Wiltshire Health and Care LLP

1-2642739822

Community health inpatient services

Quality Report

Chippenham Community Hospital
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Date of inspection visit: 28, 29 June and 3 July 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RN313	Savernake Community Hospital	Ailesbury ward	SN8 3HL
RN333	Chippenham Community Hospital	Cedar ward and Mulberry ward	SN15 2AJ
RN3C5	Warminster Community Hospital	Longleat ward	BA12 8QS

This report describes our judgement of the quality of care provided within this core service by Wiltshire Health and Care LLP. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Wiltshire Health and Care LLP and these are brought together to inform our overall judgement of Wiltshire Health and Care LLP.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

We rated inpatient community services as good because:

- There was a well-embedded culture of incident reporting and all staff we spoke with were aware of their responsibilities to identify and report incidents. There had been a high number of falls reported but staff had been proactive in looking for solutions.
- We observed all staff followed best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques. Medicines, including medicines' related stationary and medical gases, were mostly stored safely.
- The organisation was aware of staffing pressures it faced and risks were included on risk registers and reported to the board. Staffing levels were seen as being safe throughout our inspection.
- Care and treatment provided was evidence based and community hospitals participated in clinical audits. We saw good examples of audits to monitor patient outcomes.
- Most staff had received an appraisal within the last 12 months and they told us they were well supported and had good to access to training and development.
- There was effective multidisciplinary team working at community hospitals. Nursing staff talked positively about the working relationships with allied health professionals, consultants and GPs.
- There was outstanding caring to patients, who were treated with kindness, compassion and respect.
- Feedback from patients and those close to them was positive. Patients told us they were always treated with dignity and respect. We observed staff were, without exception, courteous, kind and respectful.
- Services were well-led and leadership was open and transparent. Staff felt supported and were able to raise issues and concerns. All staff were committed to delivering good compassionate care.

However:

- Access to out of hours loan arrangements for low-profile beds was inconsistent which posed a risk to patients at risk of falls.
- Arrangements for obtaining and storage of some medicines did not keep people safe.
- Informal arrangements were in place for supporting and managing staff but there was no programme of formal clinical supervision for trained nurses.
- Patients were unable to access direct admissions to Savernake and Warminster Community Hospitals due to inpatient delays.
- NHS Friends and Family Test response rates at community hospitals were low.

Summary of findings

Background to the service

Wiltshire Health and Care LLP provide inpatient care and support at three community hospitals. There are 37 beds on two wards at Chippenham Community Hospital (Mulberry ward specialising in stroke care and Cedar ward specialising in rehabilitation). There are 26 beds on Ailesbury ward at Savernake Hospital in Marlborough, and 25 beds on Longleat ward at Warminster Community Hospital, also specialising in rehabilitation. All wards provided end of life care.

Care and support is provided by nurses, health care assistants and allied health professionals, such as occupational therapists and physiotherapists. Medical support was provided by visiting consultants and local GPs. During our inspection we visited all community hospitals where inpatient beds were provided.

We visited between the 28 and 29 June 2017 on our planned inspection and on the 7 July 2017 for our unannounced inspection. We observed care and treatment of patients and looked at 20 treatment records. We reviewed policies and protocols. During our inspection we spoke with approximately 60 members of staff including nurses, consultants, doctors, receptionists, managers, physiotherapists, occupational therapists other professional care staff and support staff. We talked with 16 patients and 12 relatives. We received comments from staff at focus groups, and we reviewed performance information about the community hospitals.

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart Independent Chair

Team Leader: Alison Giles Care Quality Commission

The community inpatients team included a CQC inspector and two specialists: a qualified nurse with a master's degree in health visiting and a qualified physiotherapist who has managed a number of community services. We were also supported by two experts by experience who talked with patients and relatives/carers who had agreed we could contact them by telephone to ask about their views and opinions.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting Wiltshire Health and Care LLP community inpatient services, we reviewed a range of information we hold about the organisation, and asked other organisations to share what they knew. We carried out an announced visits on 28 and 29 June 2017. During the inspection we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and staff from other services. We observed how people were being cared for, talked with carers and/or

Summary of findings

family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the service. We carried out an unannounced visit on 3 July 2017.

What people who use the provider say

During the inspection, we spoke with 13 patients and seven relatives/carers who were extremely positive about the care and treatment they received at community hospitals. Our experts by experience telephoned three patients and five relatives/carers who used the community inpatient service. Feedback was extremely positive and complimentary. However, two relatives expressed they were unhappy about the visiting times at community hospitals. Comments included:

"Very happy with the care and discharge planning was excellent."

"Excellent caring nature of all the staff, they can do enough for you."

"I always felt safe and stay was a positive experience."

"I was never concerned about the quality of care and had no issues regarding safety."

"Staff did everything I asked of them and they always came when I pressed the buzzer."

Good practice

- Patients on Mulberry ward (the stroke unit) at Chippenham Community Hospital were actively involved in planning their stroke rehabilitation in partnership with the ward based therapy team. Patients had a personalised therapy timetable which was updated weekly and stored at the bedside to enable relatives/carers to be involved in the patient's rehabilitation.
- Staff on Longleat ward at Warminster Community Hospital were using a dementia reminiscence therapy software package. This included an interactive system that could be used by the patient's bedside. Complex care patients with a cognitive impairment or who were living with dementia benefitted from the reminiscence therapy software as it enhanced staff engagement and helped to reduce anxiety and distress.
- A mural on Longleat ward at Warminster Community Hospital had been created by a local artist. The mural displayed scenes of the local area and was developed in partnership with patients, relatives and staff to support reminiscence activities for patients living with dementia. Feedback from patients and their families was being gathered to support the development of further murals on the ward.
- All staff on Mulberry ward (the stroke unit) and staff from community hospitals, including kitchen staff, student nurses and volunteers, had attended swallowing training with the speech and language therapist.
- There were limited facilities on Mulberry ward (the stroke unit) for patients to practice daily living activities following a stroke. Therefore, the occupational therapist had implemented a weekly breakfast club on the ward to enable patients to make their own breakfast in a supported environment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- Ensure controlled drugs are managed in accordance with the legislation in the inpatient wards.

Summary of findings

- Provide assurance that medicines are stored within their recommended temperature ranges.
- Seek expert advice on the storage and signage required for medical gas storage in community inpatient wards.
- Monitor and review safe staffing levels at community hospitals.
- Make consistent out-of-hours arrangements to access low-profile beds at community hospitals.
- Continue to monitor and review the systems and processes around delayed discharges of care and the impact on patient flow at community hospitals.
- Review NHS Friends and Family Test response rates at community hospitals to increase the feedback received to at least national levels.
- Monitor and review the completion of treatment escalation plans and resuscitation decision records at community hospitals.
- Consider how the patients particularly on rehabilitation wards can self-administer their medicines in a person-centred manner to support them in continuing this safely and in a timely way when they are back at home.
- Introduce a programme of clinical supervision for nurses at community hospitals.

Wiltshire Health and Care LLP

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the community inpatients service good for safe because:

- Staff understood their responsibility to report incidents. Incidents were investigated, and as a result action was taken and learning was shared.
- There had been a high number of falls reported on some wards and staff had been proactive in looking for solutions.
- We observed all staff following best practice for infection control to reduce the risk of infection.
- Records were complete, accurate, legible and up to date. On review of records, we found comprehensive assessments and risk assessments were completed for patients.
- Medicines, including medicines' related stationary and medical gases were mostly stored safely.
- There were a number of tools and templates that staff used to assess patient risk and identify a deteriorating patient.
- Staff had completed mandatory training which allowed the delivery of training in safe systems, processes and practices.
- Staff were confident in making safeguarding referrals and knew how to access the safeguarding lead, who was visible in the organisation.
- The organisation was aware of the staffing pressures they faced and associated risks were included on the risk register and reported to the board. Staffing was planned to take account of patient's care and safety needs. Bank staff and agency staff and staff from other community hospitals were employed to ensure safe staffing levels.

However:

- Access to out of hours loan arrangements for low-profile beds were inconsistent, which posed a risk to patients at risk of falls.
- The ordering of certain controlled drugs was not in accordance with the relevant regulations and they were not stored in accordance with the organisation's policy.

Good

Are services safe?

- We were not assured that medicines stored at room temperature were stored within their recommended temperature range.
- The organisation faced challenges with staffing from competing workloads and delays in staff recruitment processes.
- Treatment escalation plans and resuscitation decision records were not fully completed on some wards.

Detailed findings

Safety performance

- Safety thermometer information was displayed on all wards at community hospitals. The NHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during a single working day. The organisation monitored safety thermometer indicators including falls, pressure ulcers, venous thromboembolism (VTE) and urinary tract infections (UTIs). Data was collected on a monthly basis and a quality dashboard was used to analyse key performance indicators. In the period February to June 2017, the percentage of patients receiving 'harm free' care in the organisation was 92%. Data from inpatient wards showed an average of 120 patients were surveyed each month. Results showed incidents of falls with harm, new pressure ulcers and new UTIs were low in the period February to June 2017. Results showed falls with harm were 3.8%, new pressure ulcers were 5% and new UTIs were 3.8%.
- In the period July 2016 to March 2017 there were 295 falls in community hospitals, of which five were falls with harm. In the period April to June 2017 there were 76 falls, of which two resulted in harm. There was an increase in falls in April 2017, which mainly occurred on Longleat ward at Warminster Community Hospital and Ailesbury ward at Savernake Community Hospital. A lack of visibility of patients was an issue at both hospitals due to the design of the ward environment. Patients at risk of falls were kept in view of the nurses' station wherever possible. Patients who were at high risk of falls had one-to-one supervision. Additional specialist equipment to help reduce falls (alarm mats) was put in place. This was supported by a post fall incident 'huddle' undertaken by staff immediately following a patient fall. The 'huddle' identified if the patient had been correctly assessed and provided with falls avoidance information. Intentional rounding (where staff attended to patients within an agreed time scale) was in place to ensure patients were reviewed by staff at least hourly.
- The lead nurse for community hospitals' monitored the wards' performance via the electronic patient safety tracker. There had been a reduction in falls in May and June 2017, with the lowest number of falls (11) reported since July 2016. This demonstrated the measures put in place by the organisation were effective in reducing the risk of falls to patients at community hospitals.
- We saw on the governance framework spreadsheet all pressure ulcers at category two and above were reported through the NHS's electronic incident reporting system. There were 34 category two pressure ulcers and one category four in the period June 2016 to March 2017. Of the 34 recorded pressure ulcers, 23 were identified as avoidable and 12 as unavoidable. Systems were in place to assess and review pressure ulcers to identify any areas community hospitals could address to prevent new pressure ulcers occurring.
- Staff notice boards displayed ongoing work around falls management and avoidance at community hospitals. Staff attendance at slips, trips and falls training was over 90% which exceeded the organisation's target of 90%.

Incident reporting, learning and improvement

- There was a well-embedded culture of incident reporting in community hospitals. Staff understood their responsibility to raise concerns, record and report safety incidents, and near misses. Learning from incidents and improvements could be demonstrated. Staff said they found the electronic reporting system easy to use and told us they could ask the quality team for advice on completing incident reports. All staff we spoke with across the community hospitals told us they received feedback when they had reported an incident and felt learning was shared in their ward teams. We saw in a safety briefing folder on Mulberry ward at Chippenham Community Hospital, an example of where learning from incidents had been shared with staff at team meetings.
- Three serious incidents which required investigation were reported in the period from July 2016 to May 2017.

These were related to patient falls, and had been investigated. All serious incidents were subject to a root cause analysis (RCA) and staff responsible for completing the RCA received specific training.

- The RCA and complex case review for the third serious incident was completed in June 2017. At the time of the inspection the lead nurse told us the lessons learnt had yet to be shared with staff on Cedar ward. The root cause of the incident was identified as the delay in providing a low-profile bed for the patient who was at risk of falls. Although the patient would still have got out of bed, equipment may have reduced the risk of injury by decreasing the height from which the patient fell. Following the incident, learning had been identified and changes would be made to clinical practice. Staff would be given clear instructions on ordering equipment out of hours and would undertake further learning regarding mental capacity assessments. A review of ward equipment (sensor pads) would be undertaken and the falls' policy would be updated. This demonstrated the organisation was taking appropriate steps to mitigate the risks of serious incidents.

Duty of Candour

- Staff we spoke with demonstrated an understanding of the duty of candour. Staff told us they had received formal training on the subject. 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) ofcertain 'notifiable safety incidents'and provide reasonable support to that person.
- We saw examples of the application of the duty of candour. Parents and relatives involved in serious incidents were offered an apology and an investigation was carried out, after which the outcome was provided to the patient and their family and was clearly documented in the patient records.

Safeguarding

- All staff we spoke with were able to describe how to recognise and report safeguarding concerns. The organisation had a safeguarding team which was available for advice and support. Staff could name the safeguarding lead and provided examples of when they had contacted them for advice and guidance. For example, on Cedar ward at Chippenham Community Hospital we saw staff reviewing the completion of a deprivation of liberty safeguarding request with the safeguarding lead before submitting it to the local authority.
- The lead nurse for community hospitals was assured that staff understood their responsibilities to follow the safeguarding policies because the number of safeguarding referrals had increased.
- Compliance in training rates for staff at community hospitals in relation to safeguarding adults was high. Staff attendance at Safeguarding Vulnerable Adults, including Disability Awareness training, was 89%.
- Complex case reviews were attended by the safeguarding lead. These meetings helped to identify complex individual cases where safeguarding alerts had been raised. Learning from these meetings was shared across the community hospitals in team meetings.
- We observed that safeguarding concerns were discussed at handovers to ensure staff remained fully informed.

Medicines

- Pharmacy staff visited community hospitals on a regular basis (usually twice a week) to review medicine charts and provide advice on the safe and effective use of medicines. If pharmacy staff were not available ward staff would contact the pharmacy department they received their medicines from.
- Systems for the ordering and safe storage of medicines including medical gases were not always followed.
- Medical gas storage and signage was variable across community hospitals. For example, at Warminster Community Hospital, an emergency contact sign was missing and old equipment was stored with gas cylinders. To aid staff administering medical gases, posters were available summarising the time the gas would last at different flow rates for the gas and the volume left in the cylinder.
- Medicines, including medicines' related stationary and medical gases, were mostly stored safely. However, unsecure medicine trolleys were used on Cedar ward at Chippenham Community Hospital. The medicine trolley at Warminster Community Hospital was of an insufficient size and medicines were stored on the bottom shelf. Patients who administered their own medicines were unable to do so when admitted to community hospitals.

Good

Are services safe?

- At Warminster Community Hospital, the pharmacist visited twice a week and staff had introduced a reconciliation process to ensure the safe administration of medicines.
- Medicines requiring refrigeration were kept within their recommended temperature ranges. However, assurance could not be provided by staff that medicines stored at room temperature were stored within their recommended temperature range.
- The ordering of certain Schedule 2 and 3 controlled drugs (CDs) was were not ordered in accordance with the relevant regulations and were not stored in accordance with the organisation's policy. Whilst controlled drug CD cupboards had posters indicating the service had a CD accountable officer for controlled drugs, the service was not listed on the Care Quality Commission (CQC) accountable officer register dated 31 May 2017. As an independent hospital the organisation may require a Home Office Controlled Drug licence there are exemptions and the onus is on the organisation to either obtain a licence or demonstrate to the CQC why it is not required. At Savernake Community Hospital, there was insufficient separation of high and low strength controlled drugs in line with best practice. Staff told us the pharmacy staff audited medicines storage and controlled drug records. However, these audits were not formally reported. The issues involving medicines were raised with the lead nurse for community hospitals at the time of the inspection.

Environment and equipment

- Premises and equipment were fit for purpose at community hospitals. Chippenham Community Hospital had two wards and Warminster and Savernake had one ward each. There was a mix of single rooms and four or six-bedded bays. There was limited visibility of patients at Warminster and Savernake Community Hospitals due to the design of the wards. This was identified as a risk to patients who were a falls risk. High risk patients were nursed in side wards close to the nurse's' station or provided with one-to-one supervision to help minimise the level of risk.
- All areas within the community hospitals were tidy and well organised and staff had access to the equipment they required to provide patient care. There was limited storage at all community hospitals for equipment not in use. Ward staff we spoke with on Longleat ward at Warminster Community Hospital told us the ward was well maintained. However, there was no refurbishment plan in place for the ward. We observed splintered wood on the door to the dayroom and chipped paint throughout the ward, which could pose an infection risk to patients or cause injury (from the splintered door) to patients or staff. A balcony area off the dayroom on Longleat ward was currently not accessible to patients as it had been deemed a safety risk. A risk assessment had been completed and patients were excluded from the area which was secured. There were no immediate plans to upgrade the area due to funding constraints.
- Equipment, including pressure relieving equipment, was readily available at each community hospital. There was an equipment loan service for specialist equipment which staff said worked well and was available out of hours. Variable-width bariatric beds for use by larger patients were on loan at community hospitals. However, due to high rental costs the organisation was planning to purchase a number of variable width bariatric beds. Therapy staff on Mulberry ward (the stroke unit) told us there were delays in obtaining specialist equipment for patients. This was a problem specifically to Mulberry ward as therapists and nurses at community hospitals told us the system worked well. Staff were able to place an order in advance of a patient's admission to the ward, which meant there were no delays in treatment. Staff said there were no delays to patients being discharged home who required specialist equipment. When equipment was cleaned, labels were attached with the date the equipment was cleaned. We saw electrical equipment was tested to ensure it was fit for use. All equipment checked was in date and was due to be checked in August 2017.
- The lead nurse for community hospitals said there were insufficient low-profile beds for patients who were at risk of falls and standard beds were not fitted with integral bed rails. This was identified as an entrapment risk following a bed audit on Ailesbury ward at Savernake Community Hospital in February 2017. There was a planned programme to replace equipment at community hospitals. For example, low-profile beds, bariatric beds and chairs. Throughout our inspection we saw new equipment being delivered to community hospitals. The risk was recorded on the risk register. Additional low-profile beds were hired from an equipment loan company when required. However,

Good

Are services safe?

following recent serious incidents, arrangements to hire low-profile beds out of hours were inconsistent and were being reviewed by the lead nurse for community hospitals.

- Staff at community hospitals had acted appropriately on a safety notice regarding patient chairs. We saw chairs had been checked in line with the safety notice and immediately removed from use if they were unsafe.
- Mulberry ward (stroke unit) at Chippenham Community Hospital had portable and ceiling track hoists. However, ceiling track hoists considered to be good practice when lifting and handling patients, were only available in single rooms. The lead nurse for community hospitals told us the order to provide additional overhead hoists had recently been approved.
- All resuscitation trolleys were tamper-evident and grab bags (small bags with resuscitation equipment for use in areas not easily accessed by a trolley, such as outdoor spaces) were regularly checked and equipment was in date
- Waste was appropriately segregated across all community hospitals with separate colour coded arrangements for clinical waste and sharps (needles). Bins were clearly marked with foot pedal operation and were within safe fill limits.

Quality of records

- Records on all wards were stored securely which meant they were only available to staff authorised to access them. All records were written and managed appropriately across the service. All nursing records were paper-based but therapists were also required to input into the electronic patient record system, yet to be implemented across the organisation. Therapists said this limited the time they were able to spend with patients. We looked at 20 care records across the community hospitals and found all entries were signed, legible and fully completed. Records were easy to follow and evidence of multidisciplinary input was evident and easy to locate. Records were subject to regular audits to ensure they were consistently completed. Areas of non-compliance were discussed with individuals or at team meetings. Records kept at the patient's bedside included observation charts and food and fluid charts.
- We reviewed 20 Treatment Escalation Plans (TEP) and resuscitation decision records that had replaced the "do not attempt cardio pulmonary resuscitation" (DNACPR) records for adults in 2014. Of the 20 forms we reviewed 10 forms were not authorised by the GP or the visiting consultant. We raised this with the ward managers at community hospitals during the inspection.

Cleanliness, infection control and hygiene

- All community hospitals were visibly clean, tidy and odour free. Patient-led assessments of the care environment (PLACE) audits and NHS Friends and Family Test scores rated community hospitals highly for cleanliness. There were antibacterial hand gel and dispensers at the entrances to the hospital and every ward. There were paper towels, liquid soap and pedal bins at each hand-wash basin. We saw staff using personal protective equipment (PPE), such as gloves and aprons, which were readily available on the wards. All wards had a number of single side rooms that could be used for looking after people who had infections. We saw one person was being barrier nursed in this way, and all relevant equipment was available outside the room. Information for staff and visitors was clearly displayed outside the side ward and we observed staff used antibacterial gels and wearing gloves and aprons when entering and leaving the room.
- We observed staff were bare below the elbow, washed their hands or used antibacterial gel before and after each patient contact. Medical wipes were used to clean equipment after use. Infection control link nurses were in place at each community hospital. The infection prevention team provided advice on the prevention and control of healthcare associated infections to both staff and people who used the service.
- Organisation-wide policies were available for infection control and hand hygiene, which were in date at the time of our inspection. Staff showed us how they accessed policies electronically and hard copies were available. Monthly hand hygiene audits were undertaken on wards. This involved staff being observed washing their hands and confirmation they had the correct hand washing practices and techniques. We saw examples of completed hand hygiene audits which demonstrated 95% compliance was achieved on wards. Training records showed all staff at community hospitals, apart from Cedar ward, had achieved above the 90% target for infection control and hand hygiene training. Cedar ward had recorded an attendance rate of 74%.

Good

Are services safe?

- Waste was appropriately segregated across all community hospitals with separate colour coded arrangements for general waste, clinical waste and sharps, (needles). Bins were clearly marked with foot pedal operation and were within safe fill limits.

Mandatory training

- After training through induction, staff completed mandatory training to be updated in safety systems, processes and practices. Staff we spoke with said the training was comprehensive and enabled them to undertake their roles safely. Staff were alerted on training due, either electronically or by their line manager. Training boards at community hospitals made staff aware of forthcoming training courses and updates. Mandatory training levels at community hospitals were between 90% and 95%. Staff undertook computer-based learning mandatory training through the academy, and based within the employing organisation. This was sometimes undertaken in staff's own time due to a lack of computers and available time in the workplace. The ward manager kept records of time taken by staff to complete their training and managed the time given back to them. The NHS survey in 2016/17 identified 100% of staff had met their mandatory training requirements
- Staff mandatory training covered a wide range of training requirements. For example, basic life support, corporate induction, fire safety awareness, nutrition screening, blood transfusion, duty of candour and end of life care. The organisation's monthly mandatory training report for May 2017 identified current compliance for inpatient services met the organisation's target of 90%.

Assessing and responding to patient risk

- There were systems in place to assess and monitor patient risks. Risk assessments were developed in line with national guidance. We reviewed a total of 20 patient records. All had completed risk assessments for patients, including falls risk assessments, nutrition assessments and skin assessments. Risk assessments we reviewed were complete and recorded whether any actions were required to reduce risks. For example, in a falls risk assessment, the patient required one-to-one supervision and an alarm mat, as they were a high risk of falls. This had been implemented.
- Patients' conditions were monitored by the use of an early warning system that tracked changes in a patient's condition and those at risk of deterioration (NEWS). Patient's' risk assessments were kept at the bedside. We saw examples of where a patient's rising score had been appropriately referred to the GP who undertook ward rounds at community hospitals. There was an escalation policy in place for staff to follow if a patient's condition deteriorated. Staff we spoke with were familiar with the escalation arrangements when patients became unwell. Staff would request an ambulance by dialling 999 to transfer the patient to the nearest accident and emergency department for onward care and told us the arrangement worked well. We saw evidence of incidents reported when this had occurred.
- Following a patient fall, a post fall incident 'huddle' would be completed by staff available at the time of the fall. The post fall review checked patients were assessed correctly and provided with the appropriate information. Patients at risk of falls were offered a 'risk of falling in hospital' leaflet and specific advice on falls reduction.
- Patients who were assessed as being at high risk of developing pressure ulcers were provided with pressure relieving equipment for their chair and bed.
- We observed handovers and multidisciplinary team meetings. Staff teams discussed patients in detail, including current or perceived risks, safe discharge planning, and patients and relatives understanding of their risks. Printed handover sheets, which each member of staff were provided with, had information about patients' past medical history, reasons for admission and highlighted risks. For example, safeguarding, pressure ulcers, nutrition, hydration and patients living with dementia.

Staffing levels and caseload

- The organisation was aware of the demand, capacity and workload pressures staff faced and where this had greater impact. Minimum safe staffing levels had been defined and were in place for each community hospital. A planned electronic nurse staffing rota produced daily reports to the lead nurse for community hospitals if vacant shifts had not been filled. Actual staffing levels compared favourably with planned levels as ward managers and the lead nurse for community hospitals had ensured vacant shifts were filled. This was through the use of back and agency staff or relocating staff.

However, ward managers were concerned about their ability to sustain the cover for vacant shifts from the existing workforce as there had been staff shortages since February 2017. The organisation needs to ensure staffing levels are sustainable across community hospitals.

- Staff used a needs-assessment acuity tool to help assess the level of patient dependency and identify appropriate staffing levels. On Ailesbury ward at Savernake Community Hospital an additional Health care assistant (HCA) had been roistered onto each shift to support a patient who was a risk from falls and required one to one supervision.
- Bank and agency staff and staff from other community hospitals were used to ensure staffing levels were safe. However, it was difficult to recruit sufficient agency nurses due the geographical location of community hospitals. This was particularly an issue for Warminster and Savernake Community Hospitals. All temporary staff completed a local induction at community hospitals. The ward manager on Longleat ward told us therapists and HCAs supported trained nurses to provide care and support to patients at times of staff shortage. Staff said "We would rather cover the ward to ensure patients receive continuity of care" and "It is difficult to get enough agency staff due to our geographical location so we always help out if there are gaps in staff rotas." This demonstrated that staff were committed to ensuring there were sufficient staff to care for patients safely.
- The organisation was advertising and promoting recruitment for roles where there were difficulties in recruiting. For example, they were holding open days to publicise the organisation and support recruitment. Recruitment was ongoing and a number of trained nurse vacancies had been filled by student nurses due to qualify in September 2017.
- There were vacancies for nurses, HCAs and therapy staff at all community hospitals. Warminster Community Hospital had four whole time equivalent (WTE) trained nurse vacancies for nurses on Longleat ward. Savernake Community Hospital had six WTE trained nurse vacancies for nurses and six WTE HCA vacancies on Ailesbury ward. Chippenham Community Hospital had 2.3 WTE trained nurse vacancies for nurses on Mulberry ward (the stroke unit). There were three trained nurses on maternity leave on Cedar ward which had yet to be covered.
- Nursing and HCA posts had been recruited to on all wards. Ward managers we spoke with told us of delays in the recruitment process provided by the employing NHS organisation. At the time of the inspection the ward manager on Longleat ward at Warminster Community Hospital had waited four weeks for staff employment-offer letters to be issued to successful candidates and had yet to receive start dates for new staff. Some successful candidates had taken employment elsewhere due to delays in the recruitment process.
- The lead nurse and ward managers undertook clinical shifts when a shift could not be covered by bank or agency staff. Staff said bank and agency staff were familiar with the respective community hospitals and worked as part of the team. A bank nurse had been recruited to a substantive post on Ailesbury ward at Savernake Community Hospital. The ward manager said, "Once staff have worked here they really want to come back and work for us permanently which is wonderful but also frustrating as to how we get the message out to the wider community that this is a great place to work."
- Although it related to all staff in Wiltshire Health and Care, in the June 2016 NHS Staff Survey, only 3.22 (out of a rating of 5) of staff agreed there were enough staff at Wiltshire Health Care to do their job properly and only 3.88 (out of a rating of 5) of staff said they had enough time to do their job properly. This supports the job and workload pressures staff were facing.
- During our inspection, we saw staff had time to attend to patients' needs and we did not see patients waiting for attention when they needed it.
- Therapists we spoke with told us there were not always sufficient staff and their therapy support worker was currently on leave. Staff said there were sufficient therapists when they were all on duty but there were no cover arrangements in place for sickness and annual leave. We did not see any evidence of this leading to problems with the delivery of therapy.
- Speech and language therapy was available on Mulberry ward (the stroke unit) each day and dietitians could be contacted when needed.
- Medical cover at community hospitals was provided by local GPs and two visiting consultants. In the evening and at weekends, staff would call the out of hour's service where patients triggering NEWS were referred to

the GP who would visit the ward. Staff we spoke with told us the system worked well as there was good GP coverage during the day and regular ward rounds meant that routine work was attended to in a timely way.

Managing anticipated risks

- Fluctuations in demand were planned for, such as winter pressures or when bad weather was forecast. Staff told us they worked with their community colleagues to ensure that during bad weather staff worked at their nearest community hospital if they could get to it and /or offer to see patients in the community if they lived nearby.

Major incident awareness and training

- There was a major incident plan in place on the provider intranet and hard copies were available on all wards at community hospitals. Local evacuation and fire risk assessments were available on each ward. Staff were aware of their roles in the major incident plan and were aware of the business continuity plan, for example, during severe weather.

Good

Are services effective?

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

Summary

We rated the community inpatients services as good for effective because:

- Care and treatment was provided in line with national and best practice guidelines and community hospitals participated in clinical audits, where they were eligible to take part.
- Staff were using national and best practice guidelines to care and treat patients across the service.
- Nutrition and fluid needs were regularly assessed and patients were well supported in meeting their nutrition and hydration needs.
- Patients' care plans and assessments were completed consistently.
- Staff had received an appraisal within the last 12 months. They told us they were well supported and had good access to training and development.
- There was effective multidisciplinary working at all community hospitals.
- A range of services had been developed to respond to the increase in demand on community inpatient services, and maintain performance.

However

- Informal supervision arrangements were in place but there was no formal programme of clinical supervision for nurses at community hospitals.
- Direct admissions (Step up beds) to Savernake and Warminster Community Hospitals were not used effectively due to the number of inpatient delays at community hospitals.

Detailed findings

Evidence based care and treatment

- Policies and procedures were developed in line with national guidance and were available for staff on the organisation's intranet.
- We saw evidence that staff followed the National Institute for Health and Care Excellence (NICE) guidance. For example, there was a policy for prevention and management of pressure ulcers (CG179). Staff took photographs of any pressure damage, either hospital-acquired or present on admission. This enabled staff to document the surface area of all pressure ulcers in adults using a validated measurement technique. This ensured pressure ulcers were categorised using a validated classification tool to guide ongoing preventative strategies and management. Documentation was repeated each time the ulcer was assessed. Compliance with NICE guidance was monitored at the WHC board. Patients were assessed using recognised risk assessment tools. For example, the PURAT (pressure ulcer risk assessment tool) assessments score were audited. This was a nationally recognised practice tool used to assess the risk to patients of developing pressure ulcers. Therapists used stroke-specific motor assessment scales and a modified Rivermead assessment tool to support the assessment and management of stroke patients.
- Nursing and therapy staff we spoke with were aware of best practice guidance and said policies were easily accessible via the organisation's intranet.

Pain relief

- Pain relief was managed on an individual basis for patients who were and were assessed as part of intentional rounding (a procedure to ensure all patients were assessed by staff at a regular interval). Patients' pain was regularly monitored by nurses, doctors and the pharmacist. There was evidence in patient's records that the correct type of pain relief had been prescribed appropriately, and was administered when patients required pain relief.
- Individual pain care plans were completed with aims and interventions. Pain relief was administered as early as possible to aid rehabilitation and mobilisation.
- Patients told us they were asked about their pain and supported to manage it.

Nutrition and hydration

- Staff had access to speech and language therapy (SALT) and dietetics and referred patients based on their

individual need. As the SALT service was provided five days a week, a grant had been obtained to fund computer software to enable staff to use a computer-based swallowing programme at weekends.

- Community hospitals had protected meal times. This was a period of time when all other ward activities stopped to give people time to eat and be supported to do so, as long as it was safe and appropriate on the ward. This allowed staff to focus on supporting patients with their nutritional needs. However, there was flexibility in the arrangements to allow relatives to help with eating and drinking in line with patients' individual care needs.
- Patients had access to fresh water, whether they were by their bed or a day room. We saw hot and cold drinks being offered to patients regularly.
- Patients had food and fluid charts where required and were in the main up to date, showing that patients were being regularly assessed in terms of their intake and output. In all care records we reviewed there was evidence that nutrition and hydration had been assessed using a nutritional screening and assessment tool (MUST). There were safe swallowing instructions, written by the speech and language therapist (SALT) at the bedside of patients who were having difficulty with swallowing following a stroke. All staff on Mulberry ward (the stroke unit) and staff from community hospitals, including kitchen staff, student nurses and volunteers had attended swallowing training with the SALT therapist.

Technology and telemedicine

- Telemedicine (the remote diagnosis and treatment of patients using technology) was not available in community hospitals. There were limitations due to the capacity and capability of the information technology infrastructure. A review of all network capacity and speed on community hospital sites was documented for upgrade in the organisation's 2017-2019 delivery plans.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits, and to the board.
- The Sentinel Stroke National Audit Programme (SNAPP) data for the stroke unit (Mulberry ward) at Chippenham Community Hospital for the period December 2016 to March 2017 showed overall scores were at level D. Scores are graded from A to E, A is the optimal score. Other organisations locally had ratings that ranged from B to D. Scores were achieved by comparing a variety of data received against a set of relevant questions about care provided post stroke. There was no change from the previous SNAPP report. To address this, a therapy working group had been organised to ensure ongoing improvement in the management of patients who had undergone a stroke. Therapy-led exercise groups and joint physiotherapy and occupational aids to daily living sessions had increased the therapy contact time for patients on Mulberry ward. Staff told us it was a challenge to input data and had attended a recent training session to help streamline the process.
- Staff acted immediately on incidents and concerns as they occurred at community hospitals. Quality and audit information was collected monthly on a single day known as 'Safety Wednesdays'. This demonstrated local audits were ongoing and staff were aware and able to act on results immediately to improve patient outcomes. This led to initiatives to help improve outcomes for patients. For example, with patient falls, alarm mats were introduced to alert staff when patients were trying to get out of bed unaided. Early supported discharge (ESD) had been introduced for stroke patients on Mulberry ward. This aimed to provide rehabilitation to eligible patients at a level and intensity appropriate to individual patients, and in line with an inpatient stroke rehabilitation unit. ESD aimed to improve individual outcomes for patients by helping to reduce the likelihood of on-going dependency on others for everyday activities, as well as reducing the demand on stroke rehabilitation units. ESD was a new and small service and was still recruiting and training the support workers who would be joining the therapists already recruited to the team. The ESD pathway had only recently been registered with SNAPP so it was not possible yet to identify patient outcomes. However, we were told two patients on Mulberry ward had referred to the scheme successfully. The ward manager told us the scheme was currently at full capacity and was awaiting the recruitment and training of additional support workers.
- The development of an ambulatory care standard procedure was in place on Cedar ward at Chippenham and Longleat ward at Warminster Community Hospital. This formed part of the organisation's high intensity care approach to reduce admissions to secondary care

through a more structured and visible approach for patients who require an increased intensity of care in the community. The ambulatory care service was in its infancy and a maximum of three patients had been referred to the service through Cedar ward in the last six months. The relative of a patient using the service said, "This has been a brilliant service for my relative who is in a local care home and would have required an admission to hospital, which would have been upsetting for them and difficult for me to travel the extra distance. We are on our fourth week of a six-week treatment programme and the care and support from staff has been excellent and made our lives so much easier".

- Physiotherapists and occupational therapists formed part of the ward teams at community hospitals. There was a plan to develop seven-day therapy services in community hospitals. Seven-day therapy services were already in place on Longleat ward at Warminster Community Hospital. On Ailesbury ward at Savernake Community Hospital a seven-day therapy rota was in place. However there were insufficient therapists to ensure the rota was always covered. On Mulberry and Cedar wards at Chippenham Community Hospital, therapy rotas covered five and six days of the week and there were no immediate plans to recruit additional therapists. Agency or bank therapy staff were not easy to employ and this resulted in some patients not getting the recommended amount of therapy each day following a stroke.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area worked.
- All staff told us they had received an annual performance review (appraisal) and said they were actively supported by senior staff.
- Data, from the 2016 NHS Staff Survey identified 92% of staff who responded to the survey had received an annual appraisal which had increased from 82% in 2015. The survey also identified only 33% of staff believed the appraisal had helped them to have clear objectives to support their work. This view was not substantiated by staff in community hospitals who told us the appraisal process was "very helpful" and "helped me to be clear about my role in the coming year and get positive feedback from my line manager".
- Staff spoke highly of the computer-based learning opportunities and we saw examples of role-specific competency-based training which enabled staff to undertake enhanced roles. For example, the administration of intravenous drug therapies and peripherally inserted central catheter (PICC line) for intravenous access that can be used for a prolonged periods of time was a course delivered to staff. All nurses (apart from bank nursing staff) were required to undertake this training to support patients on the ambulatory care pathway.
- Advanced nurse practitioners who were undergoing training were employed at Warminster and Savernake Community Hospitals to support the organisation's development of high intensity care in the community. For example, the administration of antibiotics and intravenous (IV) fluids and liquid foods through PICC lines.
- Student nurses had placements in the community hospitals. Students were given a named mentor throughout the placement and there was information regarding the placement at each community hospital.
- All new staff were required to complete a corporate and ward level induction and nurse competencies were part of this. For example, all nurses completed a competency based stroke programme on Mulberry ward, led by the therapy team.
- Nurses and therapists had informal supervision in community hospitals but there were no formal arrangements in place for clinical supervision for nurses. Therefore, there were limited opportunities for nurses to review their professional nursing practice.
- The employing organisation had a policy in place around nurse revalidation. Two nurses we spoke with told us that they were supported through the revalidation process.

Multi-disciplinary working and coordinated care pathways

- All appropriate members of the multidisciplinary team were involved with assessing, planning and implementing patient care. Staff worked well in community hospitals as part of the multidisciplinary team to promote early mobilisation and enhance patients' rehabilitation and recovery.

Good

Are services effective?

- Multidisciplinary teams were well established across all community hospitals; patients had input from a range of allied health care professionals, including occupational therapists, physiotherapists, speech and language therapists, dieticians and social workers.
- There was a cohesive and thorough approach to assessing the range of patients' needs, setting individual goals and providing patient-centred care. Nursing staff worked alongside therapy staff to provide a multidisciplinary approach and we saw evidence of this in the patients' records we reviewed. All staff we spoke with described good collaborative working practices.
- We observed a multidisciplinary team meeting. It was well organised and each member of the team was listened to and able to contribute to the meeting. All staff were aware of who was responsible for each patient. Staff showed a real understanding of patients' needs and described issues in detail during the meeting. The social worker we spoke with told us it was invaluable being included in the meetings as it allowed them to make immediate referrals for services needed following the patient's discharge. Joint meetings with the patient, social workers and relevant therapists were also set up during the multidisciplinary meetings. Formal minutes were taken so they could be referred to if any points of clarification were needed.
- Local GPs, who provided medical cover on the wards, and visiting consultants, conducted ward rounds which involved ward staff and the patient, where possible.

Referral, transfer, discharge and transition

- The organisation had a target to keep the average length of stay at or below 20 days on the three rehabilitation wards at community hospitals. Performance from July 2016 to January 2017 was constantly higher (worse) than this target and was heavily influenced by a high number of delayed transfers of care. Board meeting minutes in December 2016 reported the average length of stay on Cedar, Longleat and Ailesbury wards was 28.5 days. The December 2016 position was 30 days. For Mulberry ward (the stroke unit) it was 33.6 days in December 2016 with a year-to-date position of 38.6 days. There were 24 delayed transfers of care which equated to a loss of 714 bed days. Since July 2016 until December 2016 the organisation had lost an average of 673 bed days per month to delays in discharging patients.
- System changes around early supported discharge for stroke patients, enhancement of the 'home first' pathway, improving links through a comprehensive approach to rehabilitation and reablement continued to be developed by the organisation.
- Patients were given an estimated date of discharge on admission which was reviewed at multidisciplinary team meetings. All patients we spoke with were aware of when they were expected to go home. Information about each patient's discharge was recorded on the white board in ward offices.
- Therapy staff told us achievable goals would be set with each patient, identifying what was important to them.
- Multidisciplinary team meetings were held regularly and patients' progress was discussed. Patients who were identified as being fit for discharge would then start the process, which could include discharge planning meetings, home visits, continuing health care assessments and case conferences. There were comprehensive discharge plans in patients' care records. We heard ward staff talking to community nurse teams and passing on relevant information about patients who were going home and needed onward care.
- There were patients ready for discharge in all community hospitals during our inspection. All of these patients were waiting for packages of care to be arranged. Delayed discharges were reviewed daily by the lead nurse for community hospitals, followed by telephone discussions to social services to ensure patients ready for discharge were being prioritised. The lead nurse participated in twice-weekly teleconference calls with commissioners, social services and local care providers to provide assurance everything was being done to manage delays.
- Additional beds had been commissioned at Warminster and Savernake Community Hospitals for 'step up' care. These were patients admitted directly to a community hospital instead of to an acute hospital bed. Advanced nurse practitioners who could prescribe medications had been employed to support the 'step up' beds. However, beds were not always able to be utilised as they were occupied by people waiting to go home who required packages of care.

Access to information

- Staff had access to information they needed to deliver effective care and treatment to patients. All staff we

spoke with were aware they could easily access the organisation's information. This included policies, procedures and patient information leaflets on ward computers.
- There were computers available which gave staff access to organisational information and patient information, including blood results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff spoke we spoke with had an understanding of relevant consent and the decision-making requirements of legislation and guidance. Staff had knowledge of the Mental Capacity Act 2005 and the deprivation of liberty safeguards and how these applied to patient care. Staff also had an understanding of the difference between lawful and unlawful restraint practices, although they had not needed to use restraint.
- We saw how consent for procedures had been obtained or discussed with patients. When patients did not have the mental capacity to make decisions or give consent we saw conversations with the patient and their relative had been documented to show how a decision had been reached to act in the best interests of a patient. The reasons for the procedure were also documented. Records showed individual mental capacity had been assessed and how that impacted on the discussions about care and support required for patients.
- Training records in June 2017 showed community hospital staff were meeting the organisation's target of 80% for consent and the Mental Capacity Act and deprivation of liberty safeguards training, apart from Cedar ward at Chippenham Community Hospital where only 71% of staff had competed the training. The ward manager on Ailesbury ward at Savernake Community Hospital had arranged for the safeguarding lead to run additional training to support learning from a complaint regarding staff's lack of understanding of mental capacity assessments.

Good

Are services caring?

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

Summary

We rated the community inpatient services as good for caring because:

- Feedback from patients and those close to them was consistently positive. Patients were treated by kind, caring staff that were respectful and considerate.
- Patient's privacy and dignity was respected and staff sought permission before carrying out care and treatment.
- Staff often went out of their way to meet the emotional and physical needs of patients. Staff had taken the time to get to know and understand the needs of patients and their families.
- Patients and those close to them were treated as partners in their care and supported to make informed decisions about their care and treatment.
- Staff were, without exception, courteous, kind and helpful.
- Patient's emotional and social needs were valued and this was demonstrated in the way staff cared for patients and in patient feedback.

However:

- Some relatives expressed concerns about the rigidity of visiting times at community hospitals and felt they were "old fashioned".

Detailed findings

Compassionate care

- We observed staff took the time to interact with patients and those close to them in a respectful and considerate way. We heard of and saw many examples of staff delivering compassionate care and treating patients with kindness, dignity and respect. Relatives of a patients with a with a diagnosis of dementia told us how staff spent time with their relative and sang to them and played the music they enjoyed.
- We observed staff speaking with patients by bending down to their level, making eye contact and referring to them by preferred names. They demonstrated they had taken time to get to know the patient.
- We spoke with 16 patients who were all positive about the care and compassionate treatment they had received from staff. We saw care provided to both patients, relatives and carers, which demonstrated staff understood their patients' needs.
- Patients made comments such as: "I am cared for so well and the staff are always so kind to me" and "the care is always first class".
- Patients on all the wards felt their care needs were being met. They spoke highly of the staff who were described as caring and kind and who always went the "extra mile".
- We observed staff respected patients' confidentiality, privacy and dignity by ensuring toilet doors were closed and curtains pulled closed, and by knocking or seeking permission before entering side rooms. Staff told us and patient feedback confirmed that patients' dignity was respected. One patient who had been treated at the hospital over a number of years stated, "the staff have always cared for me with kindness and compassion and have always respected my privacy and dignity and I have been so lucky to experience such wonderful treatment on the NHS."
- The NHS Friends and Family Test were created to help service providers and commissioners understand whether patients were happy with the service provided or where improvements were needed. The Friends and Family Test response rate for community inpatients was 20%, which was lower than the national average of 25%. In May 2017, 100% of patients who took part in the test would recommend the service to friends or family.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in the decisions about their care, and relatives told us they were kept informed and updated with any changes to the patient's care. Relatives were involved in multidisciplinary team meetings if this was felt to be in the patient's best interests.
- The family of a patient admitted to Chippenham Community Hospital commented about their experience and said, "From the start of my relative's treatment she (the patient) was treated with dignity and

respect as were we as relatives. All the staff, without exception, have been friendly and kind and very helpful and have kept us informed of what is going on at all times."

- We observed staff working collaboratively with patients and carers and encouraging their involvement. For example, therapists on Longleat ward at Warminster Community Hospital described their awareness of how a diagnosis affected those close to a patient and how important it was to support the friends and families. Patients and relatives told us they were aware of discharge plans. Some expected to go home with support from community services, while others were going to alternative care settings to continue their rehabilitation.
- Some relatives we spoke with expressed mixed views about visiting times at community hospitals. The majority of relatives told us visiting times were flexible to meet the needs of family members and their working lives. A patient said "A relative came to see me outside of visiting times and the staff let him visit even though it was lunch time. They kept my lunch warm for me so I could eat it later". We overheard a telephone conversation where staff were helpful in enabling a relative from further afield to visit outside of normal visiting times. However, two (out of 12) of relatives told us visiting times were "old fashioned" and "I thought the visiting times were a bad thing as I sometimes felt pushed out". Three relatives expressed concerns about not being able to support their relative at meal times.
- All the patients and relatives we spoke with about the support that was available following discharge were complimentary about the services they received. For example, "the discharge process was fine and the lady who arranges it was wonderful" and "there were home visits to set up the discharge" and "the staff really backed us up when it came to leaving the ward".
- On Mulberry ward (the stroke unit) at Chippenham Community Hospital, all patients had a weekly therapy timetable. The timetable recorded therapy sessions with the physiotherapist and occupational therapist, activities and appointments with specialist members of the health care team. Copies of the timetable were in the patient's notes and at the patient's bedside. This enabled patients to share their treatment plans with relatives.

Emotional support

- We saw staff of all grades and roles assisting and supporting patients. Nurses, therapists and support workers took the time to talk to patients and provide them with ongoing reassurance to help them regain confidence and independence in their physical abilities.
- Staff went the extra mile to make sure patients were supported emotionally, to be as comfortable as possible and to engage in ward activities within the limitations of their clinical condition. A member of staff told us how a patient with a specific sporting interest had been enabled to watch their sport when it was televised early in the morning. A patient told us "The staff kindly took me to see my partner who was in another part of the hospital every day which was just wonderful."
- We observed a family discussion being arranged with a doctor. A room was arranged, extra chairs found, and the family escorted to the room in a supportive and caring manner. The door was closed and to ensure a private discussion could be held. This was all done in a manner which showed professionalism and a caring approach to a sensitive discussion.
- A hospital chaplain visited the community hospitals at least once or twice a week to provide emotional support to patients and their relatives.

Good

Are services responsive to people's needs?

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

Summary

We rated the community inpatient services as good for responsive because:

- Services were planned and delivered in a way that met the needs of local patients. Community hospitals offered choice and flexibility to patients and provided continuity of care.
- The service delivered was creative and was working towards improving patient flow through community hospitals
- There were dementia friendly environments with pictures and signage which helped patients living with dementia to locate the bathroom and toilet facilities.
- Community hospital staff worked closely with community specialists and integrated community teams to ensure patients had their rehabilitation, care and support needs met following discharge.
- Complaints were handled in accordance with the organisation's policy and improvements were made in response to complaints.

However:

- Processes to ensure patients who were medically fit to leave the hospital were not always effective. However, in the majority of cases, reasons for discharge delays were not attributed to the hospital but to the wider healthcare system.
- Patients were unable to manage their own medication whilst in hospital as they did prior to admission and following discharge.

Detailed findings

Planning and delivering services which meet people's needs

- Community inpatient services were developed in order to provide appropriate care for the local population. Regular meetings were held with commissioners of services to ensure the organisation was able to provide a service that met the needs of the local population. Community hospitals provided 'step up' and 'step down' care for patients who were currently unable to manage within their home environment due to mobility or nursing issues. This included supporting people in hospital and at home with long term conditions and complex needs. All staff were aware of the admissions criteria for each community hospital.
- Community hospital staff worked with community specialist nurses. For example, respiratory specialist nurses and integrated community teams. This ensured there were comprehensive packages of care for patients returning home or to another care setting.
- There were patients at all community hospitals waiting for care packages to be arranged before they could be discharged. The arrangement of care packages was not the responsibility of the organisation. However, community hospitals were working hard to ensure internal processes worked to complete discharges as smoothly and consistently as possible. At the time of our inspection, Longleat ward at Warminster Community Hospital was unable to use their 15 'step up' beds to maximise patient flow due to the number of delayed discharges on the ward.
- The service had recently introduced a 'home first' pathway. This was a recent initiative which aimed to simplify discharge from hospital and provide intensive support for patients at home. The Home First business case was approved in November 2016 with full implementation from April 2017. Staff at Savernake Community Hospital told us that, although the scheme was under development, patients with complex care needs had been referred and were being discharged earlier from the ward.
- Patients who had managed their own medication prior to admission and would do again following discharge were unable to manage their own medicines in community hospitals. Staff we spoke with told us suitable patients undergoing rehabilitation, could benefit from managing their own medication whilst in hospital. Staff told us a patient self-medication policy was being developed.
- All community hospitals had facilities and premises appropriate for patients' needs. However, the occupational therapist (OT) on Mulberry ward (the stroke unit) at Chippenham Community Hospital told us there were limited facilities to help patients to practice daily living activities following a stroke. As there were no

kitchen facilities for patients on the ward, a weekly breakfast club had been arranged by the OT for a maximum of three patients. This enabled patients to make their own breakfast in a supported environment.
- Staff told us they were informed of admissions in advance and were able to arrange for appropriate equipment for patients prior to admission.

Equality and diversity

- Staff we spoke with had an effective awareness of patients with complex needs and those patients who required additional support. Services were planned to take account of the needs of different people. Staff had access to guidance on the intranet for interpreters and translators and information on how to access services were displayed in ward areas. Staff gave examples of using the translation service to put simple conversations together for patients whose first language was not English. Leaflets were available in all community hospitals and could be ordered in other languages or in large print as required.
- Each community hospital had level access at the main entrances, with lifts available to facilities on other floors. There were disabled parking places near to the main entrances at each community hospital. Reasonable adjustments were routinely considered and made to meet the needs of patients with a disability. All areas we visited were wheelchair accessible and there were designated bathrooms for patients living with a disability.
- Equality and diversity training was available to staff through computer-based learning with the expectation staff would complete it every three years.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people in vulnerable circumstances or those with complex needs, for example, those living with dementia or a learning disability.
- Information was documented on white boards in ward offices which indicated those patients at risk of falls, patients living with dementia, or patients who required assistance with, for example, eating. All patients' risks or additional needs were highlighted during handovers and documented on printed handover sheets. In addition, these would be discussed at multidisciplinary team meetings.
- There was a range of specialist nurses available to see patients, including tissue viability, dementia and learning needs specialist nurses. Each ward had a day room with dining and activity facilities. Wards were developing 'dementia friendly' environments. For example, there was signage which indicated the day of the week and the year, large clocks and pictures on toilet and bathroom doors to help patients locate the facilities. A mural on Longleat ward at Warminster Community Hospital had been created by a local artist. The mural displayed scenes of the local area and was developed in partnership with patients and staff to support reminiscence activities for patients living with dementia. The ward manager collected feedback from patients and families to support the development of further murals on the ward.
- All community hospital wards had 'dementia champions' who were either care or therapy staff. Staff had undertaken dementia awareness training and attended link meetings to share best practice in caring for patients with a diagnosis of dementia.
- An activity assistant was employed on Longleat ward at Warminster Community Hospital to support the care and therapy team. This was to ensure patients were able to participate in their chosen activities. An exercise class was held twice a week and 11 patients attended at the time of our inspection. The class was led by the activity assistant and nursing and therapy staff supported patients to participate in accordance with their clinical condition. Patients appeared to enjoy the activity class and commented "its great fun" and "I feel better for joining the group."
- On each ward at community hospitals, we observed patient information boards along with leaflets about the service for patients and relatives. Staff told us patients were given information about the patient advice and liaison service (PALS)**.** We saw there were pictures of staff in their uniforms to help patients and relatives recognise staff caring for them.

Access to the right care at the right time

- Access to care and treatment differed between community hospitals. Rehabilitation services were not accessible to patients seven days a week. A phased approach to seven-day therapy services was being rolled out across the community hospitals. However, staff told us patients had their exercise programmes/ goals set, which patients could follow at weekends,

either independently or with assistance from nursing staff. Patients we spoke with confirmed this. Where seven-day services were already provided, staff told us how this had improved the quality of therapy services to inpatients, particularly at weekends.

- Local GPs provided medical cover for the wards, with visiting consultants providing specialist advice. Staff would contact the on call GP for advice during evenings and at weekends. Patients would be transferred to an acute hospital if required and staff would call an ambulance in emergencies.
- Within 24 hours of admission to a ward, a full assessment of the patients' needs was completed by nursing staff. Therapy assessments were carried out within one working day of admission to assess the initial moving and handling needs of the patient, set objectives and plan treatment.

Learning from complaints and concerns

- Effective systems were in place for responding to complaints. Staff told us how they learned from complaints that they had received. An example was given when following a complaint about poor communication, individual staff had one-to-one meetings and training put in place.
- Patients were provided with the appropriate information on how to make a complaint or raise a concern. Between July 2016 and March 2017 there were 20 complaints across community hospitals, of which 13 were upheld. The two main complaint themes were discharge delays and communication. A formal record was kept of all complaints at each community hospital. Each ward had a white board which displayed information for patients and their visitors including complaints and compliments. An example was Longleat ward at Warminster Community Hospital where the information displayed showed there had been one complaint and 13 compliments in May 2017.
- Staff told us they would refer any complaints made to them by patients or relatives to the ward sister, or direct the person to the patient advice and liaison service (PALS). The PALS service was provided by a local NHS trust under a service level agreement, but with a dedicated phone line and team.
- A complaint had been made at Savernake Community Hospital in May 2017 in relation to a patient's discharge. The complaint had been investigated and the relative had been given an apology. Staff had signed an action sheet which described the learning arising from the complaint. Following the complaint, a training session was arranged by the ward manager to support discharge planning on the ward.
- Complaints were reported on a monthly ward dashboard and were reviewed and discussed at team meetings. Staff told us they knew improvements were monitored through regular audits and results would be shared with them. Staff addressed problems locally to resolve issues for people at the earliest opportunity. These were discussed at handover and team meetings to ensure people knew the concerns had been addressed. Relatives told us they knew how to make a complaint and who to approach on the wards.

Good

Are services well-led?

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

Summary

We rated the community inpatient services as good for well-led because:

- The organisation had a clear statement of vision and values which was recognised by staff and was becoming integrated into the community hospitals we visited.
- There was a governance structure in place supported by risk registers which had actions identified to manage identified risks.
- Services were well-led with evidence of effective communication within ward teams.
- Staff knew how their ward performed and were involved in improvements.
- Staff felt supported and felt able to speak up if they had concerns.
- The service captured views of people who used the service.
- All staff were committed to delivering good compassionate care.
- The organisation was continually developing inpatient services to allow innovation, improvement and sustainability of services.

However:

- Although the results were good, the NHS Friends and Family Test response rates at community hospitals were low.

Detailed findings

Leadership of this service

- There was strong local and service-level leadership and staff spoke positively about their ward leaders and managers. Staff told us they felt supported by their managers and felt able to walk up to them with any concerns or questions they had.
- Staff could explain the leadership structure within their ward and community hospital and, furthermore, were aware of who the board members and senior team were.
- The lead nurse for community hospitals provided strong and consistent leadership through the sharing of best practice, service developments, and learning from incidents and concerns.
- Staff meetings were held monthly on each ward to share learning from incidents, concerns and compliments about the service, and to monitor service developments.
- All staff we spoke to at each community hospital, felt that their hospital was well-led in a supportive and friendly environment.

Service vision and strategy

- The organisation had developed a vision: “to enable people to live independent and fulfilling lives for as long as possible” and a purpose: to achieve seamless care, removing the cultural and contractual barriers to it”.
- Staff were aware of the organisation’s five year vision and delivery plan. Staff told us the vision was focused on delivering improved community services in Wiltshire to enable people to live independent and fulfilling lives for as long as possible.
- The organisation’s vision and values were prominently displayed in the community hospitals. All staff we spoke to were aware of the vision and values and told us “I really feel part of the new organisation” and “I know my ideas are listened to at all levels of the organisation.”

Governance, risk management and quality measurement

- The governance framework at community hospitals ensured the responsibilities were clear and quality, performance and risks were understood and managed. Staff were clear about their roles in relation to governance and their accountability.
- A governance database spreadsheet monitored performance and patient safety issues. For example, it included safety and clinical incidents. Risks for community hospitals were recorded on the database and were discussed at monthly governance meetings, which the lead nurse for community hospitals attended. On the risk register report for March 2017, a ‘risk of entrapment’ was identified following a bed survey at

Savernake Community Hospital. Bed rails were not integral to the beds and did not comply with the standard for eliminating the risk of entrapment and there was no evidence bed rails had been assessed. The risk was raised in March 2017 and entered onto the risk register. A replacement bed programme was being rolled out to reduce the risks to patients.

- Quality reports were produced monthly and incorporated safety issues for community hospitals, which were discussed at monthly quality assurance committee meetings. For example, in the minutes of the quality meeting in December 2016, safer staffing figures showed there was a general shortfall in the numbers of staff on wards at community hospitals. It was recorded staff and patients had not been at risk as staff had constantly reviewed the needs of the patients and risks on each ward. Staff had been moved between wards and community hospitals to provide support. Concerns were raised regarding the vacancy rates and the lack of resilience for staffing levels within community hospitals. This was discussed at senior management team meetings and added to the risk register by the head of operations.
- There were regular team meetings to discuss issues and community hospitals displayed performance information on notice boards. On the wards, files were available which included minutes of meetings, safety briefings and previous audits. Where appropriate, staff were encouraged to read and sign information regarding changes to practice to confirm they had understood the information.
- Information boards were visible in staff areas and displayed audit information and organisation-wide correspondence.

Culture within this service

- There was a strong patient-centred culture across community hospitals which was open and transparent and allowed staff to speak up when they had concerns.
- Staff felt encouraged to raise issues and concerns and felt confident to do so. They stated they felt supported by their immediate line managers.
- We observed good working relationships across the community hospitals and it was evident that morale was good and staff felt respected and valued.
- Staff told us they asked patients and their relatives for feedback and encouraged them to complete the NHS Friends and Family Test feedback questionnaire. The lead nurse for community hospitals was aware of the low response rate and this had been discussed at team meetings to identify how the response rate could be improved.

Public engagement

- Each community hospital had a number of volunteers who talked with patients and supported them to undertake a wide range of activities. We saw volunteers were well known to patients and had developed close supportive relationships with them. A volunteer awards ceremony took place to recognise the long service of volunteers and awards and were presented by the managing director of Wiltshire Health and Care.
- Each community hospital had an active League of Friends who were able to fund specific pieces of equipment. This had included books and activity materials to support reminiscence therapies for patients living with dementia.
- Feedback from patients and the public in the form of compliments to the wards or completed NHS Friends and Family Test responses were discussed at team meetings. The information was stored on the governance database and updated monthly. It was recorded on the whiteboards for patients and relatives to see.
- Community hospitals had close relationships with local schools and provided work experience placements. A student told us “I have only been here for a few days and the staff have made me feel like I am part of the team caring for the patients.” Longleat ward at Warminster Community Hospital received more applications from work experience students than it were able to place.

Staff engagement

- Staff we spoke with at all levels felt informed about their own ward and community hospital. Staff had attended open forums with the managing director and spoke positively about his community hospital visits and engagement with patients and staff.
- The chair and members of the board had undertaken visits and attended multidisciplinary team meetings at community hospitals to increase their understanding of the needs of patients and staff.
- An away day had been arranged with team leaders and ward managers to consider initial thoughts and ideas to help in the development of the values and behaviours for Wiltshire Health and Care.

Good

Are services well-led?

Innovation, improvement and sustainability

- The organisation was continually developing inpatient services to allow innovation, improvement and sustainability of services. An ambulatory intravenous therapy service had been introduced on Cedar ward at Chippenham Community Hospital. This formed part of the organisation's high intensity care approach to reduce admissions to secondary care. This enabled patients requiring daily intravenous therapy, the choice to have treatment in a community setting, rather than an overnight stay in hospital. Patients told us this had enabled them to maintain their usual exercise routines. A lack of ability to continue breathing exercises was recognised to cause deterioration in a patient's clinical condition. This demonstrated the ambulatory care service was meeting the needs of patients which kept them well, maintained their independence and avoided unnecessary hospital admissions. A patient's story was presented to the board in June 2017 which outlined the benefits of the ambulatory care service from the patient's perspective.
- There was an early supported discharge pathway for stroke patients on Mulberry ward at Chippenham Community Hospital. The service provided rehabilitation to eligible patients at a level and intensity appropriate to individual patients, and in line with an inpatient stroke rehabilitation unit. The service was still in development but patients had already been referred to the scheme successfully.
- Digital reminiscence therapy was in place for patients living with dementia on Longleat ward at Warminster Community Hospital. This was a touch screen unit which could be taken to the patient's bedside. It had archives of historical interest, music and interactive games and could be personalised to the patient.
- There was art therapy taking place on Longleat ward at Warminster Community Hospital. This was supported by a local artist who ran art groups for patients and staff.