booked through the on call telephone exchange system.

Equality and diversity

- Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant staff could communicate effectively with all patients where English was not their first language. Community nurses told us one example when the service had been accessed in the previous 12 months.
- We observed an extensive range of literature and health education leaflets mounted on purpose built racks located in waiting areas and therapy rooms. Staff told us they could access information leaflets in other languages if needed and we saw information on the back of patient information leaflets signposting patients to these.
- Physiotherapy staff tailored exercise programmes to meet individual needs taking into account age or disabilities. This meant, for example, that those patients who were wheelchair users could still participate in the recommended exercises or programme.
- We saw the organisation's equalities action plan 2014-2017. This ensured patient access to clinical services was needs based and where there were differential take up rates by equality strand (groups of people who experience particular forms of discrimination) these reflected only clinical need or patient choice. The action plan incorporated an analysis of access needs to ensure prioritisation of resource allocation to high need services. This included but was not limited to: physical access, access for sensory impaired service users, service opening hours and access for carers.
- The organisation was aware of their obligation with regards to the Workforce Race Equality Standards (WRES). Any independent unit that undertakes work for the NHS that generates an income of over £200,000 in any twelve month period is obliged to collect and publish data. This includes, but is not limited to, the ethnicity of its staff and the positions held by those staff. We saw data had been collected, an action plan was submitted and in the process of being actioned.

Meeting the needs of people in vulnerable circumstances

- The organisation had systems available to ensure services could meet the needs of people in vulnerable circumstances such as those living with dementia or a learning disability.
- Staff described examples of working closely with local GPs to provide ongoing support to patients. Staff were able to give us examples of caring for people living with dementia and the adjustments made, for example, taking time to talk to patients, using simpler language and involving carers.
- The physiotherapy gym in MCH House had a separate cubicle with a treatment couch and chair suitable for bariatric (extremely obese) patients.
- Patient's carers were included in the visits we attended. We observed a community nurse checking on a carer during a visit, ensuring they had support, and discussed the possibility of respite care.

Access to the right care at the right time

- The organisations had performance data available to help monitor and manage times taken to access initial treatment. Data collected included the average time from referral to first clinical contact for both routine and urgent referrals.

Good

Community health services for adults

- The organisation collected data of average response times for routine and urgent referrals for community health services for adults. We saw data for 2016 showed the dementia team response time was 6.6 days for routine and one day for an urgent. The community nurses' response time was 6.2 days for routine and 2.8 days for an urgent.
- The targets for the other services varied according to the service and ranged between one and 18 weeks for average routine response times. The targets for average response times varied between one day and 52.9 days (the diabetes team). We saw data for 2016 showed community health services for adults broadly met targets despite increased referrals. The physiotherapy team response time was 26 days for routine (target six weeks) and 23.5 days for urgent (target six weeks). The tissue viability team response time was 18.8 days for routine (target four weeks) and 7.1 days for urgent (target four weeks). The continence team response time was 13.2 days for routine (target four weeks) and 5.3 days for urgent (target four weeks). The diabetes team response time was 42.2 days for routine (target two weeks). The adult learning disability team response time was 31.8 days for routine (target five weeks) and 29.4 days for urgent (target five weeks).
- When appointments were cancelled by the service, patients were phoned as soon as possible and told of the delay and offered an appointment the next day if possible. If a patient was cancelled, the colour coding used to determine the urgency of the referral was changed. For example if they were green they moved to amber, and if they were amber, they moved to red, to ensure they would be prioritised when allocation for the next day was considered. Data, collected up to February 2017, showed cancellations by the services were collected as a percentage. We saw community nurses cancelled 1.35%; continence service 14.4% and dementia support 0.46%. The community physiotherapy team, rapid response team (intermediate care) and the learning disability team did not cancel any appointments during the same period.
- Overall the organisation had effective systems to prioritise care and address referral wait times, which indicated the organisation was responding effectively to ensure people had timely access to care and treatment.

Learning from complaints and concerns

- The organisation recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the organisation in order that these could be addressed.
- All staff were encouraged and empowered to identify and address any concerns or issues raised. Staff told us they would always try to address complaints informally in the first instance. The clinical lead, for example, told us how they had visited a patient at home with another colleague to allay concerns and discuss problems early, before they escalated into a full formal complaint.
- Posters advertising the contact details of the customer care team were displayed in clinic areas. Staff left information leaflets detailing how to raise a concern or complaint in patient homes. We asked patients if they were aware how to make a complaint if needed, and were told they had been provided with information in their welcome pack.
- The responsibility for all complaints rested with the managing director, and heads of service and associate directors were responsible for ensuring complaints and concerns relating to their area of responsibility were responded to. The organisation's complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. The customer experience team triaged all written complaints received and directed for appropriate management. An initial acknowledgement was required within three working days and a full response within 25 working days. If a complaint was escalated to a further stage the complainant would be given the information of the NHS Ombudsman if they remained unhappy with the outcome.
- Data showed community health services for adults had received 44 complaints in the 12 months before inspection. Seventeen of these complaints were upheld and no complaints were referred to the Ombudsman. The majority of complaints referred to level of care received, breakdown in communication and timing of appointments.
- We saw that upheld complaints had been responded to by the organisation within the required time frame by letter and a representative had met with the patient. All

Good

Community health services for adults

the complaints were resolved and showed lessons learnt from the organisation. Individual members of staff affected were provided with extra training where appropriate.

- All complainants were sent feedback surveys three months after the complaint had been resolved. This explained the lessons that had been learned and had been embedded in the service as a result of the initial complaint.
- We saw complaints and compliments were formally discussed at the governance meetings and department meetings as appropriate. This reviewed patient satisfaction data, complaint trends, onwards action as appropriate and areas for continuous improvements for the patient experience.

Are community health services for adults well-led?

Good

Service vision and strategy

- The vision of Medway Community Healthcare (MCH) was to be a successful, vibrant, community interest company that benefitted the communities they served. They aimed to develop services outside of Medway by establishing themselves as providers of accessible, high quality integrated care across Kent. As MCH was a social enterprise they had the freedom to develop their own services, whilst directly aligning them to population need.
- MCH had a five year strategic plan to develop services in Medway in order to ensure people they provided services for experienced safe, effective and responsive care. They aimed to do this by delivering a range of services for local people, support clinical teams to innovate and develop their services and support out of hospital services in order to reduce the demand for hospital services. The strategy was widely understood and supported by staff at all levels in the community health service for adults.
- MCH used 'I am…model' to demonstrate their approach to delivering personalised care with the people they cared for at the centre. This consisted of seven principles of care delivery and formed the basis of the organisation's quality framework. Each service displayed its 'pledge' signed by staff who worked in the service to show that they agreed with the vision and strategy of the service and organisation.
- The learning disability team explained their vision for the service and this included embedding their working relationship links with the liaison nurse for learning disabilities at the local NHS trust. Working closely with the Medway Council enabled the team to be aware This of the next cohort of school leavers who live with a learning disability. This meant patients would not be missed as they transferred between children and young persons and adults' services.

Governance, risk management and quality measurement

- MCH had developed a quality framework, which was in line with the five key questions of safe, effective, caring, responsive and well-led. Each key question had three commitments which were aligned with the organisational values.
- This governance framework ensured an effective organisational structure that supported the delivery of services and minimised the risks across all areas of business.
- The Governance Assurance Information Network (GAIN), Medicines Management Subcommittee, Infection Prevention and Control Subcommittee, fed into the Quality Assurance Committee (QAC). The QAC, performance overview group and audit and risk committee reported to the board.
- The QAC met every month and discussed policy updates, involvement in research and reports from the sub groups. Reports reviewed included clinical and medicines incidents. Clinical risks raised by each service were discussed at the meeting every month. Any new risks were added to the risk register and on-going risks updated.
- Staff we spoke with had a good understanding of what a risk was. They were clear who they would raise this with, that it would be acknowledged and action taken. The risk register was corporate wide and determined through the incident reporting system. A separate risk register was held for each service and could be accessed on the internal computer system. An example of a risk specific to a location referred to an exit door for Lordswood Healthy Living Centre. The door was

operated by a timer mechanism and an incident had occurred at a weekend when a group of unauthorised people had managed to gain access. This meant there was a risk staff may be in a vulnerable position.

- GAIN meetings occurred every three months. Representatives from each team were invited to attend and attendance was good. The network reviewed a number of quality issues, for example; complaints audit, health and safety and medicines management. The network carried out a number of 'quality visits'. This involved members of staff visiting other teams in the organisation and assessing the team against CQC's five key questions. It identified areas of good practice and areas for improvement. Staff we spoke with told us they overwhelmingly welcomed these visits. Not only did they feel they learnt something new about a team but they were keen to improve quality wherever possible.
- The community health service for adults had dashboards which measured a range of key performance indicators. This enabled them to monitor and measure the quality of their service regularly. Staff we spoke with were aware of key performance indicators in their teams.
- A structured audit programme supported the organisation to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and QAC meetings. These ensured lessons could be learnt and actions had been completed.
- A monthly meeting was held by the human resources department to discuss vacancies and any staffing issues. The community nursing teams attended the monthly business unit meetings and each band 7 fed down to their teams on a monthly basis. Staff told us all services attended monthly team meetings. We saw these meetings were recorded and regular items discussed were clinical updates and staff competencies.
- In addition to internal quality measurement, MCH had regular quality meetings with the local Clinical Commissioning Groups (CCGs) to discuss commissioned services.

Leadership of this service

- There was a clear management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.
- Community health services for adults were led by the director of urgent and planned care who reported directly to the managing director and the board. Heads of services oversaw the running of their respective areas and reported to the director of urgent and planned care.
- All staff we spoke with thought their line managers and senior managers were approachable and supportive. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- Staff were clear about the lines of accountability and staff we spoke with expressed confidence in the leadership of the organisation.
- Managers we spoke with appeared knowledgeable about their service users' needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.
- We saw strong leadership at a local level with staff praising their local managers regarding their support and communication. Staff also told us they felt a valued part of the organisation, their opinions and ideas were valued and listened to.
- Teams told us they felt valued and supported. They also told us that members of the board were very visible, approachable and made them feel an important part of the organisation. Board members attended staff inductions and members of the board attended local staff meetings. We saw minutes of staff meetings which indicated this happened.
- The senior leadership team 'signed up' to a set of leadership behaviours and were confident they would be held to account, as would others, if they did not reflect those behaviours.

Culture within this service

- Staff told us the organisation was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did. We spoke with staff about the organisation culture and all of them reported that they enjoyed their jobs and felt valued.
- The culture in the community teams encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned.

Good

Community health services for adults

- Staff were committed to making improvements for patients and felt they had been given the right tools to achieve this. Staff told us they felt empowered to make changes.
- The rate of sickness for the whole organisation was 3.7% for permanent staff in the 12 months before inspection. Data shown for November 2016 showed 256 members of staff had left the organisation in the previous 12 months giving a turnover rate of 19%. The provider explained turnover for this period was high because staff were made redundant as a result of the closure of St Bartholomew's Hospital and the loss of the community podiatry contract.
- The clinical lead for community nursing services acknowledged they had vacancies and these were mainly band 5's. We saw monthly recruitment events were held and these were scenario based, for example the daily role of a community nurse and an allocation exercise. Part of the recruitment process included finding out the personalities of applicants to ensure nursing in the community setting was appropriate to them. The organisation was in the process of using this system to recruit health care assistants.

Public engagement

- MCH as a community interest company, patients and the local community had a say in developing business plans for the future. This involved patients being involved in the design, location and opening times of services.
- There were effective systems in place for stakeholders and members of the public to provide feedback to MCH. We saw leaflets were provided for patients in information packs, posters displayed in clinic localities and the MCH website encouraging feedback.
- MCH had implemented a system enabling patients to text their feedback free of charge, making it easier for people to tell them about their experience using services and helping them to improve.
- We saw there was a variety of general information leaflets regarding flu advice and smoking cessation available for patients and visitors. In addition, there was information available for carers and relatives if they required additional financial or emotional support.

Staff engagement.

- MCH as a community interest company was co-owned by its staff. This meant staff had a say in developing the business plans and in designing how they provided their services.
- The organisation had an elected member's forum. This was made up of a group of staff to facilitate communication and engagement between the MCH Board and the wider organisations.
- Staff were encouraged to engage with the organisation from induction. Staff told us the induction was comprehensive and non-executive directors attended.
- The majority of staff who delivered community health services for adults had participated in an appraisal in the last year. They told us they felt this was a useful process which enabled them to identify areas for learning and access external courses.
- Staff were encouraged to attend and attended preceptorship programmes, active learning sets and a leadership programme which MCH had developed.
- Managers had introduced 'My Idea'. This was a staff suggestion scheme which encouraged staff to pitch ideas that could benefit patients.
- The organisation regularly sought the views of staff on organisational initiatives. This enabled the organisation to understand how staff can be better supported in their roles. Staff told us of an example where staff were asked for their opinions on how the flu vaccination campaign could be improved. The result of feedback received caused a change to the service offered in 2016. This included offering bookable clinics, out of hours clinics and better timed clinics for patients. This meant staff were able to be as efficient as possible within their roles, whilst protecting their own health and that of their patients.
- Managers told us the majority of students who had their placement at MCH went on to gain employment at the organisation.
- Staff had regular team meetings in all teams and also engaged in multidisciplinary team meetings and staff forums. All staff had access to and could see the dashboard for their relevant area. This was discussed with teams at staff meetings as were complaints and friends and family test results.
- The organisation provided a monthly nursing newsletter and we saw the February 2017 issue. Items covered were lessons learned from incidents and complaints. In addition updates were provided which were clinical specific. For example, the crisis packs with anticipatory

medicines for end of life care patients needed to be patient specific for controlled drugs, updates regarding documentation and updates from the GAIN meetings. Staff told us they received the newsletter by email and we saw it was displayed on notice boards.

- We saw an award for 'employee of the month' for community nurses in each locality. This was published in the community nursing newsletter. In addition we saw the certificate awarded and a picture of the winner was displayed on the community nursing information board in the waiting area of Lordswood Healthy Living Centre.
- The organisation asked staff to complete a staff survey every two years and a 'temperature check' each year. The surveys enabled the organisation to understand how staff felt about working for the organisation, what was working well and where there may be concerns. The last staff survey was completed in November 2015.
- The 'temperature check' consisted of three questions and was completed by a different business unit every three months. The results were shared with the relevant director and manager of the service who then shared and discussed the results with the teams. Staff told us these discussions included a celebration of what was working well, and action planning to address any areas of concern. We saw the overall response to 'how likely are you to recommend the organisation to your friends and family as a place of work?' for community health services for adults. There were 201 responses and the response rate was 85%.

Innovation, improvement and sustainability

- The organisation had recruited two band six paramedic practitioners who supported community nurses with advance assessment skills. Staff we spoke with told us the practitioners were an asset to the organisation. We were told the organisation was in the process of recruiting band 5 paramedics.
- The physiotherapy department won a patient experience award for improving from 'challenged' to 'great' for reducing their waiting list from 16 weeks to two weeks.
- The physiotherapy department provided a continence service for men and women. This meant the organisation had recognised National Institute for Health and Care Excellence (NICE) guidelines which recommend physiotherapy as the first treatment option, for people who experienced incontinence or bladder problems.
- The musculoskeletal physiotherapy service won the 'Turning it around when it goes wrong' award at the patient Experience Network National (PENN) Awards and the 'Transforming patient experience category' at the North Kent Clinical Commissioning Group patient experience awards. This was in recognition of the innovation, leadership, positive patient feedback (99% of patients would now recommend the service), reduced waiting times and improved access for patients.
- The tissue viability team in partnership with the local acute NHS trust was awarded Highly Commended for Innovation in service Delivery by the Molnycke Wound Academy for their development of a pressure ulcer passport.
- MCH was shortlisted at the Friends and Family Test (FFT) Awards 2016, within the 'Best FFT initiative in any other NHS-funded service' category.
- MCH board was awarded NHS Governing Body of the Year at the Kent Surrey and Sussex Leadership Recognition awards 2015 in recognition of the Board's drive to ensure all staff worked together to provide high quality care for the benefit of the local community.
- MCH was shortlisted as Health and Social Care Enterprise of the year at the Social Enterprise UK awards 2015. This was in recognition of excellent vision and strategic direction, clear leadership and management, a high degree of customer satisfaction, a clear, evidenced, social, environmental and community impact and sustainability of profit and growth.
- The patient experience team was awarded runner up Team of the Year at the Patient Experience Network National awards. This was for their 'can-do approach', use of initiative and creativity to engage with patients and staff, and for promoting a positive, open culture across the workplace.
- The occupational therapists were runners up in the outstanding service/Innovation category at the Occupational Therapy Show Awards 2015.

Community health services for children, young people and families

Good

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

Information about the service

Community health services for children, young people and families provide services for the areas of Medway and Swale. Services are provided from numerous locations across these areas and include health visiting and children's therapies.

Children and young people can be seen in school, health clinics, and community centres or at home.

The children's therapy team is a multi-professional team providing services for children with disabilities and complex needs aged 0-18 years in Medway and Swale. This includes a paediatric musculoskeletal and podiatry service. The team consists of physiotherapists, speech and language therapists, occupational therapists, podiatrists, dieticians and a continence advisor

The health visiting team provides a range of universal, preventative and targeted services from the antenatal period until children start school. The team also offer support around maternal mental health. The team consists of health visitors and visit new parents at home to offer initial advice, with on-going support available up to school age through further home visits or at local clinics and children centres.

Are community health services for children, young people and families safe?

Good

Safety performance

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.
- The service for children, young people and their families reported no never events from January to December 2016.
- In the period January to December 2016, there were no serious incidents related to services reported to the Strategic Executive Information System (STEIS). STEIS is a web-based serious incident management system, provided by NHS England, through which providers record serious incidents.
- Safety performance data was monitored by the Board, Quality Assurance Committee (QAC) and the CCG Quality Review Group.

Incident reporting, learning and improvement

- Staff used an electronic incident reporting system to report incidents. A total of 1469 incidents were reported to the electronic reporting system from March 2016 to February 2017. Data provided indicated 80 were relating to services for children, young people and families. Twenty three were classed as low harm and 57 as no harm.
- All the staff we spoke with were aware of how to report incidents. They felt they were encouraged to report incidents, patient concerns and risks to the organisation. Staff were confident that if concerns were raised to managers, action would be taken.
- If an incident occurred away from their base, staff would record the incident on the electronic reporting system

as soon as they returned to their base. We saw a log of incidents and staff had documented the location where they occurred. This enabled managers to identify any themes or trends in incidents occurring in a variety of settings.

- Staff told us incidents were discussed regularly. Minutes of meetings we looked at had no record of discussions about incidents and this was not a regular agenda item. However, the head of service for the children's therapy team produced a monthly newsletter which reported incidents, themes and trends and lessons learned. The newsletter was shared between different staff groups ensuring learning was shared.
- The heads of services discussed incidents at the QAC meeting each month and we saw minutes of these meetings which indicate this was occurring. This also enabled learning to be shared across teams.
- In addition to this, staff gave us examples of sharing information and learning following incidents. The electronic incident reporting system had a facility for staff to complete lessons learned. Staff demonstrated this to us and we saw all incidents logged onto the system from March 2016 to February 2017 had this section completed.
- We reviewed a sample of service wide clinical incidents, patient notes and root cause analysis and found that investigations had been completed thoroughly.

Duty of Candour

- Staff we spoke with were aware of the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person as well as offering an apology. Staff understood their responsibilities and the processes to follow if an incident triggered duty of candour.
- Duty of candour was included in the serious incident policy and was available on the organisation's intranet.
- The electronic reporting system had a window which indicated if duty of candour had been discharged. Staff showed how they could access this.
- We saw posters displayed in staff offices describing the duty of candour and procedures to follow in the event of a notifiable safety incident.
- No incidents had triggered duty of candour in children's and young people's services.

Safeguarding

- The organisation had a Safeguarding Children and Young People Policy, ratified in March 2017. All staff could access the policy on the organisation's intranet.
- There were systems and processes in place to keep people safe. Staff understood their responsibilities and adhered to safeguarding policies and procedures. There was a clear pathway for reporting and dealing with child protection and safeguarding concerns. The policy included a section on 'Working together to Safeguard Children 2015'; this was in-line with The Department of Health's best practice guidelines.
- At Medway Community Healthcare (MCH) the safeguarding team had recently been redesigned to have a combined adult and children safeguarding team in line with the 'Think family' model. The 'Think family' model promotes co-ordinated thinking and delivery of services to safeguard children, young people, adults, families and their carers. This provided a complete service to support children and their adults and vice versa, if any safeguarding concerns were identified. The team included a designated nurse, a specialist nurse in domestic abuse and a named nurse for each individual health visiting team.
- The safeguarding team provided training and clinical supervision to other members of staff. This was in line with the Safeguarding Children and Young People policy and the Supervision policy.
- Staff told us there were no barriers to accessing training and they received their regular safeguarding supervision sessions. As at December 2016, 100% of children's therapy team and health visitor staff had completed Safeguarding Children Level 1 training, 93% had completed Safeguarding Children Level 2 training and 89% of staff had completed Safeguarding Children Level 3.
- Staff were able to tell us how to recognise a safeguarding concern and how to report it. They were also able to provide examples of reporting concerns.
- This included the identification and reporting of children and young people who may have been subjected to female genital mutilation (FGM). This meant that staff had the knowledge necessary to safeguard children and young people in vulnerable circumstances.

Community health services for children, young people and families

Good

- CQC received no notifications relating to MCH House from January to December 2016.
- MCH had a link on their website so any member of the public could refer to a contact the local authority safeguarding team if they had concerns about a child.
- There were very good networks of support in place for Looked After Children (LAC). Staff worked closely with young people and built up close working relationships with them. Staff were dedicated to supporting looked after children and even when children moved out of the area, still worked hard to maintain contact and continue to deliver support. From April 2016 to January 2017 health visiting staff attended 1715 safeguarding meetings.
- There was a CQC safeguarding looked after children review (SLAC) in February 2016. The only action arising for this review was for MCH to undertake an audit of referrals made by the paediatric liaison nurse to the health visiting service. This was to determine if there were any barriers to information being shared or to children being accepted by the health visiting service for follow-up action following discharge from the emergency department at the local trust. We requested a copy of the audit. We received this response from the organisation; 'The actions from the CQC recommendations were reviewed and coordinated by the designated nurse for safeguarding children at the commissioning CCG. There was one action applicable to MCH but it was felt by the Commissioning CCG that it was not necessary to complete an audit as they had identified a local trust had not completed their local procedure and they were following this up.

Medicines

- The children's therapy team did not use any medicines.
- Health visiting service was not a nursing service but a Public Health Service and therefore did not manage medicines or medical gases for children in their homes or carry medicines in their cars.

Environment and equipment

- The children's therapy team had access to a variety of locations and those we visited had a wide range of equipment for staff to use in assessing and treating children. Chairs and tables were of child height.
- Staff had access to soft play areas, sensory rooms, a variety of consultation rooms and an accessible outdoor play area, so they could assess children and offer treatment in a variety of locations.
- Health visitor staff carried out clinics and classes in children's centres, healthy living centres and service users' homes.
- Managers gained assurance from landlords of locations not owned or managed by MCH House with service level agreements and by carrying out annual environmental audits. Following these audits areas for improvement were identified, action plans were developed and issued to site managers and service managers, as appropriate. Completion and compliance with these audits gave managers assurance the design, maintenance and use of facilities, kept service users safe from harm. We saw copies of these audits which indicated this was occurring.
- All locations we visited had secure access. Buildings had swipe card access or via a member of a reception team. All staff wore identity badges that clearly stated their name and role, those authorised to do so carried electronic swipe cards. Staff asked to see identification prior to entry into locations, they requested visitors books were completed and visitor badges to be worn.
- Resuscitation equipment and first aid kits were available in the areas we visited. Records demonstrated this equipment was easily accessible and regularly checked in line with best practice guidance.
- We found there were appropriate Service Level Agreements (SLA's) for the maintenance of equipment. Staff told us they had no difficulties in getting equipment checked if it was faulty.
- Records we viewed demonstrated medical devices like weighing scales were calibrated and serviced.
- We saw health visiting staff had access to specialist equipment in order to provide care and treatment to people in their homes. For example, we saw bags of play equipment available which helped staff to carry out their developmental reviews of children.
- Waste in the clinic rooms was separated and placed in different coloured bags to identify the different categories of waste. This was in line with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.

Quality of records

Community health services for children, young people and families

Good

- Services for children, young people and their families used an electronic record system. Electronic records were stored on a central computer system, which could be viewed when staff had access to a desktop computer. Staff carried a tablet computer with them when away from the desk top computer which enabled them to type their notes contemporaneously. The records from the tablet computer were then uploaded onto the central system, ensuring that a full record was stored centrally. The central system also enabled staff to share information with social services and the safeguarding team.
- Staff had their own username and password to access records, which meant they were stored securely. We saw staff lock computers when they were away from them.
- We looked at five records on the electronic system. Records were complete, identified who had completed the record and included details of any assessments and examinations undertaken by staff.
- The service carried out a quality audit of 10 records each month. From data we received on average, from April 2016 to February 2017 the children's therapy service scored 88% which was below the target of 90%. Results of the audits were fed back to individual staff for personal development. Managers audited each month and could identify whether improvements had been made or not and identified areas for further training or development, if required.
- We saw staff recording babies' heights and weights and details of any advice given in babies' 'red books' at the 'drop in' clinics.

Cleanliness, infection control and hygiene

- Locations we visited were visibly clean and tidy. Managers carried out annual infection control audits of the premises their staff used, but which were managed by external agencies. Following these audits areas for improvement were identified, action plans were developed and issued to site managers and service managers, as appropriate. Managers monitored the compliance with these action plans.
- We saw the children's therapy team ensuring equipment was cleaned between each patient use and that cleaning checklists were used. We saw staff cleaning equipment with disinfectant wipes between patient use. The checklists indicated how frequently equipment should be cleaned and we saw staff sign checklists to indicate this had been done. In the most recent decontamination of equipment audit (December 2016), the children's therapy team scored 100%.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container. We saw the temporary closure mechanism was used in every sharps bin we looked at.
- Personal protective equipment was available for staff to use in the clinic areas we visited.
- We saw hand-sanitiser was available in areas where treatment and assessment was carried out and staff were seen using hand sanitiser between patient contacts. The most recent hand hygiene audits showed the children's therapy team scored 100%.
- We saw vomit and urine spill packs and biohazard spill kits were available for staff to use in the different areas we visited.
- Staff attended infection control training as part of their mandatory training programme. We saw 97% of the children's therapy team had attended training in the last year and 90% of health visitors had attended infection control training in the same period.

Mandatory training

- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information governance, diversity awareness, moving and handling. Staff told us they were given protected time to complete mandatory courses.
- Ninety five percent of the children's therapy team had completed training in the last year and 89% of the health visitor team had completed training in the same period. Both compliance rates were better than the organisation's target of 85%.
- Managers were able to oversee mandatory training rates with an electronic reporting system.

Assessing and responding to patient risk

Community health services for children, young people and families

Good

- Health visiting staff assessed risks through discussion with parents, taking measurements of babies and children such as weight and head circumference, and observing the home environment for children. Staff recorded risks in patient records and recorded them as incidents on the electronic reporting system. If staff identified health risks, they made referrals to GPs and other health professionals.
- A range of risk assessments were utilised by the various clinical teams to assess and manage risk. Examples included risk assessments for children who were at risk of developing pressure ulcers, manual handling risk assessments, and those children who were subject to a child protection plan. Staff audited the completion of risk assessments and the service scored 100% for nutritional risk assessment completed in August, September, November and December 2016.
- Where risks were identified, staff had access to support, guidance and equipment to help manage these risks.
- We saw risk assessments had been conducted to ensure staff and patient safety. For example, risk assessments with regard to lone working of staff.
- Staff could access emergency equipment in all the areas we visited. Resuscitation trollies were available in areas where staff were appropriately trained, in community locations and MCH House. Automatic electronic defibrillators were available in other areas.
- If staff identified health risks, they made referrals to GPs and other health professionals as appropriate. In the case of emergencies, staff used the relevant emergency services and would record this as an incident. We saw examples of this on the electronic incident reporting record.
- Ninety one percent of children's therapy staff had completed paediatric basic life support training in the reporting period, which was better than the target. Eighty percent of health visitor staff had completed paediatric life support in the reporting period, which was worse than the organisation's target.

Staffing levels and caseload

- Managers collated information relating to referrals, contacts and attendances to their services in a dashboard. Using this information, they predicted referrals and staffed their service in relation to these levels and flexed their staff in line with the dashboard.
- When referrals were received, managers allocated them to staff depending on the staff member's caseload and the type of referral.
- From December 2016 to February 2017, on average the children's therapy team had 44.7 whole time equivalent (WTE) staff, which was lower than the plan of 47.1. From January to December 2016, the service used no bank or agency staff. On average from April 2016 to March 2017, the team had a caseload of 4640 children each month. This meant on average, each member of the children's therapy team had a caseload of 104.5 each month.
- From December 2016 to February 2017, on average the health visiting team had 84.2 WTE staff, which was lower than the plan of 96.3. From January to December 2016, the service used no bank or agency staff. On average from April 2016 to March 2017, the team had a caseload of 17, 712 cases each month. This meant, on average, each health visitor had a caseload of 210 each month. Of this caseload, 147 were children subject to a child protection plan, 420 children were vulnerable as a result of their circumstances and were on locally determined packages, which equated to 16 per health visitor case load. On average there were 69 looked after children as part of the total health visitor caseload each month.

Managing anticipated risks

- There was an embedded lone worker policy for staff working in the community.
- Staff carried out risk assessments prior to visits to homes.
- Children's therapy team staff had mobile telephones and signed out of a location when travelling to a child's home. Reception staff monitored if staff signed out at the end of the day or had returned following a home visit. They would call the staff member to check on their whereabouts if they had not signed out at the end of the day. In addition to this staff had electronic diaries, which other staff could access to see where they were.
- Health visitors carried phones which located all health visitors. They also used a code word on the phone to alert office if they felt unsafe. It was possible to highlight on the computer system if there should be two staff on a visit.
- We saw the organisation had adverse weather policies in place and these were accessible to staff. Mobile workers recounted examples of how they maintained the service during adverse weather events such as snow affecting the local road transport system.

Community health services for children, young people and families

Good

- The children's therapy team used a dashboard which is a management tool used to collate an overview of services. This helped them to identify any seasonal variations in referrals and attendances and adjust their service to deal with these changes. For example, they were able to run group classes during school holidays as children and their parents were able to attend together. This meant school age children, who usually had therapy at school, could access therapy during the holidays.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

- Health visitors and their teams delivered the Healthy Child Programme (HCP) to all children and families during pregnancy until five years of age. The Healthy Child Programme for the early life stages focused on a universal preventative service, providing families with a programme of screening, health and development reviews, supplemented by advice around health, wellbeing and parenting.
- Medway Community Healthcare (MCH) had been awarded UNICEF Baby Friendly accreditation Stage 3. At Stage 3, the focus is on ensuring that the Baby Friendly standards are implemented for all pregnant women and new mothers. Baby Friendly accreditation is based on a set of interlinking evidence based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.
- Health visitor teams were using a maternal mood assessment in line with NICE, clinical guideline (CG192). Antenatal and postnatal mental health: clinical management and service guidance. They had audited compliance with NICE quality standard, QS115 Antenatal and postnatal mental health
- Children, young people and their families had their needs assessed, their care goals identified and their care planned individually. Staff used 'My plan' to document goals set with children, young people and their families. We reviewed a selection of these care plans and saw goals were individual, realistic and reviewed regularly. In addition to this, the organisation audited care plans each month to assess the compliance and quality of each section completed.
- Care was delivered in line with evidence-based guidance, standards and best practice such as those developed by the National Institute for Health and Care Excellence (NICE).
- The children's, young people and families services regularly audited their service to see if they were meeting NICE guidelines, for example NG43 Transition from children's to adults' services for young people using health or social care services.
- Discrimination was avoided as health visiting services were offered to all anticipated new births and new births. The children's therapy services provided treatment to all regardless of disability, gender, gender reassignment, race, religion or belief or sexual orientation. Staff received training in equality and diversity as part of their mandatory training, so were alert to potential inequalities.
- Staff had regard to the Mental Health Act code of practise and the Special Educational Needs and Disability Code of Practice. This meant they involved children and families in decision making and treatment planning. They ensured that children had access to treatment in appropriate environments and at times to fit in with their daily lives, schooling and times appropriate for them.

Technology and telemedicine

- Staff used tablet computers to record their assessments and interactions with patients.
- Health visitors provided follow up by telephone call to families they supported.
- Children's therapy team staff provided a telephone call-back and advice system. They had 772 telephone contacts from April 2016 to January 2017.
- MCH had a comprehensive website with useful links to other information. Electronic referral was available for healthcare professionals to refer patients to MCH services.

Community health services for children, young people and families

Good

- Posters were positioned around the various MCH locations which encouraged service users to provide feedback via text, email and social media.

Patient outcomes

- The health visiting service offered five face to face contacts in order to support the Healthy Child Programme in line with Department of Health guidance.
- Targets were agreed with local commissioners
- From October 2016 to January 2017, 100% of women were offered an antenatal visit, which was in line with the organisation's target.
- In the same period, on average 91% had a Universal new birth (Face to Face) visit within and after 14 days which was below the target of 98%.
- The percentage of maternal mood assessments being undertaken from October 2016 to January 2017 was on average 85% which was in line with the organisation's target.
- In the same period, 85% of 12 month developmental and family reviews were undertaken, which was better than the target of 80%.
- On average, 87% of 15 month developmental and family reviews were undertaken from October 2016 to January 2017, there was no target for this in the data provided to us.
- From October 2016 to January 2017, 67% of 24 to 27 month developmental and family reviews were undertaken, which was worse than the target of 95%.
- Managers monitored the number of babies breastfeeding at a six to eight week check. On average 30% of babies were still being breastfed at the six to eight week check. This was below the national average of 44%. This included 20% of babies which were exclusively breastfed, which was below the national average of 30%.
- MCH had an annual audit plan, which included infection prevention and control audits, environmental audits, documentation audits (including the completion of personalised plans for patients). We looked at the results of these audits which indicated they were occurring regularly and they were achieving the targets set by the organisation. Actions arising from these audits were identified in the organisation's Quality Account 2015-16 which included timescales for review.
- Quality and outcome information was used to plan for services in the future, with regard to location, numbers and qualifications of staff. Staff were involved with monitoring outcomes, for example, the dashboards were shared with the teams and staff understood what metrics meant.

Competent staff

- Staff told us they had a comprehensive induction when they started working for MCH. The induction included a wide range of training for example, basic life support, health and safety, fire training, moving and handling.
- Competence to perform roles was continuously assessed with staff working together, providing peer review, supervision sessions and annual appraisals. Competence was also checked with monthly documentation audits.
- Staff told us they were encouraged and supported to attend external training, for example specific training for specialised conditions. For example, we saw staff had attended specialist courses for the treatment of children with cerebral palsy. They had shared learning with others at in house training sessions and enabled one child to receive treatment sessions at a specialist treatment centre.
- Ninety nine percent of children's therapy service staff had attended an appraisal in the last year which was better than the target of 90%
- Health visitors had also achieved the appraisal target as 93% had an appraisal in the last year.
- Part of the appraisal was the identification and completion of specific courses relevant to their area of expertise. Variable staff performance would be reviewed at this stage and action taken to address this was done as required.
- Staff attended regular clinical supervision sessions which involved having peer reviews of treatment sessions, discussions about treatment plans and looking at the evidence behind treatment techniques.
- Staff also attended safeguarding clinical supervision sessions every quarter.
- Health visitor and therapy staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC) and Health Care Professions Council. We saw training certificates which confirmed this.

Multi-disciplinary working and coordinated care pathways

Community health services for children, young people and families

Good

- Staff had multidisciplinary and multiagency working within the organisation.
- They provided many examples of how they worked with other members of the multidisciplinary team to be able to meet the needs of children and their families. Staff from a variety of professions worked together to provide groups and advice sessions. This provided effective care planning and delivery for children and young people, particularly those with complex needs.
- Staff told us they had good working relationships with GPs, social services, and within their own service. This meant that information was shared readily and cross agency working ensured that where there were concerns about vulnerable children, these were shared and managed. We received information from the commissioning CCG, which stated; 'MCH have been open and engaging with the CCG'.
- Staff had an awareness of the services that were available to children in the area they worked and were able to contact other teams for advice and make referrals when necessary.
- We saw from records that staff carried out joint assessment and treatment sessions regularly. Staff set joint goals with children, young people and their families.
- Staff we spoke with were committed to working together to provide a quality service for children, young people and their families.
- There was good attendance at multi-agency safeguarding meetings. From April 2016 to January 2017, health visiting staff attended 1715 safeguarding meetings.

Referral, transfer, discharge and transition

- Referrals for the health visiting team were received into the health visitor's base, put into the diary and allocated to a health visitor depending on the mother's location and the health visitor's caseload. Operational leads then check the system daily to see if any births had occurred so the new born visits could be booked in.
- Referrals for children's therapy teams were received into a central administrative point. They were triaged and allocated to the appropriate therapy staff. Health professionals could refer children via the organisation's website. Staff accepted referrals based on the criteria, but if children of school age did not meet the criteria, schools had the option to buy therapy services in.
- Staff had close links with teams providing adults' services, within the same organisation and there were procedures in place to ensure that young people made the transition to adult services.
- Health visitors worked with the children's therapy services to ensure younger children were 'school ready'. Staff supported young children starting school and their parents with skills such as 'sitting and listening', social interaction skills and offered support with toilet training.
- There were policies and procedures in place to make sure that as children transferred from health visiting to school nursing, relevant and important information was passed to the receiving clinician.
- Both health visitors and the children's therapy team told us that they worked closely with each other to make sure that vulnerable children and their families were discussed and important information shared.

Access to information

- The implementation of an electronic records system enabled all members of the multidisciplinary team to have access to patient records. However, staff who worked in children's centres had no computer access, so had to wait until they got back to their base before they could access information.
- All staff within the organisation could access the electronic care records, which enabled all staff to access information.
- Staff told us they had access to information from schools, maternity departments and GP surgeries.
- Staff could access current guidelines, policies, procedures via the intranet, which meant they could access advice and up to date guidance easily.
- The head of service for the children's therapy team produced a monthly newsletter which included messages and information from every part of the business unit and managers. Staff told us they received the newsletter monthly, were encouraged to read it and found it beneficial to see information from other team members.

Consent

- There were systems in place to gain and review consent from children and their parents or guardians.
- Staff used 'Gillick competencies' to determine whether a child was mature enough to make their own decisions

and give consent. Gillick competency is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Therapy and health visiting teams were seen to involve parents in planning children's care, including consent, and they followed national guidance on consent for children assessed as competent.
- We observed consent being obtained during the inspection. We noted the interactions as competent and professional.
- All the records we viewed demonstrated consent was always obtained and recorded.

Are community health services for children, young people and families caring?

Good

Compassionate care

- From April to December 2016, the friends and family test for children's therapy service indicated, on average 98% of patients would recommend the service. The response rate to this survey was consistently better than the organisation's target. In the same period, 98% of patients would recommend the health visiting service. The response rate to this service was consistently worse than the organisation's target.
- CQC received 36 written feedback forms during the inspection, all of which were overwhelmingly positive.
- All staff we spoke with were overwhelmingly passionate about their role, their teams and the care they were providing.
- Staff were highly motivated to deliver care that was kind and compassionate to children, young people and their families. There was a focus on providing individualised and holistic care and the records we viewed evidenced this.
- The service had a strong, tangible person centred culture. Staff placed a high value on building relationships with children, young people and supported them in a way that ensured they felt understood and valued. Staff gave examples of supporting charity events in their own time and nominated children for 'Dream flight'. Dream flight is a charity whose purpose is to send seriously ill children on the holiday of a lifetime.
- Staff sourced charity funding on behalf of children and their families for equipment, such as powered wheelchairs.
- In addition to this, staff made driving licenses, with children's photos on and awarded them to children who completed a driving course in their powered wheelchair.
- Relationships between the children and young people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- Parents told us that staff took the time to ensure that they understood what treatment their child was receiving, and that staff involved the child as far as possible. We saw staff speaking to parents and children with the greatest respect and care.
- Parents were considered to be active partners in their child's care, and staff took care to ensure that the individual needs of both patient and families were met.
- All staff wore name badges and introduced themselves by name. When working with children staff got to their level and spoke with them in an age appropriate way.
- Parents spoke positively about health visitors and the health visiting service. One parent said "they (Health visitors) are professional, helpful and friendly"
- We saw staff interacting with mothers and their babies in a kind and caring manner. They were patient and gave parents the opportunity to explain their concerns fully.

Understanding and involvement of patients and those close to them

- We observed good staff interactions between parents, babies and children. Staff listened to parents' concerns and gave them evidence- based advice which was backed up with leaflets. Staff ensured that the parent had understood the information given by using reflective conversations.
- Staff asked questions in a sensitive and non-judgemental manner, and built a positive relationship with parents. Parents appeared to be open and honest with staff as a result.

Community health services for children, young people and families

Good

- The examples provided and comments received were evidence that staff ensured that the children, their parents, guardians and siblings were provided with care that considered all their needs.
- We saw staff give detailed explanations of what treatment was going to involve. Staff involved and actively encouraged parents to carry out treatment, with support and guidance, so they could continue treatment at home. This included discussions of things they could use at home for equipment to assist with treatment. We saw mutual discussions and agreement with staff and patients about treatment goals. Staff gave a copy of children's treatment plan and goals 'My Plan' and parents were copied into reports and clinic letters to Doctors.
- Staff developed individualised care plans depending on the child's needs.
- The children's therapy team had produced leaflets for each condition that children might present for treatment with, which were clear and easy to understand.
- Health visitors gave expectant mothers a selection of leaflets relating to pregnancy, birth and breastfeeding services available from the HV team. The information pack was comprehensive and information about what the Health Visitor's role was, antenatal group sessions, how to hold a baby and caring for babies at night. The information was clear and in easy to understand language and included useful links to information provided by other services.
- We saw a member of staff documenting an assessment and interaction in a child's 'Red book', they then went on to explain to the child's mother, what they had written, why and what the next steps would be.

Emotional support

- Staff supported children, young people and families who used the service. We also observed staff providing emotional support in interactions between staff and service users.
- There was evidence of good emotional support in the feedback we received from those who used the service.
- Should further more specialised support be needed, staff were able to make referrals to other services such as child and adolescent mental health services (CAMHS), psychologists, GPs and counselling services.
- We also noted various information posters displayed in clinical areas offering emotional support to parents and young people.
- A maternal mental health contact was offered to all women to discuss issues around emotional wellbeing following the birth of a child.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

- Child health clinics were held in community venues, which meant there was easy access for parents. Children could be weighed and a health visitor was available for parents to talk with.
- Medway Community Healthcare (MCH) staff worked with other providers, including children's centres and voluntary organisations, to provide support and services to parents and their families. Clinics and support groups were set up and based in local communities to meet the needs of local people.
- The health visiting team offered five face to face contacts to mothers before and after birth. They were antenatal, new-born, maternal mental health, 12 and 27 month development review. This enabled staff to identify the needs of mothers and babies and ensure they were on the right package of care.
- The health visiting team offered a variety of packages of care, tailored to specific needs. They offered; support for child development, parenting support, support for children with additional needs, nutritional support for mothers and babies, mental health support and support for parents of children with behavioural problems. They offered; support for parents experiencing domestic abuse, parents struggling with drug and alcohol addictions and early help support.
- The package of care offered was based on the family's health needs meeting a variety of criteria and once the package was accepted staff completed a personal plan for each need identified. They then offered up to six

contacts to support the child, parent and family. Following those sessions the family's health needs were reassessed, if staff felt any needs were unresolved they would refer on to a specialist service.

- The health visiting team offered antenatal and postnatal classes in community settings and health visiting staff attended child health clinics to support the community nursing team. Child health clinics were available five days a week at 11 different locations, so parents could access a clinic close to them. The Health Visitor was available to all women attending the drop in centres if they were concerned about something and needed additional support before their next health visitor appointment. These discussions were always had in a confidential environment.
- The children's therapy team were based at a purpose built centre for providing assessment, treatment and care for children. Although the centre was not owned by MCH, MCH staff were involved in the design of the centre's rooms and location of equipment. Treatment areas were available to provide treatments in age appropriate environments.
- Colourful murals were on walls and one wall was covered in handprints. Staff told us when the centre opened; all children that attended the opening day were encouraged to put a hand print on the wall. This was in line with Section 2.9 of the Department of Health Building Notice 23, Hospital Accommodation for Children and Young People states "Interior decor, artwork, furnishings and fittings should be carefully selected to reflect their needs. Many healthcare services now encourage young people to actively assist in the design of their own environments."
- The outside play area was wheelchair accessible and staff used it as a course for children to practise driving powered wheelchairs.
- Staff were sourcing charitable money and were participating in fundraising to create a sensory garden area, which was being developed at the time of inspection.
- Children could be referred to the children's therapy team from any health professional and acceptance of the referral was based on an NHS referral criteria. If children did not meet the criteria, schools had the opportunity to buy in therapy services.
- Therapists triaged referrals and at the time of inspection, the waiting time for assessment was 2-3 weeks.
- The centre was open from 8:30am until 5pm. Staff provided services at the centre but also visited children and families at home. Therapists provided sessions at a number of community locations and in schools. This meant there were a variety of locations for children, young people and their families to access care.
- The centre ran a variety of groups throughout the summer holidays, so children and parents could attend together. These included a range of groups, such as those which concentrated on physical movement and groups for fussy eaters.
- The children's therapy team started an exercise pathway supporting children aged 12 and above with physical disabilities to access the gym and worked in partnership with the local leisure centre to design appropriate exercise for children to do independently.

Equality and diversity

- Staff had attended diversity awareness training. In the last year, 93% of children's therapy team had completed training and 89% of health visitors had attended training, which was better than the organisation's target of 85%.
- Services were designed with the needs of different people in mind. For example, staff were able to access interpreters for people whose first language was not English, or for those who had a hearing disability.
- Staff could access translation services via the MCH communications team. Buildings we visited where clinics took place were easily accessible and adhered to the requirements of the Disability Discrimination Act 1995 and the Equality Act 2010.
- MCH established the Medway Cares charity in 2012 which supports projects that address health inequalities in the Medway community.

Meeting the needs of people in vulnerable circumstances

- There were systems to ensure the service could meet the needs of children and young people in vulnerable circumstances.
- Services were tailored to the needs of local populations and most staff were able to access training specific to the needs of those supported.

Community health services for children, young people and families

Good

- MCH staff could access a domestic abuse specialist to support any parents who had experience of domestic abuse. They also offered a drop-in domestic abuse one stop service. They offered packages of care tailor-made for parents experiencing domestic abuse.
- Staff also offered specialist support to parents with drug or alcohol addictions as they and their families were vulnerable.
- Staff had access to a variety of advocacy services in caring for patients with mental health needs.
- Staff provided emotional support to children, young people and their families directly and established a variety of groups to provide specialist support. For example, a specialist breastfeeding clinic for any mothers experiencing problems breastfeeding. We saw staff interact with mothers and their babies in a supportive and understanding way.
- In addition to this staff signposted mothers to a local breastfeeding support network which offered a variety of groups and individual support from mothers who had undergone training to provide support to new mothers.
- There was also a domestic abuse service and a variety of services at Sure Start centres, including encouraging and supporting parents thinking about training or finding a new job, advice about parenting and post-natal groups.

Access to the right care at the right time

- The children's therapy team monitored their referral to treatment times. In April 2016, 68% of children waited less than 18 weeks for treatment. From September 2016, on average, 96% of children were seen within 18 weeks. This indicated children were getting the right care at the right time.
- From April 2016 to January 2017, 701 children did not attend their appointment. This was 8% of the total contacts of the children's therapy team.
- The Healthy Child Programme stipulates that a new baby review should take place by 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome.
- From October 2016 to January 2017, on average 91% of parents had new birth (Face to Face) visit within and after 14 days which was below the target of 98%.
- In the same period, 85% 12 month developmental and family reviews were undertaken, which was better than the target of 80%.
- On average, 87% of 15 month developmental and family reviews were undertaken from October 2016 to January 2017, there was no target for this in the data provided to us.
- From October 2016 to January 2017, 67% of 24 to 27 month developmental and family reviews were undertaken, which was worse than the target of 95%.

Learning from complaints and concerns

- MCH had a complaints policy, dated December 2015. MCH House and Amherst Court reported 60 complaints in the last 12 months, as at the time of reporting. Ten of these complaints were upheld, 16 were partially upheld and no complaints were referred to the Ombudsman.
- However, the children's, young people and family services received very few complaints.
- From January to December 2016, MCH received 13 complaints which related to children's therapy services and 1 complaint related to the health visiting team.
- Staff told us they discussed complaints and compliments at staff meetings and we saw minutes of these meetings, which indicated this was occurring.
- The children's therapy team fed back from complaints in the newsletter. For example the importance of keeping work calendars updated, so if a parent wanted to speak to a therapist, the reception team could inform them if the member of staff was on leave.
- The customer experience team, who logged the complaint on the electronic incident reporting system, received complaints. Staff categorised each complaint and this was used to inform MCH, commissioners and the department of health. We saw the commissioners had an oversight of complaints.
- Trends and lessons learned from complaints were shared at the Governance Assurance Information Network.
- We saw leaflets advising patients how to complain in all the areas we visited. Feedback was invited from services users and we saw posters, which indicated a variety of ways of giving feedback, which included by text and by social media.

Are community health services for children, young people and families well-led?

Community health services for children, young people and families

Good

Good

Leadership of this service

- Children's therapy and health visiting staff reported to heads of service and the heads of service reported to the associate director of therapies and children. The Associate Director of therapies and children reported to the managing director.
- The health visiting teams were divided into 'hubs' based at different locations and there was a lead at each hub.
- Staff were clear about the lines of accountability and staff we spoke with expressed confidence in the leadership of the organisation.
- Teams told us they felt valued and supported. They also told us that members of the board were very visible, approachable and made them feel an important part of the organisation. Board members attended staff inductions and members of the Board attended local staff meetings. We saw minutes of staff meetings which indicated this was occurring.
- The senior leadership team 'signed up' to a set of leadership behaviours and were confident they would be held to account, as would others, if they did not reflect those behaviours.
- Feedback from staff about local leadership was positive and complimentary.
- Staff also told us they felt a valued part of the organisation, their opinions and ideas were valued and listened to.
- Medway Community Healthcare (MCH) had developed its own leadership development programme 'LEAD' which was designed to support staff to develop the skills, knowledge and behaviours to be successful leaders.

Service vision and strategy

- MCH's vision was to be a successful, vibrant, community interest company that benefitted the communities they served.
- MCH had a five year strategic plan to develop services in Medway in order to ensure people they provided services to experienced safe, effective and responsive care. They aimed to do this by delivering a range of services for local people, supporting clinical teams to innovate and develop their services and supporting out of hospital services in order to reduce the demand for hospital services.
- They also aimed to develop services outside of Medway by establishing themselves as providers of accessible, high quality integrated care across Kent.
- The strategy was widely understood and supported by staff at all levels in the children's, young people and family's core service.
- As MCH was a social enterprise, they had the freedom to develop their own services, whilst directly aligning them to population need.

Governance, risk management and quality measurement

- MCH had developed a quality framework, which was in line with the five key questions of safe, effective, caring, responsive and well-led. Each key question had three commitments which were aligned with the organisational values.
- The Governance Assurance Information Network (GAIN), Medicines Management Subcommittee, Infection Prevention and Control Subcommittee, fed into the Quality Assurance Committee (QAC). The QAC, performance overview group and audit and risk committee reported to the board.
- The QAC met every month and discussed policy updates, involvement in research and reports from the sub groups. Reports reviewed included clinical and medicines incidents. Clinical risks raised by each service were discussed at their meeting every month. Any new risks were added to the risk register and on-going risks updated.
- Staff we spoke with had a good understanding of what a risk was, both clinical and non-clinical. They were clear about whom they would raise this with, how it would be acknowledged and what action would be taken.
- GAIN meetings occurred every three months. Representatives from each team were invited to attend and attendance was good. The network reviewed a number of quality issues, for example; complaints audit, health and safety and medicines management. The network carried out a number of 'quality visits'. This involved members of staff visiting other teams in MCH and assessing the team against CQC's five key questions.

Community health services for children, young people and families

Good

It identified areas of good practice and areas for improvement. Staff we spoke with overwhelmingly welcomed these visits. Not only did they feel they learnt something new about a team but they were keen to improve quality wherever possible.

- The children's therapy team and health visiting team had dashboards which measured a range of key performance indicators. This enabled them to monitor and measure the quality of their service regularly. Staff we spoke with were aware of key performance indicators in their teams.
- When new services were implemented, they were monitored with weekly meetings. Staff were key stakeholders in monitoring key performance indicators and evaluating the effectiveness of services.
- MCH had an annual audit plan, which included infection prevention and control audits, environmental audits and documentation audits. We looked at the results of these audits which indicated they were occurring regularly.
- When new National Institute of Health and Care Excellence (NICE) guidelines were published, working groups were structured around them to discuss how this would inform and alter practice.
- In addition to internal quality measurement, MCH had regular quality meetings with the local CCGs to discuss commissioned services.
- A director of contracting and performance oversaw service level agreements and compliance with contracts.

Culture within this service

- There was an overwhelmingly positive, healthy culture across the teams that provide services to children, young people and their families.
- Staff felt they were an important part of the organisation and were involved in delivering care but also contributed to service improvement and measuring the quality of their services.
- The whole organisation was unmistakably one team. Care, learning and development were shared across teams and services.
- Staff clearly demonstrated the organisation's values of; caring and compassionate, delivering quality and value and working in partnership.
- Social values were embedded into the business and staff culture. Managers supported teams to develop their own social value initiatives and incorporate them into their work. For example, the children's therapy team encouraged the local community to donate outgrown clothes, which could be resold for a nominal amount, which would then be donated to the organisation's charity. Staff nominated children to access charitable funds and provided 'Inspired' activities for children, such as wheelchair dancing.
- Each team had a 'pledge', which they developed themselves and was in line with the organisation's values. We saw the pledges displayed in each area we visited and staff had signed them to indicate their commitment to the pledge.
- Staff overwhelmingly spoke with pride about the work they did, the organisation they worked for and the care they were delivering. They were clearly committed to on-going service improvement.

Public engagement

- As MCH is a community interest company, patients and the local community had a say in developing business plans for the future. This involved patients being involved in the design, location and opening times of services.
- MCH engaged with the local community in a variety of on-going projects. They offered work experience for students with learning disabilities in order to develop their confidence. They offered work experience placements to local people who wished to gain experience in health and social care. This included offering placements to unemployed local people in order to help them develop the skills they needed to gain employment.
- Staff volunteered to be mentors to help support local unemployed people to move into employment or training.
- MCH established the charity 'Medway Cares', which supports projects and activities that enhance the health care and social wellbeing of the local community. Charity money had been awarded to the children's therapy team to fund an apprentice, for goody bags for children attending appointments, for sensory equipment for families with a diagnosis of autistic spectrum disorder, to purchase a stock of walkers and to fund transport for a low income family to travel to take their baby to hospital for an appointment.
- Staff engaged with the local community by contributing to public health campaigns. For example, staff ran a children's safety day at local leisure area and the

Medway Accident Prevention Scheme. This enabled families in need to buy home safety equipment at cost price. For which, the health visiting team won a 'Sign up to safety' award.
- MCH also engaged the local population with apprenticeships and the local population volunteered for MCH. For example, we saw a volunteer working with the team at a children's centre during a health clinic.

Staff engagement

- MCH is a community interest company that is co-owned with 1,359 staff (77% of staff are shareholders). This meant staff had a say in developing the business plans and in designing how they provided their services.
- A high majority of staff were shareholders; profit went back into the community. In addition to this an annual decision was made to invest profit into the 'Medway Cares' charity. Staff raised money for the charity via a variety of fundraising activities. They could then 'bid' for money to support their service. They also had the opportunity to enrol in the charity lottery.
- Elected members' forum, was made up of a group of staff to facilitate the communication and engagement between the MCH Board and the wider organisation.
- Staff were encouraged to engage with the organisation from induction. Staff told us the induction was comprehensive and non-executive directors attended.
- A majority of staff who delivered children's, young people and family services had an appraisal in the last year, they felt it was a useful process and enabled them to identify areas for learning and access external courses.
- Staff were encouraged to and attended preceptorship programmes, active learning sets and leadership programme which MCH had developed.
- Managers had introduced 'My Idea'. This was a staff suggestion scheme which encouraged staff to pitch ideas that could benefit patients. For example, a member of the children's therapy team designed 'Chatter pack'. This was tailored for children at different school age groups who were having speech and language therapy (SALT). It included activities and guidance for school staff to support SALT exercises and tied in with the child's 'my plan'.
- All staff had access to and could see the dashboard for their relevant area. This was discussed with teams at staff meetings as were complaints and friends and family test results.
- Staff had regular team meetings in all teams and engaged in multidisciplinary team meetings and staff forums.
- Managers told us that 50% of students who had their placement at MCH went on to gain employment at the organisation.
- The organisation asked staff to complete a staff survey every two years and a 'temperature check' each year. The surveys enabled the organisation to understand how staff felt about working for the organisation, what was working well and where there may be concerns. The last staff survey was completed in November 2015.
- The 'temperature check' consisted of three questions and was completed by a different business unit every three months. The results were shared with the senior leadership team and staff. The most recent 'temperature check' data for therapies and children's business unit was from April to June in 2016. We saw the overall response to 'how likely are you to recommend the organisation to your friends and family as a place of work?' was 96%. Fifty three percent of staff responded to the survey.

Innovation, improvement and sustainability

- The children's therapy team started an exercise pathway supporting children aged 12 and above with physical disabilities to access the gym and worked in partnership with the local leisure centre to design appropriate exercises for children to do independently.
- The speech and language therapy (SALT) developed the 'Chatter pack'. This was tailored for children at different school age groups who were having speech and language therapy (SALT). It included activities and guidance for school staff to support SALT exercises and tied in with the child's 'my plan' and would have a significant effect in the compliance rates with children performing their exercises regularly.
- Children's therapy team staff provided an intensive week, where occupational therapy and SALT staff would visit children every day, at different times. They would visit at breakfast, lunch, dinner and bed time, to help families and children with getting dressed, feeding and going to bed.

Community health services for children, young people and families

Good

- The organisation used electronic records and virtual desk top technology so all health care professionals could access the care record and upload records from wherever they were in the patch.
- Staff were actively involved in a variety of research projects, such as, strength training in adolescents with cerebral palsy.

Outstanding practice and areas for improvement

Outstanding practice

The culture of overwhelming pride in their work and desire to provide a service with adults, children, young people and their families at the centre.

Areas for improvement

Action the provider SHOULD take to improve

The organisation should review the Healthy Child Programme to identify the improvements required in order to ensure targets are met.