Central Surrey Health Limited

1-199797673

The New Epsom and Ewell Community Hospital

Quality Report

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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)
1-506761974	The New Epsom and Ewell Community Hospital	The New Epsom and Ewell Community Hospital	KT19 8BP

This report describes our judgement of the quality of care provided within this core service by The New Epsom and Ewell Community Hospital. 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 The New Epsom and Ewell Community Hospital and these are brought together to inform our overall judgement of The New Epsom and Ewell Community Hospital

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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Summary of findings

Overall summary

Overall rating for this core service

Overall, this core service was rated as good. We found the New Epsom and Ewell Community Hospital was good for safe, effective, caring, responsive and well led.

We inspected the regulated activities of diagnostic and screening procedures and treatment of diseases, disorders and injuries.

The provider, Central Surrey Health has been established as a social enterprise and the staff working for this organisation are co-owners and will be referred to as such throughout the report.

Our findings were as follows

- Systems to report incidents were used effectively and when indicated, practice was changed.
- Generally, patients received their medicines safely and there was good governance of medicines.
- Facilities were well maintained and there were good infection prevention and control practices which staff understood.
- There were systems for assessing and mitigating risks and initiatives were taken to keep patients safe within the hospital.
- Care was provided in line with national best practice guidance. A rolling programme of local audits ensured standards of care were maintained. Patient outcomes were monitored.
- There was a continued focus on professional development and clinical competence of co-owners and their performance was appraised.
- There was good multidisciplinary working with access to specialist services when required. The team worked cohesively.
- Patients were very positive about their experience. They were treated with kindness and respect and were included in decisions relating to their care and treatment.
- Services were planned and delivered to meet individual needs and ensured a focus on rehabilitation in an environment that was appropriate.
- There was a shared vision and philosophy of care in the service which supported a multi-disciplinary approach with strong co-ownership engagement. Senior leaders were visible and co-owners were positive about the leadership structure.

- During our inspection we spoke with six patients who were using the service and one of their relatives. We spoke with 15 co-owners including nurses, doctors, and therapy and administrative staff.

Summary of findings

Background to the service

Central Surrey Health Limited is the registered provider for The New Epsom and Ewell Community Hospital. The hospital provides a community inpatient service on one ward which has 20 beds. Four of the beds are designated for neurological rehabilitation the remaining 16 are for rehabilitation and palliative care. Patients are admitted to community inpatient services from acute hospitals or their own home. Medical cover for the hospital is provided by local General Practitioner practice.

Central Surrey Health has been established as a social enterprise and the staff working for this organisation are co-owners and will be referred to as such throughout the report.

Our inspection team

Our inspection team was led by Shaun Marten, CQC inspection manager and comprised of two inspectors and one specialist advisor with expertise in community therapy services.

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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit the inspection team:

- Visited New Epsom and Ewell Community Hospital looked at the quality of the care environment and observed how staff were caring for patients
- Spoke with six patients and one relative who were using the service
- We reviewed four feedback comment cards
- Spoke with 15 co-owners including nurses, medical staff, occupational therapist, physiotherapist, therapy technicians and administrative staff.
- Attended a multi-disciplinary meeting
- Looked at four patients' care and treatment records
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider say

- Patients were positive about their experience. Patients told us they were treated with kindness and respect, they were given choices about their care and hygiene needs and were encouraged to exercise and remain independent. A typical comment received was the 'staff are wonderful'.
- Another patient commented 'staff are wonderful' and commented that the food and the general state of hygiene on the ward was good. Several other patients commented on the good quality of the food.
- Patients we spoke to were able to tell us what discharge plans were in place and how this had been discussed with them. One patient told us about the adaptations being made at their home to enable discharge
- We spoke to one relative who said that since being a patient at the hospital his relative was confident, more mobile, had put on weight and their morale and mood had improved. The relative was pleased to be included in supporting the patient with decisions about discharge.
- Another patient had been transferred form an acute hospital and the relative felt the rehabilitation at NEECH had resulted in a good outcome with the patient ready to go home after one week. The patient's home was being prepared for the discharge, with all equipment being put in place and the patient and relative were pleased with the support.
- The hospital received one review on the NHS Choices website and this was positive.
- One patient said there could be better access to rehabilitation at weekends as there tended to be fewer therapists around at that time.

- We reviewed four patient feedback comment cards all of which included positive comments. The comments included 'staff are committed and understanding of patient needs' and 'everything is wonderful especially the care, food and physiotherapist'. All the cards commented on how good the care was.

Good practice

- The introduction of the 'blue moon' project that enabled staff to identify patients with cognitive impairment such as dementia meant that by the wearing of a blue wristband co-owners could easily identify that certain patients needed additional support to be safe in their surroundings. We saw this as enhancing safety for particularly vulnerable patients.

Central Surrey Health Limited

The New Epsom and Ewell Community Hospital

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we judged safety at New Epsom and Ewell Community Hospital as good.

- There were systems for the reporting of clinical and other incidents. Co-owners were aware of these and confident in thier use. Incidents were investigated appropriately and root cause analysis was used to review serious incidents. There were mechanisms for feeding back to individuals and staff teams. We saw that lessons learnt were widely disseminated and we saw examples of when practice had been changed as a result of learning from incidents.
- There were robust safeguarding structures and procedures and all co-owners we spoke to were aware of their responsibilities in relation to these. We saw a positive approach to ensuring staff were kept aware of how to escalate any concerns.
- Medicines were generally managed safely with appropriate governance in place. Clinical co-owners underwent relevant training and practice was supported by audit and consistent monitoring.
- The hospital was clean and tidy with cleaning checks in place. Cleaning standards were kept under review and corrective action taken if necessary. Standards were maintained with appropriate infection prevention and control practices and audit.
- Statutory and mandatory training for co-owners was monitored. Co-owners were given time to complete training and compliance was good.
- Staffing levels were maintained at an agreed level that enabled staff to meet the needs of the patients. There was adequate medical cover and medical assistance could be accessed if required.
- There were systems to identify, monitor, and manage risk to patients.
- Risks were identified and recorded on the risk register. We saw examples of risk assessments that were regularly reviewed and noted that control mechanisms were in place.

Safety performance

Good

Are services safe?

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. The hospital collected data for NHS patients and included data on patient falls, pressure ulcers, catheter and urinary tract infections.
- The NHS safety thermometer information was completed every month and we saw the results of the last twelve months which showed for nine months all patients received harm free care. For the other three months the results were between 85% and 95% with no particular trends being identified.
- Co-owners we spoke with were aware of the NHS safety thermometer and discussed initiatives such as those to manage the risk of patient falls which included the use of sensor mats on chairs and in beds to indicate when a patient might be moving without supervision and would be more at risk of falling.

Incident reporting, learning and improvement

- During January 2016 to December 2016 there was one reported serious incident requiring investigation. There were no never events reported in the past year. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The community inpatient service used an electronic incident reporting system. All co-owners we spoke to were knowledgeable about the process and could tell us how and when to report incidents. Co-owners told us they were encouraged to report incidents onto the electronic system.
- We saw a monthly incident report for clinical co-owners information. There were three incidents related to New Epsom and Ewell Community Hospital (NEECH) Community Hospital and the accompanying narrative report identified what incidents were and actions taken. The report was made available for clinical co-owners and gave an overview of incidents across Central Surrey Health and specifically for each location which enabled learning to be shared.
- There was an annual report of the reported incidents and we saw that slips, trips and falls accounted for 42% of the reported incidents. Staff told us and we corroborated by looking at minutes that this had been discussed at their regular team meetings. If staff are not present at the meeting, we saw a staff folder where minutes were available for staff to read.
- Co-owners told us they received feedback when they reported an incident. We looked at minutes of staff meetings and noted there was a standing agenda item where reported incidents and their outcomes were discussed
- There was evidence co-owners had acted on the findings from incident investigations to improve patient care and safety. For example, co-owners realised that a number of patient falls occurred at mealtimes after the patients had finished eating and were getting up to go back to the bed areas not waiting for a nurse to accompany them. In response, co-owners ensured that when assisting patients back to their bed one nurse always stayed in the dining room to ensure all other patients were safe.

Duty of Candour

- Regulation 20 of the Health and Social care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. This regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the person in relation to the incident and offer an apology.
- A policy was in place for providing care in line with duty of candour legislation. The policy was in date and readily available to co-owners.
- We asked a number of clinical co-owners about their understanding of candour and all were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.

Safeguarding

- CQC received one safeguarding alert in relation to The New Epsom and Ewell Community Hospital between 22nd October 2015 and 21st October 2016.
- There was a robust structure and arrangements in place to safeguard adults and children from abuse. There

Good

Are services safe?

were designated leads for safeguarding titled safeguarding advisors that worked across Central Surrey Health and visited New Epsom and Ewell Community Hospital on a regular basis.

- The safeguarding lead role had established links with the leads in the local NHS trust hospital to ensure their own knowledge was kept up to date and for training purposes
- We saw all safeguarding alerts were reported on the electronic incident reporting system. In addition this was monitored by using a database to enable any trends to be identified. There was a system of checks and alerts in place to identify how issues arising in one area may potentially affect others. We saw evidence that safeguarding alerts were monitored and how trends had been identified.
- Co-owners received appropriate training in safeguarding adults and children as part of the statutory and mandatory training programme. Level one adult and children safeguard training was provided for all co-owners at induction. Level two safeguarding training was provided for all clinical co-owners of grade five or above. Safeguarding leads were trained to level three. All co-owners undertook two-year refresher training.
- Safeguarding training included responsibility for PREVENT which is training to safeguard people and communities against the threat of terrorism.
- Compliance rates for adult safeguarding level one was 100% and for level two was 89%. Compliance with safeguarding PREVENT training was 77%. Where the compliance is below a target of 95%, we saw the leads are delivering additional training sessions.
- A safeguarding officer offered drop-in education sessions for all co-owners that included one-to-one coaching and support and skills assessment through scenario training .
- We saw minutes of quarterly safeguarding meetings and we were told the report from this meeting was reviewed at the clinical governance committee.
- Safeguarding concerns and alerts were reported to the Multi-Agency Safeguarding Hub (MASH), the single point of contact for all professionals to report any Adults and Children's safeguarding concerns. This group was accountable to the Surrey Safeguarding Board. There were representatives from the provider on that board.
- The safeguarding leads participated in appropriate working parties, which reported through to the Governance Committee.
- The senior team included safeguarding updates and information in monthly core briefs to co-owners. We saw evidence of recent promotional materials that were circulated to co-owners to remind them of the correct safeguarding escalation process including prompt cards, mouse mats and posters.
- Co-owners we spoke with were aware of the principles safeguarding and could describe what action they would take if they suspected abuse.

Medicines

- The pharmacy service for community inpatients was supported by a registered pharmacist employed by CSH who worked across all three community hospital sites including New Epsom and Ewell Community Hospital. This role was advisory to clinical co-owners and patients and was responsible for the training of staff and overall medicine management including the Medicine Management Committee. This role gave oversight on medicine management policies, medication ordering, prescribing and audit.
- Medication errors were reported through the Medicines Management Committee, which discussed them and implemented changes in practice. For example, following an administration error it was agreed that there would be double checking for all Parkinson's medication across all the community hospitals.
- We saw evidence of antibiotic stewardship with a monthly audit checking which antibiotics had been prescribed and that guidelines had been followed. Results were variable and ranged between 42% and 100% compliance. The small numbers of prescriptions made the variance more evident. Audit results are discussed at the governance meeting. Following the antibiotic audit we saw evidence of an email to prescribers informing them of the results and asking for corrective action.

Good

Are services safe?

- There was a service level agreement (SLA) in place with a local hospital to supply pharmacy support twice a week, to supply medicines and to provide a dispensing service for patients being discharged.
- We found an appropriate person was the accountable officer for controlled drugs.
- All nurses completed medicine management and calculation competencies on joining the hospital and 86% of nurses had completed these competencies.
- On the ward all medicines were stored in the treatment room which had a secure key pad. All cupboards containing medicines were locked and the keys were seen to be kept by the nurse in charge. On checking the medicines cupboards medicines were in date. There was evidence of over stocking making stock rotation more difficult; this was raised with the nurse in charge at the time.
- Robust procedures were in place for the monitoring of ambient room temperatures in the treatment room where medicines were stored and showed that storage temperatures were appropriate.
- Medicines were stored in dedicated medication fridges when applicable. Fridge temperature monitoring was done daily and when asked staff knew what to do if the temperatures were found to be outside the recommended range. We checked the fridge and all medicines were in date and appropriately stored.
- We observed that drug administration complied with 'Standards for medicines management' issued by the Nursing and Midwifery Council (NMC).
- We checked eight medication charts and saw that prescribing was in line with national guidance. Charts were marked as being reviewed by a pharmacist who had documented input regarding the medication. There were no omissions in giving medicines.
- We looked at controlled drugs (CDs) which are medicines liable to be misused and requiring special management in wards. We noted that CD order book showed a signed receipt of drugs. CD registers were accurately maintained and CDs were stored appropriately and balances were regularly checked.
- There was a system for obtaining and checking of medicines to be taken out (TTOs) in place. TTOs were prescribed by the doctor, checked by pharmacy and checked when delivered.
- We saw a current signature list had been sent to pharmacy and a copy was retained on the ward which meant that signatures could be validated and identified.
- Audit was completed weekly, this checked medication storage, completion of medication charts and a check of controlled drugs. We saw this showed 100% compliance.

Environment and equipment

- The hospital premises and grounds were well maintained. The surroundings were tidy and we did not identify any obvious safety risks for co-owners, patients or visitors.
- Patient led assessment of the care environment (PLACE)is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of teams to assess how the environment supports the patient's privacy and dignity, food, cleanliness and general building maintenance. PLACE assessments for 2016 awarded a score in 'condition, appearance and maintenance' of 84%, worse than the national average of 93%. We saw an action plan in response to this score that showed most actions were completed.
- Co-owners undertook health and safety training as part of the statutory training programme; this showed a compliance rate of 100%.
- Co-owners described systems for reporting concerns and repairs to us and told us that problems were addressed in a timely manner.
- On the ward we saw that all areas including the kitchen were tidy with appropriate storage of equipment. We checked patients hoist, standing aid and an ECG machine and they were clean, serviced and tested. They were labelled indicating they had been examined and were safe to use.

Good

Are services safe?

- We saw that the resuscitation equipment located in a central position in the main ward area. It was checked and the equipment was readily available. We saw daily checks of the defibrillator were made and these were complete with no omissions.
- We saw storage of medical gases was in line with safety guidance with cylinders secured to the wall.
- Equipment in sluice room was clean and tidy this area contained a spillage kit, which was in date. The staff locker room was clean and tidy.

Quality of records

- Records were stored securely in accordance with Data Protection Act 1998 and were accessible to clinical co-owners when required.
- We saw that patients transferred from acute hospitals did not always arrive with adequate information to inform staff of ongoing care. We were informed that co-owners had to be vigilant in checking what information was available and would follow up as necessary with the local NHS trust hospital.
- Co-owners were aware of their responsibilities in relation to information governance and 86% had completed training in this area.
- We viewed four sets of patients records and found them to be complete and accurate with good evidence of multidisciplinary input where required; for example, entries made by physiotherapist and occupational therapist. We saw that each patient had personal goals set and progress notes completed, which were clear legible, dated and signed.
- Patient records contained admission information, signature list, consent to treatment, admission checklist, including observations and all relevant risk assessments.
- We saw evidence of a recent medical records audit and attached action plan detailing two areas of non-compliance. There was an attached action plan which was signed and dated as completed.

Cleanliness, infection control and hygiene

- There were no cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.diff) in the last year.
- Hospital premises appeared clean and hygienic. Patients and relatives we spoke with commented positively about the cleanliness of the environment. Patient-led assessment of the care environment (PLACE) in 2016 achieved a score of 96% for cleanliness in line with the national average. We saw an action plan which showed what actions were in progress.
- Records indicated cleaning standards were audited monthly and scores showed a satisfactory level of performance with compliance at 97%. This meant that cleaning standards were kept under review and we saw evidence of corrective action taken when necessary.
- We checked areas on the ward used for storage and saw that clean and dirty items were kept segregated. We saw the use of 'I am clean stickers' when equipment was cleaned before being put back in storage.
- Cleaning and nursing co-owners clearly understood their responsibilities in relation to cleaning. We saw checklists, which clearly set this out. We saw these checklists were consistently completed.
- Infection prevention and control training was part of the statutory training for clinical co-owners. We saw records that showed that there was overall compliance rate of 86%.
- We observed co-owners used personal protective equipment when appropriate.
- We saw that co-owners decontaminated their hands in line with the World Health Organisation's guidelines (Five Moments for Hand hygiene. The most recent hand hygiene audit result related to November 2016, in which the ward achieved 100%, which was better than the target of 95%. We saw that actions that were to be taken were then shared with the clinical team.
- We were told that any patients needing isolation were moved from the general ward bay area and nursed in one of the side rooms.
- There was a lead nurse in post for infection prevention and control (IPC) and an IPC link person for the ward who attended quarterly meetings and was supported by the lead nurse in completing relevant audits.
- The infection control lead nurse was based on the ward one day per week. This individual provided targeted support to co-owners and conducted hand hygiene and

environmental audits to encourage continual compliance with good practice guidance. This nurse told us they felt infection control practice had improved as a result of co-owners feeling more empowered to challenge bad practice, such as when a colleague entered the ward with long sleeves and another individual did not gel their hands.

- We saw evidence of the infection control audit review which is completed quarterly. The most recent report showed a number of problems identified with the environment for example, some of the fans were seen to have minimal dust present. The accompanying action plan was clear what action was required, who was responsible and completion dates.
- We saw there were appropriate systems and arrangements for the segregation and disposal of domestic and clinical waste.
- There were processes for sharps management which complied with health and safety (Sharp instruments in Healthcare) regulations 2013

Mandatory training

- Statutory and mandatory training was monitored and all co-owners were expected to attend on an annual basis. The training was organised corporately by Central Surrey Health. We saw records that showed statutory training compliance was 86% and mandatory training compliance was 78%. Given the number of co –owners at the hospital we noted that in most cases non-compliance with training could be attributed to one or at the most two co-owners.
- Co-owners were required to undertake statutory 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 management, equality and diversity, safguarding adults and children at risk.
- Mandatory training was required training and role specific and both statutory and mandatory training was a combination of electronic and face-to-face training depending on the subject.
- We spoke to a new member of staff who confirmed that she had started her induction and this included time allocated to complete mandatory training.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out on admission and kept in the patient records. This included assessing the patient against the risk of falls, moving and handling, use of bedrails, skin integrity and pain assessment. In the four sets of patient records we reviewed we found risk assessments were regularly reviewed and noted that specific control mechanisms, identified on these assessments, were in place.
- We saw an initiative of using coloured wristbands to enable co-owners to easily identify how much support patients needed when mobilising. A green wristband showing the patient to be independent, yellow showing the patient required supervision and red indicating the patient needed assistance. We spoke to three patients and they all said they had given consent for the wristband to be in place and understood what the wristband meant and why it was in place. Co-owners we spoke to were positive about this initiative and said it helped them monitor patients more easily.
- For those patients that were identified to have cognitive impairment, for example dementia, we saw evidence of an initiative known as 'blue moon'. Blue wristbands were used for these patients enabling co owners to manage the patient's risks accordingly. We were told that at night the nurses would sit in the patient bays to ensure that patients identified by a blue wristband were kept under closer observation and kept safe.
- We saw that above patient beds there was information about the patient's mobility.We saw that the information was kept updated so all staff know the level of support the patient required.
- We saw that another initiative had been the introduction of two low level beds in the ward which were used for the most at risk patients. It was noted that these are positioned in a bay close to the nurse station and we were told this enabled the co-owners to keep patients more easily under observation
- There were daily nursing handovers, one at the beginning of the day, at midday and in the evening when there was an exchange of information and we were told there was a discussion about current patient risks.

Good

Are services safe?

- The hospital used a national early warning system (NEWS) track and trigger flowchart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled co-owners to identify patients who were becoming increasing unwell, and provide them with increased support. We reviewed four sets of patient's notes and found that NEWS score were correctly and consistently calculated.
- Co-owners were confident that NEWS was established and would highlight patients at risk. The co-owners escalated any concerns to the medical staff and we were given examples of when that had been necessary and what actions were taken. If a patient deteriorated significantly they were transferred by ambulance to the local NHS trust hospital.
- We saw the Medicines and Healthcare Product Regulatory Agency (MHRA) alerts were a standard agenda item on the Medicine Management Committee.

Staffing levels and caseload

- There was no acuity or labour management tool in use on the ward to assess staffing requirements. However the ward manager was able to describe how staffing levels were assessed using a risk based approach depending on patient numbers and acuity. Activities on the ward for that day were also taken into account.
- We looked at off duty rotas for the last two months and saw that during the day the ratio was between 1:3.3 and 1:4 clinical co-owners to patients and at night 1:66. These figures are calculated with all beds open. The RCN guidance on Safe Staffing for Older People's Ward (2012) suggests ratio of staff to patient should not exceed 1:7 and at an optimal level should be 1:3.8 depending on acuity, therefore the ward was compliant with the guidance.
- We noted that registered to unregistered staff ratios were maintained at least 1:1 and that the minimal number of registered nurses on duty at any time was two.
- We were told that all shifts are always covered by substantive co-owners, bank or agency workers. If someone cancelled at the last minute there was an endeavour made to cover this shift however, we could see by looking at the staff rota it was not always possible although this happened rarely. There was a flexible workforce co-ordinator who assisted with finding staff.
- We were told that if more staff are required there was a named agency they booked staff from and they tried to ensure continuity of staff.
- The ward had five full time vacancies for nurses and 1.8 vacancies for healthcare assistants. One nursing post had been recruited to and this co-owner was due to start in March 2017. An existing part time healthcare assistant had increased their hours to provide additional cover during this period.
- A local general practitioner (GP) practice held the contract to provide medical cover. A current rota showed the same GP for four days a week, and this showed the surgery available for contact until 6pm and an out of hours number was displayed. Co–owners told us this worked well and they could access medical assistance if required. There was a separate contract with three GPs for four hours of cover Saturday and Sunday.
- Patients we spoke with felt their needs and requests for help were responded to promptly.

Major incident awareness and training

- We were told by staff that there were practice fire drills but no evacuation practice. However during the inspection the fire alarm sounded and the staff were seen to respond promptly. There were designated fire marshals and all staff and patients were evacuated in a calm and appropriate way. All staff assembled in an adjoining building where patients were all accounted for, kept warm and given fluids until they were able to return to the ward. We observed that this was a well-managed situation.
- There was a major incident and business continuity plan in place. This had been updated in the previous year and provided guidance to staff on how to seek urgent help in the event of an evacuation or the building became uninhabitable. An on-call manager was available at all times and had access to an escalation process in the event a major incident interrupted the service.

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 effective as good because:

- Care was provided in line with national best practice guidance and was benchmarked nationally against other community hospitals. The hospital performed better than the national average in average length of stay and delayed transfers of care.
- Co-owners used a rolling programme of local audits to establish the standards of care and patient outcomes using recognised professional tools.
- Co-owners monitored nutrition and hydration using recognised risk assessment tools and the catering service met patients' needs by providing food to meet modified diets.
- A dedicated social worker was in post who liaised with the multidisciplinary team to ensure discharges were safe, timely and in the patient's best interests.
- Patients were cared for by a multidisciplinary team included a tissue viability nurse, a mental health practitioner and specialist Parkinson's nurses. This helped to ensure patients received specialised input in addition to the care, treatment and rehabilitation provided by co-owners.
- Consent to care was documented consistently and care was provided in line with the requirements of the Mental Capacity Act (2005).
- Co-owners had committed to achieving the Department of Health 10-point dignity challenge and Social Care Institute for Excellence dignity in care standards in relation to pain management.

Evidence based care and treatment

- Central Surrey Health participated in national benchmarking of inpatient services against the national Community Benchmarking Network. This enabled the service to compare performance in activity, quality and outcomes, staffing and finance against 72 other community organisations.
- Co-owners provided care and treatment using the Department of Health "Essence of Care" benchmarks as a baseline for safety and experience. More up to date guidance from the National Institute of Health and Care Excellence and other professional organisations was used to supplement the essence of case benchmarks and co-owners maintained up to date knowledge of these.
- Palliative care was provided in line with, and benchmarked against, NICE clinical guidance 31 in relation to care of the dying adult. This included a quarterly multidisciplinary palliative care forum attended by the local ambulance service, speech and language therapists, a heart failure nurse, adult social care, clinical nurse specialists, pharmacists, student nurses and district nurses. We looked at the minutes for the three meetings prior to our inspection and saw they were well attended and included a clear focus on patient wellbeing and outcomes.
- Co-owners undertook local audits to establish standards of care and benchmark these against organisational and national guidance. Regular audits included infection control, hand hygiene, learning disability care standards, monthly operational training and an annual record-keeping audit.
- Between April 2016 and September 2016, clinical and non-clinical teams conducted 19 local audits. This programme included audits to establish standards and benchmarks of patient care such as a ward-based intervention audit and an elderly mobility scale audit for the physiotherapy team. Audits were also carried out to identify areas of good practice and areas for improvement amongst the co-owner team, such as an audit of clinical supervisions and a record keeping audit.
- The ward manager analysed the results of re-audits to identify improvements and areas where improvements were needed. This enabled co-owners to benchmark standards of care against their own data as data available nationally was more commonly associated with acute hospitals. For example, the service analysed

the numbers of patients who were transferred back to accident and emergency after being admitted from there. In addition, patients who were discharged with the maximum package of care but were re-admitted after a fall were investigated to identify how the discharge process could be improved.

Pain relief

- Clinical co-owners were trained in nurse-led pain management and a pain-scoring tool was used during medicine rounds and administer as needed pain medicine, which we saw in practice. The physiotherapy team assessed patients for pain during rehabilitation sessions and provided pain relief in advance of planned therapy sessions.
- Co-owners used a specific care pathway to manage pain in patients who received palliative care. This included consideration of non-pharmacological pain management and a pain assessment tool based on patient behaviour.
- Each patient had a pain assessment chart in their nursing notes that co-owners used to track and monitor pain on a daily basis. We saw this in use in all of the patient records we looked at.
- Co-owners had committed to achieving the Department of Health 10-point dignity challenge and Social Care Institute for Excellence dignity in care standards in relation to pain management. Co-owners had undertaken training on the associated standards and produced a display of their work and understanding for patients, colleagues and visitors to read.

Nutrition and hydration

- The hospital had a cook and chill service. This meant food was delivered in a chilled state and then reheated with safety checks made of food temperature before serving. Catering staff kept a logbook of food temperatures, which we saw were recorded consistently.
- Patients we spoke with told us they liked the food and felt they had enough to eat and drink. Three patients we spoke with said they enjoyed the food and there was sufficient hot drinks during the day.
- In the ward kitchen we saw a board with an up to date list of special diets that were required for patients. Catering staff told us they worked closely with the nursing team to ensure patients got the right diet. This included soft diets and nutritionally enhanced foods.
- Food was available 24-hours, seven days a week. This meant patients who were admitted out of hours always had access to meals and snacks. Although patients and visitors had access to fresh water and juice, tea and coffee at all times, co-owners provided formal beverage rounds seven times daily. This helped patients to stay hydrated and provided them with an opportunity to interact with each other and socialise.
- Fresh water and juice and whole fruit was available in communal areas of the unit at all times. Patients and their visitors had access to snacks and hot drinks between meal times. The catering provider displayed allergy and ingredients information in an easy-read format and this was readily available.
- Adapted cutlery and crockery was available as well as drinking mugs with firmly fitting tops for patients who may be at risk of spilling fluids
- Co-owners encouraged patients to eat their main meals in the communal dining room. The catering contractor provided a full restaurant-style service that included table menus, taking each patient's order at the table. Co-owners joined patients during mealtimes to support them and keep them safe, such as for mobilising and monitoring choking risk. Patients with a food chart attended meals with this so co-owners could monitor their food and fluid intake. We observed a mealtime and saw co-owners facilitated a social, relaxed and friendly atmosphere and patients were able to eat at their own pace. Catering staff demonstrated personal knowledge of each patient and welcomed them warmly, which had a demonstrably positive impact on them.
- Co-owners used the malnutrition universal scoring tool (MUST) to assess the nutritional needs of each patient on admission and then at appropriate intervals. This was a nurse-led process and a neurology dietitian and neurology speech and language therapist were available for specialist support. A community neuro-

rehabilitation dietician supported patients by providing feeding regimes for the duration of their care and for their discharge. We saw evidence of this in all of the patient records we looked at.

- A dietitian was based in the community team and could assess high-risk patients who were not receiving care through a neurology pathway. The dietician could review each patient at home after discharge and on referral.

Technology and telemedicine

- Resources were available on the ward to help co-owners provide care for patients living with dementia. This included digital technology that enabled relatives and friends to record their voice into a handheld device that could display photographs and other images the patient would recognise. The unit also had a large-screen version that was mobile and could be moved to the patient's bedside.
- Staff used movement sensors to alert them to unsual patient movement during the night, such as to identify when a patient might be at risk of falling.

Patient outcomes

- A clinical lead continence nurse conducted an audit in 2016 to assess standards of care related to catheter care. This followed a serious incident in community services and aimed to ensure co-owners inpatient wards recorded the catheter care bundle in place in progress notes. The results for The New Epsom and Ewell Community Hospital showed 33% of patient notes included the catheter route. As a result of the audit, co-owners were offered training from the clinical lead continence nurse and a catheter documentation information poster was provided to support staff.
- The service used the Modified Barthel Index (MBI) to measure each patient's functional ability to complete activities of daily living and mobility between their admission and discharge. In 2015/16, NEECH demonstrated an average 11 point improvement in MBI score between admission and discharge. Co-owners used the functional independence measure (FIM) in patient notes as an additional assessment of mobility and to ensure patient's rehabilitation needs were being met.
- In the 2015/16 national benchmarking of inpatient services, NEECH reported a consistently lower average length of stay than the national average at 20 days compared with 28 days nationally. This was supported by the permanent placement of a social worker in the community hub and ward who coordinated discharges with community adult social care providers.
- The unplanned readmission rate was 1%, which was significantly better than the national average of 7%. Delayed transfers of care were significantly better than the national average, at 5% compared with 10%.
- The physiotherapy team led an audit of the elderly mobility scale (EMS) in 2015 and repeated this in 2016 to monitor the change in EMS between admission and discharge. The EMS is a tool used to identify the level of assistance patients may need and the risk of falls. The latest audit results indicated an increase in staffing numbers in the team had led to more one-to-one therapy sessions and better EMS outcomes as a result, including a 62% increase in the patients who experienced a moderate improvement in EMS by the time they were discharged. The physiotherapy team identified actions from the audit, including the introduction of additional measures to future work to identify when physiotherapists felt patients had reached their target rehabilitation goals

Competent staff

- New co-owners undertook a two-day corporate induction followed by a supernumerary period in which they were mentored by an experienced colleague. New temporary co-owners also undertook a supernumery shift. The service-specific induction included communication standards with patients and colleagues, a detailed briefing on local and organisational procedures and confirmation of their role and responsibilities.
- Agency nurses were given an induction and orientation that included emergency procedures and escalation pathways. They undertook a dedicated induction that included practical coaching on the recognition of key risks to patients, including pressure ulcers and safeguarding. The senior co-owner on shift also ensured agency staff could demonstrate suitable knowledge of

medicines management, infection control and health and safety guidance. There were no agency staff on shift during our inspection but we saw records of this process.

- The ward manager used competency tool ratification criteria to monitor co-owner clinical competencies against a skills and knowledge framework. This enabled the ward manager and co-owners to identify their level of competency, from novice to expert, in clinical activities such as the instillation of eye ointment, wound care, cardiovascular assessments and intramuscular injections. Mentors undertook additional training to enable them to assess others, such as in pressure ulcer risk assessment. We saw evidence of competency training and checks in the records we reviewed.
- Nurses undertook additional training to care for neurology patients. This included an initial care assessment, informed consent, an inspection of each patient's body and gait and testing cranial nerves and muscle tone. We viewed competency records which confirmed this.
- We spoke with the pharmacist who showed us examples of completed medicine competencies for nurses, including theory competence and observational audit.
- A specialist physiotherapist from the neurology team provided clinical co-owners with one-to-one teaching on the ward to help them provide individualised care for patients with complex needs. This was provided responsively for each patient admission with the team of co-owners that would have responsibility for them.
- All co-owners had undertaken a professional development review (PDR) within the 12 months prior to our inspection. We looked at two PDRs and found them to be structured and focused on the achievements of each individual as well as identifying opportunities for development in the following year. PDRs were empowering for co-owners and the senior team used them to encourage individuals to challenge themselves. For example, objectives included building confidence to challenge inappropriate referrals and progressing with a leadership development pathway.
- A clinical supervision audit had taken place in 2016 to establish the effectiveness of one-to-one and group specialist training amongst clinical co-owners, including nurses and therapists. Co-owners gave positive feedback about the standard, quality and usefulness of supervision and highlighted the need for more reliable protected time to avoid training being cancelled due to clinical short-staffing. The head of quality and nursing implemented an action plan as a result, which aimed to embed the clinical supervision process into each team and service to reduce the risk of short-term cancellations or missed sessions.
- All nurses had undertaken diabetes training to enable them to competently manage insulin and received additional support from community matrons and the ward manager who jointly reviewed each patient admitted with diabetes. We saw evidence of this in training records.

Multi-disciplinary working and coordinated care pathways

- Care, treatment and rehabilitation was provided by a range of health professionals as part of a multidisciplinary (MDT) team. This included clinical nurse specialists in tissue viability, enteral feeding, heart failure, respiratory, stroke, continence, multiple sclerosis and Parkinson's disease. In addition specialists in infection control and safeguarding and mental health practitioners were available.
- A social worker was available on the ward three days per week. They worked with co-owners to plan discharges and acted as a liaison with adult social care services to ensure patients experienced timely, individualised transfers home. This represented an innovative integration of health and social care that resulted in close working relationships between inpatient co-owners, district nurses, community matrons and adult social care.
- A weekly MDT discharge planning meeting (DPM) was used to review each patient and the social worker ensured an appropriate package of care and safeguards was in place in their home before they could safely leave the hospital. DPMs were attended by different specialist staff depending on the needs of patients such as mental health practitioners and the drug and alcohol liaison team.

Good

Are services effective?

- We observed a daily operations meeting that involved nurses, an occupational therapist, a physiotherapist, GP and social worker. There was a clear focus on discharge planning and assessing patient safety in the context of this.
- Patients were given a neurotherapy timetable for the day so they could prepare themselves in advance with nurse support.
- In addition to the organisation's overall multidisciplinary (MDT) approach to care and rehabilitation, a neurology MDT team was in place to provide patients with a weekly rehabilitation and therapy programme. This included input from psychology services, physiotherapists and speech and language therapists.
- The hospital was part of a health improvement health and care alliance. This aimed to facilitate teams from the hospital, adult social care, community health services and GPs, with a single-team ethos, to review planned admissions and discharges with early interventions to improve their outcomes. This included weekly meetings with social workers, therapists and paramedics who contributed to the planning model.
- Patients did not have access to podiatry input until they were discharged from the hospital. To mitigate the risks associated with this, nurses had been trained to cut, trim and take care of patients' nails as part of their personal care.

Referral, transfer, discharge and transition

- When patients were admitted to the ward from another hospital, clinical co-owners required a discharge summary, prescription information and treatment plans. However, this did not always happen and patients sometimes arrived without adequate documentation. The ward manager identified the hospital that most often discharged patients in this way and met with their senior team to identify how this process could be improved. As a result the ward manager implemented a transfer checklist for hospital staff to use. This included a check of all essential information the ward needed to safely accept patients and commence their care and rehabilitation. Co-owners told us this was a significant improvement in principle but the hospital had not adopted it. The head of the community hub was liaising with the hospital to try and overcome this issue and had led learning sessions with hospital staff on appropriate referrals and processes. This demonstrated the hospital's commitment to ensuring the safe transfer of patients from acute care.
- The admission process included a review of each patient's social needs as well as their immediate clinical needs. For example, co-owners documented each patient's social and family circumstances.
- Co-owners and the MDT team documented discharge planning for each patient when they were admitted and updated this regularly. We looked at five discharge plans and saw they included a provisional discharge date with a supporting rationale and evidence of a discussion with each patient and their relatives
- We saw the nurse in charge planned discharges each day.
- The provider did not collect information in relation to delayed discharges and planned to implement a process to do so from January 2017**.**
- In 2016 there were no delays to discharge due to awaiting social care placement**.** This was facilitated by multidisciplinary working between clinical staff and a dedicated social worker. This structure ensured the social needs of patients were identified in advance and their discharge plan included an appropriate level of social care support and accommodation.

Access to information

- Co-owners relied on hospitals discharging patients into their care to provide appropriate documentation as there was not a shared electronic records system. This had not always happened and senior co-owners had worked with the hospital to implement a standardised system that meant patients left hospital with a discharge summary and to take away medicine or prescriptions. Co-owners told us this had significantly improved the relationship and reliability of printed information

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Good

Are services effective?

- We saw that staff were aware of the need to obtain patient agreement and consent to deliver care and we observed this in practice. This meant that patients understood and participated in decisions about their care and treatment.
- There was a current Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) policy and all of the co-owners we spoke with were aware of it and how to access it. The GP we spoke with was also aware of their responsibilities under the MCA and DoLS.
- On the day of inspection we looked at the care plan of one patient with a DoLS authorisation in place. A GP had conducted an appropriate best interests assessment and there was evidence of input from the adult social care team. The hospital had submitted two standard DoLS applications between April 2016 and September 2016. This was in line with the provider's admissions policy that patients who required seclusion or segregation were not normally accepted.
- Co-owners demonstrated knowledge of the Deprivation of Liberty Safeguards (DoLS) and used appropriate documentation and assessment methods. For example, specific care plans were in place for patients with a DoLS authorisation in place. This enabled staff to provide and document the specific care patients needed to meet their needs and keep them safe. There saw best interests decision meetings had taken place between appropriate professionals and mental capacity assessments were completed. Co-owners used a DoLS decision-making tool to help them identify when an authorisation might be needed.
- All five of the patient records we looked at included their documented consent to care. Where they lacked mental capacity and could not give informed consent, an appropriate alternative had been found such as consent from a relative with lasting power of attorney or from a clinician who had completed a best interests assessment.
- Where co-owners used bed rails to protect patients from the risk of falls, they completed a mental capacity and risk assessment to ensure this was necessary.
- Therapists conducted their own mental capacity assessment on each patient in the scope of the care and rehabilitation plan. For example, a speech and language therapist and physiotherapist completed an assessment on one patient who they were concerned was at risk of choking. Documentation indicated therapists understood the provision of the MCA that patients with capacity should be free to make unwise decisions if that is there wish.
- Adults safeguarding advisors conducted a DoLS audit in 2016 to assess the knowledge and understanding of co-owners and the standard of mental capacity and consent processes on the ward. The audit identified significant gaps in knowledge for co-owners at this hospital, with only 27% able to explain what constituted a DoLS and 36% able to explain what they would do if they thought a DoLS was required. This was reflected in the low numbers of DoLS applications in comparison with the other two inpatient hospital sites. As a result of the audit targeted training was provided for co-owners on MCA and DoLS processes.

Good

Are services caring?

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

Summary

Overall, we rated caring at New Epsom and Ewell Community Hospital as good.

Patients were positive about their experience. Patients told us they were treated with kindness and respect. They were given choices about their care and were encouraged to remain independent.

During our visit, we observed that staff ensured patient's dignity and respect whilst administering care.

Patients told us they were included in discussions and decisions relating to their care and treatment, and understood their care and treatment.

Compassionate care

- During our inspection, we observed that patients were treated kindly and with respect. During our conversations with the co-owners, they talked positively about patients and their circumstances.
- The New Epsom and Ewell Community Hospital (NEECH) inpatient services administered the NHS Friends and Family Test (FFT), which is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience.
- We saw FFT information displayed on the board showing the percentage of patients that would recommend the hospital to family and friends as September 90%, October 100% and November 80%. We saw results for the past year and the percentage of patients that would recommend the hospital was 89%. We were told this information was obtained by calling patients and recording their responses. We saw that six patients responded in the most recent month, therefore caution is required interpreting these results as the sample size was small.
- Patients we spoke to were all very positive about the care they received and said they were treated with kindness and respect.
- One patient did say that at times they were concerned about the promptness of the nurse's response to the call bell and felt they may benefit from a few more staff on duty, however they commented nurses were kind and always responded in a reasonable time.
- Throughout our inspection we witnessed good co-owners interaction with patients. We observed how the clinical staff assisted patients with kindness and compassion. For example we saw one co-owner setting up the reminence television for a patient who had specifically requested to listen to some music.
- A healthcare assistant was the ward's designated dignity champion. They attended quarterly forum meetings with co-owners from all departments and reviewed feedback from patients and care regarding privacy and dignity. Improvements had been made as a result of suggestions made at forums. For example, toilets had been labelled with a male or female sign to increase privacy and protected mealtimes had been introduced.
- There were no instances of mixed sex accommodation as male and female patients were looked after in separate single sex bays.
- The New Epsom and Ewell Community Hospital achieved a score of 74% in the patient led assessments of the care environment (PLACE) 2016, for treating patients with privacy, dignity and wellbeing, which is below the organisational average of 76% and below the national average of 84%. We saw a corporate action plan that addressed all areas of non-compliance in the audit, which detailed who was responsible for actions to be taken and the timescale for this to be achieved. Most actions were already seen to be complete.
- During our observations we noted co-owners warmly welcomed relatives and visitors onto the ward. The communal area was facilitated as a lively social space and everyone was welcomed to enjoy this area.

Understanding and involvement of patients and those close to them

Good

Are services caring?

- Patients told us they were included in discussions and decisions relating to their care and treatment. We saw that discussions concerning patient treatment plans were documented in their records.
- We spoke to five patients who all said the care was good. We were told that co-owners helped them to get up and dressed every day and choice was given whether they would prefer to bath or shower.
- We saw that family meetings were encouraged and that access visits and home visits were done as required.
- Co-owners worked with patients and their relatives to help them cope with challenging circumstances. For example, when the family of one patient became increasingly upset about the lack of recovery, the ward manager set up meetings with each member of the team responsible for care, including the neurology physiotherapist and nurses. This helped the family to establish realistic expectations and also reduced pressure the co-owners and other professionals taking care of the patient.
- Each patient had a personal goals and information plan. The multidisciplinary co-owner team used this to identify the patient's future goals and what they wanted to be able to do after discharge. The document was also used to record significant updates, explain the discharge process and explain the use of coloured wristbands.
- Patients we spoke to were able to tell us what discharge plans were in place and how this had been discussed with them. One patient told us about the adaptations being made at their home to enable discharge
- We observed a discussion between the social worker and family members. The social worker provided detailed information about the discharge planning process and explained the different steps that would take place to ensure it was safe. They answered each question using understandable language and the family members were demonstrably reassured by this.
- Patients told us the nurses encouraged the them to completed their exercise programmes. We observed a physiotherapist leading an activities rehabilitation session with patients. They facilitated this as a sociable, positive and interactive experience and encouraged each patient to take part.

Emotional support

- Patient records showed nursing staff provided emotional support to patients and their families with records of decisions taken and who was involved.
- During a morning multidisciplinary meeting we attended we saw nurses, physiotherapist, occupational therapist and physiotherapist were involved and that staff discussed the emotional needs of the patient and how they would support them.
- We were told that patients had access to a multi faith room and saw that there was a quiet room on the ward that could be used for familyand patients if private discussions or support was required.
- Co-owners had access to several local support services and groups that they could use to support patients with reduced cognition and capacity or those who needed additional support to understand their care and treatment. This included mental health advocacy groups, Independent Mental Capacity Advocates and organisations with provision to support patients with specialist needs, including where they had sensory impairment

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 responsive as good because:

- Services were planned and delivered to meet individual needs. This included a modified environment to ensure rehabilitation could take place safely and resources on the ward to help patients relax and take part in activities.
- Co-owners delivered care in line with NHS England Equality Delivery System guidance on equality and diversity in healthcare. A co-owner had also undertaken specialist training to become the ward's dignity champion.
- Patients had access to a range of services and support to ensure they were comfortable and to support their rehabilitation. This included a breakfast club, exercise programme, a hairdresser service and personal goals planning.
- Co-owners supported patients living with dementia with the use of modified communication tools and the support of a dementia champion and dementia steering group.
- The complaints policy enabled all co-owners to take part in investigations and learning and there was evidence proactive improvements were made as a result
- Each patient had a personal goals and information plan. The multidisciplinary co-owner team used this to identify the patient's future goals and what they wanted to be able to do after discharge.

Planning and delivering services which meet people's needs

- Each bed bay or private room had direct access to a toilet and sink and a bath with hoist and wet room were also available. Patients were encouraged to accept personal and hygiene care every day, which we noted in daily nursing records.
- An occupational therapy kitchen was available providing patients with practical opportunities for rehabilitation exercises that would help them when they were discharged home. This included kitchen equipment such as a cooker and microwave and cooking utensils.
- Following a successful one year period of social worker support in the ward three days per week, the service was increasing to five days per week. During this period, there had been no delayed discharges as a result of waiting for a social care placement and the increased presence of a social worker would extend the ability of the service to discharge patients into re-ablement services in the local community.
- A hairdresser visited the unit weekly

Equality and diversity

- An equality and diversity statement was displayed on the ward that laid out the standards patients and relatives could expect. This included a personalised care plan and involvement in discharge planning. In addition the ward team had committed to achieving the Department of Health 10-point dignity challenge and Social Care Institute for Excellence dignity in care standards and had displayed easy-read evidence as to how they worked towards this.
- The organisation had undertaken an equality and diversity project in September 2016 to identify how teams could recognise and use the diversity within them to their advantage. This had resulted in a diversity and inclusion action plan for 2016/17 which included 11 actions to ensure the team could achieve the reporting requirements of the NHS England Equality Delivery System.
- Cultural, religious and spiritual criteria were including in training for co-owners on care after death. This meant they could provide targeted support and guidance to relatives whilst maintaining respect and knowledge of their beliefs and circumstances.
- Co-owners considered adjustments to the service to prepare for planned patient admissions. For example,

bariatric equipment was ordered in advance for a patient with a spinal injury and co-owners considered how they could make adjustments to risk assessments and communication for transgender patients.

- Food was available that met cultural or religious needs, such as Kosher and Halal meals.
- Interpreters were available on-demand and if a language barrier was identified as part of the admission process, the ward manager arranged for an interpreter to be available on arrival.

Meeting the needs of people in vulnerable circumstances

- The premises had level access from the car park to the ward, including hand rails to support people with limited mobility in the corridors. Wide-access bathrooms and showers were available for patients who used wheelchairs. Disabled toilets were clean and tidy and we saw there were a good number of toilets all appropriate for patients in wheelchairs.
- Co-owners maintained a large outdoor space including patio and grassy area with garden furniture. In good weather patients could use this area under the supervision of co-owners to relax and therapists could provide rehabilitation exercises outside with appropriate risk assessments in place
- Co-owners had sourced adapted equipment in response to the changing needs of patients, including bariatric wheelchairs.
- Co-owners took appropriate action to protect patients who had circumstances that made them vulnerable or open to abuse. For example, where co-owners noticed the friends of one patient had brought in alcohol, which could interfere with their treatment, the ward manager implemented measures to reduce the risk of them drinking alcohol whilst continuing to meet their social and health needs. For example, when friends visited the ward manager imposed a rule that the patient's bedroom door had to be kept open so co-owners could supervise the visit.
- Co-owners had access to community learning disability specialists to provide individualised care and support for patients. For example, this team had provided daily visits to support the co-owners caring for a patient with a learning disability and to ensure the patient's needs were met. A communication file was available on the ward that included visual aids and prompts to help co-owners interact with patients with a learning disability. In addition, co-owners met the needs of a previous neurology patient with a learning disability by arranging a multidisciplinary care plan with learning disability specialists.
- Services, processes and resources were in place to support patients living with dementia. For example, reminiscence materials were available on the ward and digital reminiscence software had been implemented.
- Co-owners used the Alzheimer's Society 'This is me' tool to document patient's preferences and understand how they could provide individualised care.
- Patients who were found to be vulnerable, including those living with dementia, wore a blue wristband that enabled staff to easily identify them. Red walking frames were provided that enabled patients to identify them more easily and reduce the risk they would try to mobilise without a frame.
- Although dementia training was not mandatory, staff had access to study days and development opportunities in this area. All clinical co-owners had undertaken dementia training and four annual learning events had been offered in 2016 that included training for staff in communication, swallowing, nutrition and hydration and supporting carers.Co-owners had undertaken practical role plays as part of their training including using the resources available to them on the ward.
- A dementia navigator was in post who helped co-owners, patients and carers to access specialist support.
- Co-owners screened each person on admission using the Mini-Cog screening tool for cognitive impairment in older adults. This was used to check each patient understood why they had been admitted. This formed part of a dementia care process that was used to identify any issues with cognition that would trigger a full MCA assessment or DoLS application.
- Bed bays were colour-coded so that patients living with dementia or those with reduced cognition could more easily navigate the unit. Other elements of the

environment could have been more dementia friendly. For example, signage was not easily recognisable, toilet seats were not brightly coloured and mealtime menus were not available in pictorial format.

- The multidisciplinary team worked together to plan care and their immediate response to a patient who presented a safety risk to them following abusive behaviour. For example, the social worker offered them patience and quiet time to talk and worked with the patient to identify triggers for their behaviour. As a result the team adapted the time of planned meals for the patient to give them more time to themselves at key times of day and provided structured support to re-engage with their physiotherapy rehabilitation programme.

Access to the right care at the right time

- Between January 2016 and December 2016, the average bed occupancy was 95% and the average wait for a bed following referral was one day. This was better than the national average of comparable hospitals of 2.6 days.
- Patients accessed the service as a step-up unit from the community by referral from their GP or a community matron. Doctors could also transfer patients to the ward as a step-down from acute care. Admissions criteria enabled nurses to review each patient individually as part of a multidisciplinary team and accept those with complex needs, including rehabilitation needs. This broad approach to admission enabled the service to provide individualised care for patients that improved access to rehabilitation whilst reducing pressure on acute hospital beds and home carers.
- The multidisciplinary neurology team triaged new neurology referrals with the ward manager to make sure they could meet their care and rehabilitation needs. We saw this in the patient records we looked at.
- The ward manager visited patients in hospital before approving their admission if they were unsure the ward could adequately meet their needs. This also gave patients and their relatives the opportunity to meet the ward manager and ask questions about the services provided.

Learning from complaints and concerns

- The provider had a complaints policy for all sites. This enabled the senior leadership team to monitor all complaints whilst enabling ward managers to investigate and follow up on local complaints relating to their ward. The complaints policy was readily available and on display on the ward and in the patient admissions pack. This meant patients and relatives knew how to complain because they had access to the information needed.
- There had been no formal complaints in the six months prior to our inspection. Between October 2015 and October 2016, the inpatient ward received one formal complaint, which was not upheld. However, the ward manager used the investigation to identify learning for areas of improvement, including on-going improvements to reduce the risk of falls. The ward manager invited the complainant to a meeting and resolved the situation in person.
- We saw co-owners were empowered and skilled to resolve concerns or complaints at a local level. For example, a co-owner noted in one patient's daily record they had asked to eat their evening meal by their bed as they felt they were always the last to be helped back to bed after eating. They also raised concerns about the time they felt it had taken to be helped to the toilet on the previous day. The co-owner recorded they apologised to the patient and explained the circumstances that led to previous delays, including an emergency with another patient. The co-owner also briefed their colleagues and ensured patients were helped more evenly after mealtimes

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 well led as good because:

- The leadership structure was clearly defined and supported a multidisciplinary approach to care and service that enabled each individual co-owner to make a unique contribution. Co-owners spoke positively of the leadership structure and said members of the senior team were visible and readily available.
- The organisation was accredited by the Institution of Leadership and Management to provide leadership training and a diploma-level development pathway and co-owners were supported to develop their leadership skills.
- Co-owners spoke positively of the vision and work ethos of the organisation and said they felt valued and respected.
- The organisation used a range of tools to ensure co-owners were engaged and to achieve quality assurance. This included a monthly core brief, regular walkarounds by the senior team, whole-team meetings and activities and a staff survey.
- The Clinical Commissioning Group conducted a quality assurance visit in November 2016. This found coherent and clearly functioning leadership and a team responsive to the needs of patients.
- Co-owner engagement in the 2016 survey was high, with 98% of the team contributing. Results overall were in line with or better than the organisation as a whole.
- Feedback from patients and visitors was actively sought and used to make improvements in care and the service.

Leadership of this service

- The management structure consisted of a head of community hub led inpatient services, with day-to-day clinical practice and the operation of the ward led by a ward manager and both of these co-owners reported to a senior manager, the Head of Community Hub. This manager reported to the Clinical Services Director who managed all of the organisation's hospitals, hubs and community integrated teams.
- Co-owners spoke positively of the leadership structure and said members of the senior team were visible and readily available. For example, the Head of Community Hub visited the ward at least one day per week and additional support was available from the Lead Matron if the head was unavailable. Co-owners said the human resources and IT directors were easy to reach and responsive with problem-solving.
- A leadership development pathway was available to nurse co-owners that involved additional training and mentoring from senior colleagues. This enabled them to lead shifts with supervision to help them progress their leadership skills.
- Co-owners told us the executive team often visited and they felt they knew them as colleagues. One co-owner said, "I like the philosophy here, that we're all working together for the same thing."
- Ward managers were supported by the senior team with mandatory clinical supervision, support meetings from the community hub manager, one-to-one coaching and leadership training modules. In addition, the organisation was accredited by the Institution of Leadership and Management to provide leadership training and a diploma-level development pathway.
- The head of the community hub used a daily walkaround of the unit as a quality assurance strategy to ensure the smooth running of the ward. Co-owners we spoke with said they used this time to be available for co-owners to discuss any issues, concerns or ideas.
- In the 2016 co-owner survey 100% said they felt relationships between them and the leadership team were positive.

Service vision and strategy

- Employees in the organisation were named 'co-owners' as part of the overall social enterprise approach and co-

ownership model of operation. This model also acted as a strategy to foster strong team cohesion and commitment amongst nurses, therapists and other employees. All of the co-owners we spoke with were positive about this designation. One individual said it helped to foster a team spirit and others said it made them feel more a part of the organisation rather than just an employee. In addition, 91% of respondents to the 2016 internal survey said they valued working for an organisation with a co-ownership model.

- Co-owners told us they felt involved in the vision and strategy of the organisation and understood how they could contribute to it, including in relation to the four core values shared by each individual. This included through six monthly director's brief meetings and discussions of the organisational business plan.
- Professional development records (PDRs) held by staff were linked with the organisation's values of putting people first and behaviours including integrity and exceptional delivery.
- Co-owners had the opportunity to adapt the corporate strategy to the local work, needs and development of their unit. For example, each co-owner had the opportunity to suggest contributions to the ward including the potential impact and the resources they would need. The ward manager could then support them to prepare a business case.

Governance, risk management and quality measurement

- Clinical governance was centralised in the organisation with oversight and support provided to wards by a Quality and Clinical Governance ommittee (QCGC). Seventeen distinct committees and forums informed the QCGC on an organisation-wide basis that helped maintained an understanding of performance, quality and safety at each hospital. Groups included a medical devices group, a privacy and dignity group, a diabetes forum and a falls prevention group. The QCGC met two monthly and reviewed the unit's quality assurance report for clinical services report, which included safety and risk governance such as the number of falls, pressure ulcers and multidisciplinary availability. A co-owner's council monitored, reviewed and discussed the work of the QCGC and held it to account.
- The ward manager attended a monthly core brief for all community inpatient sites with their counterparts from the Molesey and Dorking sites. This was a multidisciplinary clinical governance meeting and included the physiotherapy, occupational therapy and heart failure leads.
- The ward manager maintained oversight of the key risks posed to the ward. At the time of our inspection these included patient falls risk, site security, compliance with mandatory training and recruitment. The organisation demonstrated responsiveness to risk management. For example, the senior team approved an order for bed sensors to reduce the risk of falls and provided a security team during nearby events that had presented challenges in the past due to intruders on the site. In addition, although recruitment was an on-going risk, the ward manager said they were never refused additional agency staff or overtime whenever they asked for it. This meant overall risks were generally managed well.
- The senior team used a risk register to identify and monitor risks to the service. The ward manager and head of the community hub held responsibility for each risk and assessed each item on a quarterly basis, or more regularly if indicated by the severity. There were five risks on the risk register for this hospital, including one major risk and four high risks. Major risks were also included on the corporate risk register and reviewed by the senior leadership team as part of overall risk management. The major risk related to the risk of falls. High risks related to the lack of site security out of hours, recruitment of qualified nurses, poor estates and completion of mandatory training. Although the team had completed substantial work in reducing the risk of falls, the risk would only be removed from the risk register when there was evidence of positive impact

Culture within this service

- As part of the organisation's approach to inclusivity for the co-owner team, including empowering each individual to contribute to the development and improvement of the organisation, monthly wellbeing events were offered. Recent events included cholesterol checks, massages, back care clinics and Pilates.
- Co-owners planned and evaluated their work using a quality model they had developed called the 'house of

quality'. This was supported by results from the 2016 survey that indicated 96% of co-owners said they believed the organisation was genuinely committed to delivering high quality services.

- All of the co-owners we spoke with said they felt their contribution was valued by the senior team.
- In the 2016 co-owner survey 100% said they had a good working relationship with the rest of their team. Co-owners spoke positively of their relationships with other teams and with each other. They said they felt the working atmosphere encouraged openness and rewarded their efforts.
- We saw that clinical co-owners encouraged independence and rehabilitation and all patient were seen to be up and dressed and out of bed for mealtimes which were taken in the dining room at midday and in the evening
- We were told by a clinical co-owner who recently started working at the hospital that they were "impressed by the care given" and said, "There is a good handover of patients care." Another co-owner who was leaving the hospital said they had been very happy working there and had been well supported with training and development opportunities.
- We spoke with the ward manager about the turnover of nurses, with six leavers in the last twelve months. They told us they monitored turnover to identify themes but recent co-owners had left for a variety of reasons such as retirement and long-term sickness. We were told that they had not fully recruited to these posts but were continuing to work on this.
- Between October 2015 and October 2016, the staff sickness rate was reported as 18%. The small numbers of staff at the hospital means percetahge rates should be interpreted with caution.

Public engagement

- Co-owners provided appropriate patient information on the ward that was current and relevant for the elderly population. For example, about how to keep fit and prevent falls.
- Co-owners sought feedback from relatives and visitors and used this to improve services. For example, following patient feedback, co-owners provided blankets for patients when they were moving between the ward and the gym, which involved moving between buildings.
- Co-owners signposted patients and relatives to community groups, charities and organisations to support them with care and rehabilitation in addition to that provided by the hospital. This included two local patient representative and engagement groups. This was evident in the information provided in the ward and through our conversations with the multidisciplinary team and patients.
- Co-owners had an active relationship with a local League of Friends group. This group had provided resources for a quiet room on the ward, which could be used for private time and holding difficult conversations.

Staff engagement

- A number of regular activities took place to engage co-owners with the organisation and executive team. This included a monthly 'walkabout' by board members of the hospital, publication of a monthly electronic magazine, a bi-monthly leadership team day and a monthly 'spirit award' that recognised individual contribution.
- The organisation had involved co-owners in future planning, including in selection processes for a new chief executive officer and the mobilisation plan for the organisation's merger. Co-owners told us this was demonstrative of the approach of the senior team and they felt very much included in future planning as a result.
- Co-owner forums offered an opportunity for colleagues to get together and discuss challenges and successes in the organisation.
- Co-owner teams were assigned a representative as part of the organisation's "The Voice" programme of engagement for staff. This was part of a strategy to encourage each individual to participate in the delivery, development and evaluation of the service as well as empowering them to speak up when they had concerns or issues. The last co-owner survey identified room for improvement in the visibility of voice representatives and this was reflected in our discussions with co-owners, who did not always know about this.

Good

Are services well-led?

- Co-owners told us this identity meant they had accountability for the standard of their work and the experience of their patients. One co-owner told us it meant they approached problems collectively instead of passing it to someone with a different level of responsibility.
- We were told that emotional support and counselling for staff could be arranged through the occupational health department. An example was given by a member of staff who spoke about the support they received from the ward team.
- Although co-owners said they felt listened to and valued for their input and recommendations, there were areas in which they felt restricted. For example, due to the nature of the building contract, it was not possible to make substantive changes to the environment even if this was clinically appropriate. Co-owners told us smaller projects could take a disproportionate amount of time to organise, such as a whiteboard that was needed but had taken several months to be approved. In addition, a therapies gym had been approved for an area of the ward that was rarely used but co-owners told us this had been a very lengthy challenge to implement.

Innovation, improvement and sustainability

- The leadership team held a quarterly afternoon tea with student nurses. This event was used to understand the student experience and encourage them to continue their development to become registered nurses.
- The hospital team used placement feedback from student nurses to improve the experience of future students and to ensure the programme contributed to the future sustainability of the service.For example, an additional co-owner had been trained as a clinical mentor as a result of feedback and three student nurses had joined the organisation's central bank as nurses following their positive experiences as students.
- Co-owners were proactive in engaging with other community providers to share best practice and implement strategies to meet the needs of the local population. For example, a team from another local provider visited the ward to observe care and processes and identify how they could reduce their length of stay safely.
- The ward manager had been successful in securing funding to convert part of a lounge area into a dedicated physiotherapy gym. This would reduce the need for patients to move between buildings for therapy sessions and would enable the nursing and therapy teams to work more closely together.