Kent Community Health 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)
RYYC3	Queen Victoria Memorial Hospital including Dental Department	Community Inpatient Services	CT6 6EB

This report describes our judgement of the quality of care provided within this core service by Community Health Inpatient Services. 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 Community Health Inpatient Services and these are brought together to inform our overall judgement of Community Health Inpatient Services

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We found that overall Community health inpatient services were safe, caring, responsive effective and well led.

Key Findings

- Community health inpatient services had systems and processes in place to keep patients safe. We found there were robust reporting processes that were well understood by staff. We saw that safety information was monitored, for example the NHS Safety Thermometer system. We found evidence that changes were implemented in light of learning from safety incidents.
- The environment was clean across all wards. We saw that the requirements of Department of Health's, "Code of Practice" on the prevention and control of infections and related guidance" were being met.
- We found that there were arrangements for the safe management of medicines; however, we identified weaknesses in medicine management procedures at the Livingstone Hospital and Gravesham Community Hospital.
- We observed that policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE). Patient outcomes were in line with those expected nationally.
- We saw that patients experienced integrated care that was planned by multidisciplinary teams. This ensured that treatment was delivered by staff with the appropriate, qualifications, skills and experience.
- We received positive feedback from patients about their care and experience. A typical comment was "Excellent service. I am very pleased with everything, very safe and clean and I was listened to". We observed that patients were treated respectfully and that their dignity was maintained. We found there was an ethos that valued rehabilitation and the promotion of independence.
- Community inpatient services were responsive and we found there were arrangements to meet patients' individual needs, for example, those living with dementia. We found there were systems to gather patient feedback and saw there were positive responses with appropriate changes made as a result of this. However, we had some concerns regarding the timing of some patient admissions and we were told of instances where patients had been transferred from acute care very late in the day.
- We found that overall services were well led. Staff told us they felt supported to give high quality care by their managers, supervisors and the trust board. We found that staff were motivated and happy at work. However, we identified that the leadership in inpatient therapy services needed strengthening.

We saw some good and outstanding practice including

- Staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services. There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- There was a positive approach to safety management. All staff knew their responsibilities with regard to safety management and were aware of the major risks most relevant to their role and workplace. Incidents were reported and investigated and changes were made to practice or systems in the light of learning from incidents.
- Throughout the community hospitals we found that people's understanding of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was robust. We saw examples of how the principles of the act were implemented in day to day care and how DoLS were used to protect patients' human rights.
- At Livingstone and Gravesham Hospital we found that there was an effective falls reduction programme which has resulted in the number of falls with associated fracture reducing by one third in a year.

However, there were also areas where the Trust needs to make improvements.

Action the provider SHOULD take to improve

- Review the management of medicines at Livingstone and Gravesham Community hospitals to ensure that

there are robust systems for the supply, storage and stock control of medicines including the recording of these processes. This includes processes relating to the management of controlled drugs such as checking stock balances, and the disposal and the disposal of part-used doses.

Summary of findings

Background to the service

Kent Community Health Trust provides inpatient services from 12 community hospitals accommodating about 240 patients across the county. Approximately 3,200 patients were admitted to these facilities during the past year. Services are provided at the following community hospitals; Edenbridge Community Hospital, Faversham Cottage Hospital, Gravesham Community Hospital, Hawkhurst Community Hospital, Livingstone Community Hospital, Queen Victoria Memorial Hospital (Herne Bay), Sevenoaks Community Hospital, Sheppey Community Hospital, Sittingbourne Memorial Hospital, Tonbridge Cottage Hospital, Victoria Hospital (Deal), Whitstable and Tankerton Hospital.

The range of services from each hospital varies but there is an emphasis on rehabilitation, reablement and end of life care in all locations. Other services include diagnostics, outpatient clinics, blood transfusions and minor surgery. Care was delivered by multidisciplinary teams including GP's, nurses, support staff, and allied health professionals such as physiotherapists.

Our inspection team

Our inspection team was led by:

Chair: Carolyn White, Director of Quality/Chief Nurse

Derbyshire Community Health Services

Team Leader: Sheona Browne Inspection Manager Care Quality Commission

The team of 34 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, patients and public representatives, experts by experience and senior NHS managers.

Why we carried out this inspection

Kent Community Health NHS Trust was inspected as part part of our comprehensive community health services inspection programme we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

We visited six hospitals between 10th June and 12th June 2014, including a visit undertaken at night. We visited Whitstable and Tankerton Community Hospital, Queen Victoria Memorial Hospital (Herne Bay). Livingstone Hospital, Sheppey Community Hospital, Tonbridge Cottage Hospital and Sevenoaks Community Hospital. We also carried out an unannounced visit to Gravesham Community Hospital on the 19th June 2014.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

During our inspection we spoke with 75 staff of all grades from a variety of professions and including ancillary and support staff. We held staff focus groups at each of the hospitals we visited. We spoke with 55 patients and five relatives and we received 18 comment cards.

During out inspection we observed how people were being cared for, and carried out a Short Observational Framework for Inspection (SOFI) activity. We attended ward handovers and multidisciplinary meetings. We

Summary of findings

looked at individual care and rehabilitation plans and other clinical records. We also looked at a range records including risk registers, personnel training records, and other documents relevant to the running of the service.

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?

What people who use the provider say

We reviewed the latest survey information from in-patients for February 2014. The overall satisfaction score from all Inpatient Patient Experience questionnaires present in the system in February 2014 was 93.7%. In March 2014 when patients were asked, "Overall how would you rate the quality of care you have received", the average percentage score was 89.4%, with a range of 95.83 to 81.05%.

15 comments were received as part of this survey, and eight of these referenced the perception that more staff were required. However, staff were praised and a typical comment made was, "The care is wonderful but we need more staff as I feel they are under pressure."

The friends and family test responses for February 2014 show an overall score of +81 higher than the trust average score of +76. 123 respondents said they would be extremely likely to recommend the hospital to friends and family and 26 saying they would be likely to. One patient responded that they would be neither likely nor unlikely to make the recommendation, and no patients said they would be unlikely or extremely unlikely to recommend the hospital.

During our visits we spoke with patients and their relatives and we reviewed comment cards they had completed. Patients told us they experienced good care and that matters of dignity and respect were always considered. Overall, patients considered there were sufficient numbers of staff to care for them. A relative said, "In this hospital he is being well looked-after." A patient said, "Excellent service. I am very pleased with everything, very safe and clean and I was listened to". Another patient said, "However busy, staff will always make time to listen to you."

Patients said they were encouraged to regain their independence. One patient said, "I'm moving towards self-medication as I was before admission, "and another commented, "They keep me on my feet."

Patients told us they were treated in clean, hygienic and well maintained environments. One patient said, "Hygiene is uppermost in all the staff minds; this hospital has a high standard of cleanliness," and another commented, "The environment is bright, safe and clean."

Patients told us that there was a good choice of food that met their needs and that they were supported to eat and drink enough. One patient said, "The food is wonderful."

Patients told us adequate pain relief was provided on a regular basis, and when required. Patients were well informed about the medicines they were taking. One patient said, "I sometimes ask for extra pain-relief during the day and it's provided."

Patients told us that emotional support was provided by the staff, and that the chaplaincy service was also available to support them. They said their discharge arrangements were planned with them.

Patients told us that they considered the hospitals were well-led with staff performing their duties in a professional manner. One patient said, "I do definitely think the hospital is well managed, it soon becomes obvious if it is not." Patients said they knew how they could raise concerns with one patient telling us, "If I had any concerns about care I'd see the Sister."

Summary of findings

Good practice

- Staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services. There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- There was a positive approach to safety management. All staff knew their responsibilities with regard to safety management and were aware of the major risks most relevant to their role and workplace. Incidents were reported and investigated and changes were made to practice or systems in the light of learning from incidents.
- Throughout the community hospitals we found that people's understanding of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was robust. We saw examples of how the principles of the act were implemented in day to day care and how DoLS were used to protect patients' human rights.
- At Livingstone and Gravesham Hospital we found that there was an effective falls reduction programme which has resulted in the number of falls with associated fracture reducing by one third in a year.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Review the management of medicines at Livingstone and Gravesham Community hospitals to ensure that there are robust systems for the supply, storage and stock control of medicines including the recording of these processes. This includes processes relating to the management of controlled drugs such as checking stock balances, and the disposal and the disposal of part-used doses.

Action the provider COULD take to improve

- Review the use of the National Early Warning Score to ensure that appropriate escalation actions are understood and taken when patients are identified as at risk of deterioration. The provider could consider how the reports of deteriorating patents using the SBAR system could be recorded consistently.
- Ensure that the contents of Patient Safety Alert NPSA/2011/PSA002: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants March 2011 are implemented.
- Consider the provision of training in relation to the dietary needs of those with difficulty swallowing.
- Consider how the effectiveness of pain-relief, especially that given on an 'as required' basis is evaluated.
- Consider how those patients with cognitive impairment have their pain levels assessed.
- Review its care environments to determine the extent to which they could be considered 'dementia-friendly'.
- Review the Trust processes to minimise the numbers of out-of-hours transfers to community hospitals, and the levels of transfer back to acute care.
- Review and strengthen the leadership and management arrangements for therapists within community hospitals.
- Provide greater assurance that radiography services provided by other organisations as part of a service level agreement are compliant with the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Kent Community Health 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

Community health inpatient services had systems and processes in place to keep patients safe.

We found there were robust incident reporting processes. This was provided by an online trust wide system. We found that this system was embedded into practice and staff were confident and competent in its use. We saw that safety information was monitored, for example using the NHS Safety Thermometer system. We found evidence that incidents were investigated and changes were implemented in light of learning both at local and trust wide level.

We observed a clean and well maintained environment across all wards. We saw that the requirements of The Department of Health's, "Code of Practice" on the prevention and control of infections and related guidance" were being met.

Where people lacked the capacity to make their own decisions we found that staff acted in accordance with the Mental Capacity Act 2005 and made appropriate decisions to reflect patients' best interests. Staff sought appropriate authorisation to ensure that Deprivation of Liberty standards were met. Staff understood their responsibilities in relation to the safeguarding of vulnerable adults and could demonstrate how these had been applied.

Although there were a high level of vacancies in some hospitals, especially relating to nursing staff, we found the trust were actively recruiting staff and there were arrangements in place to ensure that staffing levels remained sufficient to meet patients' needs.

Overall, we found that there were arrangements for the safe management of medicines. However, we identified weaknesses in medicine management procedures at Livingstone and Gravesham Community hospital.

There was a system to identify patients whose condition was deteriorating, the National Early Warning Score. We found that when this score identified potential deterioration the follow up actions required were not always followed.

Good

Are services safe?

Incidents, reporting and learning

- There were no never events reported in community hospitals. From April 2013 to March 2014 community hospitals reported 1953 safety incidents. Of these 259 (13.26%) were judged to have resulted in moderate harm, 5 or (0.26%) resulted in severe harm and there was one incidence of death.
- The most common category of incident was "accidents that may result in personal injury including slips, trips and falls" and this accounted for 34.56% of all incidents. This category also represented the highest number of incidents that resulted in severe harm, four in total.
- Managers and staff were aware that slips, trips and falls were the hospitals' biggest safety risk. We saw that focussed work streams had been introduced to address the risk. An example of this was at Livingstone and Gravesham Community hospitals where patients assessed as at risk from falls were identifiable by the use of coloured risk bands. We saw that an audit of falls undertaken in February 2013 showed that 100% of community inpatients had been risk assessed for falls.
- Incidents were reported using an on line incident management system. Staff we spoke with showed an awareness of the importance of reporting any adverse incidents. Staff told us that they felt competent in using the system and were able to demonstrate its use. They also told us that when an incident was reported they received an email acknowledgement.
- We saw evidence that incidents were investigated and tools such as root cause analysis were used. We spoke to staff who undertook investigations and found that they had received appropriate training. For example at Tonbridge Cottage Hospital we saw that a fall that had resulted in a fracture of the femur had been subject to a root cause analysis. A detailed action plan had been developed in May 2014 and was in the process of implementation.
- Lessons learnt were communicated throughout the Trust and the hospitals using a variety of methods. These included team meetings, newsletters and on the Trust intranet. We saw minutes of team meetings where feedback following safety investigations had been given to staff for discussion and for use as a learning opportunity. We reviewed the regular Trust publication "lessons learnt" which was available for all staff enabling them to learn from incident which had occurred across the trust.
- We saw examples of incidents where patients or their families had been informed of the outcome of incident investigations.

Cleanliness, infection control and hygiene

- We judged that The Department of Health's, "Code of Practice" on the prevention and control of infections and related guidance" was being followed in all the hospitals that we visited.
- We observed that clinical area were clean and well maintained. There were systems to monitor cleaning standards monthly and we saw the results of these audits. Any deficiencies were identified on an action list and we saw that these issues had been addressed promptly and re-checked. A Patient Lead Assessment of the Care Environment (PLACE) in 2013 found the Kent Community Hospitals average score for cleanliness to be 89.08% (range 68.75-99.45%). However this is below the national average of 95.7%.
- Feedback regarding cleanliness from patients was good and one said "Hygiene is uppermost in all the staff minds; this hospital has a high standard of cleanliness". Another reported "They certainly do follow the hygiene standards, the shared toilet is sterilised regularly".
- We found that there were dedicated cleaning staff and managers we spoke with told us that they were able to respond to any requests for urgent cleaning. Nursing staff were aware of the equipment they were required to clean and we saw completed checklists that showed this had been completed. We saw shared patient equipment such as commodes was labelled when it had been cleaned and was ready for use.
- An annual infection control audit was undertaken by the Trust. The last audit shows an average score for community hospitals of 91.08% (range 84.41 – 97.36%).
- The Trust employed a team of specialist infection control nurses who were appropriately trained. Ward staff told us they knew how to contact these staff and that they visited regularly and attended team meetings. They also told us they valued their input. Additionally there was a link-worker scheme for ward staff and we saw that these link workers received support and training to undertake this role.
- We saw there was adequate facilities provided which enabled staff to practice good hand hygiene. We observed staff washed or sanitized their hands in line with the World Health Organisation's "Five moments of hand hygiene" guidance. Audits of hand hygiene were

Good

Are services safe?

undertaken monthly. We looked at the results for the May 2014 audit and saw that 10 out of 12 hospitals scored 100%. We looked at earlier audits and noted that 100% were usual in all areas. A total of 82.16% of staff had received hand hygiene training. We saw that staff used personal protective equipment when it was required.

- Patients were screened for MRSA and we noted that all areas achieved 100% compliance in this. There were no recent cases of hospital acquired MRSA blood stream infections.
- There were procedures for the management, storage and disposal of clinical waste. We observed that clinical waste was segregated and 'sharps' waste was handled appropriately in line with Guidance from the Health and Safety Executive issued in 2013.
- We saw where water temperatures had been checked monthly to ensure appropriate temperatures to reduce the risk of Legionella contamination. However, at Livingstone hospital we found one example of where these checks had not been carried out in accordance with the Trust policy.
- There were no cases of C Diff reported in the community hospitals from February to March 2014. During the same period there were five outbreaks of infection (unspecified) reported.

Maintenance of environment and equipment

- We found that each ward area had emergency equipment located that was easily accessible to staff and ready for use. This included items such as defibrillators and emergency medicines. We saw completed checklists that demonstrated this equipment was checked daily to ensure that it remained ready for immediate use.
- We noted that ward environments were fit for purpose and well maintained. However, at Queen Victoria Hospital (Herne Bay) we found that lack of storage facilities meant the ward appeared cluttered.
- Staff described the system for reporting faults with equipment or the environment and reported that maintenance staff responded in a timely and appropriate manner. We saw records that showed items such as hoists were maintained according to manufacturers' instructions. We saw that small electrical items had been subject to portable appliance testing in the past year. Electronic medical equipment was maintained by a separate department and staff told us they had no concerns regarding the ongoing maintenance of these items.
- We found that medical gas cylinders were stored safely with the exception of Livingstone Hospital where we found that gas cylinders were not stored on transportation trolleys in accordance with current Health and Safety Executive (2013) guidelines.
- One patient told us, "The environment is bright, safe and clean".

Medicines

- Overall we found that there were adequate arrangements for the safe supply, storage, administration and disposal of medicines. However, we found concerns about medicines management at Livingstone Hospital and Gravesham Community Hospital.
- Community hospitals reported that there had been 311 incidents related to medicine management. This represented 16.96% of all incidents reported. There were three incident of moderate harm.
- There was a pharmacy service for the community hospitals. A pharmacist visited the wards weekly and checked all prescription charts to ensure that the use of medicines was safe and appropriate. We saw that charts were annotated with essential safety information. Pharmacists also attended weekly multi-disciplinary meetings.
- We reviewed the storage and administration of controlled drugs. We found them to be stored appropriately and stock balance registers and other administration records were accurately maintained. Pharmacy staff carried out regular controlled drug audits which resulted in a red amber green safety rating. We saw that in the audits we reviewed the result was green, except at Livingstone and Gravesham Community hospitals.
- Other medications were found to be stored in locked cupboards and access to keys was safely controlled. Medications that required refrigerated storage were kept in a designated refrigerator and the temperature checked and recorded daily. The ambient temperature of rooms where drugs were stored were also checked daily to ensure that medicines remained in optimum condition.

Good

Are services safe?

- Medicines were supplied from an independent pharmacy and arrangements were in place to fulfil urgent requests. We saw records of medication orders and noted that these had been reconciled on delivery.
- Unused and out of date medications were disposed in appropriate containers following the clinical waste guidelines. We saw evidence to support that controlled drugs were destroyed on site by a pharmacist.
- We observed medicines administration and saw practice was in line with Nursing and Midwifery guidance. We checked administration records and found they were complete with no unexplained omissions.
- Patients told us they knew what their medicines were for and we saw examples of information given to patients regarding the safe use of their medications.
- Qualified staff who administered medicines had undertaken an e learning module or face-to face training. A competency assessment consisting of a self-assessment and an observation had been developed by the trust and we saw that this was being implemented at the time of our visit. Temporary nursing staff were assessed as competent to administer medicines by their employment agency and we were told this formed part of the agency's contract with the Trust.
- At Livingstone Hospital we identified a number of concerns relating to medicines management. This included the following which were not in accordance with the trusts own policy. Medicines were not stored safely in the medicines fridge. Medicines stocks were not monitored and replenish and those, including insulin, not in current use were not discarded. Frequency of controlled drug checks did not comply with the trust's policy and the time of medicines administration was not always documented, including the specific time of pain relief.
- At Gravesham Community Hospital we had concerns reacting to controlled drugs management, including clarity of stock records, methods and recording of their records, and prescriptions. We had concerns that the stock management systems for controlled drugs were not clear. We noted that delivery notices were not adequately reconciled and there were no formal mechanisms for monitoring stock levels and usage.
- We found there was a lack of awareness of risks associated with medicines management at the Livingstone hospital with no evidence that these had been mitigated against. We saw minutes of a staff meeting which showed no changes had been made in response to issues highlighted around medicines management.
- At both hospitals we saw that when part doses of controlled drugs were administered there were no processes to dispose of the unwanted portion of the medicines. We saw that part doses were taped into their original sealed packets for re-use, but were also told by other staff members that part doses were 'wasted' and were placed in the medicines disposal bin.
- We saw that the latest Controlled Drug and Medicines Management audits at Gravesham Community Hospital had identified problems and assigned a red rating to the results. We saw there was an action plan that was recorded as being implemented, but that some of the items recorded as complete were issues we identified as continuing.

Safeguarding

- The training of staff in protecting vulnerable people was mandatory. Temporary staff including agency staff were made aware of safeguarding procedures as part of their familiarisation and induction to the ward. Staff we spoke with demonstrated an understanding of the principles of safeguarding and could describe the steps they would take if they had concerns or suspected abuse. We saw that information including contact numbers to report concerns was prominently displayed in ward areas. The trust had dedicated safeguarding leads and staff knew who these were.
- Staff described safeguarding referrals they had made and showed that they had been engaged in the procedures.
- Community hospitals made 10 safeguarding referrals between April 2013 and March 2014. Six of these referrals related to neglect (mainly the development of pressure ulcers), two to physical abuse and one each related to financial and sexual abuse. The outcome of these referrals was in four cases the abuse discontinued, in two there was no abuse, one allegation was unsubstantiated and one was substantiated. Investigations continued in two cases.

Good

Are services safe?

Records

- We observed that patients' clinical records were stored securely and in such a way as to prevent any unauthorised access. However, staff were able to access these when required.
- We found that confidential information such as staff personnel records were also securely stored.
- We looked at a range of records and found they were complete, accurate and current.
- Medical records accompanied patients when they transferred from acute care. Staff told us that old patient notes could be obtained when they were required.
- Information governance training formed part of mandatory training for staff.

Assessing and responding to patient risk

- The trust participated in the National Safety Thermometer scheme to measure and monitor avoidable patient harm. The results were widely disseminated and available for patients and staff to see. We reviewed the results for February and March 2014. We noted that the incidence of harm free care was 92.08% and 89.4% for these months and includes inherited harms. However, this is meets the trust benchmark of 95% for new harms.
- Community hospitals used the national early warning scoring system (NEWS) to identify patients whose condition was deteriorating. We reviewed observation charts and saw that these scores were routinely completed. However, we noted that escalation actions prescribed by the NEWS were not always followed. Sometimes this occurred on more than one occasion for each patient. The trust has introduced the SBAR system (Situation, background, actions review) for reporting patients whose condition is deteriorating. However, there was no system for systematically recording reports made using this system although the principles were printed on observations charts. All qualified nursing staff we spoke with were clear that in the case of emergency they would contact the ambulance service on 999 according to the trust policy.

Staffing levels and caseload

- The trust undertook a community hospital staffing review in February to March 2014 using the safe staffing for older people's wards methodology developed by the Royal College of Nursing. In addition the wards used the Safer Nursing Care Tool, which the trust had adapted from a national tool to provide guidance on staffing levels aligned to the acuity and dependence of patients.
- An investment of £444,000 had been set aside in the 2014/2015 budget to facilitate the improvement of staffing levels with the aim of providing a qualified to unqualified ratio of nursing staff to 65:35 and a 1:7 patient to nurse ratio. Matrons and ward managers we spoke with confirmed that this investment was translating into increased establishment.
- Managers that we spoke with acknowledged that recruitment of staff especially qualified registered nurses was problematic. The ward vacancy rates ranged from 6.21 – 39.39% with a total of 94.24 WTE vacancies in community hospitals. We saw evidence that the trust was actively recruiting and saw that there were new staff due to start.
- The Trust used National Health Service professionals (NHSP) to cover vacant shifts and these shifts were sometimes filled by other agencies. Staff told us that requests to fill vacant shifts were always sent to NHSP and that these were usually filled. Across the whole Trust in May 2014 there was a total of 25,300 nursing hours requested of which on 6.56% were unfilled. Agency use expressed as a percentage of pay rill ranged from eight to 45% across community hospitals with an average of 22.08% in April 2014.Ward staff told us that whenever possible agency staff who were familiar with the wards were used. They valued this as they felt it provided best continuity of care for the patients and more effective team work. We saw evidence that temporary workers received adequate induction to the ward with appropriate safety awareness.
- We saw an example in Sheppey Hospital where the difficult decision to close a ward had been made due to recruitment issues and high agency use. This demonstrated that the trust prioritised safe staffing levels.
- Staff told us that they felt that generally there was enough staff to meet patients' needs. We noted that on the wards we visited staffing numbers matched the agreed staffing templates and staff told us that this was usual. Staffing numbers for each shift were displayed in ward areas but only Sheppey Hospital was compliant with government guidance contained in "Hard Truths" document which stipulates that actual numbers on duty and agreed staffing templates should both be displayed.

Good

Are services safe?

- We saw an example where additional staff had been employed to provide one to one care to patients assessed as high risk and requiring additional support. Staff we spoke with told us that this was usual practice.
- Only one patient felt there were insufficient nurses especially at night, although call bells were responded to fairly promptly or an apology offered if it was going to be delayed.
- Concern was expressed that at Livingstone hospital a single registered nurse was on duty at night. We spoke with the night staff at Livingstone hospital and undertook a night time visit. We checked the duty rotas and found that a single registered nurse was rostered on five occasions that month. The nurse explained the arrangements for providing cover for her meal-breaks, checking of controlled drugs and access to advice and support, and these were all appropriate and satisfactory.
- We observed that call bells were answered promptly and one patient told us, "I'm impressed with their keenness to give the best care they can and always have time for you".
- The community hospitals were nurse-led units. Arrangements for medical cover varied across the community hospitals and was usually provided by local GP's. Out of hours medical cover was provided by out of hours GP services. At Sheppey hospital where a GP was present three sessions a week a senior nurse told us they felt fewer patients would need to be transferred back to acute care if medical cover was available every day.

Deprivation of Liberty Safeguard and Mental Capacity Act

- Staff received training as part of the Trust mandatory training programme. Staff we spoke with demonstrated a sound and confident knowledge of the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- We saw examples of applications being made to the supervising authorities with regard to the deprivation of liberty of individual patients. We tracked applications and saw that the process had been followed in line with statutory requirements and the trust policy. We noted in one case that while authorisation was awaited suitable interim arrangements had been put in place.
- We saw clinical records that demonstrated staff had undertaken capacity assessments for specified decisions and the rationale for any decisions made on the patients behalf in their best interests was made explicit.
- We looked at Do Not Attempt Resuscitation (DNAR) orders and saw that an assessment of the patients capacity to contribute to this decision was included and had been completed in all cases. Where the patient lacked this capacity we saw evidence to show that their families had been consulted as part of the best interest decision making process. However, at Gravesham Community Hospital we found that these had not been completed with detailed dialogue between family members recorded.
- Staff gave us examples of best interest meetings being convened with all interested parties to consider complex issues where the patients had been assessed as lacking capacity.

Managing anticipated risks

- In addition to the overarching Trust risk register each hospital maintained its own local risk register and we saw examples of these. We noted that these were current and complete. However, at Livingstone hospital we found there was no evidence of a local clinical risk register for areas that were identified as a risk e.g. falls, medicines management, pressure ulcers. Staff told us that they felt confident in raising concerns or risks with managers for inclusion on risk registers both at local and organisational level.
- All managers we spoke with were able to clearly articulate the risks for their area of responsibility. During focus groups held with staff they were able to tell us the risk particularly pertinent to their working environment.
- There were robust arrangements for disseminating national safety alerts. Staff we spoke with were aware of the system and we saw minutes of team meetings where safety alerts had been discussed. We saw records of safety alerts retained in ward areas. However, we noted that a national safety alert in relation to the placement of nasogastric tubes had not been incorporated into trust policies, which were dates 2005 and required urgent updating. (Patient Safety Alert NPSA/2011/PSA002: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infant March 2011).

Good

Are services safe?

Major incident awareness and training

- Staff we spoke with were aware of the Trust's major incident plan and business continuity plans.
- Incident procedures were available to staff in prominent positions.
- During recent flooding events during the winter of 2014 the trust's business continuity plans had been tested and proved to be effective.

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

Overall, we found inpatient services effective. We observed that policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE). We found there were systems to review new guidance and to disseminate this to staff.

Patient outcomes were in line with those expected nationally.

Patients told us that they received adequate pain relief when required. We found that the nutritional needs of patients were assessed, including the risk of malnutrition. There was access to specialist input from dieticians when required and therapeutic and special cultural diets were provided. We observed patients being assisted to eat and drink. However, not all staff were sufficiently knowledgeable about diets for patients with dysphagia.

Staff completed a programme of mandatory training. They received an annual appraisal which resulted in a personal development plan. Staff told us they felt supported to develop their skills and were to access clinical supervision.

We saw that patients experienced integrated care that was planned by multidisciplinary teams. This ensured that treatment was delivered by staff with the appropriate, qualifications, skills and experience.

Evidence based care and treatment

- We found there was system for reviewing latest guidance from National Institute for Health and Care Excellence (NICE). We saw examples in ward meeting minutes where such guidance was discussed and the implications for local practice was considered.
- We saw examples of national guidance being implemented. For example in the area of nutrition we saw that guidance from the NICE relating to screening for malnutrition was in place, saw initiatives such as DAFNE (Dose Adjustment For Normal Eating) and DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) were being implemented and noted that menus at Whitstable and Tankerton Community Hospital the patients' menu had been reviewed by the dietician team to meet the latest 2013 guidance. We other aspects of NICE guidance such as Falls Management and Care of People Living with Dementia were being implemented.
- At the Queen Victoria Memorial Hospital we saw there was an information display regarding urinary tract infections which presented the latest research evidence and how this was incorporated into practice.
- We saw that patients had a range of clinical risk assessments using recognised risk assessment tools. These included assessments falls risk, manual handling and risk of tissue damage. We noted that these were completed and updated as required, usually weekly.
- We found that patients all had a care and rehabilitation plan devised to meet their needs. We saw that these were reviewed regularly and that progress was monitored. However, we found that at Livingstone hospital, pre-printed care plans were used but these were insufficiently personalised to the needs of individual patients.
- The was a programme of local audits. We saw records which showed in 2013 -14 there are a total of 37 local and national audits in progress in the community hospitals. These covered a diverse range of topics including Hydration in Community Hospitals, Record Keeping and Pain Management. The hospitals were participating in the SENTINAL national stroke audit. We noted that 11 of these audits were at the implementation of their associated action plan stage and 10 were considered completed. We also saw that the Board were appraised of the results of audit activity.
- Our monitoring showed that the trust participated in 100% of the national clinical audits for which it was eligible.

Pain relief

- Patients told us that their pain was adequately controlled. They said pain relief was provided regularly or as needed. They told us they could request pain relief when they needed it. One patient said, "I sometimes ask

for extra pain relief during the day and it is provided." We looked at medicines administration records which confirmed patients received pain relief as prescribed on both a regular and as prescribed basis.
- We did not see any evidence of non-pharmacological approaches to pain relief, and staff told us these techniques were not routinely used.
- The standard pain assessment tool was a visual analogue pain scale which was printed on observation charts. However, we saw that this was not consistently used. We did not see the use of any specialised tools to assess pain levels in those with a cognitive impairment, such as dementia.
- We checked evaluation records after we saw that as required pain relief had been given, and saw that an evaluation of its effectiveness was rarely included. As part of the comfort round systems, patients were routinely checked to ensure they were comfortable and their pain was adequately managed.

Nutrition and hydration

- Patients reported that there was a choice of food and drink available, that any special diets could be catered for although we found there was not always sufficient information about these. There was the facility to order food off-menu if this was required at most hospitals. Patients also told us that they were encouraged to drink adequate fluids and that hot drinks were available throughout the day and night. One person said, "The food is wonderful."
- We observed patients being helped to eat and drink. The wards operated a protected mealtime policy and this was advertised on the ward, but in practice this was only partially implemented. For example we saw medicines rounds that clashed with mealtimes, and not all staff were focussed on helping people to eat at mealtimes. We saw various systems that identified those who required special help with feeding to staff, for example a red tray scheme or discreet symbol displayed above patients' beds. We did not see any pictorial menus to help those with dementia or learning difficulties make food choices.
- We saw that adapted cutlery and crockery was available for patients that needed it. We saw that two hospitals were trialling a system consisting of a specialised water bottle that enabled very disabled people to drink unaided.
- We saw that patients' risk of malnutrition was assessed each week using a recognised tool. We saw that appropriate follow up actions were taken when a risk was identified. We looked at food and fluid records and found these were mainly complete, accurate and current.
- The community hospitals had access to advice from dieticians. Dieticians visited each hospital weekly and were also available to give telephone advice. We judged that this may not always be sufficient, and saw an example of a patient with a high risk body-mass index who could not be seen for a week. There was not always continuity of dietician cover for each hospital. Menus were planned by the catering teams with input from the dieticians to ensure that nutritional guidelines were met. Feedback was sought from patients and we saw examples of changes being made in the light of patients' comments.
- We found that not all staff were fully aware of the requirements of patients with difficulty swallowing and requiring modified diets, in March 2013 an audit of dysphagia patients in seven community hospitals found 14% of patients to be on a modified diet or enteral feed; 100% had been assessed by the Speech and Language Therapist. 25 thick pureed meals were audited against the Dysphagia Diet Food Texture Descriptors. Four meals (16%) failed the standards. Adaptations to the puree diet training for catering were recommended as a result of this audit.
- In a hydration audit undertaken in March 2013, fluid balance charts required for a small number of patients (17%). 75% of these patients had a chart in place with their fluid intake recorded. 56% of patients had hydration needs assessed on admission. (5.6% to 100%) and concerns were identified about the hydration of 38 (23%) patients; of these patients, 32 (84%) had a care plan in place to their hydration needs.

Patient outcomes

- Our intelligent monitoring of the Trust indicates that outcomes for patients are in line with national expectations.
- Across the Trust the incidence of pressure damage is below the average for England. In March 2014 the community hospitals the rate of pressure damage was 9.32% above the Trust benchmark of 4%.

Good

Are services effective?

- For the incidence of falls with harm, the Trust performs below the national average with community hospitals reporting a rate in March 2014 of 0% below the trust benchmark. However, in February the rate had been 0.42%.
- The Trust rate for catheter associated urinary tract infections is below the national average. In February 2014 the rate in community hospitals was 0% and 1.27% the following month. This is against a trust benchmark of 0.25%.

Performance information

- We notice that performance information was shared with managers via an Early Warning Trigger Scorecard each month. Other performance information, such as in relation Infection Control practice was also supplied. Staff told us that this performance information was shared with them. We saw examples of staff meeting minutes where current performance was discussed. We also saw that a wide range of performance information was prominently displayed in public areas for both staff, patients and the public to view. We saw that this information was current and in most cases easy to understand.

Competent staff

- Staff received an annual appraisal. In community hospitals we found a total of 74.25% had a current appraisal, with rates ranging from 9 – 97% (the median average was 85%). Staff we spoke with said they found their appraisal useful and that it had generated a personal development plan which they felt supported to achieve. Staff also received one-to-one meeting with their managers. There were opportunities for group clinical supervision, although this was variable across hospitals.
- We found there were systems to ensure that qualified staff remained registered with the Nursing and Midwifery Council, or the Health Professions Council.
- There was a programme of mandatory training, and most staff told us they were up-to-date with this. We saw ward managers retained accurate local training records and showed us plans to ensure that essential training was updated when required. Training rates for the percentage of staff who were up to date with their mandatory training ranged from 70% to 91% across the community hospitals.
- A proportion of mandatory training was moving towards e Learning modules. Some older staff expressed concern they did not have the information technology (IT) skills to make the most of this opportunity. However, we were told of buddy systems that were set up to support people who felt they lacked IT as they accessed the various training modules. Some staff commented that there was a lack of computer terminals to enable them to complete their training, but we noted that there were adequate IT facilities in the hospitals we visited.
- Staff told us they could access training, including accredited training at institutes of higher education as part of their professional development plan. We saw examples of staff being supported to complete degree level studies such as mentorship and palliative care.
- We were also shown examples where staff had been identified as lacking the required competency to fulfil their role. We found that these cases were managed using appropriate human resources policies and procedures.
- We saw that temporary staff received an induction when they first worked in a community hospital to ensure they worked safely and competently. The trust had contractual arrangements with the agencies they used to be assured that staff supplied possessed the relevant clinical competencies.

Use of equipment and facilities

- Staff told us they felt competent and confident to use the equipment available in the community hospitals.
- We found that where x-ray facilities were available within the community hospitals these were managed under a service level agreement with the provider trust. Staff told us that they were able to access timely diagnostics for in-patients and there were good integrated working arrangements. However, senior staff were unable to provide assurance that radiography services were compliant with the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- Staff at Queen Victoria Memorial Hospital reported limited access to digital x-ray systems (PACS) which impacted negatively on patients' safe treatment.
- Audits in March and July 2013 showed the site of investigation and the imaging modality was clear on 100% on request forms for radiological investigations.

Good

Are services effective?

Telemedicine

- We found that the use of telemedicine was considered as part of patients' discharge plans and heard conversations where this was discussed.

Multi-disciplinary working and working with others

- Each hospital was served by a multi-disciplinary team (MDT) and we found that staff showed a strong commitment to working using this approach.
- We saw that each hospital had a full MDT meeting at least weekly. We attended some meetings and found each patients progress and future care and therapy were discussed, along with discharge plans including an expected date of discharge. We found there was good communication in these meetings and the meetings were clearly documented in the patients' notes. We also saw that there were arrangements for therapy staff to attend daily ward handover meeting although the exact arrangements varied from hospital to hospital.
- We saw that there was liaison and collaboration with relevant adult social care departments as part of the discharge planning process and with other community services such as district nurses. At Sheppey Community Hospital there were particularly strong links with the community stroke team who co-ordinated the care of this patient group.
- At Sheppey Community and Tonbridge Cottage hospitals we saw examples of local voluntary groups providing advice services on-site to patients and their families.

Co-ordinated integrated care pathways

- We found an example of an orthopaedic care pathway was in use at Queen Victoria Memorial Hospital. However, staff expressed concerns about its content and use. They told us about six patients who they felt could be discharged with a care package, but the pathway dictated they should remain as in-patients.

Good

Are services caring?

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

Summary

Inpatient services at the Trust were caring and we found there was an ethos that valued rehabilitation and the promotion of independence.

We received positive feedback from patients about their care and experience. A typical comment was "Excellent service. I am very pleased with everything, very safe and clean and I was listened to". We observed that patients were treated respectfully and that their dignity was maintained.

Every hospital had a specific information book outlining the management arrangements and the services offered and other useful information. Each patient had a named nurse.

Patients could access emotional support from ward staff or chaplaincy service which operated at each hospital. For those requiring specialist input a referral could be made to counselling or psychology services.

Compassionate care

- During our visits we observed staff treated patients with kindness. We received many positive comments from patients and their relatives about staff. One patient said, "The nurses are lovely, they really are." One comment received noted, "Everyone from cleaners to nurses to physios are most helpful and obliging. I am slow moving but there has never been a hint of impatience."
- We carried out a Short Observational Framework for Inspection at Queen Victoria Memorial Hospital and found 63% of staff patient interactions were of good quality with only a single incidence of a poor interaction noted.
- The Trust had introduced a system of intentional rounding (comfort rounding) to promote high standards of fundamental nursing care. We saw that this system was in place and saw records of that indicated that this practice was used across the community hospitals. However, a comfort round audit carried out in November 2013 found low compliance (25%) with suggested best practice and concluded intentional rounding was not fully embedded in hospital practice across the trust although 91% of patients questioned felt it improved their hospital stay.
- The friends and family test responses for February 2014 show an overall score of +81 higher than the Trust average score of +76. 123 respondents said they would be extremely likely to recommend the hospital to friends and family and 26 saying they would be likely to. One patient responded that they would be neither likely or unlikely to make the recommendation, and no patients said they would be unlikely or extremely unlikely to recommend the hospitals.

Dignity and respect

- During our inspection we observed that patients were treated with courtesy and respect, and that their privacy and dignity was maintained. We saw that personal activities, such as toileting, were carried out discreetly. We noted that staff knocked or asked before entering patients' rooms or went behind closed doors or screens and that personal conversations were kept private.
- Patients and relatives gave positive feedback in relation to being treated respectfully. We received one comment that said, "I have been exceptionally well cared for and treated with dignity and respect at all times." Another said, "They pay heed to patients' dignity and show respect not just to patients but to patients' families."
- In the March 2014 patient survey 93.08% of respondents praised staff attitudes.
- Patient Led Audit Care Environment (PLACE) in 2013 gave an overall score of 81.53% for Privacy, Dignity and Well-being with a range of 67.11 – 89.8%.
- At Livingstone hospital we noted a toilet door opened directly onto a seating area, which made maintaining patients' privacy difficult.

Patient understanding and involvement

- In the March 2014 patient survey 95.24% of patients reported they were given necessary information, 96.85% said they were involved in discussions regarding their care and 93.08% said they felt listened to and taken seriously.

Good

Are services caring?

- We received positive feedback form patients saying they were involved in their care. One patient commented, “However busy, staff will always make time to listen to you.” Another said, “Staff were willing to listen to my personal needs but it took a while for them to put this into practice; it took a little while to accept my peculiarities.”
- We saw that each patient had a named nurse or keyworker and their name was displayed above their bed. Generally, patients we spoke with knew who their named nurse was, the doctor in charge of their care and the name of therapists treating them.
- We saw that each community hospital had a detailed patient information booklet. This contained core information, but was personalised to each site. We saw that patients received copies of these booklets. At Gravesham Community Hospital we were shown an example of an information sheet designed by a patient that was given to patients to give them a different perspective.
- Throughout the community hospitals we visited we saw that there were good supplies of patient information leaflets covering a wide range of relevant topics available for patients and their relatives. We saw there were displays that were well maintained and current showing how the ward was performing across a wide range of indicators. There were also effective displays covering health education topics.
- We observed that during day to day care, patients were asked for their agreement before care and treatment.

Emotional support

- We were told that emotional support was provided by clinical staff in the first instance. Patients could be referred to counselling or psychology services provided they met that service’s referral criteria.
- We saw that designated quiet rooms were available in the community hospitals we visited to enable patients to speak with staff, or their families or visitors in private.
- We saw that each hospital was supported by a chaplaincy team. Staff knew how to contact the chaplaincy teams and they visited the hospitals regularly. These teams were predominately Christian reflecting the mix of the local population but if a spiritual advisor from another faith was required the chaplaincy teams were able to contact them and arrange their attendance.

Promotion of self-care

- We observed that the community hospitals promoted self-care and there was an ethos that valued independence rehabilitation and reablement. We observed care practices which supported patients to be as independent as possible.
- We saw examples of patients who were being supported to administer their own medication, and one patient told us about their positive experience of this. However, we noted that at Livingstone hospital self-medication was actively discouraged, and we saw staff meeting minutes which confirmed this.

Good

Are services responsive to people's needs?

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

Summary

Community inpatient services were responsive and we found there were arrangements to meet patients' individual needs, for example, those living with dementia or following a stroke.

Patients were assessed prior to admission to ensure the hospital was able to meet their needs from the service. We were told that there were limited waiting lists for admission and bed occupancy was generally around 90%. However, we had some concerns regarding the timing of some patient admissions and we were told of instances where patients had been transferred from acute care very late in the day. We also noted the high rate of transfers back to acute care providers.

Discharge processes were well managed to ensure that patients received safe transfer of care. There were numbers of delayed transfer of care but the majority of these were outside the direct control of the Trust.

We found there were systems to gather patient feedback and deal with complaints. We saw there were positive responses to feedback including complaints and that appropriate changes and improvements had been made.

Service planning and delivery to meet the needs of different people

- The community hospitals had a fixed number of beds. The majority of admissions were 'step-down' in nature from acute hospitals although some patients were admitted on a 'step-up basis' from community based care.
- Bed occupancy was around 90%, above the nationally recognised rate of 85% which allows for maximum efficiency. There were no facilities to open extra capacity in periods of peak demand. We were told that waiting lists for admission were minimal.
- Admissions were co-ordinated through a bed management service. Patients were assessed for suitability for a community hospital bed by a member of the intermediate care team. This ensured the service was able to meet their needs safely and that the patients would benefit from the services on offer.
- We were told that patients in the community hospitals experienced delayed transfers of care. The most common reason for these discharges was local authority or continuing NHS funded healthcare funding or the availability of suitable care home vacancies. Both of these areas were outside of the direct control of the Trust.
- In April 2014 we found the numbers of delayed transfer of care, expressed as a percentage of bed days, was 6.21% overall; with a range of 0% in five hospitals to 21.71% at Tonbridge Cottage Hospital.

Access to care as close to home as possible

- Patients from the local area could be admitted to any of the community hospitals provided by the trust. However, in practice patients were admitted to the hospital most local to them enabling them to be close to their local communities.
- We saw evidence that local communities valued their local community hospitals. All the hospitals we visited all had active 'Friends' organisations which supported them.

Access to the right care at the right time

- Some community hospitals had minor injury units (MIU) attached to them which enabled people to access urgent care without attending accident and emergency departments. We visited some of these units and found they were well utilised by local people. During 2013-14, all patients who attended the MIU were seen within the four target time set by the government.
- We heard stories from staff and patients about the timing of their transfer from acute care to the community hospitals. There was widespread concern that frail people were transferred late in the day, often after 10pm. We were told this was due to problems with non-urgent transport, or delays in the acute sector such as the availability of discharge medications.
- We found that the numbers of patients transferred back to acute care was high. We saw minutes of a board meeting which said, "… drew members' attention to the level of readmissions from some of the community hospitals into acute care, highlighting in particular the level of 38.5% at Hawkhurst… With regard to the 28.6% readmissions reported at Whitstable and Tankerton Community hospital, Dr M advised that staff had raised

concerns regarding the inappropriate nature of some of the patients transferred from the local acute services during periods of high activity… Dr M advised that all transfers had to be accepted by nursing staff, usually at Band 6 level. Ms S highlighted, however, that at times of high activity, the acute providers would put pressure on the Community Hospitals to accept higher risk patients; and also that referral notes were not always accurate. Where this was the case, nurses would make direct contact with the relevant acute provider. Trust nursing staff were now embedded within Accident and Emergency services at the acute hospitals and could therefore arrange for discharge support during busy periods".

- We noted that in April 2014 readmissions following step down from acute care was 14.54% of patients, with a range of 0–37.5%.
- At Sheppey Community Hospital we noted a high level of transfers back to acute care (27% of patients). Of eight patients transferred in April 2014 we noted that two returned the next day, two were returned between for and seven days and four remained in acute care. A senior nurse attributed this rate of transfers to the availability of GP cover to the hospital.

Meeting the needs of individuals

- We found there were arrangements and facilities to meet the needs of individual patients. We saw that there was adequate equipment such as adapted bathing facilities, disabled toilets and moving and handling equipment to safely care for people. We also saw that there were adequate supplies of mobility aids and therapy equipment to enable staff to provide rehabilitation. Staff told us they could access specialised equipment for very heavy (bariatric) patients and that patients would not be admitted until this equipment was in place.
- We saw that there was a handover between each shift where the needs of individual patients were clarified. These were supported by 'handover' sheets which outlined the key needs for each patient. We saw examples of these and noted that information such as any sensory deficits such as hearing or sight loss. At Tonbridge Cottage Hospital each bed space had a magnetic board above it and staff could attach signs to this board which provided an alert to all staff of a patient's needs by means of discreet symbols.
- The community hospitals were in the process of rolling out the 'Butterfly Scheme' a nationally recognised approach to communicating with and caring for people with dementia, and for identifying these to staff so the approach can be used. The roll-out was at various stages in each hospital but staff we spoke were all aware of the scheme and its intent and many told us they had had preparatory training. These staff all seemed keen and engaged with this project. We noted that the ward environments did not yet meet the dementia friendly design principals devised by the University of Stirling. For example, there were no pictorial signs indicating key rooms, signage was at an inappropriate height and flooring was glossy and uniform.
- We were told that there were few patients with learning disabilities who use the community hospitals. However, there was a specialist learning disability team who would be able to support staff and patients with a learning disability should the need arise. Staff knew of this team and how to make contact.
- At Sheppey Community Hospital we saw pictorial communication aids for patients who had suffered a stroke and had speech and comprehension difficulties.
- We saw prominent posters alerting staff and patients to the availability of translation services. Staff all knew how to contact the service if required. The Trust used translation services on 110 occasions in 2013-14 but community hospitals used them the least.

Moving between services

- We found that discharge arrangements were made by the multi-disciplinary team in conjunction with patients, their families, community health services and the local authority social services departments. Discharge planning arrangements were well documented in patients' records.
- We were told that patients in the community hospitals experienced delayed transfers of care. The most common reason for these discharges was local authority or continuing NHS funded healthcare funding or the availability of suitable care home vacancies. Both of these areas are outside of the direct control of the trust. In April 2014 6.21% of available community hospital bed days were lost due to delayed transfers.

Good

Are services responsive to people's needs?

- There were 229 safety incidents reported by community hospital staff in 2013-14 categorised as Access, Appointment, Admission, Transfer, and Discharge. 10.92% of these were judged to have resulted in moderate harm.

Complaints handling (for this service) and learning from feedback

- We saw that information on how to make a complaint was available for patients and their relatives. However, we did not see any information about the Patient Advice and Liaison Service (PALS) displayed. We saw evidence that any complaints were investigated and that people who complained were given appropriate feedback.
- Staff described to us strategies they used to try and resolve complaints at source or as quickly as possible. This included going to visit a complainant (with their agreement) to discuss their concerns and agree a way forward.
- We saw team meeting minutes which showed that complaints and their outcomes were discussed and learning points were noted.
- Matrons told us that they monitored complaints informally to establish any trends but that there were too few complaints for this to done in a formal way that would generate reliable data.
- We saw how at Gravesham Community Hospital a patient who had complained about not having enough information regarding the daily routines of the ward had been encouraged to join a patient forum. We were shown how the complainant had subsequently developed a patient guide which had been included in the patient admission pack.

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 found that overall services were well led. However, we identified that the leadership in inpatient therapy services needed strengthening.

Staff were aware of the trust vision and we saw examples of local philosophies of care being developed.

Staff told us they felt valued and supported to give high quality care by their managers, supervisors and the trust board. We found that staff were motivated and happy at work and felt confident to raise any concerns. We were told that matrons and managers were visible and available and executive team members visited community hospitals.

There were strong governance arrangements with information regarding performance displayed prominently for both patients and staff. Each hospital had a patient experience group where members of the public were able to hear about the service and contribute to further developments.

Vision and strategy for this service

- The executive had developed a trust vision entitled 'The Golden Thread'. We saw copies of this displayed and staff we spoke with were aware of the document and could articulate its principles. All staff we spoke with were in agreement with the vision stated.
- We saw that some wards had developed local philosophies. Staff at Tonbridge Cottage Hospital were aware of their local policy and felt is helped guide their approach to caring.

Guidance, risk management and quality measurement

- Overall we found there were robust governance arrangements across the community hospitals and staff demonstrated a good awareness of governance.
- Staff at all levels were clear about their responsibilities to monitor patient safety and risk. They were clear about procedures to report incidents and all demonstrated caring attitudes believing that patients were at the centre of the work they carried out. This included incident reporting, maintaining a risk register and undertaking audits.
- Staff were able to describe how learning from incidents was implemented. For example, we were told how a system had been implemented across the community hospitals for identifying patients at risk of falls using coloured arm bands. Patients told us how effective this was and one patient said "It's a great scheme and I hope to have a green band before I leave next week"
- Staff at ward level told us that they received acknowledgement and feedback on incidents that had been reported and were aware of how these led to improvements within the service.
- We found that the service was benchmarking itself against other services within the Trust.

Leadership of this service

- Staff we spoke with were aware of key executive personnel. Staff acknowledged that the Chief Executive and Director of Nursing visited the community hospitals from time to time. Staff confirmed that executives visited their areas as part of the safety walkabout programme.
- We were told that the matrons and junior matrons provided strong leadership, were approachable and visible on the wards. We saw that these key staff were visible to both staff, patients and their families and observed them role-modelling appropriate behaviours. A patient commented that she thought the service was well-led and that "you'd soon know if it wasn't."
- We found that trust wide leadership in relation to therapy services needed strengthening. We found examples of locum therapists who had not received a formal induction, and a therapist who worked alone who had not received supervision for six months. Therapists told us they felt there was a lack of profession specific training and support for locums was poor.
- A junior therapist told us they felt they were not led, and there were no therapy managers who were driving innovation and change. For example, the award winning falls reduction programme at Livingstone hospital had

Good

Are services well-led?

not been rolled out across the organisation or the orthopaedic care pathway which was causing concerns about its appropriateness. It was reported that there were inconsistencies in ward based rehabilitation programmes and the way they fitted with ward routines which decreased their effectiveness; junior therapists felt that professional leadership was required to resolve this issue.

- We found that there was an inconsistent use of validated therapy outcome measures across the hospitals. When these were in place, we could not find evidence of their analysis and the findings being used to inform practice and service development, nor used to inform the national databases.
- A matron and therapy staff had identified a need for a therapy lead to assist the development of practice and to ensure good clinical outcomes. This was highlighted to the trust's clinical lead meeting in February 2014.

Culture within this service

- We found that staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services. There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- Staff sickness rates at the community hospitals as 6.78% (range 2.59 – 10.03%). Short-term sickness rates were 2.14% (1.28 – 3.11%). This is below the trust average of about 4.25% The stress related sickness absence rate was 1.84% (0.01 – 2.77%).

Public and staff engagement

- Each community hospital had a Patient Engagement Group which met every four months. We saw minutes of these meetings and saw they were an opportunity for members of the public to be updated about the hospital's performance and of any service developments planned. It also gave them the opportunity to give their ideas and opinions on how community hospital services should be provided.
- The Trust gathered feedback from patients on discharge using a survey. The results of this survey data was made available to staff and we saw that it was discussed at team meetings.
- There was a system of team meetings which enabled managers to engage their staff in the management and development of the service. It also gave them the opportunity to reflect on performance and practice issues raised by incidents, complaints and audit activity and national guidance. They could also be updated about trust business and priorities. In addition the trust maintained an intranet, especially 'Staffzone' which enabled staff to access a wide range of current information about the trust and their work within it.
- In May 2014 the trust commissioned external consultants to carry out a review of Inpatients Intensive Intermediate Care. A report has been generated and its proposals and recommendations were being considered by the trust board.
- Staff told us that as yet there had been no negative impact from any cost improvement plans or efficiency saving programmes.