Central Surrey Health Limited

1-199797673

Molesey 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)
1-506761990	Molesey Community Hospital	Molesey Community Hospital	KT8 2LU

This report describes our judgement of the quality of care provided within this core service by Molesey 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 Molesey Community Hospital and these are brought together to inform our overall judgement of Molesey 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, this core service was rated as good. We found the Molesey Community Hospital was good for safe. effective, caring, responsive and well led.

Our findings were as follows:

- Systems to report incidents were used effectively and when indicated, practice was changed.
- Patients received their medicines safely and there was good governance of medicines.
- 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 continual 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 together.
- Patients were very positive about their experience. They were treated with kindness, respect and dignity and were included in decisions relating to their care and treatment.
- Services were planned and delivered to meet individual need which 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.

However there were also areas where improvements needed to be made:

- Damaged Walls and floors need to be fully repaired. It is understood that Central Surrey Health has already discussed this with NHS property services who are responsible for this.
- The action plan following the fire risk assessment needed to be fully implemented with regular fire drills and evacuations carried out.

During our inspection we spoke with five patients who were using the service and two of their relatives. We spoke with 13 co-owners including nurses, doctors, and therapy and administrative staff.

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

Summary of findings

Background to the service

Central Surrey Health Limited is the registered provider for Molesey Community Hospital. The hospital provides a community inpatient service on one ward which has 12 beds. The services provided include palliative care and rehabilitation. Patients are admitted to community inpatient services from their own home or from acute hospitals. At Molesey Community Hospital medical cover is provided by local General Practitioner Practices.

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 Molesey Community Hospital and looked at the quality of the care environment and observed how staff were caring for patients
- Spoke with five patients and two relatives who were using the service
- We reviewed four feedback comment cards
- Spoke with 13 co-owners including nurses, medical staff, occupational therapist, physiotherapist, therapy technicians and administrative staff.
- Attended a multi-disciplinary meeting
- Looked at four care and treatment records of patients
- 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 extremely positive about their experience. A typical comment received was that the patient 'felt safe and cared for', 'my whole experience has been excellent' and staff were kind.
- Patients commented that they felt safe and cared for. "Everyone was helpful, kind and thoughtful", "Staff were very caring and treated me with dignity and respect, the environment is safe and hygienic". One patient stated, "My whole experience has been excellent".
- One relative described the hospital as a caring environment that had motivated, assisted, encouraged and supported their relative. A second relative who praised the caring approach and how they were given 'enough information' and were able to be part of the discharge process.
- Molesey Community Hospital received one review on the NHS Choices website, which was positive.
- One relative described the hospital as a caring environment that had motivated, assisted,encouraged and supported their relative.

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.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Management should continue to work with NHS property services to ensure environmental infection risks are mitigated by ensuring the building is maintained in good repair

Central Surrey Health Limited

Molesey 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 that safety at Molesey Community Hospital to be good:

- There were systems for the reporting of clinical and other incidents and co-owners were aware of these and confident in their 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 shared and practice had been changed in response to 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.
- Medicine management was 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.
- Statutory and mandatory training for co-owners was monitored. There was time made available for the completion of training and compliance was good.
- Staffing levels were maintained at an agreed level that enabled staff to meet the needs of the patient safely. 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 identifiedand recorded on the risk register. We saw examples of risk assessments that were regularly reviewed and noted that control mechanisms were in place.

However:

- There were infection and prevention risks as a result of the age and generally poor state of the building.
- There needs to be full implementation of the fire assessment action plan including fire drills and evacuations. Not all actions from the risk assessment appeared to be in place.

Safety performance

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient

'harm or harm free' care. The hospital collected data for the NHS patients, which the hospital are caring for on the day of the data input. The submission included data on patient falls, pressure ulcers, catheters and urinary tract infections.

- The hospital reported the occurrence of a new pressure ulcer in three months of the twelve month period December 2015 to December 2016. Falls resulting in harm occurred in two months out of the twelve months recorded.
- National benchmarking data from December 2016 indicated that the prevalence of pressure ulcers at Molesey hospital was significantly lower than the national average
- Staff we spoke with were aware of the NHS safety thermometer and discussed initiatives such as the 'safety cross' displayed outside the patient's bay indicating where falls had occurred so that staff were aware of the risk. We were told, and observed, sensor mats were being used on chairs and in beds to indicate when a patient might be moving without supervision and would be more at risk of falling.
- We observed a pressure alarm go off indicating a patient under observation was moving. We saw a member of non-clinical staff attend immediately as she was close by, a clinical member of staff then arrived and the patient was settled.

Incident reporting, learning and improvement

- 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.
- During the period October 2015 to October 2016 there were five expected deaths and one reported serious incident requiring investigation. Root cause analysis (RCA) was completed for the incident however the action log was not signed as complete. On discussion with co-owners it was apparent that actions were being undertaken and the action log needed to be updated. The provider subsequently informed us that the action plan was approved for closure by the local Clinical Commissioning Group on 27th January 2017.
- The community inpatient service used an electronic incident reporting system. All staff we spoke to were knowledgeable about the process and could tell us how and when to report incidents.
- We saw a monthly incident report for clinical co-owners information. There were four incidents related to Molesey Community Hospital. The accompanying narrative report described incidents and actions that were taken. The report was made available for clinical co-owners and gave an overview of incidents across CSH and enabled learning to be shared.
- We saw an annual report of the incidents reported and slips, trips and falls was the most commonly reported category of incident, accounting for 48% of incidents. The second most commonly reported category was related to pressure ulcers, including identification of a new ulcer or deterioration of an existing ulcer.
- We were told that if any incidents occurred the senior members of the team would lead the investigation. The ward manager and co-owners discussed incidents at handover and also discuss the investigation and learnings during the monthly team meetings. Conclusions and learnings were distributed to everyone in the service.
- We saw evidence of incidents being discussed at the privacy and dignity group and there were case studies for staff learning.

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 generally they were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.

Good

Are services safe?

- We saw the duty of candour was enacted in the RCA we reviewed.

Safeguarding

- The CQC received no safeguarding alerts or concerns in relation to Molesey Community Hospital between 19th October 2015 to 18 October 2016.
- We saw there was a robust structure and arrangements in place to safeguard adults and children from abuse. There were clearly designated leads for safeguarding titled safeguarding advisors that worked across Central Surrey Health and visited Molesey 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 band 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.
- Training rates for adult safeguarding level one and two were 100%. Safeguarding PREVENT training was 83.33%.
- We saw minutes of quarterly safeguarding meetings and we were told the report from this meeting is reviewed at the Quality and Clinical Governance Committee (QCGS).
- Safeguarding concerns and alerts were reported to Surrey Safeguarding Board and there were representatives from Central Surrey Health on that board.
- The safeguarding leads participated in appropriate working parties, which reported through to the QCGS.
- 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 Central Surrey Health (CSH) who worked across all three community hospital sites including Molesey Community Hospital. This role was advisory to clinical co-owners and patients and was responsible for the training of clinical co-owners and overall medicine management including leading the medicine management committee. This role gave oversight on medicine management policies, medication ordering, prescribing and audit.
- We saw evidence of antibiotic stewardship with a monthly audit checking which antibiotics had been prescribed, checking that guidelines had been followed. Results were variable and ranged between 50% and 100% compliance. The small numbers of prescriptions made the variance more evident. The corporate pharmacist told us that this was discussed at the governance meeting. Following the antibiotic audit we saw evidence of an email to prescribers showing results and asking for corrective action.
- In addition there was a service level agreement (SLA) in place with a local hospital to supply medication andto supply pharmacist support once a week. In between these visits, the pharmacist supported staff by email.

Good

Are services safe?

The GP covering the hospital was the prescriber. In addition, there was support from a corporate pharmacist who travelled between three community hospitals.

- We found the pharmacist ensured stock levels were maintained, made medication chart checks, reconciliation was completed and gave advice when necessary. We saw stock checks were done monthly. Medicines were delivered on same day as ordered and these were signed for.
- We found an appropriate person was the accountable officer for controlled drugs.
- Training records showed that nurses completed medicine management training and calculation competencies on joining the hospital. We saw that 86% of nurses had completed this training.
- Medicines were stored securely in locked cupboards or trolleys. We saw a medicine trolley was in use and was secured appropriately in the treatment room. The door to the treatment room had keypad entry and access to keys was controlled by the nurse in charge.
- We found that medicine cupboards were locked and when checked were orderly and tidy. There was evidence of stock rotation and no stock checked was out of date.
- There was same day delivery of drugs from the external pharmacy. For any drugs required urgently the clinical co-owners faxed the local trust hospital.
- The ambient temperature of the room where the medicines were stored was checked with no omissions which meant that medicines were stored at appropriate temperatures.
- 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 saw that FP0 prescriptions were stored in a locked cupboard. A record was kept of the prescription numbers when issued in line with national guidance from NHS Protect.
- We checked eight medicine charts and saw that prescribing was in line with national guidance. We saw that charts were marked as being reviewed by a pharmacist who had documented input regarding the medication. There were no omissions in giving medicines.
- There was a list of clinical co-owners signatures where drugs were dispensed in order to provide an audit trail in the case of any medication issues.
- We looked at CDs (medicines liable to be misused and requiring special management) and we saw these were checked once a day and records confirmed this with no omissions. We saw a limited stock is held and on a random check of one drug the stock balance was seen to be correct.
- We saw that delivery orders were signed and an audit trail for one drug was seen to be correct. There were appropriate arrangements were in place for the destruction of CDs. We also noted that the establishment is exempt from a home office license as they are a social enterprise.
- Medication storage, prescribing and administering checks were made weekly on five charts and we saw that the results were consistently close to or at 100%.
- Pharmacists, co-owners and GPs had access to the same electronic patient records system. This was implemented following issues whereby patients were issued with out of date prescriptions after they were discharged home. Shared access to the system meant prescriptions could be tracked and reduced the risk of medicine errors.

Environment and equipment

- Molesey Community Hospital is the oldest of the community hospitals in the Surrey Downs area. The building is old and the current layout is outdated and in a generally poor state of repair. The maintenance and upkeep of the building externally and internally is the responsibility of NHS Property Services (NHSPS) Ltd. Correspondence has shown there to be ongoing discussions between Central Surrey Health and NHSPS regarding the environmental needs for Molesey Community Hospital. The grounds of the hospital were noted to be clean and tidy.

Good

Are services safe?

- 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 87% below the national average of 93%.
- Co-owners received health and safety training as part of the statutory training programme and this showed a compliance rate of 92%.
- Co-owners described systems for reporting concerns and repairs to us and told us that problems were addressed in a timely manner. On call arrangements for maintenance and the estate maintenance log was seen.;
- The general ward area, patient bays, kitchen and corridors appeared to be clean and tidy but parts of the general environment was in a poor state of repair. In particular we noted the dining room had areas where the integrity of the wall was not complete with small holes in the plasterwork. This would be an infection prevention and control (IPC) risk. The phone point in this area was broken and not made secure. This area was carpeted and appeared to be clean.
- All patient chairs were wipeable in line with hospital building note (HBN) 00/09.
- In one patient toilet we noted that the floor was in a poor state of repair and the floor of the dining room store room was damaged and not completely repaired by masking tape that was not fully stuck down. Department Department of Health Building Note (HBN) 00-09: infection control in the built environment, says, "Flooring should be seamless and smooth, easily cleaned and appropriately wear-resistant". Flooring that has tape in place or is damaged can harbour dirt and dust and make the cleaning difficult. Therefore, the hospital was not meeting this requirement.
- The staff toilet wall had small holes in the plasterwork. In one of the sluices sluice we saw that wood surfaces were not sealed we saw exposed plasterwork and holes in the wall. In the walk in shower area the chipboard casing by the window was exposed and warped. The incomplete integrity of the walls posed an infection prevention and control risk.
- In the reception area, dining room store room, linen room and treatment room we saw storage of boxes on the floor which would make cleaning of these areas more difficult and would therefore present an infection risk. In the store room there were boxes stored on the floor and the floor was damaged and repaired with tape.
- Sluice areas were checked and commodes stored in this area were clean. One macerator was out of use meaning that waste had to be carried along the corridor to the second sluice. We did see evidence that this had been reported but not prioritised as urgent.
- We checked six pieces of clinical equipment and four non-clinical pieces of equipment and found these to be clean, serviced and tested. A label provided a visual check that they had been examined and were safe to use.
- In the assisted bathroom we saw that regular water flushing was carried out to minimise the risk of legionella.
- There was a gym area available for patients to receive therapy. However this was located away from the ward area and we noted the therapist could be quite isolated at times, especially when the technician was absent. We saw a call bell which meant the therapist could summon assistance.
- Patients had access to an outside patio with sitting areas and direct access from each communal bay and most private rooms. In warm weather patients could use this area for rehabilitation exercises and to relax in the fresh air.
- We saw that emergency equipment was available including an automated defibrillator and grab bag containing required equipment and that daily checks were made with no omissions. First line emergency drugs were available. Oxygen cylindres were stored safely and in date.
- At main reception there was an up to date list of first aiders and fire marshals. We saw records that showed a fire alarm test was done every week and there were no omissions in the checks. Two fire extinguishers were checked and in date.

Good

Are services safe?

- Co-owners were responsible for securing the building at night and two individuals completed a security sweep each evening to ensure patients and the co-owner team were safe. Night lights were used on the ward to reassure patients and to help co-owners monitor them
- A fire risk assessment in February 2016 resulted in a 45-point action plan for improvements to fire safety that were to be completed by April 2016. There was limited assurance improvements had been made during our inspection. For example, the fire exit from the gym was still partially blocked and an escape ramp was still coated in moss, which the risk assessment had identified as a slip risk for people evacuating the building. The last documented fire drill was July 2013 despite the risk assessment identifying this as an area of priority to be rectified. Although a fire marshal was in post, they told us the last planned fire drill had been cancelled and had not been rescheduled.
- We received an up to date copy of the fire risk assessment following the inspection including a report dated December 2016. The action plan showed all areas of concern were either complete or in the process of being completed.

Quality of records

- Records were stored securely in accordance with the Data Protection Act 1998 and were accessible to clinical co-owners when needed.
- Co-owners were aware of their responsibilities in relation to information governance and 92% had completed training in this area.
- We viewed four sets of patient records and saw a good standard of record keeping. The records contained all required information such as admission details, signature list and consent to treatment.
- The care records included multidisciplinary input where required for example, entries made by physiotherapist, occupational and mental health practitioner. Progress notes were complete, clear, legible, dated and signed.
- We saw results of a record keeping audit dated September 2016, with two areas of non-compliance. There was an attached action plan but it was not clear that actions had been completed.
- Three do not attempt cardiopulmonary resuscitation forms were seen in patient records, appropriately filled out, signed and dated in line with guidance published in 2016.

Cleanliness, infection control and hygiene

- In the PLACE audit 2016, Molesey Community Hospital scored 96% for cleanliness, worse than the national average of 98%.The PLACE audit was completed in October 2016 and we saw a detailed action plan which showed what actions were underway to improve compliance.
- Cleaning checklists for each day were completed and we saw examples for the current and previous month. We saw there was a completed deep cleaning schedule for the ward area. Records showed that cleaning standards were audited monthly and scores showed a satisfactory level of performance with compliance at 97%.
- We saw evidence of an environment audit being done in August 2016 an action plan resulting from this audit was seen to be fully complete. 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 and there were 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, records that showed that there was overall compliance rate of 83%.
- The ward manager had implemented a weekly cleaning audit for nurse co-owners as an additional measure to the work undertaken by the cleaning contractor. This enabled co-owners to manage a challenging environment and included tidying responsibilities for each individual. We saw weekly tidying of areas was done and signed. Mattress checks were completed. Disposable curtains were regularly changed and dated in line with guidance.

Good

Are services safe?

- We saw that co-owners used personal protective equipment when appropriate.
- Co-owners decontaminated their hands in line with the World Health Organisation's guidelines (Five Moments for Hand Hygiene). Hand washing sinks were available with sanitising hand gel through the all the areas we inspected. We saw posters of 'hand washing technique' displayed and witnessed that staff used good handwashing techniquecompliant with Health Protection Agency (HPA) guidelines. The most recent hand hygiene audit dated November 2016, showed the ward achieved 100%, much better than the target of 95%.
- We were told any patients needing isolation would be moved from the general ward area and nursed in one of the side rooms, but were unable to test this during our visit.
- 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. We saw recent IPC meeting minutes and these were available for the clinical co-owners.
- 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.
- There were appropriate systems and arrangements for the segregation and disposal of domestic and clinical waste. There were good processes in place for sharps management which complied with the health and safety Sharp Instruments in Healthcare Regulations 2013.
- We saw that patients had access to infection prevention and control information in the patient information files that were kept at the bedside. We observed that patients were given hand wipes prior to their meals.

Mandatory training

- Statutory and mandatory training was monitored and all co-owners were expected to attend on an annual basis. Records indicated that statutory training compliance was 90% and mandatory training compliance was 70% worse than the target of 100%. However, the small numbers of staff at the hospital would adversely affect percentage calculations.
- 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, safeguarding 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 saw evidence that time was allocated for co-owners to attend training and that a current record was available for co-owners to check. We were told that training compliance was discussed at team meetings and at appraisals and saw evidence of this in team meeting minutes.
- One member of locum staff that was working at the hospital long term had all their training done by the supplying agency and went to complete a hospital induction.

Assessing and responding to patient risk

- We saw comprehensive risk assessments were carried out on patient admission and kept in the patient records. This included assessing the patient for example 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, risk assessments had been regularly reviewed and we noted that specific control mechanisms indicated were in place.
- We saw on the notice board there was a floorplan of the ward with markings where falls had occurred, this enabled staff to realise the areas of risk in the ward area. We saw that the ward had a number of bed and chair sensors that could be used if the patient was at risk of falling.

Good

Are services safe?

- We saw an initiative of using coloured wristbands to enable co-owners to easily identify how much support patients needed when walking. For example, a green wristband indicated the patient was independent, a yellow wristband indicated the patient required supervision and a red wristband indicated the patient needed assistance. We spoke with 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 with were positive about this initiative and said it helped them monitor patients more easily.
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and the other towards the end of the day.
- 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 generally the NEWS score was calculated consistently and accurately. Co-owners we spoke with were confident that NEWS was established and would effectively highlight patients at risk.
- Co-owners introduced a 'cohort' system to the ward as a strategy to reduce the risk of falls overnight. This meant patients with similar risks were cared for in the same bed bay so they could be observed together more closely. For example, the bay nearest to the nurse station was used for patients at high risk of falls and during the night a co-owner was based within viewing distance of the area. This enabled them to identify if patients were trying to get out of bed or were unsettled more quickly.
- The Health and Safety folder contained an annual inspection report, risk assessments for all areas and a health and safety action plan that was completed. There was a health and safety checklist which showed that there was continual surveillance in place.
- Medicines and Healthcare Product Regulatory Agency (MHRA) alerts were a standard agenda item on the medicine management committee and we saw this in meeting minutes.

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 managed using a risk based approach depending on patient numbers and acuity. Activities on the ward for that day were taken into account.
- We looked at off duty rotas over the last two months and saw that during the day the nurse to patient ratio was 1:3 in line with The Royal College of Nursing guidance on Safe Staffing for Older People's Wards (2012) which suggests ratio of staff to patient should not exceed 1:7 and at an optimal level should be 1:38 depending on acuity. We noted 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 cancels at the last minute there is an endeavour made to cover this shift however we could see by looking at the staff rota it was not always possible. We could see that this happened rarely.
- We were told that if more staff are required there is a named agency that they book staff from and they will try to ensure continuity of staff. A flexible workforce co-ordinator assisted with finding staff.
- Patients we spoke with felt their requests for help were responded to promptly.
- Staffing levels for therapy staff was seen to be adequate with a Monday to Friday service and the therapist supported by a technician. We noted use of long-term locum staff to cover therapy services.
- Medical cover was seen to be provided by local General Practitioner medical practices with two GPs providing most of the daily cover based on the ward area from 8.30am. In the evening the GPs offered an on-call service. Other out of hours cover was provided by a third

party provider. We observed that the medical staff member was doing a ward round and were told this is done daily in order to assess patients changing conditions and their treatment needs.

Major incident awareness and training

- We saw Molesey hospital had a major incident plan with an action plan kept on the ward. However when we asked a co-owner said they were unaware and could not locate the plan. We were told they would phone their manager. A second co-owner we asked was aware of the contents of the major incident plan folder.
- The staff told us that major incident plan training was carried out 'a while ago' and there were no scenarios carried out to test the robustness of the plan. .
- We were told there had been no fire evacuation exercises for 'a couple of years'. We were told that the fire officer from the local trust hospital were going to arrange an exercise at Molesey Community Hospital and this was scheduled on an action plan we reviewed.

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 patient's needs by providing food to meet modified diets and those with cultural or religious needs.
- There was a continued focus on the professional development and ongoing clinical competency assessment for co-owners at all levels.
- Co-owners undertook an annual appraisal and a professional development review (PDR).
- Patients were cared for by a multidisciplinary team including a tissue viability nurse, a mental health practitioner and specialist Parkinson's nurses.
- Consent to care was documented consistently and care was provided in line with the requirements of the Mental Capacity Act (2005). Care plans and guidance policies were available for staff to provide care to patients with a Deprivation of Liberty Safeguards authorisation in place.
- A dedicated specialist nurse from the local authority worked with co-owners to coordinate complex discharges, including facilitating a multidisciplinary approach to patients with complex social needs.

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.
- Between April 2016 and September 2016, clinical and non-clinical teams conducted 26 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 initially. 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 observed in practice. The physiotherapy team assessed patients for pain during rehabilitation sessions and provided pain relief in advance of planned therapy sessions, which we saw in practice.
- 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.
- All of the patients we spoke with said they felt staff had managed their pain relief well.

Nutrition and hydration

- 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 and continuous availability of drinks. 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. A community dietician was available to review each patient at home after discharge on referral.
- We observed that patient's coming back from treatment were made comfortable and were given fluids.
- 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 log book of food temperatures, which were recorded consistently.
- Catering staff maintained an up to date record of special diets that were required for patients and 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 at regular intervals. This helped patients to stay hydrated and provided them with an opportunity to interact with each other and socialise.
- The catering provider displayed allergy and ingredients information in an easy-read format and this was readily available.
- The hospital had been awarded a maximum five star rating from the Food Standards Agency for food hygiene and safety, structural compliance and management.
- The hospital participated in the patient-led assessments of the care environment (PLACE). In 2016, the hospital scored 99% for satisfaction and experience of food service.

Technology and telemedicine

- As a strategy to improve the accuracy and continuity of discharge notes, the hospital had introduced the same electronic records system that was used by local GPs. This meant when a patient was discharged, their home GP could access their notes and information immediately. This ensured continuity of care and reduced the risk of medicines errors because GPs could see the prescription each patient left the hospital with.
- 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

Good

Are services effective?

- 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 progress notes. The results for Molesey Hospital showed no 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, Molesey Community Hospital demonstrated an average 20 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, Molesey Community Hospital reported an average length of stay of 21 days, which was better than the national average of 28 days. The unplanned readmission rate was 4%, which was better than the national average of 7%.
- 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 and agency nurses were given an induction and orientation that included emergency procedures and escalation pathways. 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 staff 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 detailing their induction.
- The ward manager used a 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 syringe drivers, phlebotomy, female catheter care and the aseptic non-touch technique. We reviewed competency documents to confirm this.
- In the 12 months prior to our inspection, 82% of co-owners had undertaken a professional development review and 91% of co-owners had an up to date appraisal. 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.

Multi-disciplinary working and coordinated care pathways

- We observed a twice-weekly operations meeting that involved nurses, a GP, a mental health practitioner and a local authority nurse specialist. There was a clear focus on discharge planning and assessing patient safety in the context of this.
- Co-owners had access to specialist input, including a geriatrician, pathology service and diagnostic imaging.
- A dietitian was based in the community team and could assess high-risk patients. Each patient was also reviewed by the community dietitian once they were discharged home.
- 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.
- 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 into 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.
- The service had facilitated an innovative new relationship with a community specialist nurse from the local authority. The nurse acted as a discharge liaison between the hospital and community adult social care providers. They attended daily operational and patient review meetings and worked with the ward manager, nurses and therapies team to coordinate appropriate discharges and packages of care.
- Occupational therapists were available and were focused on discharge planning. There was limited scope to support patients in functional practice of daily activities such as washing and dressing or opportunities for socialising.

Referral, transfer, discharge and transition

- Senior co-owners worked with staff in acute hospital NHS trust accident and emergency departments to reduce inappropriate transfers. This included where patients were transferred to the unit without complete records or a full discharge review of their medical condition and needs. In addition, patients were sometimes transferred without a nurse with them, which meant co-owners did not receive a full nurse to nurse handover. In such circumstances co-owners followed an escalation pathway to the acute hospital site manager to obtain critical information needed for the patient. Co-owners were proactive in submitting incident reports in relation to potentially unsafe admissions.
- A specialist community nurse supported patients with complex health and social care needs to leave the inpatient ward with an appropriate package of care in place. This individual coordinated with the multidisciplinary community team, GPs and nurse co-owners to plan discharge as part of the admissions process. This included assessing patients for NHS continuing care. The discharge coordinator used a continuing care checklist that included a decision support tool to ensure referrals were appropriate and in the best interests of patients.
- A weekly discharge meeting included input from the community nurse, ward nurses and a GP. Families and patients were involved in discharge planning and were invited to join the meeting. We saw this in patient notes and in the minutes of meetings. When preparing for patient discharge we were told that patients could be discharged to either to their home, nursing or residential home and that staff would discuss this with the patient first but include appropriate family members.
- Delayed transfers of care were significantly better than the national average, at 4% compared with 10%.

Access to information

- GPs had access to the electronic patient record system, which meant discharge summaries were immediately available when patients left the ward.
- Co-owners and GPs had access to a picture archiving and communication system that enabled them to access diagnostic results electronically.

Good

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There was an up to date 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 for reference. The GP we spoke with was also aware of their responsibilities under the MCA and in regards to DoLS.
- We saw that clinical co-owners 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.
- On the day of inspection no patients had DoLS in place. The hospital had submitted seven DoLS applications, including one urgent application, 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 this. 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 was evidence best interests decision meetings had taken place between appropriate professionals and mental capacity assessments. Co-owners used a DoLS decision-making tool to help them identify when an authorisation might be needed.
- 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 areas of good practice in the completion of the mental capacity assessment process and liaising with the next of kin of patients. Amongst co-owners at this hospital, 67% were able to explain what constituted a DoLS and 100% able to explain what they would do if they thought a DoLS was required.

Good

Are services caring?

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

Summary

Overall we judged caring Molesey Community Hospital to be good. This was because:

- Patients were extremely positive about their experience. Patients told us they were treated with kindness and compassion.
- We observed that staff were thoughtful in their approach to patients and carried out personal care in a respectful way. We saw that patients were encouraged to remain independent.
- We saw patients were included in discussions and decisions relating to their care and treatment.

Compassionate care

- We observed that patients were treated with kindness and respect during our inspection. During conversations with each other, staff talked compassionately about patients and their circumstances.
- Molesey Community Hospital 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.FFT information was displayed in the staff office and the staff we spoke to were aware of the process and results of gathering this information.
- We saw monthly results from November 2015 to November 2016 and the percentage of patients that would recommend the hospital to family and friends ranged from 100% to 62.5% with an average score of 93.5%. However, caution is required in interpreting these results, as often the sample size was small.
- During our visit we spoke to five patients and one relative who were very positive about the care they received.
- We observed the nurses being kind and compassionate in their care. We saw that curtains were pulled round the patient bed when personal care was being given to ensure a patient's privacy and that permission was asked before any member of staff entered the area around the bed.
- Throughout our inspection we witnessed kind and thoughtful staff interaction with patients. We observed how the clinical staff assisted patients with patience and compassion. For example we observed that patients coming back from treatment were made comfortable and given fluids.
- We reviewed four patient feedback comment cards all of which were positive.
- There were no instances of mixed sex accommodation as male and female patients were looked after in single sex bays.
- Molesey Community Hospital achieved a score of 73% in the patient led assessments of the care environment (PLACE) audit 2016, for treating the patients with privacy, dignity and wellbeing, which is below the organisational average of 76% and worse than the national average of 84%. We saw a corporate action plan that addressed all areas of noncompliance within the PLACE audit with a list local actions, who was responsible and dates for each action to be completed.
- Co-owners demonstrated kindness and compassion when supporting patients and their relatives during end of life care. For example, one patient had been cared for in a room in which the window blind was broken. This increased the temperature to uncomfortable levels and the nurse in charge could not obtain support from the estates team. To help the patient and their relative feel more comfortable, co-owners pinned up a blind themselves to help reduce the temperature and provide some privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients told us they were included in discussions and decisions relating to their care and treatment and this was recorded in the patient records we reviewed.
- We spoke to a patient's relative who praised the caring approach and how they were given 'enough information' and were able to be part of the discharge process.

Good

Are services caring?

- 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.
- The occupational therapists had developed a visual information board to demonstrate to patients and their relatives the types of therapy provided. This included guidance on constructing action plans for the home, such as to prevent falls and how to get help if they experienced a fall.
- There was a strong ethos of promoting independence and rehabilitation and all patients were encouraged to be up and dressed out of bed for meals. We saw that staff took time to ensure the patient was ready for their meal times, all patients were walked to the dining room for lunch. Patients were allowed to make their way in their own time and were given a choice of where to sit.

Emotional support

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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 response 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.
- 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.
- Co-owners had developed knowledge and strategies for providing end of life care in response to an increasing number of patients on such a pathway.
- 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, including in standards of communication.

Planning and delivering services which meet people's needs

- Facilities were provided for patients and relatives including a quiet room, chapel and outside patio areas for use in good weather.
- Patients were given an information pack on admission that included a pictorial diagram of co-owners and their responsibilities as a well as a photograph of each individual they might meet during their care.
- Co-owners were working with a Clinical Commissioning Group project manager to establish a 'step down' project that improved the assessments of clinical and social needs through their care pathway between the hospital and adult social care. This meant patients with complex social needs had a structured, planned discharge and package of care that enabled them to leave the hospital and return home safely. The step down project facilitated hospital staff, community teams and social care services to work together to reduce the amount of time patients needed to spend in hospital. The project supported the movement of patients to their next place of care, such as a nursing home. This enabled patients to move more effectively through the service and provided a full assessment that extended from the hospital to the nursing home. The project manager attended patient review and discharge meetings in order to identify patients that are appropriate for this.
- 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.
- The CCG had facilitated a public consultation with the local community regarding the future of the hospital. The provider had supported the CCG in this and played an active role. As a result, it was decided to maintain the hospital with its established inpatient and rehabilitation services.
- Staff had modified the ward environment to help patients relax and facilitate them taking part in activities. This included open space for patients to play games, socialise, exercise and read.

Equality and diversity

- 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.
- 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.
- Food was available that met cultural and religious needs such as Kosher and Halal meals

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- A learning disability team was available locally and provided support on referral. This included supporting patients and staff to communicate and providing resources to help patients relax and encourage their rehabilitation.
- Co-owners had developed knowledge and strategies for providing end of life care in response to an increasing number of patients on such a pathway. This included taking intensive training and working with community nurse teams to meet individual needs.
- Records showed that intentional rounding was in place and we saw evidence in the patient records that at night the patients are checked on an hourly basis to ensure they were safe and comfortable.
- Services, processes and resources were in place to support patients living with dementia. For example, reminiscence materials were available on the ward. Co-owners had completed their training for this and were awaiting its delivery.
- Co-owners used the Alzheimer's Society 'This is me' tool to document patient's preferences and understand how they could provide individualised care.
- 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.
- 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 could trigger a full MCA assessment or DoLS application.
- For those patients that were identified to have cognitive impairment such as dementia, we saw evidence of an initiative called '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 use of red walking frames as part of a pilot study being done to enable easy identification of patients with dementia.
- Although the service did not provide pictorial menus for patients, a nurse sat with patients with visual or cognitive impairment before each meal to help them choose from the menu.
- 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.
- We observed staff attending to patients' hair and supporting them in exercising in-between sessions with the therapist. This showed staff responded to patients' individual needs and circumstances.
- There was no formal activities programme and there were limited resources for stimulation when the therapies team was not present.

Access to the right care at the right time

- Between January 2016 and December 2016, the average bed occupancy was 93% 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.
- The provider did not collect information in relation to delayed discharges and planned to implement a process to do so from January 2017.

Learning from complaints and concerns

- A patient information folder was available at each bed space, which contained information asking patients to give feedback and contained information on how to raise a complaint. This meant patients and relatives knew how to complain because they had access to information they needed

Good

Are services responsive to people's needs?

- Between October 2015 and October 2016, the inpatient ward received three formal complaints. One complaint was upheld, one complaint was partly upheld and one complaint was not upheld. In each case the hospital team identified learning from the investigation and used this to improve practice and care. For example, co-owners encouraged patients and their relatives to have the confidence to talk to them during their stay to discuss any issues or concerns. The ward manager also asked one complainant to reflect on what nurses could have done differently in the circumstances of their complaint so they could discuss this with the team.

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. 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.
- 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, including in identifying strategies to reduce risks.
- 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

- There was a clear leadership model. A head of community hub led the inpatient services, with day-to-day clinical practice and the operation of the ward led by a ward manager. Both 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 interim director visited the ward at least one day per week and support could be obtained 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.
- The head of the community hub used a daily walk around 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.
- The ward manager was 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.

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 Committee (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 Dorking and Epsom sites. This was a multidisciplinary clinical governance meeting and included the physiotherapy, occupational therapy and heart failure leads. We looked at the minutes of three meetings and saw they were well attended with clear actions followed up afterwards.
- 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

- Co-owners spoke positively about the working culture of the organisation. One individual said the relationship between nurses and GPs was very positive and it was clear that a good working atmosphere with therapists meant patients experienced a more caring service.
- It was clear from looking at PDRs that co-owners worked in a culture that valued their commitment and dedication and supported them to develop. For example, senior co-owners praised individuals for investing time in supporting each other's ideas and helping colleagues who were struggling with a task or a shift. Clinical achievements were also praised, such as for contributing to reaching a quality target for the use of a cognitive assessment tool.
- 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.
- All of the co-owners we spoke with said they felt their contribution was valued by the senior team.
- 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.

Public engagement

Good

Are services well-led?

- 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.
- Co-owners proactively sought feedback from relatives and visitors and used this to improve the service. For example, darker blinds had been provided in bedrooms to reduce the heat in the summer and improved communication with GPs in the community had been implemented following concerns about medicines management after discharge.

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 bimonthly leadership team day and a monthly 'spirit award' that recognised individual contribution.
- We spoke with three co-owners who said they were happy in their role and felt they were "part of a good team" and felt involved.
- 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 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.
- 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 was arranged through the occupational health department.

Innovation, improvement and sustainability

- The ward manager had implemented new processes for co-owners to complete their clinical competency updates through a process of self-reflection and benchmarking against clinical standards. This enabled each individual to take charge of their learning and development needs and to establish their own needs and goals.
- 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.