East Cheshire NHS Trust

RJN

Community health inpatient services

Quality Report

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

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

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

Summary of findings

Ratings

Overall rating for Community Health Inpatient Services	Good
Are Community health inpatient services safe?	Good
Are Community health inpatient services effective?	Good
Are Community health inpatient services caring?	Good
Are Community health inpatient services responsive?	Good
Are Community health inpatient services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

There were processes in place for reporting and learning from incidents. Staff were clear about what incidents to report and how to do this. Managers were confident that incidents were being reported appropriately. Staff knew how to raise a safeguarding alert and were familiar with the Mental Capacity Act and deprivation of liberty safeguards. Staff had access to training and felt well supported. They had annual appraisals that identified training needs.

There were good joint working arrangements in place and team members were respected and listened to. Patients were treated respectfully, with sensitivity and patience, and were involved in the planning of their care and discharge. Services were responsive to the individual needs of the patients they were caring for.

Staff generally felt well connected to the trust and were clear about the purpose of the services they provided. External organisations had been used to help staff teams improve the quality of services they provided and we saw examples of local initiatives that had led to an improved service for patients.

Total staffing numbers were adequate at the time of our inspection but staff skill mix and registered nurse staff numbers was not always in line with the trust's planned figures. Bank and agency staff were used to cover staff vacancies and there were processes in place to ensure continuity of care as much as possible.

Summary of findings

Background to the service

East Cheshire NHS Trust provides inpatient community services at Macclesfield District General Hospital and Congleton War Memorial Hospital and has intermediate care beds based in nursing homes across Cheshire.

During our inspection we visited Aston unit at Congleton War Memorial Hospital and Langley ward (Ward 10) at Macclesfield District General Hospital. We also visited intermediate care beds based at Elmhurst Intermediate Care Centre, Hollins View and Station House Care Home.

Aston unit is a 28-bed ward. The ward has three female bays, one male bay, two single rooms and one double room. Langley ward is a 30-bed ward with approximately 25% (7 beds) for transitional care. The majority of admissions to both units are people from local hospital accident and emergency departments who require nursing care and time for rehabilitation before returning home or to an alternative placement. Some people are admitted from home. In addition to nursing care, the units provide intensive occupational therapy and physiotherapy interventions supported by rehabilitation assistants. As part of the rehabilitation process, staff encourage patients to take part in day-to-day living activities, to take an active role in their care and to be as independent as possible.

Hollins View is a residential short break service for up to 40 adults and includes 10 intermediate care beds that are managed by East Cheshire NHS Trust. Respite care is provided by a local social care provider. For the purpose of this inspection, we spoke only to intermediate care team members. Station House Care Home also has intermediate care beds; East Cheshire NHS Trust provides in-reach support services for people using these beds.

Elmhurst Intermediate Care Centre has 30 beds. The building is owned by NHS Properties. The unit manager and nursing staff are managed by another local trust while therapy staff are managed by East Cheshire NHS Trust. For the purposes of this inspection, we looked at therapy services only. The trust responsible for managing the service had been inspected by the Care Quality Commission in October 2014.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd: Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Care Quality Commission

The inspection team included: a CQC inspector and an allied health professional specialist adviser.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of East Cheshire NHS Trust.

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, we reviewed a range of information we hold about the core service and asked other

Summary of findings

organisations to share what they knew. We held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of adult community health services. Some people also shared their experiences by email or telephone. We carried out an announced visit from 9 to 12 December 2014.

During the visit we spoke with 25 members of staff who worked within the service, including nurses, occupational therapists and physiotherapists, social worker, a GP, the pharmacist, managers, healthcare and rehabilitation assistants and household services staff. We observed how people were being cared for and reviewed the care or treatment records of people who used the service. We met with people who used the service and with carers, who shared their views and experiences of the core service.

What people who use the provider say

We spoke to nine patients during our inspection. Everyone we spoke with told us that they were happy with the care they received.

One person said: "We are treated with kindness and patience. Staff are always kind; you never hear a harsh word." They told us that staff were usually very responsive when needed; sometimes, when they were short-staffed, patients might need to wait a little longer, but they were "never forgotten". The person felt fully involved in their treatment and plans to return home.

Another person said: "Staff are great and look after me. I have been here three weeks; I am looking at a home visit tomorrow." Other comments included: "I feel safe here"; "Everything is explained to me"; "Staff are caring, especially the physiotherapist who is brilliant. They look after us and we have a good laugh as well"; "They are always cleaning in here and I try to help by setting the tables."

Other comments we received included: "The care is wonderful; staff listen to me and involve me. I am encouraged to do things for myself"; "We decide the day before what we would like to eat and we have had plenty of vegetables and a good quantity"; "The ward is really good; staff are nice"; "Food is generally good; you get enough to eat"; "Food is really nice"; and "The staff can never do enough for me."

Good practice

Our inspection team highlighted the following areas of good practice:

Across all services we inspected we saw good multidisciplinary team and multi-agency working. There was good communication within and between teams through handover and staff meetings and multidisciplinary team meetings.

We saw good examples of discharge planning across the services we inspected that were a direct response to the wishes of patients.

Langley ward had improved the quality of care provided and reduced pressure sores through the development of a 'skin bundle' that had involved tissue viability and continence nurses.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Not Applicable

East Cheshire NHS Trust

Community health inpatient services

Detailed findings from this inspection

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

Good

Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

There were processes in place for reporting and learning from incidents. Staff were clear about what incidents to report and how to do this. Managers were confident that incidents were being reported appropriately.

Wards were clean and the outcome of the patient-led assessments of the care environment (PLACE) put the wards at Congleton and Macclesfield above the national average for cleanliness. Hand-washing procedures were followed and weekly hand-washing audits were undertaken. Equipment was checked regularly and staff told us that they had the equipment they required.

Processes were in place for the management of medicines and wards had good support from the pharmacy team. Staff were aware of how to raise safeguarding alerts and gave examples of when they had done this. Staff were familiar with the Mental Capacity Act and deprivation of liberty safeguards. We saw evidence of correct processes being followed when people were assessed as lacking capacity. There were processes in place to share information between teams and to ensure that necessary information was available to provide coordinated and effective care. Patient safety was maintained through regular risk assessments and the updating of care plans. There were structures in place to ensure good handover between staff.

Total staffing numbers were adequate at the time of our inspection but staff skill mix and registered nurse staff numbers was not always in line with the trust's planned figures. Bank and agency staff were used to cover staff vacancies and there were processes in place to ensure continuity of care as much as possible. Arrangements for out-of-hours medical cover were in place and staff told us that these generally worked well.

Detailed findings

Incidents, reporting and learning

- Staff were confident about reporting incidents, near misses and poor practice.

- Incidents were reported via the electronic incident reporting system for issues such as abuse from patients, medication errors and patient falls.
- Incidents were investigated appropriately and involved all relevant members of the multidisciplinary team. There was evidence of learning from incidents and actions taken to prevent recurrence. For example, at Hollins View a patient fall had triggered an investigation that highlighted a concern that nursing and therapy notes were recorded and kept separately. A review meeting was held and an action plan developed locally with a range of staff involved. This led to integrated notes and a clarification that therapy assessments would be filed separately so that they were easily available for social workers.
- Learning from incidents was cascaded via regular team meetings and handover meetings. We saw evidence of this from team meeting minutes.
- On Langley ward, we reviewed the notes for a person who had recently fallen. The notes contained the incident number and description of the incident. The notes demonstrated that actions had been completed, including informing relatives and conducting a risk assessment, and that the care plan had been reviewed and updated.

Cleanliness, infection control and hygiene

- All wards we visited were clean and well maintained. All staff were aware of current infection prevention and control guidelines.
- Data from the PLACE audit was better than the national average for both Congleton and Macclesfield hospitals, where Aston and Langley wards were located. One patient we spoke with onAston unit said: "It is as clean and tidy as it can be."
- Staff consistently followed hand hygiene practice and 'bare below the elbows' guidance. Personal protective equipment (PPE), such as aprons and gloves, was readily available and in use in all the areas we visited.
- Hand hygiene audits were undertaken regularly; these showed good levels of compliance with best practice.
- The minutes of the Aston unit team meeting in September 2014 gave positive feedback to staff regarding management of Clostridium difficile (C. difficile) due to the use of good infection control measures by staff. Notes of the October 2014 meeting recorded that consideration was being given to using disposable curtains around the beds to improve the appearance of the unit and as good infection control practice. This showed that staff were constantly looking at ways to improve their practice.

Maintenance of environment and equipment

- Equipment on Aston unit was serviced annually. The unit manager said: "We are very well off for equipment; we get fantastic support and we are asked every three months what we need."
- Aston unit was located in an older building and was cluttered due to a lack of storage space. Despite this, staff managed the environment well and this did not cause a problem. We saw household services staff wiping down equipment with sterile wipes.
- Therapy equipment on Langley ward was cleaned and checked by the rehabilitation assistant. The manual handling team undertook safety checks as required. We saw that equipment checks had been completed by the estates department and stickers were visible on hoists detailing the date of the last check.

Medicines management

- Medicines were provided, stored and administered in a safe and appropriate way.
- A member of the pharmacy team (a pharmacist or pharmacy technician) visited Aston unit three mornings a week. The pharmacist told us that when a person was admitted to the unit they checked the patient's medicines and completed a medicines history on the drug chart. They checked that the chart was up to date and correct and would talk to the patient to make sure that everything was in order. Similar support was also provided on Langley ward.
- A technician also visited the units at least weekly to check the medicines in stock and order any medicines required. The pharmacist undertook a regular audit of controlled drugs and also an audit of safe medicines storage.
- The pharmacist undertook a comprehensive assessment of the medicines that were prescribed to patients and did a weekly check of the drug charts. A member of staff told us: "The pharmacist provides good advice."

- We observed staff administering medicines and noted that the identity of patients was checked carefully prior to administration. We saw that staff explained to patients what the medicines were and what they were for.
- There were suitable arrangements in place to store and administer controlled drugs. We checked a random selection of controlled drugs in stock on Aston unit and in Langley ward and saw that these were in date and tallied with the stock noted in the controlled drugs book. We saw that records were completed correctly and up to date.
- Drug errors were reported to the unit manager and doctor and any additional required observations would be carried out. An incident report was also completed.
- We saw that a person was receiving oxygen treatment and found that this had been prescribed appropriately.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and knew who to inform if they had safeguarding concerns.
- All staff had completed safeguarding training. Staff confirmed that they had received training and could describe the different forms of abuse and the action they would take if they had any concerns.
- At Elmhurst Intermediate Care Centre we saw that a flow chart for action to be taken if staff had concerns was displayed on the multidisciplinary team noticeboard.

Records systems and management

- Care plans were individualised and nursing notes reflected identified goals. The care plans considered a wide range of issues, including mental health and social factors such as family circumstances and pets, and involved the all relevant members of the multidisciplinary team. Care plans reflected expected outcomes and discharge goals consistent with the purpose of an intermediate care service.
- There was comprehensive admission information from the 'handover team' which noted consent and capacity. We saw evidence of a wide range of assessments completed, including Waterlow (pressure sore risk assessment); mini mental states; MoCA (Montreal Cognitive Assessment); manual handling; falls risk; and MUST (malnutrition universal screening tool). Home environment and physiotherapy assessments and detailed reports showed evidence that mobility, transfers, balance and links to daily function were considered.
- We saw evidence of record keeping that included two-hourly checks completed throughout the patient's admission. Any actions taken were documented. Regular physical health checks were completed. Blood test results returned within 48 hours.
- Daily progress notes were completed throughout the day. These were person-centred and clearly related to the care plan. Notes also included a record of contact with carers.
- Where intermediate care services were provided within nursing or respite facilities, there were robust systems in place to ensure that information was accessible and shared between teams. For example, at Elmhurst only one set of notes was kept; therapists completed notes in the 'significant events' section and assessments were filed in the 'therapy' section of the notes. All staff knew where information could be found. Information on admission included an intermediate care assessment sent by NHS secure email; this contained relevant information and alerted the team to possible risks. Occupational therapists also did an initial screening that had been shown to improve outcomes for people.
- Notes were legible, comprehensive and written in a respectful way.

Assessing and responding to patient risk

- The unit manager on Aston unit informed us that patients often received pressure area care prior to admission to the unit. This meant that there was a high incidence of pressure ulcer reporting. A skin check was undertaken within four hours of a person being admitted to the unit. Any pressure ulcers identified as a consequence of the skin check were reported via the electronic incident-reporting system.
- A healthcare assistant on Aston unit told us: "Handover meetings are a good source of information about patients on the ward." A rehabilitation assistant told us that they received "good quality information about patients at handover meetings".
- Pressure ulcer risk assessment was undertaken, and, if the person was assessed as requiring equipment such as a pressure mattress or air cushion, this would be supplied. If the person spent a lot of time in bed, positioning charts would be used and people were

encouraged to eat and drink well. Barrier creams were available to use if it was noted that skin was becoming red. Staff were good at reporting the early signs. We were told that there were no problems in obtaining the necessary equipment.

- There had been a higher than average incidence of pressure ulcers on Langley ward when figures were compared with other local data. Root cause analysis had identified that pressure ulcers started as moisture lesions and that continence had not been managed. An analysis of falls had shown that they related to continence and toileting needs. As a result, work had been completed on developing a 'skin bundle' in conjunction with the tissue viability service and continence specialist nursing services. New documentation, a staff training package and a supply of continence aids had also been agreed.

Staffing levels and caseload

- The trust used a recognised adult acuity and dependency measurement tool to determine the appropriate levels of staffing required on Aston unit. A document reviewed by the trust board dated 27 March 2014 titled 'Nurse Staffing Establishments – Inpatient Services' stated that Aston unit was funded for three registered nurses (RNs) and five healthcare assistants (HCAs) for each early shift; three RNs and two HCAs for each late shift and two RNs and two HCAs for each night shift. Appendix one of the document shows that for week commencing 3 March 2014 there had been a shortfall of one RN every day for each early and late shift. This had been offset by increasing the number of HCAs on duty. The report states that as a result the "skill mix [was] incorrect but overall numbers as expected".
- At the time of our inspection we found there were nine staff in total on the early shift (two to three RNs and the rest HCAs); six staff on the late shift (two RNs and the rest HCAs) and four staff on the night shift (two RNs and two HCAs). This meant the number of staff on shift was correct but the number of registered nurses on shift during the day was not always in line with the trust's planned figures. (Although, this did not include the unit manager or the unit sister who was supposed to be supernumerary).
- This meant there was an average ration on an early shift of three patients to every member of staff but the ration of patients to registered nurses varied from nine to 14. This was not in line with best practice guidance.
- From January 2014 to July 2014, Aston unit had a sickness rate ranging from 14% to 7%. The unit reported a staff turnover of 2.5% from April 2014 to August 2014.
- At the time of our inspection, following successful recruitment, the Aston unit was fully staffed with healthcare assistants but there was a full-time nursing vacancy; this post was being advertised.
- Vacancies and absences put increased pressure on staff. Processes were in place to use bank or agency staff where possible. However, bank and agency usage for Aston Unit appeared to be low given the sickness/ absence rate and the ongoing registered nurse vacancy. Records showed nurse bank and agency use from January 2014 to August 2014 was less than 1%.
- Where possible, regular bank and agency staff were used to promote continuity of care and to minimise risk. New agency staff received a short induction to orient them to the service prior to commencing their shift. The Aston unit manager said: "The qualified staff supplied by the agency are excellent and fill you with confidence. Healthcare assistants tend to be regular bank staff to help ensure continuity of care."
- We saw that notes of staff meetings on Aston unit included a discussion about plans to trial a 'twilight' shift to help cover late and night shifts. This showed that the unit was looking at ways to ensure that consistent and safe staffing levels could be maintained.
- A therapist told us that acuity levels (the level of severity of illness) of people admitted to Langley ward had increased over the past year, and this had resulted in them not being able to give as much time to people. This was managed by prioritising workloads and focusing on the 'poorly' patients. This meant that it was not possible to see all the people every day, which they felt was a loss. They said: "It is very busy and hard and a bit frustrating [we] can't achieve the standards [we] would like because of staffing numbers."
- On Langley ward, medical cover was provided by a consultant who visited the wards two to three times a week and also joined the weekly ward round. A registrar visited most days and a senior house officer (SHO) was present on the wards five days a week. It was reported that when the SHO was on holiday or absent, this could be a problem, but the medical team was very supportive. Out of hours, the on-call doctors at Macclesfield provided support and the nursing team felt confident and competent to pursue actions as appropriate.

- Out-of-hours medical cover on Aston unit was provided by GPs; the unit sister reported that this was "generally working OK". If on occasion the doctor was unable to respond to the out-of-hours call in a timely way, people had to be transferred to Macclesfield District General Hospital. We were told that this could happen up to two times a month. As much as possible, the unit tried to plan ahead to avoid this happening.
- Out-of-hours medical cover at Hollins View was also provided by GPs. Nursing staff were trained to identify when accident and emergency was required and when the GP out-of-hours service could be used.
- Therapy staff told us that they felt the staffing establishment was "about right" when there were no absences. They provided a six-day service; when they were short-staffed, the 'at home' team would try to provide some support. On occasion, the therapy staff at Elmhurst would support the 'at home' team.

Deprivation of liberty safeguards

- When a patient lacked capacity to make decisions, staff consulted with appropriate professionals and others so that a decision could be made in the person's best interests.
- On Aston unit, all qualified staff had received training updates on the Mental Capacity Act and deprivation of liberty safeguards (DoLS); healthcare assistants were due to be updated.
- On Langley ward, the ward sister told us that staff were in the process of completing Mental Capacity Act training.
- Staff had knowledge and understanding of procedures relating to DoLS. Staff told us of examples where DoLS had been applied for and approved, and we reviewed patient records containing DoLS applications. We found that DoLS paperwork had been completed fully and appropriately.

Managing anticipated risks

- Winter pressure money had been approved to improve the ratio of therapy staff to patients by increasing staffing levels by one band 5 physiotherapist working flexibly 18.75 hours a week. There were no plans to increase staffing on a permanent basis in the near future. Therapists told us that, if they were short-staffed, physiotherapy support could be provided from the main physiotherapy department.
- The use of additional staff when a person had high dependency needs was supported by the trust.

Good

Are Community Health Inpatient 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.

Care was provided in line with evidence-based, best practice guidelines. Implementation of the 'skin bundle' on Langley ward had resulted in a decrease in spending on incontinence products, a reduction in pressure ulcers and a reduction in falls.

Outcome measures showed that patients had received appropriate care that promoted rehabilitation and independence. Scores from the outcome measures were fed back to practice forums and also reviewed in clinical supervision sessions.

Staff told us that they had access to training and felt well supported. The majority of received annual appraisals and regular supervision sessions. All staff told us that there was good multidisciplinary working. There was evidence of good multidisciplinary team working in all the services we inspected.

Detailed findings

Evidence-based care and treatment

- Care was provided in line with evidence-based, best practice guidelines.
- The trust intranet site had links to National Institute for Health and Care Excellence (NICE) guidance and email alerts were issued when guidance was updated or new information published.
- A staff nurse informed us that they had been involved in a joint learning audit the previous week when they had 'swapped' wards with a colleague and had given feedback on good practice seen and possible improvements. They told us that this had been useful and felt that both wards had benefitted. They gave an example of changes they would make when administering medicines.

Nutrition and hydration

- On Aston unit we observed staff interacting with patients at lunchtime. We saw that there was a friendly atmosphere and the environment was relaxed. Both staff and patients on the ward appeared to enjoy mealtimes. People were positioned with others of similar functioning and skills to encourage social interaction. Staff ensured that everyone had been given a meal and that they were eating. We saw discreet encouragement given to a patient who did not want to eat due to low mood.
- Food was prepared and cooked on-site so a wide range of dietary needs could be accommodated. Recently a patient could not have pork or derivatives of pork. This had been discussed with the kitchen and the person's needs had been met. The housekeeper also told us that it was possible to be flexible with regard to the preferences people had. For example, soup was given to one patient as an alternative to a midday meal as this is what they had always had and they wanted to continue with it.
- On Langley ward, one patient told us that staff were very conscious of the need for them to have fluids. They told us there was a choice of food and that, although the menu had not varied much, if they wanted something else they could have it. Another patient told us: "Food is generally good; you get enough to eat."

Approach to monitoring quality, people's outcomes and patient outcomes performance

- Various standardised outcome measures were used by the therapy teams, including the Barthel index, that measures independence and need for assistance in mobility and self-care, the Berg balance scale ,used to measure the balance of older adults in clinical settings, the Tinetti gait and balance assessment tool, the standardised Elderly Mobility Scale and the Canadian Occupational Performance Measure. Scores from the outcome measures were fed back to practice forums and also reviewed in clinical supervision sessions.
- The key performance indicator report for Langley ward for the period from April to August 2014 showed that the Barthel score was between 40.2 and 48.8 on admission and between 74.2 and 78.2 on discharge. The average for the period was 44.5 on admission and 76.6 on discharge. This showed that, during the period of admission, patients had become more independent.
- The ward had used an external service to undertake an audit of the service the ward provided. At the time of our inspection, the ward was waiting for the results but we

were told that verbal feedback provided had highlighted that the ward demonstrated good progress in helping people to be more independent through the improvement in Barthel scores from admission to discharge and also in providing care for people with co-morbidity.

- Implementation of the 'skin bundle' project following an increase in pressure ulcer prevalence resulted in a decrease in spending on incontinence products, a reduction in pressure ulcers and a reduction in falls. We were told that, as a result of the pilot, the 'skin bundle' would initially be used on two other wards.
- At Hollins View, there was a follow-up call after three months following discharge to see whether the person had stayed at home.
- At Elmhurst Intermediate Care Centre, we reviewed two sets of notes and saw that outcome measures used by occupational therapists and physiotherapists showed evidence of progress. We saw that, on a daily basis, staff noted evidence of people's progress in function through an assessment of personal activities of daily living (PADL) and domestic activities of daily living (DADL).

Competent staff

- The majority of staff received an annual appraisal and regular supervision sessions. Staff told us that the trust supported staff development and was "good on staff training".
- New staff received a trust induction and were supernumerary on the unit for the first two weeks. A staff nurse told us that they had started working on the unit three months ago. They reported that they were very happy with the level of support they received: "There was always someone to ask and support me." They told us that there had been two staff meetings since they had started work on the unit. This showed that new staff had a good induction to the ward environment.
- Mandatory training was mainly provided online. Lack of access to computers on the Aston unit sometimes made this difficult for staff. The unit manager told us that there were insufficient computers on the ward, but, following a large donation from a patient's family, they were planning to purchase an additional computer. This would make it easier for staff to access online training.
- Thirty-seven staff were employed on the unit and 25 of them had received an appraisal in the previous five months, with a further six scheduled for January. We were told that plans were in place for staff who had not had a recent appraisal due to sickness or absence.
- On Langley ward, there was a weekly meeting for band 7 staff and a monthly integrated care sister's meeting that the matron attended. Every three months there was a band 7 staff 'time out' session with the matron and deputy director of nursing present. A monthly ward staff meeting was held when possible, although we were told that this was sometimes not possible and therefore meetings were less frequent.
- A manager told us that they undertook management and clinical supervision for therapy staff on two sites (Elmhurst and Station House). They supervised 11 people and ensured that this happened every six to eight weeks. Copies of supervision meeting minutes were held by the member of staff and a copy was kept in personnel files. The manager received one-to-one supervision from a band 8 colleague at Station House every six weeks and reported good management supervision. They said they had limited access to one-to-one clinical supervision but that they had peer supervision with a band 7 colleague.
- Therapy staff received regular supervision every two to three months with informal supervision on an ongoing basis as required. All staff told us that they had had a recent appraisal and that these were always completed on time. There was support for in-house training but funding was harder to obtain for external training courses. Therapy staff told us that they were welcome to join training offered to the nursing team. All therapists were up to date with their mandatory training.
- At Elmhurst Intermediate Care Centre, therapy staff had access to local training such as end of life care through the local hospice, as well as dementia training. They told us that this training had been helpful and relevant to their work. End of life training was also included in mandatory training.
- The therapy lead told us that they had been nominated for a master's level management training module and were waiting to hear the outcome. They had also received in-house team leader training.

Multidisciplinary working and coordination of care pathways

Good

Are Community Health Inpatient Services effective?

- The manager on Aston unit told us that they had "excellent experienced therapists and good multidisciplinary team working". They reported good communication between staff through handover meetings and regular multidisciplinary team meetings. There was good informal communication within the unit. Therapists participated in best interest meetings when required.
- The weekly multidisciplinary team meeting on Langley ward included ward staff, therapy staff and a social worker. The meeting focused on discussing the patient's progress and reviewing their predicted discharge date. Planning for discharge began soon after admission. A review of two sets of notes showed that multidisciplinary meeting reviews had been undertaken weekly.
- Occupational therapy and physiotherapy staff worked Monday to Friday and rehabilitation assistants worked evenings and weekends; this ensured that treatment continued at these times. A therapist said: "I love my job … The team are really supportive and we work across boundaries."
- At Elmhurst Intermediate Care Centre, therapists described the service as putting the person at the centre of a very integrated team. There were weekly multidisciplinary team meetings. Close working between therapists and nursing staff with some overlap of roles meant that care and treatment were enhanced by working with the natural flow of the day. For example, the occupational therapist would help with breakfasts, which supported assessment of function. Healthcare assistants supported therapy staff.
- We joined the weekly multidisciplinary meeting that was chaired by the GP and attended by the unit manager, social worker, occupational therapist and physiotherapist. We observed good team working and clear decision making and saw that the opinions of each member of the team were valued.
- At Hollins View, a social worker told us that they felt there was a good level of integration between health and social care. The team had been successful in breaking down barriers and making decisions together. The weekly multidisciplinary team meetings were a particularly useful forum for decision making.
- At Station House, the manager reported a close working relationship between the care home (where six intermediate care beds were located) and the intermediate care team, with good communication mechanisms in place. A multidisciplinary team meeting was held weekly; this was attended by the nursing staff from the home as well as occupational therapy, physiotherapy, the district nurse, pharmacist and GP.

Good

Are Community health inpatient services caring?

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

Services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect. Patients were involved in planning their care and discharge. Throughout the Aston unit we saw 'No decision about me without me' posters displayed, encouraging people to talk to staff about any concerns they had in relation to their care and treatment.

Patients we spoke with were very positive about the care they received. Family and Friends Test results indicated that the majority of people were likely to recommend services as places in which to receive care and treatment. Patients were encouraged to be independent and to socialise with other patients.

Detailed findings

Compassionate care

- Services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect.
- We observed several examples of compassionate care. At Aston unit we saw a healthcare assistant treating a person sensitively and with patience during a transfer from the patient's wheelchair to an armchair. The member of staff explained what was happening and regularly checked that the person was feeling alright. After the transfer, the staff asked if the person wanted a cardigan and ensured that they had a drink.
- Friends and Family Test data for October 2014 showed that 50% of eligible responses had been returned and 100% of respondents said that they would recommend the Langley ward.
- Friends and Family Test data for October 2014 for Aston unit showed that 26% of eligible responses had been returned and 86% of respondents would recommend the ward as a place in which receive care and treatment. (0% of respondents would not recommend the ward).
- A patient described interventions by a range of staff, including physiotherapists, occupational therapists and a social worker. They told us that they understood the treatment they had received and felt that staff interactions were gentle but encouraging. They told us: "The staff can never do enough for me."
- A patient told us that when they had been admitted they felt very low, lacked motivation and were tearful and fearful. They explained to us that nurses had been supportive and were sensitive and responsive to their needs. Staff had reflected on the progress they had made and this had helped to motivate them further.

Dignity and respect

- During our visit to Aston unit, one patient particularly asked to speak with us. They said: "We are treated with kindness and patience; staff are always kind – you never hear a harsh word." They told us that staff were usually very responsive when needed. Sometimes, when the unit was short-staffed, they might need to wait a little longer, but they were "never forgotten".
- Another patient said: "I have been here five weeks. The staff are very good and I get looked after. The staff know what they are doing. I feel safe and cared for. Staff are polite and respectful all of the time. The physiotherapist is brilliant."
- On Langley ward, one patient told us that they were looked after very well and felt that they were treated with dignity and respect. They were happy with the treatment they had received.

Patient understanding and involvement

- Throughout the Aston unit we saw 'No decision about me without me' posters displayed, encouraging people to talk to staff about any concerns they had in relation to their care and treatment.
- One patient told us that they had been included in their discharge planning and understood why they were not able to go home and the challenges this presented. Two other patients told us that they understood the care plan in place and the treatment they received. Care was explained regularly and they felt involved in decisions made about their care.
- The ward sister on Langley ward told us that, three to four days after admission, one of the therapy staff sat with the family and the patient and used the family questionnaire to obtain a history and to clarify expectations regarding the admission. A therapist told us that there was good involvement with relatives via the family questionnaire, case conferences and

Good

Are Community health inpatient services caring?

meetings, as well as through meetings with relatives as part of the care plan development. We reviewed two sets of notes and saw that they included a record of contact with carers.

- We observed a person's discharge plan being discussed in the ward round. The person was given an opportunity to discuss with the registrar any concerns they might have.
- We spoke with a patient who described their treatment plan and how they had been involved in making decisions about their care. Another patient told us that they felt they were involved in their care and staff listened to their wishes. A patient described how their parents had also been involved in their discharge plan.
- Patients at Elmhurst Intermediate Care Centre held their own care plans and were involved in developing these. Patients and their families had full access to care plans. The care plan followed the patient. Two sets of notes we reviewed showed that the care plans were personalised and had been reviewed regularly.
- At Hollins View, funding for one year had been approved for the Advancing Quality Alliance (AQuA) to provide support to look at how the quality of care and safety of people could be improved. This work had identified the need for people to identify their own goals. Staff explained to the patient what the service was about and clarified the patient's understanding of independence. Goals the patient wanted to achieve were set, and these were reviewed after one to two weeks. People were allocated a keyworker within one day and it was expected that personal, measurable goals would be identified within three days. We saw evidence of consultation with the patient about their care. We saw evidence of patient-centred goals such as "I would like to dress myself independently" and clear care plans to support these goals. We reviewed two sets of notes and saw that these were comprehensive and written in a respectful way.

Emotional support

- The manager on Aston unit told us that emotional support was given to patients by staff taking the time to talk and treat people as individuals. All staff had developed good communication skills and got to know patients and the best way to offer support. Private areas were available for one-to-one chats.
- A staff nurse told us: "We give emotional support to families so when their relative goes home they don't need to worry. Our role is to talk to and support family carers." Records showed that discharge care plans were also written for carers.
- A chaplain visited Aston unit once a week to offer religious and spiritual care. We were told by ward staff that they would approach other faith leaders if required.
- In records we saw details of staff having worked proactively with a patient who was low in mood. They identified the progress the person made on a regular basis and allowed time for the patient to talk.
- On Langley ward, side rooms were available for patients who may be distressed and required emotional support.
- We observed the ward sister devoting one-to-one time with a patient so that they could respond to a concern about the person's social circumstances.
- At Elmhurst Intermediate Care Centre, we found that emotional factors affecting possible discharge were discussed during the multidisciplinary team meeting.

Promotion of self-care

- As part of the rehabilitation process on Aston unit, the staff encouraged day-to-day living and encouraged patients to go to the lounge area to socialise and to have meals in the dining room. Patients were encouraged to take an active role in their care and be as independent as possible. A staff nurse said: "I am happy here, patients and their families are happy. We see people with limited mobility leave mobile due to good team work. We have personal individualised care plans to help maximise people's independence that help people to go home and get back on their feet or have support with appropriate care packages."
- Team members at Hollins View told us that working within a social care environment provided good opportunities for patients to develop their independence. For example, patients were able to self-medicate (after assessment), which helped prepare them for their return home.
- The multidisciplinary team meeting at Station House included a discussion about the patients' progress and their level of independence. We heard examples of where telecare equipment was to be fitted to allow discharge home.

Good

Are Community health inpatient services responsive to people's needs?

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

Services were responsive to the individual needs of patients. We saw examples of staff responding through the use of 'passports' to patients who had difficulty communicating their wishes. This helped people tell staff about their needs, preferences, likes, dislikes and interests.

Support was available from other teams, such as learning disability, mental health and end of life teams, when this was required. Staff told us that there was good multidisciplinary working and we saw evidence of this at meetings we attended. This helped ensure that patients received care and treatment that were well coordinated.

There was good discharge planning that respected the wishes of patients. Telecare was used when appropriate to help people return home. Information was given to patients that included details of how to complain and there was reference to learning from complaints in staff meeting minutes.

Sometimes patients who did not meet the admission criteria were admitted to intermediate care beds. This would happen at times of 'red alert' due to a shortage of beds within the hospital.

Detailed findings

Service planning and delivery to meet the needs of different people

- The sister on Aston unit told us that patients with diverse needs could be accommodated on the unit. People living with dementia or learning disabilities had a patient passport and timely support was available from the mental health team for people with mental health needs. The unit had experienced therapists with experience of working with people with mental health needs and also people with a learning disability. There was good multidisciplinary team working. The psycho-geriatrician had a clinic on the same site, which was described as "very helpful".
- The unit manager told us that money in a trust fund had enabled a transfer aid to be purchased. This was the same as the one patients used when living at home, and so it enabled people to practise using the equipment while in the unit.
- Ward staff showed us the prompt cards they used to aid communication and we saw that information was available in 'easy read' format and large print.
- There was access to an interpreter if required. We were informed that leaflets in other languages were available.
- Langley ward was able to access a small store of bariatric equipment. There were some challenges due to a lack of supplies. It was also reported that it could be difficult to access the correct transport, which could result in slow or delayed discharge.
- Therapists on Langley ward had access to the necessary equipment for therapy and the therapy treatment area was suitable for patients' needs. The equipment available in the hospital did not match community equipment; this could be confusing for people as they were not able to practise with community equipment within the hospital. Staff went into the patient's home to assess their use of equipment.
- A therapist told us about the Falls Awareness Project. An occupational therapist and physiotherapist facilitated a short training course to help carers prevent and manage falls by their relatives.
- We joined a multidisciplinary team meeting at Station House at which it was noted that, following completion of an environmental assessment, a patient's guitar had been brought back to the unit. The patient had been able to play their guitar and this helped to increase their self-esteem.

Access to the right care at the right time

- The sister on Aston unit described the majority of admissions as "true intermediate care admissions". The 'gatekeeper' for the service was the intermediate care and discharge team, but on occasion their decisions could be overridden by the bed manager due to the need to admit patients to acute beds. On average, two such admissions could occur over a six-month period, but usually the beds were full and therefore not accessible. We were told that, on the day of our visit, all 26 admissions were appropriate.
- Staff told us that end of life care was not often required on the unit but support and training were available from the local hospice. When people were at the end of their life there was open visiting and the person would be

moved to a quieter area nearer to the nursing office. The unit manager told us that there was good support from the end of life team, and training was also offered. Some staff had also attended training provided by the local hospice.

- A patient told us that they had been discharged home from hospital after an operation and found they were unable to cope. They had explained this to the visiting community nurse on a Sunday and had been admitted to the Aston unit a few hours later. They told us that they had not thought it would be possible to be admitted so quickly.
- When the trust was on 'red alert', people who did not meet the admission criteria were sometimes admitted to the Langley ward. We were told that ward staff were involved in the decision-making process whenever possible but that such admissions happened "quite regularly".
- The senior sister reported that there could be peaks and troughs in the flow of people discharged from the ward, and that this could result in high numbers of admissions at the same time, which increased pressure on ward staff. Staff were trying to manage the flow of people through the ward by managing discharges in order to reduce peaks in the number of admissions. The senior sister told us that community services were investigating this.
- One member of staff told us that they had some concerns about some patients' lack of access to physiotherapy. The needs of patients admitted to the ward were not always consistent with the remit of the service. They told us that changes in acuity (the severity of illness) had had an impact on the level of personalised care it was possible to provide and the time available to promote independence. A therapist informed us that additional band 5 hours had recently been approved and felt this had been a positive response to the challenges they had identified.
- The intermediate care team assessed people to check whether it was appropriate to admit them to the Hollins View service; generally, people were admitted appropriately. The majority of patients came from hospital (a 'step down') but some were also admitted from home ('step up'). The team had a duty system in place and the team member on duty would complete the assessment.

Discharge, referral and transition arrangements

- A social worker on Aston unit told us that, as soon as a person was deemed medically well, work began on active discharge in conjunction with the therapists who undertook home visits. Usually there was no delay in home assessments being completed. They social worker explained that delays in discharge were primarily due to issues outside the service's control. Therapists told us that accessing basic equipment to support discharge was straightforward, but obtaining larger items of equipment was more challenging. Some discharges could be delayed due to a lack of bariatric equipment and transport.
- A patient told us that they hoped to go home in two days' time after being on the ward for two weeks. They had been on a home visit with the occupational therapist, who had gone through "everything I needed to do and checked aids and equipment I needed". A comprehensive care package had been arranged.
- We reviewed two sets of patient records on Langley ward and saw evidence of discharge planning detailing the support required, the reason for choice, of discharge destination, risks and any equipment required. The carer's views and the views of the person were also recorded.
- We observed a multidisciplinary team meeting at Elmhurst Intermediate Care Centre and saw that the meeting focused on the progress patients had made and reviewed predicted discharge dates and discharge plans. There was evidence of good discharge planning; this took a holistic view that considered psychological, emotional and physical factors to ensure that all of the person's needs were met. The use of telecare was discussed: that is, offering remote care to provide the care and reassurance needed to allow people to remain living in their own homes.
- Therapists told us that delays in discharges were due to a number of possible factors, most of which were outside the service's control. Timely provision of equipment could also result in some delays. Any equipment required as a consequence of a home visit assessment was ordered online. We were told that the process was a little unwieldy but work was in progress to streamline this.

Complaints handling and learning from feedback

Good

Are Community health inpatient services responsive to people's needs?

- On the Aston unit, patients were given a 'Welcome to Aston Unit' leaflet that included information about making a complaint or compliment. The leaflet also included information about unit values, hand hygiene and infection control, and identified staff and their roles.
- Staff described the process for responding to concerns and complaints and the systems for reporting these. Staff tried to resolve complaints locally if possible and had provided feedback at the staff meeting when issues were raised. We saw notes for the meeting held in November 2014 and saw that issues discussed at the meeting included learning from a complaint that had resulted in clear guidance for staff to follow.
- One patient on Langley ward told us that they were not sure how to make a complaint if they needed to. Staff told us that this information was included in the pack people were given when they were admitted.
- Another patient told us that, if they had any questions or concerns, they knew who to ask. They said that they had "no reason to complain though".
- At Hollins View, information on how to complain was included in the information pack. This pack was comprehensive and included details of contacts for Healthwatch and the Care Quality Commission.

Good

Are Community health inpatient 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.

Staff generally felt well connected to the trust and told us that they received regular information from the executive team. Teams were clear about the purpose of the services they provided and individual staff were clear about their roles within the team. Staff felt well supported and able to raise issues with their managers. They reported that they had regular appraisals and felt that they were valued members of the team.

We saw that regular audits had been undertaken and there was evidence of learning from incidents and complaints. External organisations had been used to help staff teams improve the quality of the services they provided and we saw examples of local initiatives that had led to improved services for patients. Where staff from different organisations were based within the same building, governance arrangements were in place to ensure the safety of patients and staff.

Detailed findings

Vision and strategy for this service

- The sister on Aston unit told us that they felt connected to the organisation at times but were not sure whether ward staff at Macclesfield Hospital had a clear understanding of what the service on Aston unit offered. They told us that the chief executive had visited and felt they "have a say and would be heard". The aim of the unit was to provide individualised, person-centred care incorporating the 'six Cs' in everything they did: care, compassion, competence, communication, courage and commitment.
- A director visited the unit every quarter and talked to staff; this helped to give the board a "grassroots feel of what is happening". Staff told us that the vision and strategy for the trust were printed on appraisal documents.
- A housekeeper told us that they felt communication from the trust had improved over the past six years but sometimes this "broke down". However, they felt connected to the trust through regular email updates and information available on the intranet.
- A healthcare assistant told us that they felt more isolated from the trust since working on the intermediate care ward. They did not feel that information filtered down to healthcare assistants regarding the trust vision. They reported that they had not seen much of the trust board.
- At Elmhurst Intermediate Care Centre, a therapist reported good communication from the trust regarding strategy and intermediate care beds and was able to feed this information to the staff team. They went to Macclesfield Hospital for training and felt connected to the trust.

Governance, risk management and quality measurement

- A weekly audit of care files was undertaken by unit managers. We saw details of the most recent audit undertaken by the ward manager on Langley ward. The audit included medication charts, risk assessments and care plans. The audit also included a weekly check of such areas as whether a safety brief was completed each day; whether the ward was clean and tidy; the fridge temperature checked daily; controlled drugs checked daily; and reasonable adjustments made for adults with a learning disability. The Barthel index of activities of daily living was completed on admission to and discharge from Langley ward. Key performance indicators were collected; these included numbers of admissions and discharges; average length of stay; destination on discharge; reason for admission; and Barthel score on admission and discharge. For example, from April 2014 to September 2014, the average length of stay for patients in intermediate care beds was 31.9 days.
- We were informed that the therapy team at Elmhurst Intermediate Care Centre worked to two sets of policies due to the joint nature of its management. (Clinical policies were provided by another local trust and East Cheshire NHS Trust provided human resource policies.) There were governance arrangements in place between the two organisations to ensure a clear and consistent approach and oversight.
- There were local risk registers in place that identified relevant risks that were monitored regularly.

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Are Community health inpatient services well-led?

Leadership of this service

- Teams worked closely together and had good informal support for emotional or traumatic issues. The sister on Aston unit reported that the matron was very supportive and visited the unit once or twice a week.
- Staff confirmed that they could take any issues of concern to the unit manager, who had an 'open-door' policy. Senior nurses on Langley ward reported that the deputy director of nursing responded quickly to concerns and the team felt well supported. Matrons provided clinical support.
- Senior nurses described the chief executive podcasts as informative and useful. They also felt connected through monthly staff briefings and the weekly online bulletin.
- Therapists at Elmhurst Intermediate Care Centre told us that they felt there had been great improvements in trust and team briefings to which the therapy lead was invited. They believed that improvements in communication were a result of feedback provided in the past and said "communication has been much better over the past 12 months".
- Therapists shared concerns that there was no specific professional lead for occupational therapy within the trust.
- Therapists at Aston unit told us that they sometimes felt distant from the trust due to the geographical location of the unit, but the service manager did visit the unit. They told us that they received information through the trust email system and intranet. They also told us that the team leader passed on information to the team.
- Therapists told us that senior managers had visited the unit previously but not very frequently. Staff told us that they felt the trust would "respond to issues that were serious enough".
- At Hollins View, there were regular team meetings and a monthly forum for sharing information from the trust; this was chaired by the service manager.

Culture within this service

- Staff told us that they felt listened to and were respected as valued members of the team. A social worker told us that they "love working on the ward – there is a good team spirit with good communication supported by a 'hands-on' manager. Support and advice is always available."
- Therapists at Elmhurst Intermediate Care Centre told us: "[They] liked being here", "I like my job" and "I am getting the best support I have ever had in this team." They told us they got on really well as a team; they supported each other and shared expertise.
- One member of staff told us that the trust had been very responsive to the difficulty they had in adapting to using information technology by giving them extra time to learn how to do this.

Public and staff engagement

- Patient satisfaction questionnaires were completed on discharge from Aston unit and support was given to patients to complete the forms if this was required. The completed forms were sent to the communication team and results fed back on a quarterly basis to the unit. The results of the survey were fed back at staff meetings.
- We saw the summaries of feedback received and noted that negative comments included: "improve heating in bathroom" and "waiting after mealtimes to go to the toilet". Positive comments were received in relation to quality of care and staff.
- Staff told us that they felt able to report concerns and would be supported in doing so. On Langley ward, a healthcare assistant told us that they were confident about whistleblowing but were not sure about the trust policy.
- The weekly bulletin 'Staff Matters' was distributed by email, with 'Staff Matters Light' as an easy, quick-read version.

Innovation, improvement and sustainability

- We saw evidence of ward managers and their teams working to improve the quality of the service they were providing. For example, on Langley ward the development of the 'skin bundle' (a pressure ulcer prevention initiative) had resulted in a decrease in spending on incontinence products, a reduction in pressure ulcers and a reduction in falls. We were informed that the 'skin bundle' would now be implemented on two other wards. The ward was using visual means such as the pressure ulcer cross to show how it was performing in key areas such as pressure ulcers.
- A staff nurse working on Aston unit had been involved in a joint learning audit the previous week when they had 'swapped' wards with a colleague and had given feedback on good practice seen and possible

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Are Community health inpatient services well-led?

improvements. They told us that this had been useful and felt that both parties had benefitted, giving an example of changes they would make when administering medicines.

- External organisations had been used to look at services and how these could be improved. For example, at Hollins View, funding had been awarded to enable the Advancing Quality Alliance (AQuA) to provide support to look at how the quality of care and safety of people could be improved.
- Minutes of meetings demonstrated an ongoing evaluation of the service provided. Meetings included a discussion of quality monitoring data and the trialling of new care plans and other documentation.
- A pilot initiated by one of the local clinical commissioning groups provided intermediate care beds in nursing homes (known as community intervention beds). Patients who required a short stay admission as an alternative to an acute hospital admission would continue to be managed by their own GP practice for a period of up to 21 days and would receive 24-hour nursing care. We visited Station House, where this initiative helped patients who required such treatment to access it closer to home. The intermediate care manager told us that it was hoped the scheme would continue in some form after the end of the pilot period.