Central and North West London NHS Foundation Trust

RV3

Community health inpatient services

Quality Report

Trust Headquarters
Stephenson House
75 Hampstead Road
London NW1 2PL
Tel: 020 3214 5700
Website: www.feedback.cnwl@nhs.net

Date of inspection visit: 27-29 February 2015
Date of publication: 19/06/2015

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)
RV3HE	Windsor Intermediate Care Unit	Community health inpatient services	MK3 6EN
RV3AN	Hillingdon Hospital Mental Health Site	Community health inpatient services	UB8 3NN
RV3DY	South Wing St Pancras Hospital	Community health inpatient services	NW1 0PE

This report describes our judgement of the quality of care provided within this core service by Central and North West London 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 Central and North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central and North West London 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

Contents

Summary of findings

Overall summary

Services were found to be effective, caring, responsive and well led. There was a holistic approach to providing treatment and care to the patient which included involving their family members. Patients and their relatives reported they felt involved in the planning of their care and treatment. Support and training were provided to family members so they could provide safe and effective care and support when patients were discharged and returned home.

Services aimed to meet patients individual needs. It had been identified that high numbers of patients admitted to the wards were living with dementia. Some wards had been refurbished to promote a dementia friendly environment and work was on going at South Wing, St Pancras.

There was an embedded culture of reporting incidents. The trust had worked with staff to ensure risks would be reported in the correct manner, and to ensure incidents were fully investigated and action was taken to reduce the risk of similar incidents occurring.

Areas were clean and appropriate infection control practices were followed. Staffing levels met the planned staffing numbers through the use of agency staff. An active recruitment strategy was in place.

Medicines were managed to ensure the safety of patients. There were arrangements at all hospitals so patients had access to medical treatment in a timely and responsive manner. For patients at Hawthorn unit, Hillingdon the service was being improved with the introduction of seven day working for some therapists.

Staff reported they had access to training other than the required mandatory training. There was good multidisciplinary and integrated working between staff, who were respectful and caring.

There was good local leadership for staff and staff reported an open and supportive culture. Individual wards and departments had their own quality improvement plans. This allowed them to take ownership of their service and the changes they made to improve outcomes for patients.

Summary of findings

Background to the service

Adult community inpatient services are provided at three community health inpatient units. During the announced inspection we visited all three community inpatient units:

- Windsor Unit, Milton Keynes
- Hillingdon Intermediate Care Unit, CNWL Woodlands building, Hillingdon Hospital
- South Wing, St Pancras Hospital, London

All community in patient units provided sub-acute care, treatment, and rehabilitation. South Wing, St Pancras has three wards: Rochester East; Rochester West; Oakwood. The services in Hillingdon and Milton Keynes were one ward.

Our judgements were made across all of the community in patient units visited, where differences occurred at particular hospitals we have highlighted them in the report.

Our inspection team

The team that inspected community health inpatient services included a CQC inspector, Expert by Experience (a person who uses services), and a variety of specialists, including a continence nurse, dietician, tissue viability nurse, speech and language therapist and two pharmacists.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?'

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 27-29 February 2015.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 49 patients and 6 relatives or carers
- spoke with the managers
- spoke with 40 staff on the ward including two clinical leads; five ward managers; one GP; one junior doctor; 14 nurses; two occupational therapists; four physiotherapists; three pharmacists; one physiotherapy assistant; five health care assistants; one student nurse; one chaplain/volunteer; three cleaners; one facilities manager; one discharge co-ordinator; and four administrators.

We also:

- looked at care records of patients

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

We spoke with 49 patients and 6 relatives, in face to face conversations. All spoke positively about the care and support they had received. Patients said they were fully informed and involved in their care and treatment.

Relatives told us about how staff involved carers and family members in the planning for treatment and discharge. Patients told us they were fully involved in their discharge arrangements.

Patients told us their privacy and dignity was always considered.

Patients commented staff were busy, but, call bells were generally answered quickly.

Patients were satisfied with the food provision. Patients said they were welcomed and provided with information when they were admitted onto the units.

Patients and relatives knew how to make a complaint and felt confident complaints and concerns would be taken seriously.

Overall, patients said they were happy with their care and treatment. They felt safe at the community hospitals.

Good practice

South Wing St Pancras had introduced weekly observations of staff practice. Ward managers visited and observed the practice of staff on other wards. The ward managers relayed their findings to the clinical lead at the St Pancras community in patient weekly clinical indicator team meetings.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should provide facilities for patients to store their medication where they are able to self-administer.
- The staff at the Windsor unit in Milton Keynes should receive regular supervision.
- The trust should ensure that patient records at the Windsor unit in Milton Keynes are well organised.
- The trust should ensure the manager post at the Windsor unit in Milton Keynes is filled.
- The trust should ensure good practice is shared across the community inpatient services.

Central and North West London 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 safe a **good** because

Staff reported incidents and there was learning from incidents. Staff were aware of safeguarding procedures and knew how to report safeguarding concerns.

Medicines were managed appropriately and complied with national guidance.

Equipment was well maintained and where required checks were completed and documented.

The inpatient services were clean and when infection control concerns had been identified action had been taken to reduce risks of cross infection.

Staffing levels generally maintained and met the needs of patients using the services. Whilst permanent staff were being recruited agency staff were used.

Detailed findings

Incident reporting, learning and improvement

- Staff reported incidents on the trust wide electronic reporting system. Staff we spoke with said they felt confident in using the trust's electronic incident reporting system. Staff believed there was a good incident reporting culture in their particular units. However, staff at Windsor ward, Milton Keynes were unsure of the correct process for handling medicines incidents. They told us that medicines incidents would be recorded on the Milton Keynes acute hospital reporting system, and not the CNWL incident reporting system.
- At a local level, staff received feedback about incidents they had reported. This was done in team and ward meetings, handovers and by electronic communications. We saw evidence of action plans developed as a result of incidents at the Hillingdon unit, and at St Pancras. We saw evidence of feedback in weekly ward managers' meetings at St Pancras, and at team meetings at the Hillingdon unit. Staff we asked reported they received feedback about incidents related

to their area of working. We saw that information about learning from reported incidents across the organisation was fed back to staff through feed back in meetings and through bulletins.

- Root cause analysis (RCA is a method of problem solving that tries to identify the root causes of faults or problems) had taken place where needed and the findings were shared in care quality meetings to reduce the risk of similar incidents occurring. We saw that the documentation the trust used for recording serious incidents prompted staff to consider the views of patients and families involved in incidents. Staff told us where it was deemed appropriate, psychological or counselling support was available for patients following an incident.
- At St Pancras all wards had a white quality board which made patients and visitors aware of each ward's performance with regard to safety issues such as patient falls; hospital acquired infections; and acquired pressure ulcers. The quality board displayed how many days had elapsed on the ward since a patient had experienced any of the above.
- The trust used the NHS safety thermometer information which is a tool developed to ensure care environments were free from harm. The trust had a designated staff member who monitored safety thermometer information, and this was used to assess and monitor the safety of patients across all the community in patient units. Staff at all the units reported they were compliant with the safety targets they had been set. This included pressure ulcer care, VTE's (deep vein thrombosis and pulmonary embolism), falls, and urinary tract infections (UTI).
- There were systems in place to manage safety alerts, and these were circulated to the teams by the trust's governance team. Safety alerts were issued when there was a specific safety issue that without immediate action being taken could result in a serious or fatal injury. Teams had to acknowledge safety alerts and feed back to the governance team, on whether the alert was relevant to their service. If the alert was relevant they had to report on any action they had taken in response to the alert.

Duty of Candour

- Staff we asked were aware of the trust's duty of candour. They felt the trust was open and honest with people when something goes wrong with their care and treatment.

Safeguarding

- The trust had a divisional safeguarding lead professional. Individual community in patient units had members of staff who acted as local safeguarding leads. At St Pancras staff told us the clinical director had visited the unit and chaired staff meetings to discuss safeguarding.
- Posters carrying information on how patients could report safeguarding concerns were displayed on walls at the Hillingdon unit; and at the Windsor unit, Milton Keynes. This meant patients were able to contact safeguarding authorities if they had concerns.
- Safeguarding training was part of staff mandatory training. Staff said they were able to complete safeguarding training in a timely manner. We viewed staff training records and saw most staff had received or updated their safeguarding training.

Medicines management

- We found outstanding multi-disciplinary practice between the pharmacist and staff at the Hillingdon unit, in both medicines for patients on the unit, and medicines for patients when discharged.
- Appropriate arrangements were in place in relation to obtaining medicines. Records demonstrated staff requested medicines from the pharmacy as required.
- We observed medicine rounds occurring in all of the inpatient units visited. All used drug trolleys. The member of staff administering medicines wore a tabard to indicate they were not to be disturbed whilst administering medicines. This was to reduce the risk of medicine errors occurring. We observed staff carrying out appropriate checks to confirm the identity of the patients, taking time to give medicine to patients, explaining what the medicines were for and remaining with the patient until the medicine had been swallowed. If a member of staff had to leave the trolley, we observed it was always locked before it was left.
- Pharmacists monitored the management of medicines on the units. Medicines were safely administered and

appropriate arrangements were in place in relation to the recording of medicines. Doctors prescribed medicines on prescription charts and signed for them as required. Nurses administered medicines at the prescribed time and signed their initials on the prescription chart at the time the medicine was given to the patient. We reviewed a sample of medicine administration records and noted they were correctly completed, including details about patients' allergies. When medicines had not been administered, the reason for the medicine not being given was detailed. However, when we looked at the prescription charts on Windsor unit, Milton Keynes, we saw that there were gaps on prescriptions charts on 11 occasions and therefore we could not tell if some doses of medicines had been given on these occasions. We also noted that eight people at the Windsor unit, Milton Keynes, had allergies to medicines recorded in their records but the type and severity of reaction was recorded for only two of these people. The trust had already identified issues with medicines management at Milton Keynes prior to our inspection. The chief pharmacist told us that the trust had obtained approval to recruit a pharmacist to oversee medicines management at Milton Keynes.

- There were arrangements for patients to self-administer their medicines where appropriate. The trust's pharmacists were involved in assessing patients' ability to self-administer their medicines. At the Hillingdon unit, we were told that people were supported to self-administer certain medicines, such as insulin, eye drops and inhalers; however, people were unable to keep and self-administer all of their medicines because there was only one key for all of the medicines bedside lockers on the unit. At Rochester East, St Pancras, medicines were supplied in compliance aids and blister packs to support people who wanted to self-administer however, there were no bedside medicines lockers to enable people to keep their medicines during their stay on the ward.
- The temperatures of medicine fridges were correctly monitored and temperatures in medication storage rooms were within the expected range. However, we noted that on 10 occasions in the past 12 months temperatures had been recorded below the minimum temperature for safe storage of medicine at Windsor unit, Milton Keynes. Also, at the Hillingdon unit, we saw records that the room used to store medicines was too warm. Staff told us an air-conditioning unit was due to be installed in the next three to four weeks to rectify this. This meant work was in progress to ensure medicines were being stored at an optimum temperature that would ensure their effectiveness
- There were appropriate arrangements for the safe keeping of medicines. Medicines in regular use at Hillingdon and Camden were kept in locked trolleys, which were stored in secure clinical rooms. The keys for medicine trolleys were kept by staff nurses. In Milton Keynes each patients room had a lockable medicines cupboard. Controlled drugs (CDs) were stored securely in locked cupboards within a locked cupboard. CDs administered were counter signed by two nurses. There was secure management of prescription pads. Medicines were disposed of appropriately by the pharmacist.
- Pharmacist support was available across all units for five days a week. There was also limited pharmacy support at all units over the weekend.

Safety of equipment

- Building maintenance at Milton Keynes was provided by the company who owned the building, as the community in patient unit premises were leased. Staff knew how to contact the provider and told us the provider's responses to maintenance requests were timely. Maintenance at St Pancras was provided by the hospitals facilities department. We saw work being undertaken to renovate two rooms on Rochester East with en-suite facilities. The renovation work had been risk assessed by the estates management department and risk management procedures were in place to ensure the safety of patients and staff. Maintenance at the Hillingdon unit, was provided by the hospitals facilities department.
- Emergency equipment, including resuscitation equipment, was checked every day. However, we noted the resuscitation bag at Rochester East, St Pancras, did not have a list of equipment. However all wards had a checklist that is signed each day.
- Pressure-relieving equipment was available on site in all hospital wards. Where additional equipment was needed, staff told us they were able to order more and it was delivered in a timely way. Staff such as physiotherapists said equipment arrived promptly.

Good

Are services safe?

- There were established service agreements and contracts for maintenance of equipment. Staff said these processes worked well. We checked a random sample of ward equipment and noted all equipment was labelled when it was last seen and had been subject to a safety check. All equipment had been checked in recent months.
- The Hillingdon unit, and Windsor unit, Milton Keynes, had access to outside space, which was well maintained. We did see some old equipment being stored at the back of the South Wing at St Pancras. Whilst this did not create a risk to patients, it was not the most attractive environment for people who wished to walk around the building.
- All the community in patient units were accessible to patients who used wheelchairs. At St Pancras, the community in patient wards were on upper floors. There was a lift to take patients who could not mobilise on the stairs to the wards. The main lift broke down for an hour during our visit. However, there was an alternative service lift. Patients were moved between floors using the service lift whilst repairs were made to the main lift. The hospital facilities department told us the lift servicing was up to date, and the lift breaking down was a rare event.

Records and management

- Patient records were kept securely in notes trolleys or in locked filing cabinets. Patient monitoring charts were kept at the end of their beds. At Windsor unit, Milton Keynes, patient records were stored on the wall in the corridor. Staff told us the notes contained a patient identifier and not patients names. Staff said people could not be identified even in the event of an unauthorised person reading the notes.
- We reviewed a sample of care records across all the community inpatient wards and found they were up to date, legible, and completed without gaps. Patient care records at Hawthorn unit, Hillingdon, were regularly audited to ensure patients and staff had signed them, and to ensure they were fit for purpose.
- Each ward used its own local documents to assess and plan patient care. This meant that patients in South Wing, St Pancras received comprehensive and individualised continence assessments; whilst patients at the Hillingdon unit, and Windsor unit, Milton Keynes, had their continence assessed as part of their activities of daily living assessment. Staff on all wards told us they had access to continence nurse specialists by referral for patients with continence needs.

Cleanliness, infection control and hygiene

- All hospital community inpatient units inspected were clean and tidy. All units had boards displaying ward specific infection control information. Staff hand hygiene technique was regularly audited and showed a high level of compliance. At Windsor unit, Milton Keynes, there was an infection control wall board in the reception area. The wall board included the results of hand hygiene audits.
- Information was displayed throughout the intermediate care units advising visitors of the need for good hand hygiene. There were hand gel sanitizers throughout the units to support visitors and staff with hand hygiene.
- All of the community in patient units had patient-led assessments of the care environment (PLACE) audits undertaken in 2014. As a result of the audits, individual units had PLACE action plans that identified issues raised during the audit. The action plans identified the actions required to improve the care environment. Records we viewed confirmed all of the units had implemented action plans in response to the PLACE audits.
- Staff had access to personal protective equipment (PPE), such as gloves and aprons. We observed instances of patients being cared for in Windsor unit, Milton Keynes, due to infection risks. We saw the trust's infection control lead visiting and providing advice and information to staff on infection control practice.
- The trust infection control lead at Windsor unit, Milton Keynes, told us staff had engaged with infection control processes. From viewing the staff training records across all community inpatient units we saw staff mandatory training in infection control had been undertaken and was up to date.
- All community inpatient units had monthly cleanliness control audits carried out by operational leads. They were performing above national standards.
- We saw staff had access to safe sharps procedures at the point of use. A sharps container was available at the point of use in all community in patient units.

Good

Are services safe?

- All units had appropriate arrangements for managing waste and clinical specimens to ensure the safety of patients and staff. The trust had contracts with other providers for the managing and disposal of clinical waste. Coloured bags were used to differentiate between domestic waste and clinical waste. There was guidance for staff online on the safe handling of clinical waste, diagnostic specimens, and safe sharps practice.
- The trust had effective processes and systems to ensure equipment was clean. The units had introduced "I am clean" stickers which detailed the time and date equipment had been cleaned. The stickers were easily visible to staff. This meant staff could be sure the equipment they were using was clean.
- Patients in all hospitals we inspected were impressed with the standard of cleanliness and cleaning. Comments included "It's a beautiful clean place", and "It's very clean everywhere".

Mandatory training

- In general, from staff reports and staff training records, we found most staff had completed mandatory training within the required time scales. However, a number of staff at Windsor unit, Milton Keynes, had fire safety training which had recently become out of date. Staff at Milton Keynes told us work was in progress to update training.
- Staff told us training could also be tailored to meet the needs of individual community inpatient services. For example, staff at St Pancras had recently received extensive training in the Mental Capacity Act 2005.

Assessing and responding to patient risk

- Across all community inpatient units people's care was assessed, and care and treatment was planned and delivered in line with their individual care plan. There was evidence risk assessments were completed for all patients as part of the admission procedure. Risk assessments, including risks of falls, development of pressure ulcers, malnutrition and mobility were completed for all patients. Staff could explain individual patient's risk assessments and how patients were continuously monitored.
- Patients who had pressure ulcers on admission were recorded on the electronic monitoring system. This allowed the trust to monitor pressure ulcer care across all community in patient units.
- Quality governance meeting minutes, 26 January 2015, recorded how practices on Oakwood ward, St Pancras had been changed during the afternoon handover, with healthcare assistants staying on the ward to assist patients. Records we viewed confirmed incidents of patient falls had reduced as a result of the measures. This meant people's risk of falls was reduced as a result of the trust's quality monitoring processes, and Oakwood ward, St Pancras, acting upon the information.

Staffing levels and caseload

- The trust had carried out needs analysis and risk assessments as the basis for deciding sufficient staffing levels in community in patient units. Staffing levels were based upon NICE safe staffing guidelines.
- All of the community inpatient services displayed the planned staffing numbers and the actual staffing numbers on each shift. It was clear from this information, staff rotas, and discussions with staff that agency staff were used regularly in most areas. However, this was needed to ensure community inpatient services achieved the agreed minimum staffing numbers for nurses and healthcare assistants.
- Most patients we spoke with considered there were sufficient staff to provide their care and support. Call buzzers were within easy reach of patients and when used, staff responded in a timely manner. However, some patients across all the community inpatient units commented on staff being busy.
- Staff identified staff recruitment as the priority on the trust's risk register. We noted the trust had recently implemented a comprehensive recruitment and retention strategy to address staffing issues.
- There was an induction process to ensure agency staff had appropriate information about the environment, relevant procedures, the running of the ward, and the needs of patients. Agency staff we spoke with confirmed they had received an induction to the area they were working in. At Windsor unit, Milton Keynes, staff told us agency staff were given a minimal induction as they are

Good

Are services safe?

expected to hit the ground running. However, staff added they regularly used the same agency and asked the agency to supply staff that had previous experience of working at the unit. The Hillingdon unit had introduced a comprehensive induction for agency staff, this included orientation to the building, and opportunities for agency staff to read policies and procedures.

- In the event of shifts not filled by agency, staff worked flexibly to cover shifts. However, it was noted in some areas staff were asked to work extra hours to fill vacant shifts and ensure care provision was safe. Unfilled shifts were reported via the incident reporting system.
- Staff told us they were able to request additional nursing staff when it had been identified that a patient required enhanced support.
- The trust employed physiotherapists and occupational therapists to support community inpatient rehabilitation. Some community inpatient units had therapy input at weekends. However, most had physiotherapist and occupational therapist input Monday to Friday. Wards had access to speech and language therapists (SALT) and dieticians as required. The trust was trialling a seven day working project for therapists at Hillingdon. An additional support worker had recently been appointed to facilitate people being discharged over the weekend. The project had been extended for 12 months, due to a significant reduction in patients' length of stay.
- The Windsor unit, Milton Keynes, had a manager vacancy. Staff informed us that interviews to fill the position were being arranged.
- Arrangements for medical staffing varied across the hospitals. The Hillingdon unit had a weekly ward round from a consultant and daily junior doctor input from Hillingdon Hospital, and had GP visits Monday to Friday and at weekends. All community inpatient wards had GP support from GP services. At all community inpatient units out of hours medical cover was provided by out of hours services, or 999 in the case of medical emergencies. All the staff we spoke to knew how to access medical support both in the day time hours and in the evenings and at weekends.

Managing anticipated risks

- All community in patient units had a business continuity plan; these identified what actions the community inpatient unit would take in the event of adverse weather.
- Patients had personal emergency evacuation plans (PEEP), to ensure they could be evacuated in a timely way in the event of fire or flood.
- The service had a medical emergency policy and had appropriate equipment in place, including grab bags and resuscitation equipment.
- Community inpatient staff training records demonstrated most nurses and health care assistants had attended annual training on resuscitation, anaphylaxis and fire safety.

Major incident awareness and training

- Staff were aware the trust had a major incident policy and knew how to access it. Staff at the Hillingdon unit, told us discussions were in progress for staff to have a simulated training exercise in dealing with a major incident.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as **good** because:

Community inpatients services provided care and treatment in line with national guidance. There was a system for monitoring outcomes for patients. The trust acted on results of audits to improve outcomes for patients.

Multidisciplinary working was evident across all patient areas with discharge planning commencing on admission to the inpatient areas.

Food provision was rated highly by patients and care was provided to ensure people had enough to drink and eat.

Staff had been trained and made appropriate use of the Mental Capacity Act.

Detailed findings

Evidence based care and treatment

- The trust's policies and procedures were developed in line with national guidance and were available for all staff and the public on the trust's website.
- The trust had a clinical professionals advisory group (CPAG). The group advised staff on best practice and circulated guidance to teams.
- Specialist nurses, such as tissue viability nurses, infection control lead and falls prevention leads provided support and current guidance for staff working in community inpatient units. We saw the infection control lead visiting and providing best practice guidance to staff at Windsor ward, Milton Keynes, to reduce the risk of cross infection.
- At St Pancras the trust had introduced clinical governance review meetings. An aspect of these reviews was to monitor the implementation of best practice guidelines from the National Institute for Health and Care Excellence (NICE). At the Hillingdon unit, staff review meetings considered the unit's implementation of NICE guidelines. Whilst, Windsor unit, Milton Keynes, had a staff member who was the allocated lead for NICE guidelines implementation. This meant patients could be sure staff were taking account of best practice guidance when providing their care.

Pain relief

- Patients were prescribed pain relief, as appropriate. Most wards received daily visits, Monday to Friday, by GPs or junior doctors, who were able to adjust prescriptions for analgesia, as required.
- We saw patients had been prescribed regular analgesia (pain relieving medicines) which had been given to prevent pain developing.
- For patients who had been prescribed analgesia to have as required, we observed nursing staff asking them whether they had pain and whether they required the medicine before administering it.

Nutrition and hydration

- Assessments were made of patients' risk of malnutrition. There were variations in the tools used across the service. Some units used a nationally recognised tool. However, where patients were identified as being at risk of malnutrition, actions were taken to address this. This included monitoring patient's food and fluid intake, provision of nutritional supplements, and referral to dieticians.
- Most of the food and fluid charts we viewed had been completed well, this meant the risk of people having insufficient food and fluid was recognised. We saw that food temperatures were checked prior to serving of the meals. Patients had a choice of food at meal times with choices being made at the point of delivery. At Winsor unit, Milton Keynes, a cook from a private on-site company who cooked patients' food, served the meals, which meant the food provider was able to gain insight into the menu wishes of patients. Meals at the Hillingdon unit, and at St Pancras were supplied by external providers.
- There was a trust policy for staff to follow in relation to protected meal times. The scheme was designed to

allow patients to eat their meals without disruption and enable staff to focus on providing assistance to those patients unable to eat independently. However, we observed at St Pancras this was not being fully followed with patients having visits during the mealtime. This meant patients were having their meals interrupted which was not in line with national guidance. Staff told us the protected meal times were flexible for families who could only visit during lunch. Staff added families whose relative required assistance with feeding, and who wished to assist with the task, were encouraged to attend meal times, to provide them with opportunities to learn appropriate feeding skills.

- Patients had access to speech and language therapists (SALT) and dieticians across the community in patient units. Staff reported that there was good access to SALT and dieticians in order to provide appropriate support and guidance.
- Patients spoke highly of the meals provided at all hospitals.

Approach to monitoring quality and people's outcomes and outcomes of care and treatment

.

- We saw the trust regularly collected and monitored information about the outcomes of patients care and treatment. The trust produced regular quality governance reports which carried information on clinical audits. Quality improvement action plans were implemented where results indicated changes or improvements were required. For example, all units had audits that monitored their compliance with mandatory training, numbers of complaints received, results of patient experience feedback, numbers of reported incidents and operational issues including patients' length of stay.
- The trust had a comprehensive programme of audits and internal inspections that had been completed during the year 2013/2014 in the community inpatient areas. These included audits of inpatient falls, management of controlled drugs, and standard infection control precautions across all inpatient areas. Action plans were developed where the need for improvement was identified.
- All the community in patient units had local audits. For example, the Hillingdon unit had audited all the information they held on patients at risk of malnutrition. As a result of the audit the unit had produced an action plan; this included the clinical lead meeting with the dietician to improve menu choices and improved communication with patients about their nutritional needs.
- The trust had taken part in the National Intermediate Care Audit in 2014.

Competent staff

- Staff received annual appraisals and these were up to date across all units. Records we viewed confirmed staff having received regular one to one supervision sessions. Staff at Windsor unit, Milton Keynes, told us supervision was an area that had "slipped" due to a manager vacancy. However, all staff commented that they could seek support from the relief manager at any time.
- Allied health professionals, physiotherapists and occupational therapists, reported that they received supervision from a member of their own profession.
- Staff told us the availability of training was good. Staff told us they received mandatory training and could request further specific training. For example, at St Pancras staff had attended dementia study days. A member of staff at the Hillingdon unit, told us they were being supported by the trust to start a course in leadership.
- We saw records that showed community inpatient nursing staff had their competence in medicines administration assessed annually.

Multi-disciplinary working and coordination of care pathways

- A multi-disciplinary team supported patients with their care, including: nursing, medical, therapies and social work.
- Across the community inpatient units weekly multidisciplinary team meetings were held to review patients' progress. Local authority social workers were invited to attend the multi-disciplinary meetings.
- We observed a multi-disciplinary meeting at the unit in Hillingdon. Staff were very aware of family inclusion in care planning and managing patients' expectations.

Good

Are services effective?

- Staff reported that, whilst outside of the control of the hospitals and wider trust, some people remained in hospital longer than was required to meet their health needs, due to delays caused by external organisations. Staff said the trust was working with these organisations to address delays.
- Staff at St Pancras held a multi-disciplinary workshop in February 2015. As a result of the workshop nursing and therapy staff had created an integrated assessment tool to identify patients care goals.

Referral, transfer, discharge and transition

- Information was provided for patients in the form of a welcome pack at the patient's bedside. Information included falls prevention, Patient Advisory Liaison Service (PALS), prevention of infection, and general hospital information.
- Staff were aware of patient care pathways from admission to discharge. St Pancras had support from the Central Access Team (CAT), who monitored referrals and completed pre-admission checks on patients. The CAT team included a care pathway co-ordinator and a qualified nurse. This had led to improvements for patients in transition from acute hospital settings to community in-patients settings.
- The trust had clear policies and procedures for discharge planning. The trust had produced patient pathway flowcharts. These were used to provide patients, families, and staff with a concise view of the units' admission and discharge planning processes. The charts could be used to understand the stage a patient was at in their care pathway and what would happen next.
- Discharge planning commenced when patients were admitted to the wards. Records and conversations with patients and staff demonstrated discharge was discussed when patients were admitted.
- Patient records demonstrated discussions were held with patients and their representatives about plans of care and discharge arrangements. All patients and their representative's received a formal invitation to attend a family meeting about their planned care and prospective discharge. A record of this meeting was held in patients' records and a copy provided to the patient, this demonstrated that the views of patients were being taken into consideration in the planning of care and discharge.

Availability of information

- Paper record systems were used on all the community inpatient hospital wards. There was variation in the documentation of patient records held at the different community inpatient units.
- In general, patient records were well organised which meant information was easily accessible. Care plans clearly detailed patient goals and the actions required by staff to support patients to achieve the goals. However, at Windsor unit, Milton Keynes, we found patient records were not consistently organised in a structured manner, which meant it took longer to locate information about specific needs of patients.
- At the service in Milton Keynes, patients living with dementia had copies of 'This is me' documentation. This is a tool that people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. However, this was not consistently used across the intermediate care units. This meant in some areas staff might not have relevant information to help them communicate and care for vulnerable patients with dementia in an effective and individualised manner.
- All hospital wards had processes in place for sending information about their care and treatment to a patient's GP on discharge. Relevant discharge information was also sent to community nurses or care homes as required.

Consent

- Patient records demonstrated in the majority of cases consent was sought regarding plans of care and any treatment provided. Patients confirmed their consent was sought before care and treatment was delivered. However, we noted two of six patient care planning records we viewed at Windsor unit, Milton Keynes, were not signed by the patient. The manager told us work was in progress to review care records, but had been delayed due to the unit not having had a permanent manager since January 2015.

Good

Are services effective?

- Staff had received training demonstrated a good understanding about the Mental Capacity Act 2005 (MCA) in relation to seeking patient consent prior to significant decisions. Capacity assessments were completed where needed. Best interest meetings were help when needed.
- Staff told us about patients that had an authorized Deprivation of Liberty Safeguard (DoLS) in place. We viewed records at Rochester East, St Pancras, and saw an application for a DoLS had been submitted. The Hillingdon service had two patients who had authorised DoLS in place.

Good

Are services caring?

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

Summary

We found caring was **good** because:

Staff provided sensitive and caring support to patients. Staff were kind and compassionate. Care was provided with privacy and dignity in mind.

Patients and their relatives and carers were engaged with their plan of care and understood and agreed to their plans for discharge. Patients were actively supported to be more independent.

Detailed findings

Dignity, respect and compassionate care

- We observed that staff in all wards responded to patients in a kind and compassionate manner. For example, we saw a patient being treated in a caring way by staff when being transferred from their room to the dining room at the Hillingdon service. We saw staff responded to patient's wishes, involved them in conversations and considered patients views, across all the community inpatient units.
- Most patients and relatives told us staff were very caring.
- Care was provided in a range of accommodation from single rooms to four bedded bays. Each bay was single sex accommodation in accordance with national guidance.
- Each unit had a member of staff who was the allocated dignity champion. The role involved the staff member acting as a role model for person-centred, compassionate care and in educating and informing other members of staff.
- We saw staff closing curtains and doors when providing care, to protect patient privacy and dignity. Patients commented their privacy was protected by staff closing curtains and doors. Staff were observed at the Windsor unit, Milton Keynes, knocking on doors before entering rooms.

Patient understanding and involvement

- Patients confirmed they were involved in the planning of their care with explanations given to them in a manner they understood.
- There were examples of patients being involved in service development. These included patient survey feedback and learning from complaints.

.

Emotional support

- We observed that staff treated patients with compassion and sensitivity, taking into account their emotional needs.
- Staff said they had access to a range of counselling and psychological services they could refer patients to if required.

Promotion of self-care

- Patients spoke about how staff encouraged them to take responsibility for their own care where appropriate. We saw some patients had taken responsibility for their own medicines across all units.
- Patients told us staff assessed their safety in the kitchen to check whether they were able to manage at home. We saw patients being supported to be independently mobile, and patients being assessed and supported with their ability to use stairs.

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 found responsive was **good** because:

Community inpatient services were responsive to patient's needs. The trust consulted with local groups and organisations about the service provided in their hospitals. Changes were being made to the environment of the wards to make them easier for patients living with dementia to navigate, and to create a pleasant environment.

Peoples individual needs in terms of their language, religion, culture and disability were met.

Complaints were taken seriously and changes were made following complaint investigations.

We found responsive was **good** because:

Community inpatient services were responsive to patient's needs. The trust consulted with local groups and organisations about the service provided in their hospitals. Changes were being made to the environment of the wards to make them easier for patients living with dementia to navigate, and to create a pleasant environment.

Peoples individual needs in terms of their language, religion, culture and disability were met.

Complaints were taken seriously and changes were made following complaint investigations.

Detailed findings

Planning and delivering services which meet people's needs

- The trust was committed to involving local communities in the development of their services.
- The trust was involved in a project with University College London Hospitals NHS Foundation Trust (UCLH) and the National Hospital for Neurology and Neurosurgery (NHNN). The project involved staff at the Oakwood ward, St Pancras, working together with UCLH and NHNN to help support stroke patients in Camden and Islington return safely home as soon as possible.
- At the Hillingdon unit, there was good evidence of close working with commissioners on integrated care pathways to ensure patients received a seamless service from the main acute hospital to the community inpatient unit.

Equality and diversity

- The trust had identified a need to improve the environment of wards in the community inpatient units to meet the needs of the increasing number of patients living with dementia**.** The Hillingdon service, had been fully refurbished to create a "dementia friendly" environment. We were told work was in progress to refurbish all wards at St Pancras to promote dementia friendly environments.
- An interpreter was available to support a patient at St Pancras. Staff told us that interpreters could be accessed across the service for patients where English was not their first language.
- Patients' records included specific information on their cultural or religious dietary preferences, ensuring that food and drink met their religious or cultural needs.
- The trust had a communication department that could provide information documents in other languages, large print, Braille and audio format upon request.

Meeting the needs of people in vulnerable circumstances

- Staff told us they could liaise with their colleagues in older persons mental health wards for support and guidance in caring for patients living with dementia or who had specific mental health needs.
- Patients could access independent mental capacity advocates, (IMCA), if required.

Access to the right care at the right time

- Staff reported that there was good access to medical, therapy, pharmacy and other specialist input in a timely manner where patients needed this input.

Complaints handling (for this service) and learning from feedback

Good

Are services responsive to people's needs?

- Information about making a complaint was available in the information provided to patients on all units and on the trust's website.
- Patients we spoke with said they felt confident to make a complaint and believed any concern or complaint would be taken seriously. A patient we spoke with told us they had made a verbal complaint and it had been attended to immediately.
- Staff were aware of the trust's complaints process. We saw documentary evidence that demonstrated staff had referred patients and their representatives to the Patient Advice and Liaison Service (PALS) team, who would support patients with making a complaint about the service.
- We were given several examples of changes made to services in response to patient's comments and complaints. One of these had identified an issue with communication between the community inpatient unit and families at the Hillingdon service. As a result, the unit had introduced regular family meetings to provide families with information and opportunities to ask questions.
- We saw examples of how the service provided patients with information on how to contact the ombudsman if they were dissatisfied with the service's complaints handling. For example, the clinical leads at Hillingdon, and St Pancras, each showed us written responses to complaints. The response letters included details of the rights of patients to contact the Parliamentary and Health Service Ombudsman if they were dissatisfied with the outcome of the community in patient units' complaints investigation.

Planning and delivering services which meet people's needs

- The trust was committed to involving local communities in the development of their services.
- The trust was involved in a project with University College London Hospitals NHS Foundation Trust (UCLH) and the National Hospital for Neurology and Neurosurgery (NHNN). The project involved staff at the Oakwood ward, St Pancras, working together with UCLH and NHNN to help support stroke patients in Camden and Islington return safely home as soon as possible.
- At the Hillingdon unit, there was good evidence of close working with commissioners on integrated care pathways to ensure patients received a seamless service from the main acute hospital to the community inpatient unit.

Equality and diversity

- The trust had identified a need to improve the environment of wards in the community inpatient units to meet the needs of the increasing number of patients living with dementia**.** The Hillingdon service, had been fully refurbished to create a "dementia friendly" environment. We were told work was in progress to refurbish all wards at St Pancras to promote dementia friendly environments.
- An interpreter was available to support a patient at St Pancras. Staff told us that interpreters could be accessed across the service for patients where English was not their first language.
- Patients' records included specific information on their cultural or religious dietary preferences, ensuring that food and drink met their religious or cultural needs.
- The trust had a communication department that could provide information documents in other languages, large print, Braille and audio format upon request.

Meeting the needs of people in vulnerable circumstances

- Staff told us they could liaise with their colleagues in older persons mental health wards for support and guidance in caring for patients living with dementia or who had specific mental health needs.
- Patients could access independent mental capacity advocates, (IMCA), if required.

Access to the right care at the right time

- Staff reported that there was good access to medical, therapy, pharmacy and other specialist input in a timely manner where patients needed this input.

Complaints handling (for this service) and learning from feedback

- Information about making a complaint was available in the information provided to patients on all units and on the trust's website.

Good

Are services responsive to people's needs?

- Patients we spoke with said they felt confident to make a complaint and believed any concern or complaint would be taken seriously. A patient we spoke with told us they had made a verbal complaint and it had been attended to immediately.
- Staff were aware of the trust's complaints process. We saw documentary evidence that demonstrated staff had referred patients and their representatives to the Patient Advice and Liaison Service (PALS) team, who would support patients with making a complaint about the service.
- We were given several examples of changes made to services in response to patient's comments and complaints. One of these had identified an issue with communication between the community inpatient unit and families at the Hillingdon service. As a result, the unit had introduced regular family meetings to provide families with information and opportunities to ask questions.
- We saw examples of how the service provided patients with information on how to contact the ombudsman if they were dissatisfied with the service's complaints handling. For example, the clinical leads at Hillingdon, and St Pancras, each showed us written responses to complaints. The response letters included details of the rights of patients to contact the Parliamentary and Health Service Ombudsman if they were dissatisfied with the outcome of the community in patient units' complaints investigation.

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 well led was **good** because:

Staff were aware of the trust's vision and values. Staff on most wards reported good leadership, with ward managers and clinical leads being approachable and supportive.

Governance processes were in place which allowed for messages to be taken from ward level to the senior management level, and for messages on learning and improvement to be passed from senior management to ward level.

Detailed findings

Service vision and strategy

- Community inpatient services were part of the trust vision to provide integrated care and treatment with the aspiration of being a learning organisation that strived for continuous improvement of patient care.
- The visions and values of the trust were displayed in all the wards we visited. Staff we asked were able to tell us how their working practices incorporated the visions and values of the trust and some staff were able to quote the vision and values.
- Staff at the Hillingdon unit, told us the trust's values has been discussed in team meetings, and the unit was in the process of implementing a local vision for the unit, that would complement the trust's vision and values.

Governance, risk management and quality measurement

- We saw clinical leads and ward managers were visible on the wards.
- The leads of community in patient areas attended regular divisional care quality meetings. Records from these meetings and discussion with staff showed that this was an opportunity for them to raise issues through the trust's management structure as well as receiving information that was passed down from the trust board.
- There was a trust and divisional risk register, which detailed all risks. There was a separate risk register for the individual inpatient units. Staff were able to identify the risk management priorities of their units, all reported staff recruitment as the priority. The trust had responded by implementing a staff recruitment and retention strategy.
- Quality measures were monitored at a trust and divisional level. This included monthly quality assurance meetings between the divisional directors and clinical leads where staff sickness, bed occupancy, and the numbers of agency staff used were discussed.
- The trust had a programme of comprehensive audits that were completed monthly. This process looked at all areas of the service provision in line with the Health and Social Care Act 2008 regulatory requirements. This included information about the available workforce, the use of agency staff, each unit's compliance with mandatory training, numbers of complaints received, results of patient experience feedback, and numbers of reported incidents.
- We saw that the community inpatient service was using audit information to identify and respond to risk of poor quality care. All community in patient units had local improvement plan projects. For example Hillingdon, had a service improvement programme that included the unit implementing step by step guidance on what to do with a deteriorating patient. This had been circulated to all staff and staff had been briefed on the procedures. The Hillingdon, improvement plan had also led to commissioning of leadership and advanced nursing skills training from the University of Buckinghamshire for some nursing staff.
- A quarterly performance report was provided by the trust. The report highlighted improvements, positive observations, and areas for improvement. This meant staff could easily identify their achievements, areas of good practice and areas for improvement. For example, the quarter three 2014-15 report noted the falls rate at Windsor unit, Milton Keynes, was of on-going concern. However, the report highlighted actions implemented to improve outcomes in this area. This included the implementation of a falls care bundle, and the review of all falls incidents to ensure learning from incidents.

Good

Are services well-led?

Leadership of this service

- Staff were aware of who most of the senior board members were. Most staff said the divisional director, responsible for their area, had visited their unit. Community in patient unit clinical leads told us there was strong clinical leadership within the trust. Each trust division had a nursing director and a medical director.
- Most community inpatient units we visited had good local leadership. Staff reported confidence in the leadership of their ward managers. They told us ward managers and clinical leads were approachable and provided support to their staff. Staff at the Hillingdon unit, commented on the support the ward manager and clinical lead provided.
- At Winsor unit, Milton Keynes, the ward manager position was vacant, and the role was being covered for half a day from Monday to Friday by a relief manager. From conversations with the staff it was clear the staff did not think the manager had received enough support to lead the ward effectively. For example, staff said they had seen their supervision time reduced due to the manager having a limited amount of time to spend at the unit.
- Senior staff spoke positively about the trust's leadership programme. They said it had enabled them to reflect on their management style and skills and identify where changes in management of their service could be made to improve outcomes for patients.

Culture within this service

- Most staff reported an open and learning culture. They felt able to raise issues with managers, if required. Managers were visible on the wards, with staff able to raise concerns and issues with the clinical leads and ward managers.
- The trust had a whistleblowing policy, which was available for staff on the trust intranet. Staff told us the trust took whistleblowing information seriously and were confident that the trust took all action to protect the identity of whistle-blowers.

Public and staff engagement

- Most of the community hospitals had involvement from volunteers to offer visits and support. We saw evidence of community investment. For example, at Hillingdon the League of Friends had provided funds for the unit to purchase tactile pictures for the walls in communal areas.
- St Pancras displayed, "you said- we did", notice boards where patient feedback and the response to the feedback was displayed.
- The trust completed annual staff surveys. Staff responded anonymously to the staff questionnaire. The staff survey results were monitored by the trust and posted online.

Innovation, improvement and sustainability

- The Hillingdon unit, had been involved in a project with commissioners. This had included the introduction of seven day working for therapists and specialists. The project had resulted in a significant reduction in patients' length of stay due to seven day multi-disciplinary working.
- Individual wards and hospitals had their own quality improvement plans. This meant they had ownership of their service and the changes they made to improve outcomes for patients.
- The Hillingdon unit and South Wing, St Pancras, had worked collaboratively on a project to implement new multi-disciplinary recording documentation and procedures.