South Essex Partnership University NHS Foundation Trust

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Community health inpatient services

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)
RWNZ3	Bedford Health Village	Archer Unit	MK40 2NT
RWNY6	Cumberlege Intermediate Care Centre	Cumberlege Intermediate Care Centre	SS2 4BD
RWNX7	Saffron Walden Community Hospital	Saffron Walden Community Hospital	CB11 3HY
RWNZ1	St Margaret's Community Hospital	St Margaret's Community Hospital	CM16 6TN

This report describes our judgement of the quality of care provided within this core service by South Essex Partnership University NHS Foundation 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 South Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of South Essex Partnership University NHS Foundation Trust

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

We gave an overall rating for community health services for adult inpatients as good because:

- Each hospital had processes in place for reporting, investigating and monitoring incidents which caused harm to patients.
- Safety performance was monitored. Each hospital contributed information to the to the trust's safety thermometer on the number of falls, pressure ulcers and urinary tract infections.
- Staff were aware of the trust's incident reporting system and had been trained to use the trusts computerised incident reporting system. Managers were alerted to any incident reports submitted so that these could be investigated and followed up. Examples of changes in practice which had been implemented following the investigation of incidents and accidents were identified.
- Effective assessment and care planning processes were in place. Patient care was reviewed by multidisciplinary teams of medical, nursing, therapy and social care staff. Individual outcomes were monitored and compared.
- Staff were supervised and new staff completed a two week induction programme to familiarise them with their role.
- Each hospital had scored higher than the national average for cleanliness for community services in a patient led assessment of the care environment (PLACE). Three out of the four units scored higher than the national average for the condition, appearance and maintenance of the unit. The Archer unit scored 88% compared with the national average of 91% for similar services.
- Effective arrangements were in place for providing timely access to services. At Saffron Walden community hospital they aimed to admit patients before 10 am to enable them to settle in and adjust to their environment. The service at the Cumberlege centre aimed to admit new referrals within two hours of arrival on the unit.
- Staff spoke highly of the local managers who led the provision of services.
- The trust's vision and strategy was clear and we saw examples of posters on display describing this for staff.

However:

- There was significant use of agency staff at Saffron Walden hospital, the Cumberlege centre and St Margaret's hospital. The service relied on agency staff to cover for vacancies. Staff sickness rates were high at St Margaret's and Saffron Walden hospitals with rates ranging from 8-12%.
- The trust did not carry out ongoing competency checks to ensure agency staff were competent to administer medication.
- There was limited or no access to medical staff with specialist knowledge about dementia. Advice from specialist mental health liaison staff was limited which meant that it was not always possible to provide people with the specialist support they required.
- Some staff working in these hospitals had not received the necessary skills and training to support patients with semi acute conditions and to care for people at the end of their life.

Summary of findings

Background to the service

The trust provided adult community inpatient services at locations across West and South East Essex and Bedfordshire with a total of a total of 102 community inpatient beds. Services were provided across both urban and rural areas with wide variation in the levels of deprivation, as well as pockets of relative affluence.

During our inspection we visited four adult community inpatient services:

- The Archer unit had 20 beds comprising four bays of four beds plus four single rooms. There was no mixed sex accommodation.
- Avocet ward had 19 beds in a mix of single rooms and six single-sex bed bays.
- The Cumberlege centre had 22 beds which were all single rooms.
- St Margaret's hospital with 54 beds with a further 12 'winter pressure' beds.

Community inpatient services included a range of services for example rehabilitation, intermediate care, nursing and medical care for people with long term conditions, care for people with progressive life limiting conditions, the frail elderly and people at the end of life.

The average bed occupancy for the period 1 October 2014 to 31 March 2015 was:

- The Archer unit - 87.5%.
- Saffron Walden hospital - 89.5%
- Cumberlege centre - 91%.
- St Margaret's hospital - 97%

Medical cover was provided through the day from 9am-5pm by medical staff employed by the trust on the Archer unit, Saffron Walden and St Margaret's hospital. A local GP provides medical cover Monday – Friday at the Cumberledge Intermediate Care Centre. Supported by a community geriatrician three days a week.

Medical cover at night and at week-ends for all the services was provided by the local GP 'out of hour' service.

The service at St Margaret's hospital had access to a consultant who specialised in the care of the elderly and a consultant psychiatrist.

Our inspection team

Chair: Karen Dowman, Chief Executive, Black Country Partnership NHS Foundation Trust

Team Leader: Julie Meikle, head of hospital inspection (mental health) CQC

Inspection Manager: Peter Johnson, mental health hospitals CQC

The team that inspected this service was comprised of three CQC inspectors, one specialist professional advisor and one doctor.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive inspection programme of mental health and community health NHS trusts.

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, 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 and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Spoke with 11 patients who were using these services.
- Met with eight carers.
- Reviewed 12 care and treatment records.
- Examined the trust's policies and procedures used by these services.
- Interviewed the managers for each service.
- Spoke with 18 other staff members.
- Observed ward rounds at two of the services we inspected and attended three multi-disciplinary team meetings.

What people who use the provider say

- Patients and relatives were enthusiastic about the care and treatment which they received and said staff were kind, caring and respectful. Relatives said that staff listened to their opinions.
- Most patients were positive about the meals provided and said that there was a good choice. They spoke highly of individual therapists and the support they were getting to enable them to return home.
- Patients felt able to express any concerns and felt that these had been addressed by the hospital. Any specific concerns raised by individuals were shared with the senior staff for that particular service for them to address in line with the trust's own policy and procedures.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should undertake a recruitment campaign to reduce their reliance on agency staff within these hospitals.
- The trust should carry out carry out ongoing competency checks to ensure agency staff are competent to administer medication.
- The trust should develop care pathways for people with dementia being cared for in community hospitals and ensure that all staff are suitably trained to provide the appropriate care.
- The trust should ensure that all staff working in community hospitals have the skills and training to support patients with semi acute conditions and to care for people at the end of life.

South Essex Partnership University NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community health services for adult inpatients as good for safe because:

- Each hospital had processes in a place for reporting, investigating and monitoring incidents which caused harm to patients.
- Safety performance was monitored. Each hospital contributed information to the to the trusts safety thermometer on the number of falls, pressure ulcers and urinary tract infections. This is a national audit which allows trusts to monitor safety issues and compares performance with other similar organisations.
- Quality and safety groups for the community services division reviewed patient safety incident and audits. For example, we saw the Cumberlege centre had audited the administration of medicines following a number of errors. The quality and safety group had reviewed the results of the audit which had been repeated to ensure changes in practice had been embedded within the service.
- Staff had been trained to use the trust's computerised incident reporting system. Managers were alerted to any incident reports submitted so that these could be investigated and followed up.
- Examples of safety alerts and the results of investigations and reviews were shared across all inpatient settings.
- There was a system in place for placing dated 'I am clean' stickers on all items of equipment which had been cleaned so that staff could use equipment knowing it was ready for use.
- Staff understood their responsibilities for protecting people from the risk of abuse and reporting any concerns. We saw posters in community locality bases highlighting who to contact when staff or family members had concerns about a person who might be at risk of abuse.
- There was significant use of agency staff at Saffron Walden hospital, the Cumberlege centre and St Margaret's hospital. Staff told us the service relied on agency staff but that they could have provided a more

consistent service to patients if they were able to recruit to vacant posts. Staff sickness rates were high at St Margaret's and Saffron Walden hospitals with rates ranging from 8-12%.

Safety performance

- Each hospital contributed to the trust's community inpatient safety thermometer. The safety thermometer was a national audit which allows comparisons to be made over time and with other services. An example of this was monitoring the number of new pressure ulcers monthly over the 12 month period from April 2014 to April 2015. This showed the rate for new pressure ulcers was highest in August 2014 and for four months there were no new pressure ulcers reported.
- Inpatient services reported a total of 23 serious incidents which required further investigation between 1 January 2014 and 31 December 2014. The majority (52%) of incidents were grade three pressure ulcers. Pressure ulcers were graded from grade one to four with four as the most serious. Falls accounted for 30% of incidents. Some falls had resulted in fractures. The third most frequently reported incident related to ward closures due to a norovirus outbreak.
- A quality and safety group was in place which was responsible for reviewing patient safety issues. We saw the agenda and minutes of a meeting held on 25 March 2015. These showed us that issues about protecting people from the risk of abuse, infection control, the safety of medical devices, complaints, the results of audits, safety alerts and the results of the annual health and safety inspection were discussed. Reports from other groups who had oversight of particular paitient safety issues for example the medicines management and health and safety committees were considered at these meetings.

Incident reporting, learning and improvement

- There was a process in place for reporting serious incidents. Reports on the lessons learned were presented to the quality governance committee and there was a trust database in place for recording the recommendations from each serious incident.
- There were other groups for monitoring and disseminating information about the lessons learnt such as the serious incident review group (Bedfordshire), a trust learning lessons review group and front line staff learning events.
- A new head of serious incidents had been appointed who was leading a review of the current system. As a result, a new learning lessons oversight subcommittee had been set up chaired by the medical director to provide an overview of incidents across the trust.
- We reviewed four recent incident reports that had been fully completed and submitted on the day the incident occurred. These included reports about pressure ulcers and medicines records omissions.
- We saw an example of a root cause analysis which had reviewed an incident where a patient had fallen at the Cumberlege centre. A root cause analysis was a detailed review of the circumstances contributing to an incident. It identified what action could be put in place to reduce the risk of a similar incident occurring again and to enable the lessons learned to be shared.
- We were informed of a serious incident which had occurred at one of the trust's other community hospitals. A member of staff had inappropriately applied a compression bandage. We were told that the learning from this serious untoward incident had resulted in compression bandages being locked away which only suitably trained staff had access to. Further guidance had been developed for those staff responsible for giving this treatment.
- We saw the record of an Archer unit staff team meeting dated 30 April 2015. These showed us that the trust's risk register had been discussed together with complaints and compliments, incidents and falls. Gaps in the recording of the administration of medicines had also been discussed. Training days had been set up to provide refresher training for staff. Duty of candour had also been discussed. Controlling the temperature of the ward environment had been identified as a risk which was added to the hospital's risk register.

Safeguarding

- The trust followed specific guidance on staff safeguarding training for adults. Level one training was provided for all staff including bank staff. This was an electronic learning programme. Level two training was provide for or all clinical staff which was also delivered as an electronic learning programme. Level three training was provided for all staff that might be responsible for assessing or managing a safeguarding incident. This was provided as face to face training.

Good

Are services safe?

- Staff training records demonstrated that all required staff had completed their level two safeguarding training on line and had received additional training from the safeguarding lead nurse in the Mental Capacity Act and Deprivation of Liberty (DoLS). Further training opportunities had been scheduled to provide 'refresher' training. Staff were aware of their responsibilities for identifying and reporting any potential safeguarding issues.
- One patient at Saffron Walden hospital raised a safeguarding concern. We brought the matter to the attention of the matron and this was investigated using the trust's safeguarding procedures.
- An audit of adult safeguarding procedures within the trust had been undertaken for the local authority safeguarding board in January 2015 which showed the trust had robust processes in place.

Medicines

- A ward based pharmacist told us their role was to check people's medicines to ensure they were receiving their medicines according to their prescriptions. They said they checked the person's hospital discharge summary from the acute hospital, checked for drug interactions and checked test results to ensure key processes such as their kidney function was operating effectively. They told us a pharmacy technician checked the medicines in people's lockers and the medicines trolleys.
- Systems were in place for the secure storage and safe administration iof controlled drugs. These systems were audited by the trust as part of their overall quality monitoring process.
- Some patients managed their own medicines independently and kept their medicines in their secured room lockers.
- In response to a series of medicines errors in 2014 the trust had completed an audit which showed that 1% of all medicines administered were not properly recorded. This led to the inclusion of a zero tolerance target for mis -recording as part of the trust's quality strategy, further training for trained staff and further audits which demonstrated improvement. The matron at the Archer unit showed us examples of the checks the hospital were required to undertake weekly to ensure medicines were being administered correctly.

Environment and equipment

- The resuscitation trolleys contained the correct equipment which was checked daily. Daily checks took place to ensure that the correct equipment and medicines were available for people who might require resuscitation.
- Medical equipment such as hoists had been serviced regularly. The records showed us that the required checks had been carried out and were up to date.
- Risks around the storage of cleaning material in areas which were unlocked and potentially accessible to patients at the Cumberledge centre were identified. There was a number of unlocked store rooms. Some of the storage areas had signs which stated the door should be locked at all times. Senior staff informed us that these should be kept shut but not necessarily locked. Cleaning materials were kept in one of these. Senior managers confirmed that they would immediately review the signs on the door and the current storage arrangements.
- Concerns about the lack of hand washing facilities in the sluice at Cumberlege was identified. Staff washed their hands at the nurse's station. The issue had been identified in an infection control review. Senior staff had put arrangements in place to audit staff hand washing when they left this sluice. We saw this had been raised as an issue in an external infection control audit dated 19 May 2015. We also noticed an unpleasant odour in the sluice room. This was bought to the attention of front line staff.
- Staff at Cumberlege told us the building had originally been a residential home. Bedrooms were single rooms. They found it difficult to monitor patient safety when they were in their room and identified that the majority of falls occurred in people's room. Patients had been provided with pendant alarms and sensor mats so that they could summons assistance if they were at risk of falling. Senior managers confirmed that it was difficult to monitor people in single rooms but said they reduced the risk by only accepting patients who were medically fit. This was not currently on the local risk register but would be reviewed based on the identified concerns.
- Staff could not control the temperature on the ward in the Archer unit because the thermostat was located in the boiler room and not the ward. This had been reported to the estates service and recorded on the hospital's risk register.

Good

Are services safe?

Quality of records

- We reviewed 12 sets of care and treatment records and found the majority had been completed appropriately. The remainder had some minor gaps which were identified to staff.
- Records contained an index which described the information contained in each section of the care plan. There was a comprehensive assessment process which identified the person's needs. Individual needs had been assessed by a multi-disciplinary team comprising an occupational therapist, nurse and a physiotherapist who had signed the assessment and care plan.
- The paper based and computer records we saw were completed appropriately. Care plans contained nationally recognised tools for assessing the risk of patients developing pressure ulcers, falls, dehydration and malnutrition.
- Patient's needs were assessed on admission. For example, we saw staff at the Archer unit identified the activities people were able to carry out when they were admitted. This allowed staff to identify improvements to their condition to enable effective discharge planning.
- Some patient records were stored electronically on the trusts computer records system. However, agency staff who worked at Saffron Walden hospital were not able to access the trust's computer system. The situation at St Margaret's Hospital was similar but staff told us they kept daily records which meant agency and other staff could access hand written notes about people's care. Staff access to computers was limited. This meant that not all staff could access a computer to check people's records.

Cleanliness, infection control and hygiene

- Each hospital was clean and well maintained. Hand-washing facilities were readily available and there were anti- bacterial gel dispensers at the entrance to all clinical areas. We saw staff using personal protective equipment (PPE) for example when they served food or provided personal care.
- There was a system in place for placing dated 'I am clean' stickers on all items of equipment which had been cleaned so that staff could use equipment knowing it was ready for use.
- Arrangements were in place for screening new admissions for MRSA. Unannounced infection control audits took place and included ward cleanliness, pressure area care, hand hygiene, sharps management, waste management, catheter care, peripheral venous cannula management and any required ward decontamination.
- Cleaning was carried out by an external company. Supervisors from this company checked that cleaning had been carried out according to the cleaning schedules. However, it was not clear how any issues identified were dealt with or who was responsible for monitoring compliance with identified concerns.
- Each hospital had scored higher than the national average for cleanliness for community services in a patient led assessment of the care environment. Three out of the four units scored higher than the national average for the condition, appearance and maintenance of the unit. The Archer unit scored 88% compared with the national average of 91% for similar services.

Mandatory training

- The trust had developed a policy for mandatory training which specified the training to be completed by different staff groups, the frequency and what was covered by the training. Examples of this mandatory training included safeguarding, health and safety and moving and handling.
- The trust provide an analysis of staff compliance for these hospitals. This showed high levels of compliance at the Cumberlege centre 91%, 95% at the Archer unit and 81% for the wards at St Margaret's hospital.

Assessing and responding to patient risk

- A quality and safety group for the community services division reviewed patient safety incident and audits. For example we saw the Cumberlege centre had audited the administration of medicines following a number of errors. The quality and safety group had reviewed the results of the audit which had been repeated to ensure changes in practice had been embedded within the service. Staff had been trained to use the trusts computerised incident reporting system. Managers were alerted to any incident reports submitted so that these could be investigated and followed up.
- Examples of safety alerts and the results of investigations and reviews were shared across all inpatient settings. Staff reported that that risk assessments had been carried out for each patient. This included the use of early warning signs to identify patients who may be detorating..

Good

Are services safe?

- Examples of patient completed rehabilitation contracts were seen at the Archer and Cumberlege units. These showed that the person had consented to the care being provided and had agreed to comply with their rehabilitation care plan.
- Completed assessments were in place. These included, venous thrombosis and embolism, pressure ulcers and malnutrition risks. Daily living (Barthel score) assessments took place on the Archer unit.
- Physiotherapy and wound care assessments were in place and gave detailed guidance for staff. For example, staff used a wide ranging approach to skin integrity for example, by promoting healthy eating and drinking fluids to maintain good levels of hydration. Staff checked skin when they provided personal care and re-positioned patients who were at high risk of developing pressure ulcers. The records showed that individual skin care plans were reviewed daily by staff.

Staffing levels and caseload

- Trust provided data for February to April 2015 demonstrated that there were 73 whole time equivalent (wte) trained nurses and 113 wte nursing assistants with a vacancy rate of 28% (trained) and 15% (NA). The South East Essex quality and safety committee had discussed staffing levels across community services including inpatients. This included discussions regarding the reliance on agency staff.
- Agency staff provided a significant proportion of staff cover at night at Saffron Walden hospital. Approximately 60% of night shifts had been covered by agency staff over the last two years. Agency staff had been on duty at night over the previous three weekends. Recruitment difficulties were being discussed with the trust's human resources department to try and address this staffing shortfall.
- Concerns about the induction process for agency staff were identified. We found that different induction packs were used and that some were more up to date than others. This meant not all new agency staff received the same information during the induction process.
- Trust provided data on staff sickness levels identified that these were highest at 12.1% on Beech ward, 11.6% on Poplar ward and 6.2% on Plane ward at St Margaret's hospital. These compared with 5.5% on the Archer unit and, 7.1% at the Cumberlege centre and 8.5% at Saffron Walden community hospital.
- The Archer unit had the highest number of qualified nurse and health care assistant vacancies due to uncertain commissioning arrangements. The Cumberlege centre had the highest number of shifts filled by bank and agency staff.

Managing anticipated risks

- Alternative arrangements were in place in case of a fire emergency. For example, at the Archer unit and at Saffron Walden hospitals, the trust contingency plans included the use the facilities of local residential homes if the buildings had to be evacuated. .
- The business continuity plan for the Cumberlege centre described the arrangements in place to cover and number of risks to the service such as loss of utilities for example gas, water and electricity or in following a fire or breakdown of communication systems.
- An trust led exercise had taken place in June 2015 to plan the evacuation of St Margaret's hospital in an emergency. This exercise involved managers from the trust, neighbouring acute hospitals, the local authority and police.

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 community health services for adult inpatients as good for effective because:

- There were processes in place for seeking consent. Patients were asked to agree to an individual contract which meant they supported the goals of the care plan which had been developed with them.
- There were effective assessment and care planning processes in place. People's care was reviewed by multidisciplinary teams of medical, nursing, therapy and social care staff. Patient outcomes were monitored and compared.
- Staff were competent to carry out their roles. Staff were well supported with training supervision and appraisals.

However:

- There was a high reliance on agency staff and some medicines administration recording errors had been made by agency staff. Whilst the trust provided medication administration training on induction for agency staff, they did not carry out ongoing competency checks to ensure agency staff were competent to administer medication.
- Some staff working in these hospitals had not received the necessary skills and training to support patients with semi acute conditions and to care for people at the end of their life.

Evidence based care and treatment

- Pathways of care were based on national guidelines. For example ,the care of patients who had suffered a stroke was based on the National Institute for Health and Care Excellence (NICE) guidelines. Staff were aware of this guidance and how care delivery was based on these.The Archer Unit and St Margaret's hospital had contributed to the national audit of sentinel stroke.
- Trust compliance with NICE guidelines was reviewed by the South East Essex quality and safety group. Any approved guidance went to the trust's quality risk committee and was then cascaded throughout the trust
- Assessment forms for patients referred to the Cumberlege centre included a mental health examination score where clinically indicated..
- Staff working at Saffron Walden hospital described how the trust had developed a new pathway based on 'priorities for care of the dying' which had replaced the Liverpool Care Pathway.
- Trust wide audits took place to measure outcomes for patients. For example, Saffron Walden staff had audited their pathway for supporting people with delirium.

Pain relief

- Medical staff carried out pain assessments during ward rounds. Patients requested and received analgesia as prescribed for pain relief. Patients told us that their pain was being well managed by staff.

Nutrition and hydration

- Nutritional assessments took place. These included the malnutrition universal screening tool. Staff had access to the trust's dietetics service if required. Patients told us that staff encouraged them to drink. We saw staff offering people ice lollies to help people keep cool and hydrated during the hot weather.
- At three of the four hospitals, meals were cooked off site and re-heated on the ward. Meals at the Cumberlege centre were cooked on site. Staff were aware of the importance of good nutrition for assisting rehabilitation and about the role of diet and hydration for maintaining tissue viability. Most people told us they liked the food and were offered choice. Meals looked appetising and nutritious.

Technology and telemedicine

- Systems were in place to use technology to promote patient safety. For example, sensor mats were used at the Cumberlege unit for those patients who were at risk of falling. Pendant alarms had been provided which could alert staff if a patient had concerns about falling or if their call assistance bell was out of reach.
- A Doppler machine was available at the Archer unit to check if people had a deep vein thrombosis (DVT). Some staff had been trained to carry out these assessments.

Good

Are services effective?

Patient outcomes

- The Archer unit used a nationally recognised assessment tool, the Barthel scale, for identifying patient need and to assess if they would be able to manage independently at home.
- The minutes of a meeting of the South East Essex quality and safety committee showed the number of pressure sores reported by these services and that the actions taken to address any avoidable pressure sores had been discussed.
- This committee also oversaw the trust's contribution to the national stroke audit and reviewed a falls audit which had been undertaken at the Cumberlege centre.
- A skin matters panel was in place at St Margaret's hospital. The group reviewed all new pressure ulcers acquired by patients to determine if the pressure sore had been avoidable or not and what action or learning could be put in place to prevent a similar occurance.

Competent staff

- A member of staff who had recently joined the service confirmed that they had received two weeks of induction training and felt supported by colleagues and their manager. The trust's induction pack included information about policies including fire procedures, life support procedures and record keeping.
- The trust's induction plan provided a mixture of corporate and a local induction and was delivered via e-learning and face to face training opportunities. Staff received regular supervision and appraisal. Trust provided data showed us that 93% at St Margaret Hospital 96% on the Cumberlege unit, 96 % at Saffron Walden hospital and 100% at the Archer unit had received an appraisal. Therapists who worked for the service told us they had professional supervision from a band 7 physiotherapist. Healthcare assistants working on the Archer unit were required to complete a training programme based on the national standards for care.
- Staff meeting minutes demonstrated that staff discussed the lessons learnt from incidents and meetings were also used to raise concerns. For example, we saw staff had requested training on the mental capacity act which managers said they would arrange.
- The Cumberlege centre had appointed a consultant who specialised in the care of the elderly to work on the unit three days a week from 15 August 2015.
- There was limited or no access to medical staff with specialist knowledge about dementia. Advice from specialist mental health liaison staff was limited which meant that it was not always possible to provide people with the specialist support they required.
- Some staff working in these hospitals had not received the necessary skills and training to support patients with semi acute conditions and to care for people at the end of their life.

Multi-disciplinary working and coordinated care pathways

- People's care was reviewed by multidisciplinary teams of medical, nursing, therapy and social care staff. Patient outcomes were monitored and compared.
- Three staff handover meetings were attended. We found that the multidisciplinary team discussed individual care episodes. Staff contributed constructively to these meetings. Social services staff attended multi-disciplinary meetings to discuss individual social care needs. A folder which contained the notes of the weekly multi-disciplinary team meetings was available for staff to read about any changes to people's care plans agreed at this meeting.
- Staff took responsibility for responding to people's needs for example one person's condition had deteriorated and the nurse responsible for the patient's care took the lead in organising admission to the acute hospital and arranged ambulance transport. Two staff had been deployed to stay with the patient until they could be transferred.
- Medical and nursing staff engaged patients in discussions about their care. For example, one person was waiting to go home. Staff explained that the care package they needed was not yet in place but would keep the patient informed.
- Therapy staff told us they were involved in assessing and planning individual care plans and reviewing progress at the weekly multi-disciplinary meetings. They assessed the person's home circumstances and were involved in meetings with the person's family to organise their discharge and ensure the necessary equipment was in place. They took some patients to the supermarket to assess how they might manage their shopping.

Good

Are services effective?

- There was a weekly tele-conference on the Archer unit with community staff colleagues to discuss patients being cared for in the hospital and the care they would require when they went home.
- There was a mental health worker at St Margarets hospital who gave advice and support to staff around patient mental health care.

Referral, transfer, discharge and transition

- Each hospital had clearly defined criteria for admitting patients. For example, we saw that discharge facilitators were based at Bedford hospital and assessed all new referrals to ensure they were appropriate for admission to the Archer unit. However, this unit had limited access to specialist support for people with dementia and therefore did not accept patients with a primary diagnosis of dementia. Their admission criteria stated that people should be medically fit and that the service provided care for patients requiring rehabilitation for up to six weeks.
- Social care staff contributed to the work of the referral centre at Bedford hospital. There had been delays in social care assessments due to social worker capacity but another post had recently been put in place to reduce the number of delayed transfers.
- Two beds at Saffron Walden hospital were allocated to referrals assessed through the trust's single point of access service based at St Margaret's Hospital. Referrals to the wards at St Margaret's hospital were made through this service and accepted referrals for patients from district nurses, GPs and referring hospitals.
- Staff at Saffron Walden hospital aimed to facilitate transfer from referring hospitals by ten o'clock in the morning to ensure patients had time to settle in.
- Some patients admitted to these hospitals had dementia in addition to other health conditions. Staff told us they did not feel they had the necessary training to support people with dementia. Whilst they had access to a dementia liaison nurse; they often had to wait a long time for their assessment or advice.
- Discharge co-ordinators were employed at three of the four hospitals. Staff confirmed that this role had contributed to reducing people's length of stay.
- One patient on Plane ward at St Margaret's hospital had been there for 10 weeks. They told us they were unhappy and wanted to go home. When we asked about their discharge plan we found this was not in place. This was bought to the attention of senior staff who agreed to investigate these concerns.

Access to information

- Patients and their families could find out about services in Bedfordshire from a directory of services which provided an overview of each service, hours of operation, how to access the service, the referral criteria used by the service, any exclusions, the response time patients could expect and the managers responsible for the service.
- We saw information leaflets for patients with advice on maintaining hydration, eating well and accessing advocacy services.
- Each hospital held weekly multidisciplinary team meetings where people's care was reviewed. As a result each member of staff had been provided with a summary of people's care. This was updated weekly to monitor individual progress and to plan their discharge.
- Medical staff at the Archer unit told us they did not have electronic access to test results and had to contact or visit the acute trust for these.
- There was up to date, hand written notes for use by staff that did not have access to the trust's electronic records system at St Margaret's hospital. This was not in use at all of the hospitals.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- As part of the face to face training undertaken by the trust, Mental Capacity Act / Deprivation of Liberty (DoLs) champions had been trained to provide further support to colleagues. DoLs champions were available at St Margaret's and Saffron Walden hospitals. Robust mental capacity assessments in records were in place on Plane ward at St Margaret's hospital.
- 90% of staff had received training in the Mental Capacity Act. However, some staff were not fully aware of the Mental Capacity Act requirements. Staff at the Cumberlege intermediate care centre told us they had access to advice and support from a social worker if there were any concerns about a patient's capacity to consent to treatment. Staff at Saffron Walden Hospital

Good

Are services effective?

and the Cumberlege centre were aware they needed training to ensure they were able effectively support people when there was a concern about their capacity to make decisions.

Good

Are services caring?

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

Summary

We rated community health services for adult inpatients as good for caring because:

- We saw that staff treated people with care and compassion during our observations of direct care. Staff showed us that they understood people's needs and how to meet them. Patients and their relatives told us they had been treated with care and compassion.

Compassionate care

- We spoke with 11 patients. Everyone told us they had been treated with care and compassion. However, one patient told us they had witnessed one person who was not treated with compassion. We asked senior trust staff to investigate these concerns using the trust's safeguarding procedures. The matter was followed up with the service following our inspection. We saw that staff tried to get to know people to understand their needs and concerns.

Understanding and involvement of patients and those close to them

- Two relatives felt very involved in the care being provided. One relative told us staff kept them informed of any changes every time they visited. Five patients told us they felt staff involved them in decisions about their care. For example, one person felt very well consulted with about their care and treatment. A therapist described how they had involved a person's relative in discussions about their discharge home.
- However, some care and treatment records contained limited information about the person beyond the clinical information required to support the person's treatment.
- The trust scored an average of 78% for their friends and family test as a service to receive care in. An analysis had taken place of these services' specific results. Managers were aware of these findings and the steps being taken by the trust to address the identified concerns.

Emotional support

- Some hospitals used the 'butterfly' scheme to support patients with memory loss and dementia. This is a national scheme aimed at promoting the needs of people with memory loss or dementia.
- Patients could ask for a paper butterfly to be displayed by their bed to signify they had a problem with their memory. The colour of the butterfly indicated whether the person had been diagnosed with dementia or had a problem with their memory which had not been diagnosed. We saw this scheme was used at Saffron Walden and St Margaret's hospitals.
- We saw that where appropriate referrals were made for a carer's assessment.

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 community health services for adult inpatients as good for responsive because:

- Services were planned and delivered to meet people's needs. For example, effective arrangements were in place for providing timely access to services. At Saffron Walden community hospital they aimed to admit patients before 10 am to enable them to settle in and adjust to the hospital. The service at the Cumberlege centre aimed to admit new referrals within two hours of arrival on the unit.
- Staff had received training in equality and diversity and understood the importance of treating everyone equally. For example, there was a multi-faith prayer room at Saffron Walden and posters on display at the Archer unit which referred to the spiritual and emotional support patients could access.

However

- Staff told us they were caring for more people with dementia and semi acute conditions and felt pathways could be developed to improve the care provided. They thought that they needed more training for example in dementia care.

Planning and delivering services which meet people's needs

- The trust worked collaboratively with commissioners and other stakeholders to ensure that services were planned to meet the needs of the local population.
- Staff pro-actively engaged with patients. We noted that they responded promptly when patients used their call alarm system although one patient on the Cumberlege centre told us they sometimes had to wait a long time for a member of staff to respond at night and the ward was noisy because of unanswered call bells.
- Each hospital had protected meal times. However, staff told us there was some flexibility if relatives had travelled a long way to visit.
- Patients were encouraged to maintain their independence. We saw that they were encouraged to move safely around each ward. For example, eating their meals in the day area. Volunteers were present on some wards and they engaged with patients in a friendly manner, and took account of different people's needs.
- The care and treatment provided for people living with dementia varied across all of the hospital. Access to specialist dementia advice and support was variable. Staff considered that they would benefit from further specialist dementia training on some units.
- Staff at Saffron Walden hospital followed national 'priorities for care' guidance which helped to ensure that a person likely to die in the next few days was assisted to make decisions about their care which were reviewed regularly by doctors and nurses. This guidance had replaced the Liverpool care pathway in 2014 as the basis for caring for someone at the end of their life.

Equality and diversity

- Staff had received training in equality and diversity and understood the importance of treating everyone equally. For example, there was a multi-faith prayer room at Saffron Walden and posters on display at the Archer unit which referred to the spiritual and emotional support patients could access.
- Patient information could be made available in different languages. Staff had acess to the trust's interpreting and translation services

Meeting the needs of people in vulnerable circumstances

- Staff confirmed that they could access advice and support from other services within the trust. For example, from the learning disability and community mental health teams.
- Posters were on display throughout each hospital, promoting and publicising the trust's independent advocacy services.
- Patients at St Margaret's hospital were supported by local volunteers many of whom had previously worked at the hospital.

Access to the right care at the right time

- Effective arrangements were in place for providing timely access to services. At Saffron Walden community

Good

Are services responsive to people's needs?

hospital they aimed to admit patients before 10 am to enable them to settle in and adjust to the hospital. The service at the Cumberlege centre aimed to admit new referrals within two hours of arrival on the unit.

- The service at the Archer unit and at the Cumberlege centre provided referring services with feedback on inappropriate referrals. The trust employed assessment staff who were based at Bedford hospital. This team checked all new referrals received to ensure they were suitable for admission and treatment.
- A single point of access (SPA) team was based at St Margaret's hospital. This meant GPs and district nurses could contact the SPA team for rapid access to the beds at St Margaret's and the two beds allocated at Saffron Walden community hospital.
- St Margarets hospital had the highest occupancy rate of 97% within this core service.
- Robust arrangements were in place regarding discharge planning. Staff worked closely with patients, their families and social services to promote effective discharges wherever possible.
- There had been 11 delayed discharges and seven re-admissions to these services within 90 days between January and June 2015. The reasons for these was varied and had been reviewed by the trust.

Learning from complaints and concerns

- These hospitals had received a total of 18 complaints in the last 12 months. 12 of the 18 complaints received had been upheld. Evidence was seen of learning from these and actions had been taken by the trust to minimise any re-occurrence
- Minutes from the trust's quality and strategy group meetings demonstrated that formal complaints were discussed and reviewed.
- The trust had policies in place for following up any actions this included root cause analysis for serious incidents. Learning from incidents was fed back at team meetings. Incidents were discussed at the directorate wide business meeting to decide whether there wider issues for the directorate to review in depth.
- A recent duty of candour letter had been sent to a patient within 10 days, following a fall. This contained an apology and listed the steps that the unit was taking to try and minimise any re-occurrence.

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 community health services for adult inpatients as good for well led because:

- Staff knew the trust's vision and strategy and we saw examples of posters on display describing this. This had been developed following consultation with staff, patients and other stakeholders.
- Staff spoke highly of the managers who led the provision of services. One member of staff told us there had been difficulties when they first started work at the service. They said the manager had listened and acted decisively to resolve the concerns.
- There were effective arrangements in place to monitor the quality and safety of the services provided and managers were clear about their role in ensuring services were well managed.

However.

- There was uncertainty about the future of Biggleswade community hospital. Staff from that hospital had been re-deployed to work on the Archer unit but they were not clear when the trust and commissioners would make a decision about the future of the hospital.

Service vision and strategy

- Staff knew the trust's vision and strategy and we saw examples of posters on display describing this. These had been developed following consultation with staff, patients and other stakeholders. However, some staff told us that as the trust was large and spread across a number of locations; it felt remote from where they worked.

Governance, risk management and quality measurement

- The trust had clear governance and clinical effectiveness arrangements in place to ensure that the quality of care being provided at these hospitals was being monitored.
- A number of quality audits had been carried out. Learning from these had been disseminated to front line staff.
- Staff told us that complaints, incidents, learning from incidents, safeguarding and policy reviews were discussed at team meetings. This was supported by those minutes seen.

Leadership of this service

- Staff spoke highly of the managers who led the provision of services. One member of staff told us there had been difficulties when they first started work at the service. They said the manager had listened and acted decisively to resolve the concerns.They felt supported and could discuss any issues. Example were seen of where the trust had acted proactively when addressing any concerns identified by patients, families and staff.
- Senior members of the executive team had visited services and that their direct managers were approachable and that they felt they could raise any issues or concerns with them.

Culture within this service

- The culture was positive within the local teams and staff felt empowered to do their job and be involved in the service delivery.
- Systems and process were in place to ensure that staff worked in a safe environment.
- The teams worked well with others and there was a great level of respect for other services involved in care in their communities such as social care and general practitioners.
- Staff were passionate about their roles and this promoted a caring culture within the service. For example, a therapist told us their service was well led and they provided a high quality service which they described as proper rehabilitation.

Public engagement

- The trust were hosting public feedback sessions called "take it to the top" in June and July 2015 organised by the trust's patient experience team.
- There was a range of local advocacy services and 25 patient representative groups with addresses and contact details made available to patients and the public.

Good

Are services well-led?

- Relatives told us that they were directly involved in making decisions about their relatives care and that staff listened to them.

Staff engagement

- We saw an analysis of the friends and family test feedback submitted by community services staff for the period April 2014 to March 2015. We saw examples of positive comments about team work and high quality services based on the most up to date policies and guidelines.Those negative comments seen related to staffing levels, the need to improve the fabric of buildings and difficulties achieving waiting time targets.
- Staff confirmed that their line managers had an 'open door' policy and were prepared to listen to concerns and suggestions for service improvements.

Innovation, improvement and sustainability

- A poster at Saffron Walden hospital displayed information about the improvements staff had made through their involvement on the productive ward innovation programme. This showed the programme had resulted in reduced staff sickness and reduced the number of patient accidents.
- The wards at St Margaret's and Saffron Walden hospitals were similarly organised to help staff rotate between the hospitals where this was required.
- Staff were working with GPs in primary care on a project to support the care of the frail elderly to prevent admissions to acute hospitals particularly during the winter. The project plan showed staff in community hospitals were to receive additional training for example in caring for people at the end of life. This meant GPs could refer patients to community hospitals as an alternative to being admitted to acute hospitals.