Oxleas NHS Foundation Trust

RPG

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)
RPGX6	Greenwich Intermediate Care Unit	Greenwich Intermediate Care Unit	SE9 5DQ
RPGFD	Meadowview Unit	Meadowview Intermediate Care Unit, Meadowview neuro-rehabilitation	DA14 6LT

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

Overall, this core service was rated as 'Good. This was because:

- Systems used to identify patients at risk of deterioration were used effectively.
- Patients received their medicines safely when they were prescribed.
- Facilities were well maintained in a clean and hygienic condition and staff employed recognised infection control practices.
- Adequate numbers of suitably qualified and experienced staff met patients' needs, and kept them safe and patients received adequate medical supervision.
- Robust systems for assessing and mitigating risks were embedded. When incidents did occur, there were well understood systems for reporting and investigating these, and changes were made to practice in light of the lessons learnt.
- Patients received care that followed latest published guidance and best practice and outcomes were in line with national averages.
- Patients received adequate pain relief.
- Patients were supported to eat and drink suitable food in sufficient quantities. However feedback from patients about the quality of food was mixed.
- Staff received adequate training to safely undertake their role, and their performance was supervised and appraised.
- Patients received care from a multidisciplinary team who worked cohesively to deliver care that met their needs.
- Patients were positive about their experience. They were treated with compassion and their privacy and dignity were respected.
- The service was well placed to meet the diverse needs of patients and was committed to providing care as close to home as possible.
- Admissions to the service were well managed to minimise risks to patients. Discharge from the service was well planned to ensure the needs of patients would continue to be met. Delayed discharges were usually beyond the control of the hospitals.
- Staff shared a vision and philosophy of care within the service, with a strong rehabilitative ethos. Senior leaders were visible and staff were supported by their immediate managers to provide high quality services.

We saw some good practice, including:

- Compliance with national infection control guidance.
- A strong ethos of promoting independence and rehabilitation.
- The implementation of a system called pressure ulcer prevention strategy (Pups) to reduce pressure ulcers.
- Multidisciplinary team working between nursing, therapy and social care staff.

Summary of findings

Background to the service

Information about the service

Oxleas NHS Foundation Trust provides community inpatient services in two locations. These are Greenwich which is based at Eltham Community Hospital in Eltham, and Meadowview which is based at Queen Mary's Hospital in Sidcup. In-patient services provided vary from location to location, but include intermediate care, and rehabilitation. Patients are admitted to community inpatient services from their own homes, or from acute hospitals. At Queen Mary's Hospital, care is consultant-led and at Eltham medical services were provided by local GPs.

Both locations treated a total of 722 patients between April 2015 and February 2016. The regulated activities carried out across the two hospitals are diagnostic and screening procedures and treatment of diseases and disorder and injury.

We visited the following locations;

- Greenwich Intermediate Care Unit (Eltham community Hospital)
- Meadowview Intermediate Care Unit (Queen Mary's Hospital)

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty

Team Leader: Pauline Carpenter, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a specialist nurse, a junior doctor and a specialist occupational therapist. We also included an Expert by Experience, a layperson with experience of using community health services, in our team

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

To get to the heart of patients' experiences 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 between 26th and 28th April 2016. We visited the two community hospitals comprising this core service.

During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We spoke with a range of staff including two operational managers, a consultant geriatrician, two doctors, 10 staff nurses, five healthcare assistants, five therapists and 10 members of support staff.

Summary of findings

We observed how people were being cared for and talked with carers and family members. We met with people who use the services and carers, who shared their views and experiences. We spoke with approximately 25 patients and 12 relatives of patients.

We reviewed patients' care or treatment records and a wide range of other documents such as policies, performance reports and records relevant to the running of the service.

What people who use the provider say

During our visits we spoke with patients and their relatives and we reviewed completed comment cards. 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 getting my life back together thanks to these people in this hospital", and another commented, "They keep me on my feet, everything is first class."

Patients told us they were treated in clean, hygienic and well maintained environments. One patient said, "Hygiene is a big part of the hospital, it has a high standard of cleanliness," and another commented, "The environment is bright, safe and clean."

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 if I need it during the day and it's always there for me."

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, they are all very professional and above average as a hospital."

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 matron, I see her first thing every morning as she pops by to ask if everything is ok."

Good practice

Outstanding Practice

In recognition of avoidable pressure ulcers in the service a pressure ulcer prevention strategy (Pups) has been implemented .Patients who are at risk are given information to help them understand how to prevent pressure ulcers and a pup picture (using fruits or puppy pictures) is chosen by a patient and this picture is kept in their room so that every staff member is aware that the patient is high risk. This has led to a reduction in incidences of Oxleas acquired grade 4 pressure ulcers.

The use of daily morning board meetings which involves all staff from all levels provides an effective method of information sharing so that everyone on the ward is up to date and involved in the daily care of each patient

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust should take to improve

- Ensure all staff are aware of their responsibilities adhering to the MCA.
- Ensure that medicines given on an 'as required' basis are suitably evaluated.
- Consider pain assessment strategies for those with dementia or learning disabilities.
- Consider taking action to make the care environment more dementia friendly.

Oxleas 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

Overall, we judged that safety in community inpatient services were good. This was because:

- We saw that safety incidents were reported investigated appropriately and the technique of root cause analysis was used for reviewing serious incidents.
- There were good mechanisms for feeding back the outcomes of investigations to individual staff and to staff teams. We saw that lessons learnt were widely disseminated and we saw examples of when practice had been changed as a result.
- The National Early Warning System (NEWS) had been implemented. This is a system to identify patients whose condition is deteriorating.
- Hospitals we visited appeared clean and hygienic and the fabric of the buildings and equipment were well maintained.
- Patients received their medicines safely when they were prescribed. Nurse staffing levels had been reviewed and were maintained at an agreed level that enabled staff to meet the needs of patients safely.
- All staff we spoke with were aware of local safeguarding procedures and their responsibilities in relation to these.
- There were systems in place to identify, monitor and manage risks to patients. Risks were identified and recorded on risk registers. There was a system for disseminating national safety alerts and ensuring that these were reviewed by the appropriate staff
- The organisation had major incident and business continuity plans in place.

Detailed findings

Incident reporting learning and improvement.

- During the period 3rd December 2014 to 1st December 2015, there were six serious incidents requiring investigation reported. These related to pressure ulcers and falls.

Good

Are services safe?

- There were no Never Events reported in the past year. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The community inpatient services used an electronic incident reporting system. All staff we spoke with were knowledgeable about the process and could tell us how and when to report incidents.
- Staff told us they received feedback when they reported an incident. We looked at minutes of staff meetings and noted that there was a standing agenda item where reported incidents and their outcomes were discussed with ward based teams. We observed the daily board round where all members of staff on the ward at all levels had a meeting to discuss any changes or review of care and discharge information, feedback from any incidents and any learning from incidents was discussed at these meetings.
- We saw that lessons learnt were widely disseminated and we saw examples of when practice had been changed. For example, at Meadowview we found that changes to information regarding supervision of a patient at handovers had been modified following a serious fall This demonstrated that there was an effective system for the management of critical incidents
- At Meadowview, Queen Mary's Hospital, we saw that staff had identified falls as a concern and had introduced the use of sensor mats for patients who were regarded as high risk.
- A Quality Board Group meets monthly and acts as an expert group to identify a best practice system of identifying patients at risk of falling and provide guidance to staff and managers on falls prevention.
- We saw that a root cause analysis (RCA) investigation was performed for serious incidents.
- We saw examples of these investigations and saw they were comprehensive and detailed. They all contained an action plan. We followed up an RCA action plan in one of the hospitals and found that it had been implemented and that staff were aware of the incident and the associated learning.
- Managers told us they received regular reports or up to minute e mails of incidents in their areas and trust-wide and were thus able to identify themes and trends. We saw examples of these emails.

Duty of Candour

• All NHS trusts are required to be open and transparent. This includes a Duty of Candour that requires the trust will ensure any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered. This is regardless of whether a complaint has been made or a question asked about it.

• Staff told us they were confident about reporting incidents and were aware of their responsibilities to be open and transparent with patients and their relatives if anything went wrong with their care.

• Staff were aware of and knew how to access the trust's whistleblowing policy and we saw that the trust had created a staff leaflet explaining the New Duty of Candour regulation 2014, outlining the responsibility for staff to include openness and honesty with patients especially if things go wrong. This leaflet was available across both wards

Safety Thermometer

- The community inpatient services collected data for the national Safety Thermometer programme, which enabled us to judge their performance and inform future practice in relation to minimising patient harm.
- We reviewed Safety Thermometer data and we found that 92.6% of patients experienced harm-free care in community inpatient services from March 2015- 2016. This is below the national target of 95%.
- In this same period, 98.8% were free from pressure damage and of those patients that were cared for with a urinary catheter in situ; 0.5% of these contracted a catheter-associated urinary tract infection. 0.6% developed a venous thrombosis and about 0.9% of inpatients experienced a fall, 0.33% of these resulted in low harm with 0.04% resulting in severe harm. The performance measured was in line with national averages.
- In recognition of avoidable pressure ulcers in the service a pressure ulcer prevention strategy (Pups) has been implemented. Patients who are at risk are given information to help them understand how to prevent pressure ulcers and a pup picture (using fruits or puppy

pictures is chosen by a patient and this picture is kept in their room so that every staff member is aware that the patient is high risk. This has led to a reduction in incidences of Oxleas acquired grade 4 pressure ulcers.
- We saw display performance information displayed on the wards, including staffing levels, incidences of harm, such as falls, pressure areas and patient feedback.

Safeguarding

- Staff received appropriate training in safeguarding adults and children as part of the mandatory training programme. Training rates for adult safeguarding across sites averaged at 94%**.**
- Staff we spoke with were aware of the principles of safeguarding and could describe what action they would take if they suspected abuse. We saw that safeguarding policies agreed with local authorities were available for staff to reference.
- We were given examples of safeguarding referrals and the sequence of events that followed to ensure people were protected from abuse. Social care staff we spoke with praised the engagement of community inpatient service staff in safeguarding procedures. This demonstrated that staff worked collaboratively with social care colleagues to protect people at risk of abuse.
- All patients we spoke with told us they felt safe.

Medicines

- Overall, we found that there were good systems for the safe supply, storage, administration and disposal of patients' medicines.
- We saw induction records that showed that new nurses' competency in medicines administration was assessed. Training records showed staff had attended formal training in medicines administration and transcribing of prescriptions. This meant that, although new staff demonstrated competency, the available training was not compulsory and ongoing competency was not re-evaluated formally.
- Community inpatient services were served by a pharmacy service with registered pharmacists and technicians visiting the clinical areas.
- Registered pharmacists visited the wards and provided a clinical pharmacy service that ensured that the delivery of patients' medicines was optimised. This meant that community inpatient services had access to a comprehensive pharmacy service. Stock medicines were obtained from the trust pharmacy service. Individual patient medicines were generally obtained from local pharmacies. We saw examples of orders being made and delivered promptly.
- We saw records that showed medicine deliveries were signed for.
- Medicines were stored securely in locked cabinets or trolleys. We observed that these storage facilities were locked and that access to keys was controlled by the nurse in charge.
- The ambient temperature of rooms where medicines were stored were checked and recorded. Medicines, if required, were stored in locked, designated refrigerators to ensure they remained in good condition. The temperatures of the refrigerators were recorded regularly during each day.
- We observed nurses administering medicines and found that they complied with 'Standards for medicines management' issued by the Nursing and Midwifery Council (NMC).
- We checked patients' medicine prescriptions and administration records and found that they met legal requirements. We generally found administration records to be accurate and complete with the reasons for any omissions recorded.
- There were no errors in oresribing or admisitration that caused serious harm reported. Staff had good awareness of how to report errors.
- Prescription charts developed for use at Eltham community hospital promoted medicines optimisation.
- We observed there were adequate arrangements for the disposal of unused or unwanted medicines. These medicines were stored in distinctive bins with while awaiting collection by a suitable waste contractor. Staff we spoke with could describe systems in our discussions with them.
- The range of emergency medicines held at services across the Trust met both NICE NG10 and Resuscitation Council guidelines
- There were good examples of provision of information about medicines (in a range of formats) for people who use them.
- Controlled drugs (CDs) are medicines which are subject to additional controls as they are liable to be misused. We found that ordering and delivery systems for CDs met legal requirements, that CD registers were accurately maintained and that CDs were stored

appropriately and balances were regularly checked. Unwanted CDs were destroyed with a member of pharmacy staff using denaturing kits, which we saw were available.

Environment and Equipment

- Community inpatient services, premises and grounds were well maintained.
- We did not identify any obvious safety risks for staff, patients or visitors. We looked at an inspection carried out in detail and noted that there were two potential risks identified, one of these was rated moderate and one minor. We saw that actions to mitigate these risks were being progressed.
- We were shown quarterly health and safety site inspection reports, which had been carried out. These reports identified any actions that were taken to address any identified deficiencies.
- Staff received health and safety training as part of the mandatory training programme with a completion rate of 94%.
- Staff described systems for reporting concerns and repairs to us and told us that problems were addressed in a timely manner. We saw from records how this had been recorded and reviewed to ensure that the work was completed by the maintenance staff. Records that showed that equipment was regularly checked and maintained.
- There were arrangements for checking mattresses to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients. We saw checklists that showed mattresses were checked regularly and removed from use if found to be inadequate.
- There was adequate emergency equipment, including automated defibrillators, airway management equipment and oxygen readily available and staff could tell us where it was located.
- Staff knew there was a system for checking equipment to ensure it remained ready for immediate use. We saw completed checklists, which showed this practice was well embedded
- Staff described how electrical medical equipment (EME) was checked and maintained by the trust's EME department. They told us that any faults or concerns were responded to quickly.
- We saw staff induction records, which showed that new staff were trained, and had their competency assessed, in the use of equipment found in their work area. In each area, staff had access to a current, site-specific management of medical devices manual for reference. This meant staff were able to use equipment safely.

Quality of records

- Records were stored securely, but were accessible to staff when they needed them.
- Patients transferred from acute hospital arrived with adequate information to inform their ongoing care. However, it was reported to us that staff needed to be vigilant in ensuring that patients arrived with their old records and sufficient and accurate assessment.
- Staff were aware of their responsibilities in relation to information governance and 94% had completed training in this area.
- We viewed patient records and overall found them to be complete, current, and accurate and fit for purpose. We found that other records, such as checklists were consistently completed and retained.
- Staff records were stored securely and were only available to those who needed to see them.

Cleanliness, infection control and hygiene

- The community inpatient premises were clean and hygienic. Patients we spoke with commented positively about the cleanliness of the environment**.**
- We found practice conformed to guidance issued by the Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015).
- The trust maintains effective infection prevention and control arrangements through a fully constituted Infection Prevention and Control Committee; The committee meets quarterly and reports directly to the Patient Safety Group.
- The Infection Prevention and Control Committee produce an annual work plan which describes objectives, actions and how these provide assurance against strategic objectives, priorities, and external indicator.
- The Infection Prevention and Control Committee maintain a Risk Register, which includes controls, assurances and gaps in control

Good

Are services safe?

- Patient-led assessments of the care environment (PLACE) in 2015 achieved cleaning scores of 99%. This is slightly above the expected national average of 98%.
- We saw records that cleaning standards were audited monthly and that scores showed a satisfactory level of performance.
- Feedback reports from the audit was returned to the Infection Prevention Team which is monitored by the Infection Prevention and Control committee and the Patient Safety Group. We noted that remedial actions were identified at the time of audit and were followed through. This meant that cleaning standards were monitored and corrective actions were taken when elements of cleaning were deemed to be unsatisfactory.
- We saw schedules and checklists, which showed cleaning and nursing staff clearly understood their responsibilities in relation to cleaning. We were shown checklists completed by cleaning staff and nurses that showed when designated tasks were carried out and these were consistently completed.
- Infection control training formed part of the mandatory training programme. We saw records showing an overall training compliance rate of 95%.
- We saw that staff used personal protective equipment when appropriate.
- Staff decontaminated their hands in line with the World Health Organization's guidelines 'Five Moments for Hand Hygiene. Hand hygiene audits were carried out on a monthly basis.
- The Infection Prevention Team also undertake an annual unannounced audit. Audits are conducted using two measures, environmental/equipment and from observation. For Meadowview the annual compliance rate from April 2015 – March 2016 was 97% for environment/.equipment and 96% for observation. At Greenwich, there were three months were audits were not returned so recorded compliance rates over the 9 month period were 100% for environment and equipment and 99% for observation.
- There were few outbreaks of infection in the community inpatient services. There had been two instances of MRSA but these had been infections that were contracted whilst the patient was in the acute hospital and prior to admission to Queen Mary's. There had been no recorded incidences of Clostridium Difficile infection.
- Each service had access to adequate patient isolation facilities.
- Equipment that was shared between patients was clearly labelled as having been decontaminated and ready for use We observed staff cleaning shared equipment using appropriate methods. We observed that single-use or single patient equipment was used appropriately.
- There were appropriate systems and arrangements for the segregation and disposal of domestic and clinical waste. Disposal of 'sharps' met Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'.

Mandatory Training

- The community hospitals took part in the organisation's mandatory training programme. We noted that staff were attending mandatory training and relevant updates.
- Staff we spoke with confirmed they received mandatory training either online or face-to-face and were supported to attend. Training records showed that overall compliance rates were 94%.
- We saw ward managers retained accurate local training records and showed us plans to ensure that essential training was updated when required

Assessing and responding to patient risk

- Standardised, validated risk assessments were used to determine specific patient risks and to inform an appropriate response. Risk assessments were updated at regular intervals.
- Risk assessments included the Waterlow risk assessment score (to determine risk of pressure damage), venous thromboembolism (VTE or blood clot) risk assessments and dementia screening tools. Local risk assessment tools were used to assess the risk of falls and those associated with the moving and handling of patients.
- The National Early Warning system (NEWS) had been implemented. This is a system to identify patients whose condition is deteriorating .We found that the early warning scores were regularly and accurately calculated. We found numerous examples where the escalation processes described in NEWS had been followed and saw examples where nursing records reflected the risk scores and described any action taken.

Good

Are services safe?

This protocol was audited monthly .This meant patients whose conditions were deteriorating have been identified at an early stage with the risk that their care needs have been escalated appropriately.

- Results from an audit for the month of February to March 2016 showed 100% of deteriorating patients were escalated using the protocol. We found numerous examples where the escalation processes described in NEWS had been followed and saw examples where nursing records and handovers both verbal and written reflected these risk scores, with a specific action.
- At Queen Mary's Community Hospital, we saw in the records that a patient had been transferred to an acute hospital the previous day. Staff were able to describe how they had recognised the patient was becoming unwell, had used the NEWS score to objectively describe their concern to the GP and arranged transfer to a more appropriate care setting.
- Staff told us that if they had concerns regarding a patient's condition they had the option of calling 999, and gave us examples of when they had done this. This demonstrated if a patient's condition is deteriorating, staff took appropriate action.

Staffing levels and caseload

- Since December 2015 Oxleas had employed a locum specialty doctor for Greenwich Intermediate Care unit (GICU) based at Eltham Community Hospital, Monday to Friday 9am -5pm. The role provided medical leadership to the service and managed intermediate care patients. The medical cover for Meadowview consisted of a Consultant Geriatrician, who worked across community and the bedded unit, Monday to Friday. Support was provided by a full time locum registrar grade doctor who also worked Monday to Friday.
- Out-of-hours medical cover was provided by GP on-call services. Staff told us that this arrangement worked well and that they could access medical assistance if required.
- We saw that nursing staffing levels, for community inpatient services, had been agreed at an organisational review of staffing levels. The trust had agreed nurse staffing levels that meant there were nurse to patient ratios were at about 1:7 during the day, 1:8 during the evening and 1:9 at night.
- Average fill rate of registered nurses in Greenwich during the day from January 2016 until March 2016 was 91% care staff for the same period, night fill rates of Registered nurses was 98% whilst night care staff was also 98%. In the same three month period at Meadowview Registered Nurses fill rate during the day was 91%, day care staff was 99%, night Registered nurse fill rate was 98% and night care staff was 99%.
- Staff felt that, generally, there were sufficient nursing staff to meet patient needs. Staff said "it gets busy at times" but none felt that any pressures were due to inadequate staffing levels.
- Most patients we spoke with felt that their needs and requests for help were responded to promptly. However, some patients in Meadowview commented that they were surprised at the length of waits for assistance to use the lavatory.
- Vacancy rates at community inpatient services ranged from 50% for trust level qualified nurses and 24% for nursing assistants. Managers told us recruitment of staff was a big challenge that was recognised at trust headquarters and action plans were in place to try and look for innovative ways to recruit staff, for example setting up a trust stall in local community shopping centres.
- The trust were actively recruiting into vacant posts and we saw evidence of new staff who were waiting to start employment. We also saw evidence of the additional challenges of recruitment, for example five nurses from overseas who had been employed, received training and been inducted but left within three months of their contract start date to work in central London.
- Members of a temporary workforce were used to cover gaps in rotas. Most of these staff were members of staff working additional hours, or 'bank' staff familiar to staff and the service.
- A high level of agency staff were employed. In the period December 2014 to December 2015 community inpatients had 1,914 shifts filled by bank and agency staff, there was no available data to show many shifts were not filled by bank and agency staff although the nurse staffing fill rates indicated this was not an issue.
- Where possible management requested agency staff who were familiar to the running of the unit. We spoke to five agency staff who had worked regularly in each unit, they were familiar with how the unit was managed and their responsibilities on reporting and recording.
- We witnessed an agency nurse working at Eltham Community Hospital during our visit had received an

orientation to the ward and had had key skills observed. This induction was recorded and retained. We were told that agency staff are trained to use, the electronic patients records system. This meant that temporary staff were adequately prepared to work in the service.

- Patients spoke positively about bank and agency staff and whilst they preferred to have the same set of carers they said agency staff were competent and caring.

Major incident awareness and training

- There were major incident and business continuity plans in place. Staff were aware of these and knew how to access them. They could clearly tell us their responsibilities in the event of a major incident.
- We saw records to show that staff had participated in emergency evacuation scenarios both during the day and night. This meant that staff were confident in the procedures to adopt in the event of an incident.
- We saw records that showed that managers providing an on-call service to community inpatient services had received major incident training. This showed that there were contingency plans to ensure patients remained safe in case of 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

Overall, we judged that community inpatient services were effective and we rated them good in this domain. This was because:

- Patients received comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and well-being and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.
- We saw examples of care pathways being used to ensure that patients received evidence-based care at the right time.
- Patients we spoke with told us that they were provided with adequate pain relief. However, we found that there was limited use of objective pain scoring systems, including those specifically for people living with dementia.
- We found that patients' nutritional needs were assessed, and that they were provided with choices of nutritionally balanced food and drink, in sufficient quantities, to meet their individual needs.
- We found that junior staff had an annual appraisal and they could access further training as part of their personal development plans.
- We saw evidence of the use of appropriate telemedicine technology.
- We found that patients could access the full multidisciplinary team, including social care staff from the local authority and staff worked as a cohesive team demonstrating a strong commitment to multidisciplinary working.

Detailed findings

Evidence based care and treatment

- We viewed twelve records that demonstrated patient needs were assessed on arrival and those assessments were regularly reviewed.
- We saw that there were plans of care that were designed to meet patient needs.
- We saw through our review of ten care plans that relevant NICE guidance, relating to Falls (CG161), Infection prevention and control (QS61) Medicines adherence (CG76), Pressure ulcers (CG179) and VTE (QS3) were all being broadly followed.
- At Queen Mary's, we saw a stroke pathway in use and when we reviewed a sample of patient records we saw how multidisciplinary teams had been involved, including therapists, stroke nurses, and discharge coordinators. This meant that patients received care using evidence-based treatment pathways.
- During multidisciplinary meetings and handover we observed that staff demonstrated sound knowledge of their patients' conditions, their individual circumstances and care preferences. They were aware of current best practice and the theoretical basis underpinning their practice.

Pain relief

- Patients we spoke with told us that they were provided with adequate pain relief. We looked at records, which demonstrated that patients were given pain relief when it was required. We found that objective pain scoring systems were available and were included on observation charts.
- Staff did not use, or show awareness of pain assessment tools that have been developed for people living with dementia or learning disabilities. This presents a risk that for these people; their pain could be poorly assessed and inappropriately managed.
- We tracked the records of patients who had been given analgesia as required and sometimes high-strength pain killers. We found that the reason for administration was recorded with specific information around why the patient had requested the pain relief. However, evaluation of analgesia "as required" was not always carried out.

Nutrition and hydration

- The trust's arrangements for the provision of food and drink were compliant with the Hospital Caterers'

Good

Are services effective?

Association Better Hospital Food programme (2006) guidance, the National Patient Safety Association document 'Nutrition and Hydration' (2008) and NICE guidance 'Nutrition Support in Adults' (QS24).

- Patient-led assessments of the care environment (PLACE) earlier in the year had scored community inpatient services in at 92% which is slightly above the national expected average of 90%. This demonstrated that patients were somewhat satisfied with the quality of food provided.
- The community inpatient service was able to provide a full range of therapeutic diets and also diets that met the individual religious or cultural needs of patients. When required, food charts were kept and accurately maintained.
- Patients were risk assessed for possible nutrition using the malnutrition universal screening tool (MUST) within 24 hours of admission and at least every seven days thereafter. When we reviewed patient notes we found that MUST assessments were accurate and completed in a timely way. This showed that patients' nutritional needs were regularly assessed using a validated tool.
- We looked at the notes of ten patients and found when patients were assessed as being 'at risk' the correct processes had been followed. We did find some examples of a delayed referral to a dietician, and were told that as the dietetic service did not always respond promptly, ward staff managed the risk themselves. While not ideal, we did note that, in these cases, patient care was appropriate.
- We observed meal services. Food was tested to ensure it was at the correct temperature and there was a choice of menu options. Meals appeared well presented with a choice of portion size.
- Patients were encouraged to eat in a dining room and they told us they enjoyed this. We observed there were sufficient staff available to help patients eat and to encourage them when necessary and we saw them doing this. Appropriate equipment was available to help patients and promote their independence when eating.
- Staff encouraged people to drink adequate fluids throughout the day. The patients we spoke with appeared adequately hydrated.
- Staff told us that patients could access food and drink at any time on request. Patients we spoke with confirmed this.
- As part of rehabilitation assessments and plans, the occupational therapist was able to carry out functional feeding assessments and provide adaptive cutlery, if required.
- Weekly breakfast clubs were used as part of rehabilitation plans where patients prepared and ate breakfast together under the supervision of therapy staff.
- Tables, chairs and work surfaces were designed to lower and heighten to accommodate the needs of wheelchair users and nutritional care was integrated into rehabilitation plans.

Technology and telemedicine

- Staff were aware of how new technologies could be used to improve the care and safety of patients. We observed the use of sensor mats and movement alarms at Queen Mary's.
- We attended a multidisciplinary team meeting at both hospitals, where patients' suitability for various telecare solutions on discharge was discussed and referrals organised. Staff were familiar with the technologies available and demonstrated an understanding of when their use would be appropriate.

Patient outcomes

- In the National Audit of Intermediate Care 2015 we noted that both community in-patient services performed in line with national averages. We noted the service user outcome measure using nationally recognised dependency tool was better than national averages at Eltham Community Hospital which archived scores of 80.7 on discharge, better than the national average of 76.4.
- However, Meadowview scored worse with a score of 62.8. It is worth noting that at Meadowview admission scores were significantly worse than national averages and that the level of improvement was in line with that of other units.
- Meadowview discharged a higher percentage of patients to their own home than the national averages, 81% compared to an average of 62%. There was no data reported for Eltham Community Hospital on this point.

Competent staff

- We found that staff participated in an annual appraisal. Overall appraisal rates were 91%.

Good

Are services effective?

- Junior staff told us that they could access further training as part of their personal development plans. 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.
- We found there were systems to ensure that qualified staff remained registered with the Nursing and Midwifery Council, or the Health Professions Council. We saw an instance where a nurse was being supported through a return to practice nursing programme to enable them to update their registration with the NMC. Other staff we spoke with also indicated they had received appropriate trust and local inductions.
- 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 further professional development. We spoke with one healthcare assistant who was being supported to become a registered general nurse.
- 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 arrangements with the agencies they used to be assured that staff supplied possessed the clinical competencies.
- Staff felt supervision and appraisal were essential for morale and personal development and said that management made sure that deadlines for supervision and appraisal were always met.
- Staff we spoke expressed confidence in the abilities of colleagues. One commented, “Staff are confident in what they are doing”. Another said “there is loads of training, loads of support and regular opportunities to discuss your work.”

Multi-disciplinary working and coordinated care pathways

- Generally, we found that patients could access the full multidisciplinary team, including social care staff from the local authority. We observed that staff worked as a cohesive team and they demonstrated a strong commitment to multidisciplinary working. Staff demonstrated a sound understanding of each other’s roles, and commented that all staff were treated with respect.
- Therapy staff we spoke with praised the skills of nursing staff in relation to rehabilitation.
- All community inpatient service sites held weekly multidisciplinary meetings to discuss the ongoing care and treatment plans of patients, which meant care was planned and coordinated. Although patients did not attend these, their views were sought beforehand and there was feedback given to them and their families.
- When planning complex discharges, discharge-planning meetings were convened.
- We found access to speech and language therapy and a dietician was sometimes delayed. We heard examples of delays in these staff being able to respond to referrals, which meant that there was a risk that patient care was compromised. A patient told us, “You can see the staff work together helping each other no matter the grade; it’s good to see.”

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff were aware of the need to obtain patient agreement and consent to deliver care and we observed this in practice. This meant that patients understood and participated in decisions about their care and treatment, and they were asked for their consent when appropriate.
- Training in the application of the Mental Capacity Act was not mandatory. Most staff had a good understanding of the act. However, some staff were unsure about the main principles of the act and its implementation. For example some staff felt it was solely the domain of social workers to always carry out capacity assessments on patients.
- On the units we saw contact information for an advocacy service which provided support to patients and carers.

Good

Are services caring?

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

Summary

Overall, we rated community inpatient services as good for caring. This was because:

- Patients were overwhelmingly positive about their experience.
- Patients told us that they were treated with kindness and compassion and that their dignity was maintained and privacy upheld.
- Patients told us they were included in discussions and decisions relating to their care and treatment.

Detailed findings

Compassionate care

- We observed that patients were treated with dignity and their privacy was maintained. We saw staff using people's preferred names.
- Patient care was given in private and discreet conversations, especially those relating to personal care. One patient said, "They are good, young staff who are really caring. I feel able to keep my dignity, even when needing help in the shower." Another patient said, "the staff are amazing, they are genuinely interested in people and that really do care".
- There were no instances of mixed sex accommodation reported in quarter one in 2016,staff we spoke with said they hadn't observed it and stated that there was a commitment trust wide to eliminating mixed sex accommodation
- Patient-led assessments of the care environment (PLACE) in relation to dignity and wellbeing in 2015 at Meadowview, Queen Mary's hospital scored 80% which was below the trust average of 92% and below the England average of 86%. However, during our visit we only received positive comments about how staff maintained people's dignity and wellbeing.
- The In-patient 'Patient Experience' questionnaires results dated June 2015, 96% of patients felt they were treated with dignity and respect.
- Results from the Friends and Family test completed by community health servicesstated that 56%of patients were extremely likely to recommend the hospital whilst 36% were likely to recommend. However, response rates are so low that the results cast doubt on whether the findings are representative of the patients' views as a whole.

Understanding and involvement of patients and those close to them

- Patients told us they were included in discussions and decisions relating to their care and treatment. We saw that discussions concerning patient treatment plans were documented in their records.
- We observed that there was a strong ethos of promoting independence and rehabilitation in the service. We saw that staff encouraged patients with kindness and patience to undertake tasks for themselves where this would aid their recovery.
- Patients had copies of their rehabilitation plans setting out personal goals and how these might be achieved, or a timetable of planned therapy sessions and activities. This meant that patients and their families always had access to their rehabilitation plans.
- In the In-patient 'Patient Experience' questionnaires results dated June 2015, 96% of patients felt they had enough information, and 92% rated helpfulness as excellent.

Emotional support

- We reviewed records that showed that nursing staff provided emotional support to patients and their families with details of conversations recorded.
- Staff discussed the emotional needs of patients, and the strategies they would use to support them. We witnessed this at handover meetings we attended.
- 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. We reviewed records that showed that nursing staff provided emotional support to patients and their families.

- At handovers we attended, staff discussed the emotional needs of patients, and the strategies they would use to support them.

Good

Are services responsive to people's needs?

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

Summary

Overall, we rated community inpatient services as good for responsive. This was because:

- Services are planned and delivered in a way that meets the needs of the local population with the importance of flexibility, choice and continuity of care is reflected in the service design.
- Referrals and admissions of the community inpatient services were generally well managed to ensure that the needs of people admitted to the service could be safely met.
- Care and treatment was coordinated with other services and other providers and patients could access the right care at the right time.
- There were systems in place to manage referrals and ensure that the services were effectively utilised for the benefit of the local population.
- We found there were clear procedures for receiving, handling, investigating and responding to complaints.

Planning and delivering services which meet people's needs

- Overall, the bed occupancy for the service was 92%, which was above the national recommendation of 85% for effective management of hospital services.
- The average length of a patient's stay was 27 days. The inpatient community services were operating a pathway with a 21 to 28 day length of stay. This meant that length of stay was in line with the planned and commissioned pathway.
- The local Clinical Commissioning Group had commissioned 74 of the 75 available beds. This meant that there was scope to increase capacity during periods of peak demand. Staff told us that had happened during the winter, and that staffing levels had been revised upwards to manage the increase in demand.
- There was the facility to flex admission criteria in times of peak demand to prevent unnecessary admissions and to promote effective discharge from acute beds during periods of high usage. Responsibility for this lay with the locum specialty doctor for Greenwich Intermediate Care unit.
- The community hospitals prioritised admissions for patients with a local GP, or connection in order to provide services as close to home as possible.
- All staff showed knowledge of the local resources that would benefit patients and their families in the short, medium and long term.

Meeting the needs of people in vulnerable circumstances

- There were facilities and resources available to meet the diverse needs of patients. This included the provision of adaptive equipment, mobility aids, bariatric equipment and interpreting services.
- There were arrangements to provide interpreting services for those for whom English was not their first language. Although no referrals had been made to interpreting services in the past year, staff were all aware of how to access these should they be needed. For example directing people to the Asian advice project which provides advice to Asian women in the borough of Greenwich speaking Punjabi, Hindi, Urdu and Gujarati.
- Equality and diversity training formed part of the mandatory training programme 94% of staff had completed this. Although the community inpatient services did not serve a particularly diverse population, staff were aware of the need to recognise and celebrate diversity.
- We saw that some specific measures were in place to meet the needs of people living with dementia, but observed that the environment was not yet dementia friendly. We were told that there had not been any environmental audit of the ward areas regarding dementia friendliness but given the increase in admission of more complex patients staff were aware this would have to be given consideration.
- The service cared for few patients with learning disabilities. Staff told us they could access specialist support if they needed to and showed us a resource folder they could reference.
- We saw that community inpatient areas were accessible for people with disabilities or limited mobility.

Good

Are services responsive to people's needs?

- Patients we spoke with had mixed views about the quality of the food. Typical comments were "The food is good, I've got no complaints" and "it's better than home". Other comments included "Its (the food) just reheats and I don't consider that a cooked meal" and "it's really not very good and lacks quality", another patient said "you soon get very fed up with the food in here."
- Facilities for patients' visitors were satisfactory. We found that waiting areas were pleasant and comfortable.
- There were adequate parking facilities at Queen Mary's but very limited parking at Eltham Hospital. An on-site shop and bistro were available for patients and their visitors.

Access to the right care at the right time

- We found there were systems in place to manage referrals and ensure that the services were effectively utilised for the benefit of the local population.
- Referrals were managed through a centralised group called the Flow Team. The Flow Team summarised the medical assessment and care needs of patients prior to referral to ensure they were appropriate for care in a community in-patient setting.
- We saw that the flow Team provided basic referral information, but that service managers needed to liaise further to ensure that inappropriate admissions were minimised.
- At both Queen Mary's and Eltham Hospital staff were particularly vigilant in ensuring that patient needs were in line with the organisation's intermediate care beds admission criteria before they were admitted. Four beds are commissioned under a flexi criteria arrangement, whereby, support is provided for patients with a range of needs and not specifically for rehabilitation enablement or therapeutic non-medical management. However, the ethos of the staff we spoke with was that every patient regardless of their condition, needs or illness "had rehabilitation potential " and everyone is treated with the same attitude
- We were told that there were minimal delays in accessing a bed in the community inpatient service, although occasionally a waiting list was operated by the Flow Team during periods of peak demand.
- During our inspection, we found that there was capacity that allowed for admission once referral had been accepted and agreed. We were told that there were minimal delays in accessing a bed in the community inpatient service, although occasionally a waiting list was operated by the Flow Team during periods of peak demand.
- We found that there was an appropriate emphasis on discharge planning and observed good practice in this area. Patients, their families, and outside agencies were engaged in discharge-planning processes. This meant patients were discharged safely and their needs continued to be met after they left the hospital.
- We saw that, where appropriate, discharge-planning meetings were held to plan the discharge of patients with complex needs. We saw that a wide range of assessments by the multidisciplinary team were performed, including home assessments and access visits by therapy staff.
- We saw evidence that demonstrated staff were aware of the availability of NHS continuing healthcare funding and the process for ensuring people were assessed for this as part of their discharge planning. When appropriate, patients were referred and received an assessment to establish their eligibility for this funding.
- The trust reported non-acute delayed transfers of care as a percentage of occupied bed days. The overall average from January 2015 to December 2015 was 17%. There were some delayed transfers of care, and staff told us that this was usually due to awaiting NHS funded continuing healthcare assessments, awaiting local authority funding or a lack of local availability in care homes. These situations are beyond the control of the trust, but remain within their sphere of influence and we found that staff worked to minimise any delays.

Learning from complaints and concerns

- We found there were clear procedures for receiving, handling, investigating and responding to complaints. Patients we spoke with all knew how to raise a concern, and we saw information about the complaints process was made available to patients and their families.
- From the data submitted from the trust, community inpatients received 9 complaints from February 2015 – September 2015, two of the complaints we looked at were undated. This showed a low level of formal complaints. Of the 9 complaints 5 were fully upheld and

Good

Are services responsive to people's needs?

4 were partially upheld. There was no recurring themes and we could see that action was taken to address the complaint and we saw some examples of working practices changing as a result of the complaint.

- We saw meeting minutes, which showed that concerns, complaints, and plaudits were discussed at team meetings and that action plans were formulated and implemented in response to these.
- Ward areas displayed 'You said, we did' information. For example, we saw examples of positive feedback and an intention to act in response to patients complaints referring to activities, food, and visiting hours. Staff we spoke with told us how they made sure that patients' families knew who to contact to discuss out-of-hours visiting if they felt this was required. This showed that actions were taken as a result of concerns raised, and patients and their families were made aware of a response.

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

Overall, we judged that community inpatient services were well-led and rated them 'good' in this domain. This was because:

- We observed that the trust values were prominently displayed and staff we spoke with showed an awareness of these values
- We saw that individual ward areas had local philosophies of care and staff told us that they were formulated and owned by the ward team.
- Staff told us they felt supported by their immediate managers to provide good quality care, and that managers were approachable and visible.
- We observed that staff all exhibited a positive attitude in relation to their jobs and s we noted that among nursing staff morale was high.
- We saw that staff worked collaboratively and staff told us that they valued the good teamwork and peer support they enjoyed at work.
- There was a strong ethos of promoting independence and rehabilitation.
- There were active 'Friends' organisations at each site these are independent charitable and voluntary organisations that support a wide range of hospital departments and facilities.

Service vision and strategy

- We observed that the trust values were prominently displayed. Staff we spoke with showed an awareness of these values in our discussions with them.
- We saw that individual ward areas had local philosophies of care and staff told us that they were formulated and owned by the ward team.
- During our visit, we saw that staff worked to put these values into their everyday practice. This showed that the services had a vision and sense of common-purpose that helped ensure patients received quality care.

Governance, risk management and quality measurement

- At community inpatient service level we found there were robust governance arrangements The Director of Adult Community Services works closely with the Head of Nursing and Clinical Director. They in turn worked closely with heads of departments and heads of service. The directorate were active in visiting the services, meeting the staff and reinforcing trust values and strategy on integrating physical and mental healthcare.
- We saw a good example at Meadowview where senior clinicians do joint round on older peoples and mental health wards, and another where tissue viability nurses provide advice to mental health services. Staff from all levels we spoke with confirmed that they knew the directorate and felt they were visible, supportive and approachable.
- We were told about the Quality (risk) board meeting which met monthly and this ensured that quality and safety matters received due consideration and that actions were agreed and progress monitored. We saw the minutes of the most recent meeting which focussed on 'quality', 'patient safety', 'patient experience' and 'clinical effectiveness'
- Quality and risk panel meetings occurred every four weeks where local mangers met with senior leaders. These included discussion and analysis of incident reporting data. This meant there were systems to identify and mitigate any emerging safety risks.
- We saw minutes of ward meetings where there was a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated.
- We saw that there were systems to identify, monitor and manage risks to patients. Risks were identified and recorded on risk registers. Staff were aware of local and organisational risk registers and referred to these during our discussions.
- We saw examples of risk assessments that were regularly reviewed and noted that specific control mechanisms, identified on these assessments, were in place.

Good

Are services well-led?

- There was a system for disseminating national safety alerts and ensuring that these were reviewed by the appropriate staff. This showed there was a proactive approach to managing risks.

Leadership of this service

- Staff we spoke with told us they felt supported by their immediate managers to provide good quality care, and felt that managers were approachable and visible.
- Senior leaders for example the Head of Nursing for the Adult Community Services Directorate, the director of adult community services and clinical director visited the ward areas regularly and staff knew who they were.
- There were vacancies for key therapy roles, but the organisation was recruiting into these. This potentially restricted the development of therapy services at the time of our inspection.
- Patients we spoke with were confident and felt secure in the management of the hospital.

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. We observed that staff all exhibited a positive attitude in relation to their jobs, and patients noticed this and commented on it.
- In our discussions with staff, we noted that morale was high. We saw that staff worked collaboratively, and staff told us that they valued the good teamwork and peer support they enjoyed at work.
- There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- Community inpatient sickness rates were 7.1%, above the trust average of 4.2%. Staff sickness is viewed as indicator of staff satisfaction and morale, although in this case the above average sickness level did not correlate with the views of staff we spoke with.

Public engagement

- We saw minutes that confirmed that site team meetings took place, which afforded staff the opportunity to discuss both local and wider organisational issues and to be kept updated with service developments.
- Each site had an active Friends organisation and staff could tell us about the financial support they received to purchase equipment and to improve facilities. Advertising materials about the Friends organisations was displayed throughout the service.
- 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 it discussed at team meetings.

Staff engagement

- 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, audit activity and national guidance.
- We saw minutes that confirmed that site team meetings took place, which afforded staff the opportunity to discuss both local and wider organisational issues and to be kept updated with service developments.
- 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
- Healthcare assistants held their own meetings every two weeks to discuss any issues and these were fed back to senior management.
- In 2015 Oxleas was ranked in the top ten of in the Health Service Journal list of 100 best NHS organisations to work for in England.
- A total of 837 of Oxleas' staff responded to the NHS staff survey and subsequently it was rated as one of the best in the country for effective team working, effective appraisals, reporting errors/incidents, fairness of reporting incidents and not experiencing work related stress.
- The trust hold annual Staff Recognition Awards which are presented at the Members' Meeting in categories based on their six values, excellence, having a user focus, partnership, being responsive, safety learning with one additional category for leading and inspiring. In 2015 they trust received 205 nominations from service users, carers, members, staff and colleagues in partner organisations.

Good

Are services well-led?

Innovation, improvement and sustainability

- Oxleas NHS Foundation Trust had improvement plans with a projected spend of £21.9 million to improve serves at Queen Mary's Hospital. The investment includes a new entrance and reception area as well as an out-patient area, urgent care centre, dispensary and phlebotomy services. This meant the trust was investing in services to make them more attractive to use, and broadening the services available in a community hospital setting.
- The Oxleas Information Team was shortlisted for a National Award in the "Improving Efficiency Through Technology" category and was 'highly commended' for its Clinical Task List. Clinical Task List (CLT) is a web based system to help healthcare professionals see what key data is missing from patient records so that staff can then update the information to help improve the quality of patient care. This demonstrates and innovation to improve the quality of services.