Care Quality Commission

Virgin Care Services Limited

1-351584301

Community health inpatient services

Quality Report

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Date of inspection visit: 14 and 15 February 2017
Date of publication: 10/08/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-365636965	Farnham Hospital for Health		
1-365627764	Milford Specialist Rehabilitation Hospital		
1-365636607	Haslemere Hospital		

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

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?	**Outstanding**

Summary of findings

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Summary of findings

Overall summary

Safety was a primary strength of this service at both local and provider level. There were very effective systems in place for monitoring the quality of care and safety of services. Local staff were encouraged to take responsibility for using the corporate tools (such as the Internal Service Review) to drive improvement in patient safety.

There were highly effective corporate safety systems for monitoring services and acting on concerns. Performance was shown to improve over time across all services in the organisation. Any dips in performance trajectories were investigated and the root cause identified. Openness and transparency about safety was actively promoted. Staff understood and fulfilled their responsibilities to report incidents and near misses.

The provider gave high priority to safeguarding people from abuse, there was good leadership nationally of both adult and child safeguarding. Staff were knowledgeable and had completed the appropriate level of training.

There was a proactive stance in identifying individual needs and preferences.

Medicines were managed appropriately and staff had been assessed as competent to administer medicines against the corporate medicines management policies. There was good oversight by the Chief Pharmacist.

People had comprehensive assessment of needs that included clinical and social needs. The multidisciplinary care plans created from patient assessments were reviewed and updated regularly. Care and treatment was planned in delivered with due consideration of national and best practice guidance. Care and treatment outcomes were monitored to ensure consistency across the entire organisation.

Staff were supported through a comprehensive education programme. Core skills such as medicines administration were assessed using a competency based framework. Revalidation for nurses and other professionals was supported and monitored.

There was evidence of good multidisciplinary working and we observed good inter-professional communication.

Consent to care and treatment was sought in accordance with national guidance and corporate policies. Staff had a good understanding of capacity to consent and knew how to respond if they felt someone lacked capacity.

We observed that people were treated with compassion and dignity. Feedback from patients and their carers was continually positive with high scores in the Friends and Family Test.

There was good service planning to meet the needs of the local communities serviced by the hospitals. The delivery of services was planned in consultation with Clinical Commissioning Groups (CCGs) and other providers, even where the provider had lost services in the commissioning process. Planning for newly acquired services was comprehensive and covered a 100 day period when all aspects of the new services were reviewed.

Facilities were appropriate to the services being delivered. Some premises were in need of refurbishment and VCSL staff were in on-going discussion with NHS Property Services (NHSPS) about this. Patient led assessment of the care environment (PLACE) scores were consistently high, particularly so given the poor fabric of the buildings in some settings. PLACE is an annual assessment of inpatient healthcare sites in England that have more than 10 beds.

Care was individualised and took account of peoples preferences and specific needs.

There were few complaints but those received were reviewed with consideration of clinical risk and safeguarding by senior staff within the business unit. Responses were appropriate and timely.

There was very strong corporate and local leadership. Staff reported positively on their managers and said they were supportive and encouraging. Staff felt the provider encouraged good practice and allowed staff to innovate.

Staff understood VCSL's vision and strategic plans. They felt empowered to innovate and were supported to do so.

The local and corporate monitoring and governance was a real strength with the board having a very clear picture of the performance of individual teams.

Summary of findings

However;

Staffing within the inpatient units was a challenge and there were a number of shifts where the staffing on duty was less than the planned numbers of staff.

There was room for improvement in the documentation of Do Not Attempt Cardio Pulmonary Resuscitation decisions. The service had not yet implemented the new Recommended Summary Plan for Emergency Care and Treatment

The Dementia Strategy needed further work to embed fully in practice.

Summary of findings

Background to the service

Virgin Care Services Limited (VCSL) provides community inpatient services on behalf of NHS commissioning groups in Surrey and has recently acquired community inpatient service contracts in Kent. Several of the hospitals previously manged by VCSL have been subject to retendering and have moved to other providers from 1 April 2017. We did not inspect the newly acquired hospitals or those transferring to other providers.

Haslemere Hospital has a 16 bedded unit that provides rehabilitation services to local residents. The inpatient service provides clinical intervention and rehabilitation for older people. Patient care is managed by multi-disciplinary teams (MDT) which include social care and community services. The aim of the inpatient service is to provide an effective and efficient episode of care to enable patients to return to their own home wherever possible.

Milford Specialist Rehabilitation Hospital has 34 beds also provides rehabilitation services to local residents. Farnham Hospital for Health has 42 beds provides a similar service but also has an 11 bedded stroke rehabilitation unit and elderly rehabilitation beds within the service.

During the inspection of the Surrey services, we spoke with more than 30 members of staff including managers, physiotherapists, occupational therapists, health care assistants, nurses and doctors. During our inspection, we spoke with 27 patients and their relatives/carers, observed care being provided and reviewed 24 patient care records and 24 medication charts. We reviewed a variety of data, for example meeting minutes, policies and performance data prior to, during and after the inspection.

Our inspection team

Our inspection team was led by: Terri Salt, Inspection Manager, Care Quality Commission

The team included CQC inspectors and inspection managers and a variety of specialists: Senior community nurses/matrons and a community NHS trust medical director, a physiotherapist, community children's nurses, a deputy director of quality and governance and an adult and child safeguarding advisor.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot 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 provider and asked other organisations to share what they knew. We used this information to determine which locations would be visited to ensure we gained an accurate reflection of the overall quality of service provision,

Summary of findings

We carried out announced visits during February and March 2017. Prior to the visits we held focus groups with a range of staff who worked within the service, such as nurses, therapists and ancillary and support staff. We talked with people who use services. We observed how people were being cared for and talked with patients, carers and family members about their experiences.

We reviewed care or treatment records of people who used services and service management records.

We carried out an unannounced visit on 27 February 2017.

We met with members of the Board and executive team after the visits to enable us to understand how they monitored the quality and safety of services being provided nationally

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As part of this inspection we visited serviced in the Luton area, including community health services, rehabilitation and intermediate care services. A narrative report for these services has been used to provide specific local feedback and to inform the provider ratings.

Prison Healthcare Services were not inspected, due to the specialist nature of the services provided.

What people who use the provider say

Overall, people were very positive about the services they received. They spoke about kind and gentle staff, said they felt listened to and respected and were actively involved in their care. Patients said the nurses and physiotherapists worked them hard but that they knew what they were doing and they only wanted what was best for the patients.

The overwhelming majority of the patients we spoke with felt they were receiving a very high quality service and that they were supported to make good progress. They talked about being free to make choices, good food and assistance being provided when needed.

There were a couple of patients that we spoke with who felt the nurses were occasionally too busy to pay attention to detail and who said that they disliked asking for help because the staff were so rushed.

Good practice

- Nurses and AHPs had participated in a job exchange programme that enabled both professional teams to develop their understanding of the others' work as part of a strategy to improve rehabilitation outside of targeted therapy sessions. As part of the programme, occupational therapists led training groups for nurses to enable them to use the Montreal Cognitive Assessment tool and nurses joined therapists on home visits.
- The motor neurone disease multidisciplinary team from Farnham Hospital had received the 'Extra Mile' award from the Motor Neurone Disease Association in recognition of the exceptional level of care they had provided to patients.
- VCSL were part of the carers collaborative that won the HSJ Commissioning for Carers Award.
- The tissue viability nurse team had been shortlisted for a National Patient Safety Award for their publication of a pressure ulcer audit in an international clinical journal.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should:

- Continue to review the staffing within the inpatient units and identify recruitment opportunities to ensure that planned staffing levels are met.

Summary of findings

- Review the documentation of Do Not Attempt Cardio Pulmonary Resuscitation decisions and take action to ensure that the provider policies are adhered to.
- Continue to work on the Dementia Strategy to ensure it is embedded fully in practice.

Action the provider COULD take to improve

Care Quality Commission

Virgin Care Services Limited

Community health inpatient services

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- There was an open and transparent culture that encouraged staff to report incidents and near misses. There was evidence of learning from incidents, including in changes to therapies staff processes and in the labelling of medical devices. Corporately, there were very strong systems for investigating and sharing learning from incidents.
- Learning from incidents was shared locally and across the organisation through well established and effective systems. Staff worked within a culture that supported them to submit incident reports and the senior team demonstrating appropriate investigations and learning through root cause analyses.
- Safeguarding was given a high priority. Staff had up to date safeguarding adults and children training and we saw evidence on each ward that staff understood local policies and their responsibilities in order to keep people safe.
- Inpatient services demonstrated a track record of safety performance, including 12 months with no hospital-acquired methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. diff) infections.
- Medicines were stored, managed and administered in line with national guidance. This included the administration of controlled drugs and regular medicines management audits. A dedicated pharmacy team provided regular support to each ward, including in managing medicine errors and implementing changes to policy and practice.
- A proactive approach was taken to anticipating and managing risk to patients. The systems for identifying and mitigating risk were well embedded in practice. The quality of patient records was consistent, with risk assessments always completed within 24 hours of admission.
- Staffing levels were stable and there were only eight full time nurse vacancies across inpatient services. The provider used a staffing planning tool to ensure safe staffing levels.

Good

Are services safe?

- The provider had appropriate staff and policies in place to monitor and develop fire and emergency planning. Improvements were identified and implemented as a result of fire risk assessments. Where fire risk assessments identified areas for improvement, the fire and emergency planning officer demonstrated appropriate action.

However,

- Staffing continued to be a challenge and there were times when planned staffing was not achieved. However, the provider was taking steps to address this.

Detailed findings

Safety performance

- Processes were in place to ensure services were provided safely. This included a clinical quality and risk group and patient safety committee. The Patient safety committee has input from the clinical commissioning group. Both groups formed part of the overarching clinical governance and risk management structure and provided safety-related guidance and insight into hospital procedures.
- The provider used a clinical governance safety dashboard to monitor safety performance. Staff used the dashboard to maintain an overall understanding of safety performance. This included monitoring results from safety audits, including in medicines management, as well as tracking the completion of incident investigations. Between February 2016 and January 2017, average safety performance scores ranged between 88% in September 2016 and 94% in January 2017, with an overall average score of 91%.
- Each ward displayed falls data, infection control information and pressure damage information in a prominent place. For example, for Oak ward the information displayed showed that there had been six falls in November 2016, six in December 2016 and no falls in January 2017. There had been no infection control incidents or reports of pressure damage between November 2016 and January 2017.
- In the 12 months prior to our inspection, there had been no instances of methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. diff).

Incident reporting, learning and improvement

- There were no never events reported between September 2015 and September 2016 across VCSL. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The total number of Serious Incidents reported across all VCSL (including prison services) during the period October 2016 to October 2016 was 98.
- The provider monitored the number and grade of incidents through the Quality and Safety Tableau.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The incident reporting form was accessible for all staff via an electronic online system. Once reported, managers reviewed the incidents and, where necessary investigated.
- In all business units the Business Unit Head and clinical governance lead read every incident report personally.
- Staff used an electronic incident reporting system that alerted senior nursing staff by email when an incident had been reported. A matron or senior member of the team investigated each incident, which they graded as low, medium or high severity. The provider's policy included individual feedback for staff after the submitted an incident report and the senior team tracked incidents to identify trends.
- We saw action was taken and processes improved as a result of learning from incidents. For example, following an incident at Haslemere Hospital that involved the prescription of an asthma inhaler, staff introduced a new labelling system that enabled them to track when new medical equipment was introduced to ensure patients did not receive a duplicated dose of treatment.
- In accordance with the Serious Incident Framework 2015, inpatient services reported nine serious incidents (SIs) between November 2015 and January 2017. This included four SIs at Farnham Hospital, three SIs at Milford Hospital and two SIs at Haslemere Hospital. Five incidents related to a fall and fracture, two related to grade three pressure ulcers, one SI related to a fall and subsequent patient death and one had been raised by paramedics in relation to pressure care.
- Not all nurses we spoke with felt that incidents were taken seriously or that they received constructive

feedback as a result of submitting reports. For example, one nurse told us they received no feedback after submitting an incident report when they were assaulted by a patient.

- All of the Allied Health Professionals we spoke with said they had received individual feedback from incident reports and that senior staff worked with them to identify learning during incident investigations.
- Senior staff used an SBAR model ('situation, background, assessment, recommendations') to investigate incidents and communicate learning and outcomes to their teams. For example, an internal review identified room for improvement in the maintenance of some medical devices that delivered oxygen to patients. As a result, staff were provided with information about how to carry out basic maintenance in line with manufacturer guidelines.
- Senior staff investigated incidents using root causes analyses (RCA) and ward staff were invited to mock RCA panels to help them develop their skills in investigations and how to identify areas for improvement. A formal RCA panel met monthly to review each incident. We looked at the minutes of RCA panel meetings and saw they were attended by matrons, clinical leads and clinical nurse specialists involved with investigations.
- A named physiotherapist was the lead amongst Allied Health Professionals (AHPs) for incident reviews. Incidents in this team were investigated collaboratively amongst staff and the findings and outcomes presented at a staff meeting. We saw evidence of how learning from incidents resulted in changes in practice. For example, one incident had occurred where a patient with diabetes had missed lunch because they were anxious about a home visit. When physiotherapists took them home, the patient became unwell and staff liaised with a dietician at the hospital to provide urgent help to the patient and ensure their blood sugar was increased. As a result all vehicles used by the allied health professional (AHP) team was equipped with information for patients with diabetes, glucose tablets and information for staff on the action to take if patients became unwell during visits outside of the hospital.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'.
- The incident reporting form included guidance for staff on the duty of candour. This included a process staff could use to identify if the duty of candour applied.
- All of the staff we spoke with were aware of their responsibilities under the duty of candour and could explain how they adhered to this, including through open and honest communication with patients and relatives.
- The root cause analysis process included a requirement that the duty of candour be considered. We saw staff documented this in practice.

Safeguarding

- We saw the policies for safeguarding vulnerable adults and children, which were in date and referenced national guidance.
- There was a national Safeguarding Adults Lead and a national Safeguarding Children Lead. The national leads provided strategic safeguarding leadership and expertise across the organisation.
- Each business unit had a safeguarding adult's lead and a safeguarding children's lead who reported to the national leads for safeguarding. They in turn reported to the Chief Nurse and Executive Lead for safeguarding. Staff were able to tell us the names of their business unit safeguarding leads.
- There was a national Safeguarding Adults and Children Governance Group that was informed by the Business Unit Clinical Governance Committee and which reported to the national Clinical Governance Committee.
- All business units had safeguarding leads and each team had a safeguarding champion.
- We saw safeguarding was a standing agenda item on every business unit clinical governance team meeting.
- The provider completed annual safeguarding audits and developed an action plan from the findings. There were separate audits for adult and child safeguarding.
- The 2016 combined adult and children's audit focussed on seven areas relating to safeguarding governance including management of complaints, recruitment and whistleblowing.

Good

Are services safe?

- This audit showed that all services completed the safeguarding audit and 93% were RAG (red, amber, green) rated green. The audit did not identify any significant concerns or risks across the organisation.
- Clinical staff had received national 'prevent' training, which aims to reduce the risk of radicalisation through early recognition of coercion or control. The provider's Prevent strategy was clearly displayed in staff areas and an escalation policy was in place if a member of staff was concerned about a colleague, patient or visitor.
- All staff followed the safeguarding training in line with intercollegiate guidelines of children and the proposed guidance for children.
- There was evidence that the provider considered and took action in response to national reviews for example the Francis report.
- The provider disseminated information to staff regarding updates and changes to the safeguarding policy. This included information on Prevent duty section 26 of the Counter Terrorism and Security Act 2015, Female Genital Mutilation and the Care Act 2014.
- All safeguarding risks were entered on a risk register and escalated to the national clinical governance committee.
- Staff working in the Surrey hospitals demonstrated confidence and knowledge in safeguarding policies and responsibilities, including in recognising and responding to suspected abuse and coercion. For example, staff could demonstrate how they accessed policies and care pathways for patients they suspected were at risk of abuse and were knowledgeable of their responsibilities with regards to this.
- Safeguarding formed part of mandatory training for all staff. At the time of our inspection, 100% of all ward staff and inpatient therapies staff had up to date safeguarding adults and children training, with the exception of Bentley ward at Farnham Hospital where 93% of staff had up to date safeguarding adults training.
- A safeguarding operations group was in place as part of the provider's risk management and clinical governance structure. This group met monthly and reviewed incidents and changes in national practice.

Medicines

- VCSL had a Chief Pharmacist who had overall responsibility for the oversight of medicines managed by operational staff.
- They were supported at national level by two deputies with differing remits.
- The National Quality Pharmacist was responsible for medicines management policies, education and competency, and medicines management practice.
- The National Development Pharmacist was responsible for procurement and relationships with preferred providers, for mobilisation of new services where there was medicines optimisation with a 100 day plan from the time services were acquired.
- The development pharmacist was working to reduce the number of preferred providers from 60 to less than five to streamline medicines provision across the organisation.
- Each business unit had a designated lead pharmacist that was responsible for the safe handling of medicines in their region. They were line managed by the Chief Pharmacist.
- Each business unit had a Medicines Management Group that was operationally based and had representatives from all staff groups. This group escalated concerns to the business unit clinical governance meetings, which had a direct link to the Medicines Optimisation Committee.
- An Annual Medicines Management Audit was undertaken with over 250 questions about how the services were providing medicines within their team. Any outlier teams identified through the audit triggered a review at business unit level and also as the national Medicines Management Committee.
- Medicines were stored appropriately in locked rooms with temperature controls and recording in place. Where patients were admitted with their own medicine this was clearly labelled and stored securely.
- Emergency medicines were stored securely with documented weekly checks.
- There was a team of designated prescribers who met monthly with ward pharmacists to review practice, incidents and national guidance. We looked at the minutes of the most recent meeting for each ward and saw they resulted in improvements in practice, such as better documentation for the administration of controlled drugs.
- Staff documented the temperature of medicine storage rooms and fridges daily. We looked at the records kept on each ward for the three months prior to our inspection. We saw in all cases documentation was

consistent and staff had taken appropriate action where temperatures had increased. This meant medicines remained effective because they were stored within the manufacturers' safe storage temperature guidelines.

- The nurse in charge of each ward conducted a check of the medication administration records (MARs) for each patient at the start of every shift. This enabled them to make sure medicine administration was accurate and to respond quickly to any missed or incorrect doses.
- We looked at the MARs records for six patients at Farnham Hospital. Each patient had their allergy status recorded and nurses had signed and dated the administering of medicine appropriately.
- A MARs audit in September 2016 indicated an improvement in the documentation of allergies. For example, 92% of 161 patient charts included a medicine allergy status. This was an improvement from the previous audit, which had indicated only 82% of patient records included a medicine allergy status. In addition, the latest audit found 100% of charts were legible and signed.
- Controlled drugs (CDs) were stored in line with national safety standards. This meant they were stored in locked cupboards that were in areas with restricted access. We saw staff documented weekly checks of CDs and the pharmacy team destroyed expired items immediately.
- Patients were prescribed to take away medicine as part of their discharge plan and a pharmacist and clinician maintained oversight of this.
- The pharmacy team provided support to staff in the event of medicines errors. For example, following an incident of a missed dose at Milford Hospital, a pharmacist identified the unusual time a medicine had been prescribed as a contributing factor. In response they worked with the patient's consultant to schedule a new time for their medicine that meant it could more easily be administered by staff.
- A protocol was in place for nurses to administer nine 'homely remedies', which were over-the-counter medicines patients might normally take at home. These included paracetamol, simple linctus and medicine for heartburn. The matron and pharmacy team had updated the protocol in January 2017 and we saw it had been updated whenever changes were made in national guidance with regards to any of the medicines. Only staff that had successfully completed training were able to administer items and there was a documented list with sample signatures in place.
- Each ward maintained a stock of end of life care and anticipatory medicines and pharmacy teams could provide syringe drivers at short notice if needed.

Environment and equipment

- Haslemere Hospital had 16 beds that were part of a single ward, although they were physically separated by a corridor. There were ten female beds and six male beds. The hospital had facilities to increase capacity to 26 beds, on demand, if approved by local commissioners.
- Each hospital had an occupational therapy room and a gym for physiotherapy. We saw gyms were spacious, well equipped and in a good state of repair.
- There were two wards at Farnham Hospital, each with 21 private bedrooms with en-suite facilities. Each ward had a therapy room, a dining area and a family meeting room which could also be used as a group session room. Each room on both wards had a television that had been purchased by the friends of the hospital. Three rooms were equipped with ceiling track hoists although the nurse in charge told us these were rarely used as it was safer to use individual hoists at the bed-side.
- Fire risk assessments in each ward had been undertaken in January 2017. The risk assessment at Milford Hospital found four areas of concern. This included that staff had not undertaken evacuation training in the previous 12 months, a lack of suitable escape routes, fire extinguishers that were overdue for discharge testing and a need for fire action signs by alarm points. The estates and facilities were not provided by VCSL but by a third party. We saw documentary evidence of ongoing discussion and action plans to address these issues through the estates contract monitoring.
- Overnight there were four members of staff in the main building at Haslemere Hospital, with no on-site security provision. The nurse in charge of the day shift conducted a security sweep of the building before handing over to nightshift but staff told us they often felt vulnerable overnight.
- Each ward participated in the patient led assessment of the care environment (PLACE). PLACE benchmarks hospital environments against a number of care standards criteria including the quality of cleanliness, food, privacy and dignity and care for patients living with dementia. The three inpatient facilities performed variably compared with national averages. For example,

all three hospitals performed better than the national average of 75% in the care of patients living with dementia. This was because Farnham Hospital scored 80%, Milford Hospital scored 76% and Haslemere Hospital scored 76%. For the quality of food, all three hospitals scored better than the national average of 88%. This included scores of 94% at Farnham Hospital, 90% at Milford Hospital and 93% at Haslemere Hospital.

Quality of records

- We looked at a sample of 27 records across all three hospitals. In all of the records staff documented risk assessments in line with the provider's standards. This included risk assessments for venous thromboembolism, bleeding, malnutrition, continence, skin integrity and bleeding risks within 24 hours of admission followed by reassessment at intervals appropriate to each patient's needs. Each patient also had a transfers and posture assessment to help staff identify any additional moving and handling or mobility needs.
- AHPs had access to nursing notes and documented the results of assessments and rehabilitation sessions in both.
- VCSL undertook information governance (IG) audit across the organisation in November 2016. In business unit 4 this showed that between 01 November and 30 November there were 22 IG breaches or near miss IG breaches. The most common breach (14) was emails sent insecurely. This audit showed a good reporting culture of IG breaches or near misses. An action plan was developed to reduce the amount of IG breeches. The findings of the audit were shared with staff via the business unit newsletter 'top tips on IG security' and on the local intranet.
- One of the actions from the audit was to ensure all staff had completed IG training by the end of December 2016.Data supplied to us by the provider showed all staff had completed the training with the exception of the rapid response and rehabilitation team who were 75% compliant. This was worse than the VCSL target of 100%.
- VCSL submitted a Community Healthcare Information Governance Toolkit is March 2016 for an independent assessment of evidence by an NHS internal audit agency. The audit scored 76% which gave the provider a rating of 'Significant Assurance'.
- The information governance team carry out site visits and local audits to review the security and confidentiality of information being held.
- Local teams undertook quarterly self-assessment confidentiality audits. When a service was recently acquired, the audits were monthly until the initial targets were reached.

Cleanliness, infection control and hygiene

- There was a VCSL Infection Control Committee which fed into the Clinical Quality Review meeting, who had overarching infection control and prevention responsibility.
- The local infection control forum fed into the VCSL infection control committee and was responsible for the day-to-day operations of infection control and prevention.
- VC Surrey produced bi-monthly infection control and prevention (ICP) newsletters for staff. These provided information and details of who to contact if staff required support or advice relating to ICP.
- The hotel services team within each hospital was responsible for daily and weekly cleaning, which they documented using specific checklists. We looked at a sample of checklists in every ward we visited and found that staff had completed documentation consistently in the previous three months.
- Hotel services staff explained how they worked across wards and were sub-contracted to provide housekeeping services to other providers at the hospital.
- We were told by housekeeping staff that they had the right equipment and enough of it to be able to do their job effectively.
- Staff used bright green 'I'm clean' labels to indicate when an item of equipment or furniture had been cleaned and sanitised.
- Each bed space had a disposable curtain and staff had documented the last time each curtain had been changed. This was displayed in every bed space we looked at and all curtains had been replaced in the previous six months.
- Each hospital had a register of chemical products and risk assessments in line with the control of substances hazardous to health guidance.

- Infection control formed part of the mandatory training for all staff. In February 2017, 97% of staff had up to date training. This included 100% of staff at Milford Hospital, Haslemere ward and on Runfold ward at Farnham Hospital.

Mandatory training

- All of the staff we spoke with were up to date with mandatory training and staff gave variable feedback in relation to this. For example, one individual said they were given protected time for training and the matron monitored and senior sisters supported staff to stay up to date by working with them to schedule training time. Another member of staff said they had completed all of their online training unpaid and in their own time and were trying to resolve this with the provider.
- The provider's mandatory training programme included 12 core subjects such as infection control, moving and handling, basic life support and conflict resolution. At the time of our inspection up to date training varied slightly across teams from 89% on Bentley ward at Farnham Hospital to 99% on Oak ward at Milford Hospital. The inpatient therapies team had 97% up to date training, including 100% in six of the twelve core subjects.

Assessing and responding to patient risk

- Therapies staff used risk assessments to make sure patients could safely use walking frames before they were issued. We saw examples of completed risk assessments and found them to be thorough and individualised to each patient.
- Specific care pathways were in place for patients with high risks of falls, pressure ulcers and malnutrition. We saw staff conducted and documented regular reassessments of these risks based on individual need. This included daily bed rails reassessments where patients had initially been assessed as needing this intervention.

Staffing levels and caseload

- Each inpatient service, including inpatient therapies, had a core team of substantive staff that included 156 qualified nurses. This included 53 staff at Farnham Hospital, 40 staff at Milford Hospital, 23 staff at Haslemere Hospital and 32 inpatient therapies staff. Vacancies varied from 4% at Haslemere Hospital to 11% at Milford Hospital and turnover varied from 6% at Farnham Hospital to 31% in inpatient therapies. In February 2017 there were eight nurse vacancies and seven nursing assistant vacancies.
- Between February 2016 and February 2017, 534 shifts were filled by agency or bank nurses and 844 shifts were filled by agency nursing assistants. During this period 26 nurse shifts and five nursing assistant shifts went uncovered because agency or bank staff could not be secured.
- At Milford Hospital, each ward had a sister, two registered nurses and three healthcare assistants during day shifts. The matron worked both clinical and management days and when they worked a clinical shift, they were the nurse in charge instead of the sister.
- At Haslemere Hospital, each ward had a sister, two registered nurses and two healthcare assistants during day shifts.
- Nurse staffing levels overnight had recently been reduced by one registered nurse on each ward and staff told us this often had an impact on patients. For example, a medicine round took place at 6am, during which time staff also offered tea and a snack and helped to prepare patients to get up for the day. However as there was only one nurse and one HCA, staff said the process could be delayed if a patient needed the assistance of two staff, if anyone had become unwell or if more than one person needed help to use the toilet.
- At Farnham Hospital, on an early shift there were 2 Registered Nurses and 4 HCAs. On a late shift there were 2 registered Nurses and 2 HCA per ward. Overnight, two registered nurses and three HCAs were on shift on each ward.
- However, due to short staffing one ward sometimes operated with only one registered nurse. This meant the administration of medicine could be delayed if a patient needed a controlled drug because the nurse had to wait for help from the adjacent ward to meet the requirement that two nurses administered this type of medicine.
- Nurse and HCA staffing levels in each ward had been reduced following a period of restructuring. Staff spoke variably about this. For example, one HCA told us the team had been involved in the restructuring and they had not noticed a significant increase in work or a negative impact on patients as a result. However, four nurses we spoke with said there had been a significant impact on patients because the reduction of one nurse

overnight meant patients received less care and attention and that medicine rounds were often delayed as a result. On one day of our inspection a patient experienced a fall whilst trying to mobilise themselves to use the toilet. The nurse on the ward told us the patient had asked them for help but they were the only qualified person on shift and had to finish medicine duties before they could help them to the toilet. As a result, the patient tried to move themselves and fell. The incident was reported appropriately.

- Senior staff had access to an agency to obtain nurses to cover gaps in the rota for unexpected absence or sickness. However, all of the staff we spoke with said this process was counterproductive and said their experience with the agency was poor. One senior nurse said their previous experience of staff supplied by the agency meant they would rather run a ward short-staffed and two other senior nurses said that trying to deal with the agency would always be a “last resort.”
- Although nurses in charge were able to request agency nurses in the event of short staffing, the agency was not able to reliably provide cover. For example, on one day of our inspection at Milford Hospital, one patient needed one-to-one care to help keep them safe. The agency had failed to provide an additional nurse on request and so the team had to position the patient so that they were in sight of staff at all times. We saw this worked in practice to provide the patient with the support they needed and the matron and duty manager had tried to resolve the situation with the agency.
- Nursing staff completed a twice-daily handover that included a review of each patient’s discharge plans including social history and needs.
- A senior member of staff told us how an outside organisation had conducted a ‘time and motion study’ which had resulted in the HCA numbers being reduced from four to three. This had caused them to become stretched at times, particularly when staff were off sick at short notice.
- Staff at Haslemere Hospital told us the wards did not feel safe as a result of the staffing restructure. For example. there were occasions when there would be only two trained staff and one HCA. If administering CDs, two staff would be required leaving just one member of staff to cover all of the patients.
- A clinical lead led medical care in all of the inpatient wards and provided clinical supervision for nurses, doctors and locums.
- Medical cover was provided from Monday to Friday between 9am and 5pm. Outside of these hours a GP was available on call and at weekends a GP conducted a ward round to review each patient.
- Four visiting consultants, a full time staff grade doctor and a part time staff grade doctor provided medical cover at Milford Hospital. This team carried out four ward rounds each week in addition to daily reviews by a GP. At Farnham Hospital, two consultants provided a weekly ward round.
- There was no on-site medical cover at Farnham Hospital on Saturdays and Sundays and nurses relied on the North Hampshire Urgent Care service if they needed further clinical input.
- Locum staff did not always have the resources or access to the systems they needed to work safely and effectively. For example, one locum had received an induction that included only the location of paperwork and fire safety procedures. After eight days in post they had not been given access to IT systems, which meant they could not view blood results and had to call the laboratory every time they needed information. In addition there was not always consistent communication between permanent medical staff, nurses and locum doctors. For example, at Farnham Hospital, a locum doctor had expected a consultant ward round to take place but was told after one hour the consultant was on leave and no cover had been provided.

Managing anticipated risks

- The provider recognised that it was difficult for staff to leave work and attend briefings and workshops. The Quality and Clinical Effectiveness Lead (QCEL) built on the work of the acute sector safety huddles and introduced Quality and Patient Safety Briefings where they visited teams and talked with them about incident reporting, the details of information needed and feedback mechanisms. Discussions took place about the effectiveness of safety alerts, the Freedom to Speak Out guardian and staff safety. The QCEL had visited 180 staff to date.
- At Milford Hospital the clinical team operated a cohort service to patient admissions that meant those with multiple conditions or complex needs were admitted to Holly ward. This meant staff could focus the resources needed for complex care on one ward to provide a more efficient and coordinated service.

- Due to the length of time some patients spent at Milford Hospital, each patient was given a weekly dependency score.
- Each ward had an automatic defibrillator, manual resuscitators, emergency drugs, an anaphylaxis kit, a cardiac arrest kit and oxygen with adult and child masks. Staff documented weekly checks on all of the equipment, including the expiry date of medicine and the pressure of the oxygen.
- Basic life support training formed part of the provider's mandatory training programme. At the time of our inspection compliance amongst clinical teams was variable. For example, 70% of staff on Bentley ward at Farnham Hospital had up to date training and 100% of staff on Oak ward at Milford Hospital and on Haslemere ward had up to date training.
- Staff used highly visible red stickers on the front of patient records to indicate there was another patient admitted with a similar name.
- Staff demonstrated understanding of managing aggressive or inappropriate behaviour. For example, an HCA said if a patient became aggressive their first action was to make sure both the patient and staff present were kept safe. After the episode they would work with colleagues to identify triggers to the behaviour and ensure these were avoided wherever possible. Staff also recognised the anxiety patients could feel during a hospital admission and worked to promote their usual level of independence wherever this was possible. Observational behaviour charts were available to help staff track and predict aggressive behaviour and we saw this worked well in practice. For example, an HCA noticed one individual became agitated and aggressive when they were amongst groups of people. In response they ensured care was provided on a one-to-one basis and the patient was offered meals alone. This resulted in a rapid reduction in aggression and the patient was demonstrably calmer.

Major incident awareness and training (only include at service level if variation or specific conerns)

- A fire and emergency planning manager was in post who led fire safety on each site and maintained oversight of fire risk assessments. This individual also liaised with the NHS Property services responsible for maintaining premises and equipment where issues were identified. For example, a fire risk assessment at Milford Hospital found some fire extinguishers were overdue a service. However, the hospital was not able to arrange a service itself as this was part of the contractual responsibility of an NHS office, which had not yet commissioned the work.
- All of the staff we spoke with demonstrated a clear understanding of fire and emergency procedures. This included the roles and responsibilities of each member of staff and who would make the decision to evacuate the building. A trained fire incident controller or fire warden was always on shift on each ward. However, it was not always evident staff had appropriate training, experience or proven competency in this area. For example, one nurse told us they had been asked to assume the fire warden role during a shift despite having not been trained for this.
- Ward staff at Farnham Hospital maintained an up to date 'fire list' that included each patient and the reason for their admission. This meant staff had immediate access to information that would help them prioritise who to assist in an evacuation.
- Staff used a daily system resilience conference call to coordinate resources and ensure each site had sufficient staff cover to operate safely.
- A fire risk assessment at Milford Hospital identified some escape routes were compromised due to building works on the site. To ensure the inpatient wards could continue to operate safely, the fire and emergency planning manager took aerial photographs of the site to identify the key risks and provide staff with information on the appropriate evacuation routes to use.
- A contingency planning lead was in post who was responsible for ensuring patients and staff were safe after an evacuation and putting the business continuity plan into place.
- Each ward had staff who had received additional training to become a fire incident controller in the event of an emergency. This team of staff had undertaken a fire awareness and evacuation course including the use of slide sheets to evacuate immobile patients.
- In the 12 months prior to our inspection Haslemere Hospital had experienced an emergency and ward staff had initiated evacuation procedures. These were in line with their training and hospital policy and staff received a debrief and discussion on their performance to identify any areas for learning.

Good

Are services safe?

- A fire and evacuation drill had been completed in the previous 12 months at Milford Hospital and the fire and emergency planning manager had observed staff prepare for an evacuation, including a check of their actions and initial preparations.
- A fire safety group met quarterly at each hospital with a representative from each ward. The group discussed any incidents that involved fire safety and staff identified areas for improvement in emergency planning.

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

- Clinical staff delivered care and treatment in line with national and international best practice guidance, which they used to benchmark patient outcomes within a programme of audits.
- Information provided to patients and relatives was benchmarked against the national Accessible Information Standard.
- An audit programme was in place across all inpatient wards that involved all staff. This included 29 audits between the nursing and Allied Health Professional teams and there was evidence of service improvement as a result of audits.
- A series of outcomes-based groups provided services to patients based on their specific needs and care and treatment plans. This included an occupational therapy falls group and a Renablement Group.
- Staff recognised the need for social opportunities, empowerment and the reduction of social isolation as part of each patient's rehabilitation plan.
- Between January 2016 and January 2017 the average length of stay in each ward varied widely between a low of 19 days to a high of 80 days, both of which were at Milford Hospital.
- Although staff had access to additional and regular training, this was not always in line with the needs of patients they regularly cared for. This included patients living with dementia and those who received end of life care.
- Care was delivered by a multidisciplinary team that included inpatient therapists and access to community psychologists.
- Between May 2016 and October 2016, 75 patients at Farnham Hospital experienced a delayed discharge. In the same period 121 patients experienced a delayed discharge from Milford Hospital and 29 patients experienced a delayed discharge from Haslemere Hospital.
- Specialist training was usually provided when requested by staff, such as that delivered by the Stroke Association to help with the rehabilitation of patients who had suffered a stroke.
- Staff had access to established cognitive assessment tools and training on the Mental Capacity Act (2005) to help them act in patient's best interests.

However,

- Documentation with regards to capacity assessments was inconsistent and sometimes contradictory. .
- There was room for improvement in the documentation related to do not attempt cardiopulmonary resuscitation (DNACPR) authorisations.

Evidence based care and treatment

- All Staff had access to up to date policies and documents through 'The Jam', which was the VCSL intranet. We spoke to staff who found this extremely useful and informative. Staff were also informed of up to date changes in guidance through weekly newsletters and team meetings.
- Any changes to national guidelines, for example National Institute for Care Excellence (NICE) guidelines, were discussed and disseminated to staff through the Clinical Audit Committee and Information Government (IG) meetings. We saw minutes from these meetings in which changes were documented. We also saw guideline changes were a regular item in the agenda.
- Central Alerting System (CAS) information was, cascaded through a Safety Alert Management system, which tracked responses to alerts. CAS is a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. There was an audit tracker, which captured all NICE guidance, quality standards and technical appraisals. NICE baseline audits and action plans were also embedded into the tracker.
- Staff delivered care and treatment in line with national and international best practice guidelines. For example, nurses assessed patients for pressure ulcer risks using care and assessment pathways from the European Pressure Ulcer Advisory Panel. This helped to establish the urgency of action against defined criteria. Nurses and Allied Health Professionals (AHPs) used a series of

recognised tools, pathways and assessments to establish patient need and to plan appropriate care. This included the Camberwell Assessment of Need for the Elderly and the Parkinsons UK palpitation pathway.

- Non-clinical elements of the service were also evidence-based. For example, information about care and treatment was provided against standards set by the national Accessible Information Standard. This meant information was readily accessible and available in a range of different formats, including in Braille, easy-read, large-print, electronically and by staff trained in British Sign Language.
- AHPs were involved in audits of their notes, including the quality of risk assessments and care planning. Individuals we spoke with said this was a positive experience in quality assurance and evidence based practice because it enabled them to reflect on their practice and learn from each other.
- AHPs provided care in line with the Royal College of Physiotherapists standards and the senior team ensured staff remained up to date with current guidance through team meetings and handovers. This team also followed relevant National Institute for Health and Care Excellence (NICE) guidance, such as in the care of patients on a stroke upper limb rehabilitation pathway.
- All members of the AHP team were encouraged to take part in a site-wide audit programme. In the 12 months prior to our inspection this had included 10 audits such as inpatient falls and clinical supervision and peer review. Inpatient ward teams contributed to 19 audits in the same time period, including for dementia screening, safety thermometer harm-free care and a pressure-relieving equipment audit. The standardisation of audits across the three hospital sites enabled staff to benchmark practice between wards.
- There was evidence of improvements to practice and policies as a result of clinical audits. For example, an antibiotic prescribing audit in August 2016 found overall high standards of practice in line with local pharmacy team and formulary guidance. However, the audit identified room for improvement in the documentation of review dates for antibiotics, which was implemented across all wards.

Pain relief

- Clinical staff and pharmacists had lead roles in pain relief. Pain management documentation was in place and we saw nurses consistently recorded pain scores and discussions with patients. Each patient had a pain management plan, which we saw included as-needed medicine that nurses could administer out of hours if needed without the need for a doctor.
- Staff used body map charts to document complaints of physical pain from patients.

Nutrition and hydration

- We reviewed patient care records and saw patients were assessed using the **Malnutrition Universal Screening Tool** (MUST); this is a nationally recognised and recommended tool to identify a patient's malnutrition risk.
- Each patient had a nutrition and hydration care plan that staff used to meet their individual needs. For example, staff assessed patients' current abilities to feed themselves with or without assistive equipment, noted recent changes in appetite and completed a plan to meet the dietary needs of their rehabilitation goals.
- Catering services were able to provide food in line with specific needs, such as fortified food or food of a different consistency.

Patient outcomes

- A series of outcomes based groups provided services to patients based on their specific needs and care and treatment plans. For example, a renablement group had completed risk assessments to safely visit the wards with Pets As Therapy (PAT) dogs. PAT dogs are specifically trained dogs that help patients with rehabilitation needs to improve muscle function and reduce anxiety and stress.
- A breakfast group helped patients to develop their independence in preparing simple food and a newspaper group helped to promote discussion and socialisation to keep the mind active and to help patients motivate themselves to stay up to date with current events. An occupational therapy falls group supplemented patients' prescribed therapies time and promoted physical recovery. All of the groups were focused on improving rehabilitation as a patient outcome.
- Staff recognised the importance of managing the risks associated with social isolation and facilitated opportunities for patients to socialise in addition to helping them spend the time alone they wanted. For example, relatives were able to bring in hot meals to eat

with their family member and staff encouraged this to take place during set meal times to ensure patients could eat together. In addition, all of the outcomes based activities groups included staff facilitation to improve patients' opportunities to meet each other and socialise.

- A weekly activity group was facilitated by a specialist non-profit organisation that helped to provide patients with the opportunity to take their mind away from being in hospital and have some fun.
- There was a 'whole team' approach to care planning that involved the AHPs therapies team, community tissue viability nurse, district nurses and consultant psychologist for patients living with dementia.
- Staff used the patient reported outcome measures (PROMS) to identify patient's own experiences of their rehabilitation and therapy and to identify areas of good practice. We spoke with the nurse in charge of the diagnostic and treatment centre at Farnham Hospital who told us nursing staff and AHPs were involved with PROMS and showed us displays of evidence of good practice, including photographs of therapy and exercise sessions and feedback from patients. Nurses provided care that included health promotion to help patients maintain healthy lifestyles and habits after they were discharged and exercise and therapy was provided after AHPs completed a geriatric assessment.
- PROMS scores for the local CCGs did not differentiate between the elements provided by the acute hospitals and the elements provided by VCSL rehabilitation programmes. All of the CCGs that commission with VCSL showed PROMS scores in line with the national averages for Hip and Knee replacement.
- At Farnham Hospital, staff on the inpatient wards and AHPs worked with the diagnostic and treatment centre to provide rehabilitation for patients who had experienced a fall. This included a monthly falls group that included multidisciplinary input and a six-weekly recovery programme with input from a Parkinson's clinical nurse specialist.
- From looking at patient notes it was not always evident staff had appropriate training and knowledge in providing and documenting end of life care. For example, in one patient's notes at Farnham Hospital, there was a gap of four days between a note that staff wanted to provide end of life care and the death of the patient. There was no ceiling of care information documented, staff had administered non-essential medicine and a hospice referral four days before the patient died had not been followed up.

Competent staff

- Staff were recruited safely; we reviewed staff files and saw they contained references, photographic identification, copies of certificates, Nursing and Midwifery (NMC) registration validation and disclosure and barring service (DBS) checks.
- New starters used a Book of Service Standards (BoSS) for community nursing. This was very detailed and covered information such as organisational structure, the Virgin Care vision and goals, common processes, standard operating procedures (SOP), information governance guidance and professional service standards.
- New starters to VCSL confirmed they had attended an in house orientation and a period of shadowing to ensure they were comfortable and confident. This shadowing period was determined by on an individual basis. One new community nurse explained how they had first shadowed other community nurses, and then performed care under supervision before being allocated their own caseload. This had made them feel supported and helped build their confidence.
- The Human Resource (HR) department used an electronic staff record (ESR) that linked to the General Medical Council (GMC) and NMC registration sites. The provider produced a report from this, twice monthly, to identify when registrations were due to lapse. Staff were sent a reminder three weeks prior to the date and then a further two reminders if confirmation of re registration was not received. We were told in the event a registration had lapsed, staff were employed as health care assistants (HCAs) until they had renewed their registration.
- Staff did not always feel they had appropriate training to meet the specialist needs of some patients. For example, nurses at all three hospitals said they often looked after patients with dementia but had not received specific dementia training; only a short discussion as part of their safeguarding training. This was, however being addressed by the provider.
- Staff spoke positively about the system for appraisals and said they felt this supported them in their professional development. For example, one nurse told

us they had mentioned in their appraisal that they struggled to complete discharge paperwork for social services and as a result they were provided with training. A healthcare assistant said their appraisal had been very useful because it helped them to reflect on their experiences to date and ask for support in developing professionally in their areas of interest.

- At the time of our inspection 100% of AHPs had received an appraisal in the previous 12 months.
- The service sometimes used locum doctors to help meet demand or to cover absence. There was a locum induction pack in place that was up to date and included critical information on local procedures and contacts. We spoke with a locum doctor who said they were well supported and had received a structured induction to be able to work in the wards safely.
- A clinical lead led weekly education sessions for doctors that included clinical scenarios as well as training in discharge planning, mental capacity assessment and effective use of the Deprivation of Liberty Safeguards (DoLS).
- When new staff joined the hospital team they were assigned an experienced mentor and allocated a period of supernumerary time. This meant they were given time to adjust to their ward and begin applying their skills immediately with the security of a supervisory mentor at all times. We asked a healthcare assistant about this process. They said the supernumerary and induction processes had worked very well and they felt it had been a reflective period of time to help them develop and that they had been listened to. For example, when they asked for an extended period of time with an experienced member of staff to help them develop specific skills, this had been provided without question.
- Nurses did not routinely undertake palliative care training although they regularly cared for patients at the end of life. For example, nurses at Farnham Hospital said they had received no end of life care education or guidance on paperwork although three patients had died on the ward recently. One nurse said a local hospice had provided advice by telephone but this was not an official or structured arrangement.
- New therapies staff that joined the organisation were able to spend time on multidisciplinary shadowing shifts as part of their induction. For example, new physiotherapists worked with speech and language therapy (SaLT) staff to enable them to understand their work and how they contributed as part of a multidisciplinary team.
- Staff had undertaken ward-based training delivered by the Stroke Association. This had involved working alongside patients and relatives to understand their experience of stroke and how nurses and AHPs could take this into account when delivering care.
- Nurses and AHPs had participated in a job exchange programme that enabled both professional teams to develop their understanding of the others' work as part of a strategy to improve rehabilitation outside of targeted therapy sessions. As part of the programme, occupational therapists led training groups for nurses to enable them to use the Montreal Cognitive Assessment tool and nurses joined therapists on home visits.
- In the AHPs team, 96% of staff had up to date training in cognitive screening and assessment and 100% had up to date conflict resolution training.

Multi-disciplinary working and coordinated care pathways

- VCSL could demonstrate through documented evidence that following acquisition of services, they had managed to bring about sustained, significant improvements to patient outcomes. The Clinical Governance RAG rating score for Wiltshire services, acquired in June 2016, had improved month on month from 45% to 85% in an eight month period. Similar patterns of improvement could be seen for other acquired services. Some more established services sustained scores of over 90% with North East Lincolnshire scoring 100% over the reporting year.
- A pilot mortality review had been undertaken between July 2016 and August 2017 in response to a national report into the deaths of people with learning difficulties or mental health illness in an NHS trust. Zero attributable harm was identified through the review but the provider is widening the pilot review and establishing a mortality reporting database.
- We saw evidence of a core audit programme, which included Infection control, medicines management, safeguarding, hand hygiene, and health and safety. We saw that the audits were based on nationally recognised

tools, for example, the clinical records audit was checked against the Healthcare Quality Improvement Partnership (HQIP) tool, the best practice recommended tool.

- Inpatient services in Surrey had established a discharge action group that met weekly during the winter months and fortnightly at other times. The group included the matron, therapy leads, clinical commissioning group, social services and the rapid response team. The group had a discharge facilitator who worked with the multidisciplinary team to coordinate complex discharges, including securing a package of care where appropriate.
- There was a weekly discharge planning meeting with social services, therapists and senior nursing staff. Each patient was assessed and an estimated date of discharge agreed. New packages of care and changes to existing packages of care were established. The stroke team for early discharge (STED) proactively reviewed each patient admitted following a stroke. STED was a specialist multidisciplinary team that consisted of nurses, occupational therapists, physiotherapists, speech and language therapists and rehabilitation assistants.
- The hospital had two social workers based at the hospital, although at the time of the inspection there was one social worker covering both of the wards. The social workers were employed by the local authority. The social workers worked at the hospital Monday to Friday. The social worker would keep up to date with who had been admitted to determine whether they knew the patient and if so, did they have a package of care at the time of admission and their funding status. When a patient was nearing their estimated date of discharge, the social worker wold work with the therapies staff to ensure that the patient was ready to leave and their package of care was in place.
- The social worker reported that they had good working relationships with all staff at the hospital. We were also told by therapies and nursing staff that they had a good working relationship with the social worker. Although there were occasions where there had been disagreements, the teams and social workers were able to resolve these. It was explained that the co-locating of the social worker meant that any issues were dealt with quickly and effectively.
- A team of physiotherapists provided individual therapies to patients at each hospital Monday to Friday. This team included two full time senior physiotherapists, two part time physiotherapists and a full time technician instructor. Occupational therapists provided services Monday to Friday.
- A dietician reviewed patients on each ward every two weeks and provides patient specific advice on a daily basis.
- A pharmacist visited each ward two days per week.
- Speech and language therapists (SaLT), podiatrists and community mental health staff were available on-demand.
- A consultant-led multidisciplinary meeting took place weekly on each ward with the nurse in charge, AHPs and social workers. In addition, the AHP team at each ward completed a daily handover to plan care for the day with the nursing team.
- Staff had access to a psychiatric liaison nurse although there was not a direct referral pathway available to a consultant psychiatrist. Advanced psychiatric services could be accessed through NHS acute trusts and medical staff we spoke with were aware of this procedure.
- AHPs worked closely with nurses and doctors as part of a coordinated approach to delivering patient care and developing skills. For example, physiotherapists told us doctors spent time explaining x-rays to them and doctors asked to observe physiotherapy sessions to gain a better understanding of the processes the team used.
- AHPs had a combination of roles fixed at certain hospitals and rotational posts where staff could work at any of the three hospitals. Therapists could also complete rotations into the community as well as in specialist pathways such as musculoskeletal physiotherapy and stroke rehabilitation.
- The AHP team had introduced a key worker scheme on each ward that meant patients received continuity of care from a named therapist who worked with them to plan their recovery.
- The SaLT team and the motor neurone disease (MND) team had worked together to establish a multidisciplinary team with a local hospice. This enabled them to provide coordinated and rapid response care to patients living with MND who deteriorated and required end of life care.

Referral, transfer, discharge and transition

Good

Are services effective?

- Discharge planning and delivery was completed by a multidisciplinary team. This included the patient's main doctor, a nurse, physiotherapist, occupational therapist, SaLT and social care staff if they had been involved in the patient's care.
- Between 1 May 2016 and 31 October 2016 there had been 225 delayed discharges. There were 75 delayed discharges from Farnham Hospital, 121 from Milford Hospital and 29 from Halsemere Hospital. There had been no re-admissions to the any of the three community inpatient hospitals within 90 days of discharge.

Access to information

- From reviewing discharge summaries and information, we saw the medical team routinely sent a discharge letter to GPs and contacted them personally where a patient's needs were complex. Community specialists were also contacted at this stage to ensure patients had access to continuing care, including frailty leads.
- The AHP team had access to a shared electronic storage drive across all sites. This meant they could store secure information for review by each other and had access to the same policies and procedures regardless of where they were working.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- AHPs completed a treatment consent checklist before initiating any treatment programme or care plan. This included a documented discussion with the patient that they had the right to be involved with every aspect of their treatment, that they could withdraw consent at any time and that there might be a student therapist present during their treatment.
- Staff used established tools to assess mental capacity and cognition within 24 hours of admission. This included the short cognitive assessment method (CAM) for mental function and the abbreviated mental test score (AMTS). We saw from looking at records that patients had both assessments completed and these were in place before AHPs implemented a rehabilitation plan. We saw staff also completed a dementia diagnostic assessment where appropriate.
- However, documentation with regards to mental capacity was not always consistent, detailed and clear. For example, in one patient's record at Haslmere Hospital we saw different staff had documented conflicting information about a patient's mental health and cognition. In another example at Farnham Hospital, a member of staff had noted a patient was confused but there was no further detail or completed mental capacity assessment. In addition, there was no record of confusion in the patient's communication record and staff told us the individual had dementia but there was no record of this in their notes.
- The Mental Capacity Act (2005) and DoLS formed part of the provider's mandatory training for all staff. At the time of our inspection, the inpatient therapies team, Haslemere ward and Oak ward at Milford Hospital demonstrated 100% compliance with up to date training. Other wards varied from 78% on Bentley ward at Farnham Hospital to 94% on Holly ward at Milford Hospital.
- Staff could demonstrate how they adhered to their training and national policy. For example, a senior member of staff had raised a DoLS with a local authority because a patient had alcohol related dementia and needed to be prevented from leaving the hospital for their own safety. Senior staff from the hospital arranged a best interest meeting with the local authority and an independent mental capacity advocate. The patient was successfully treated and was able to be moved to another part of the country to be closer to family.
- There was room for improvement in the documentation related to do not attempt cardiopulmonary resuscitation (DNACPR) authorisations. For example, a doctor had signed a DNACPR order for one patient without recording a check of their identity and NHS number. In addition there was no indication that the patient or their relatives had been involved in a discussion about this. In another patient's notes a DNACPR was in place with no evidence of a mental capacity assessment. We spoke with a relative who agreed the DNACPR was appropriate and said they had spoken with the doctor about this but there was no record of the discussion.
- When electronic systems failed it was not evident staff had access to appropriate back-ups. For example, staff we spoke with at Farnham Hospital did not know which patients had a DNACPR authorisation in place because of a systems fault that meant this information had not

been recorded on handover sheets. This meant staff would need to search patient's individual records in the event a patient deteriorated and they needed to know whether to perform a lifesaving intervention.

Good

Are services caring?

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

Summary

- Patients and their relatives were generally very positive about the care they received. We were told and observed that staff treated patients with kindness, dignity and respect.
- People felt involved in their care and their preferences were considered when delivering care.
- Friends and Family test results were consistently high.

However,

- Patient led assessment of the care environment (PLACE) assessment scored were variable with some being better than the England average but the Haslemere Hospital score being worse than the VCSL and England average.

Detailed findings

Compassionate care

- Senior nursing staff told us how they were proud of the level of care that was provided to patients. All staff will work late if it was necessary and they demonstrated how they provided extra care for patients, such as by collecting newspapers on their way to work if a patient wanted one.
- We observed members of the physiotherapy team treating patients. We saw the therapists were patient, clear in their communication, encouraging and supportive of the patients. Patients were addressed using their first names, which helped to deliver a personalised service.
- The hospital had been assessed in 2016 using the patient led assessment of the care environment (PLACE).PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care. They assess such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia. Scores for community inpatients hospitals were 90% for Farnham Hospital, 80% for Haslemere Hospital and 88% for Milford Hospital. Both Farnham and Milford Hospital scored better than the VCSL average of 86% and the England average of 87%. However, the scores for Haslemere hospital were worse than the VCSL and England average.
- Staff at Haslemere Hospital held a party with the patients to help celebrate the Queen's 90th birthday. Tea and cake were provided.
- Each ward displayed numerous cards and letters of gratitude from patients and relatives. One card was received just before our inspection and was from the relative of a person who had received end of life care support. The card noted how grateful family members were for the compassion of staff and for their inclusive approach when involving them in final care planning.
- We spoke with two patients and two relatives at Farnham Hospital. In all cases they were positive about the kindness and attitude of staff.

Understanding and involvement of patients and those close to them

- Families and friends of patients were asked to bring in two or three changes of clothes and collect and wash them when necessary. We were told that staff took patients clothes to wash if they don't have any friends or family that were able to do it.
- The therapists had a good understanding of each patients needs and were able to adapt the therapy techniques provided depending on the how well the patient was doing.
- We observed how the approach of the therapist had enabled the patient to gain more confidence and be able to move more freely and confidently after ten minutes.
- Friends and Family test results for January to March 2016 showed a total of 96% were either likely or extremely likely to recommend the services at Virgin Care Community Hospitals.

Emotional support

- We spoke with two patients at Milford Hospital, both were overwhelmingly positive about their experiences of care. One described the care as very good, the staff always made time to talk to them. The staff always referred to them by their first name. They told us how

Good

Are services caring?

they have had their care tailored to their own needs and they appreciated that they could make their own decisions. We were told how the staff had been excellent when they had got upset about the length of time they had been in hospital. The patient preferred to have their meal in their side room. The staff were happy with the arrangement and did not try to force the patient to eat with the other patients.

- Another patient told us how their pain had been managed well, that the care had been excellent and the staff were all very obliging and kind. They felt well looked after and the staff were pleasant.
- A carer's information board at Milford Hospital provided signposting and guidance, such as to local support groups. Information included details on the court of protection, lasting power of attorney and advance decision-making.
- A multi-faith chaplain was available on demand and visited each ward weekly.

Good

Are services responsive to people's needs?

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

Summary

- Care and treatment plans were created with due consideration of individual preferences and needs. Services were adapted to ensure that patients' specific needs were met.
- Corporately planning for newly acquired or transferring services was comprehensive, with clear accountabilities to ensure that the transition was smooth for staff and patients.
- As part of the wider Virgin group, VCSL had access to resources and advice about the business arrangements but recognised that services were best localised to meet the needs of the community using the individual services.
- Staff had completed online equality and diversity training and had an awareness of how this impacted on their work.
- The response to complaints both corporately and locally was good. Complaints were responded to within the timescale detailed in the provider policy.

However,

- The Dementia Strategy was newly ratified and had not been in place sufficient time for it to be fully embedded at the time of our visits. There was good work beginning but not all staff had yet had training. The provider recognised there was more work to do in this area.

Detailed findings

Planning and delivering services which meet people's needs

- Corporately there was a clear business plan and model for how the provider wanted the service to grow and develop moving forward. At the time of the inspection there were significant changes to the contracts with CCGs taking place. Some services were being acquired and others were being transferred to other providers as contracts were split. There arrangements are outside the remit of this inspection.
- Where services were acquired or due to transfer out, the provider had a very clear 100 day planning process to ensure a seamless transition for staff and patients.
- Some support services were centralised and benefitted from the resources of the wider Virgin Holdings parent company. There remained, however a view that some services were best kept at local level with national support. This included business unit based human resources staff and IT engineers and finance staff.
- All acquired services went through a robust assessment process to enable staff to work within the VCSL framework and to VCSL policies. Support and guidance was provided throughout the transfer period.
- Local staff were encouraged to have ownership and to be involved in service planning to meet the needs of their local community.
- Most patients treated at Milford Hospital had previously been inpatients at the local NHS acute hospital and were admitted as part of an elective rehabilitation pathway.
- Haslemere Hospital and Milford Hospital had x-ray facilities on-site.
- Holly Ward at Milford Hospital primarily cared for patients that were recovering from a stroke although they would also care for patients recovering from fractured neck of femur (hip).Staff told us that, although they do care for some patients that aren't typically suited to being cared for in a community hospital, all patients see some benefit from the time they spent there.
- We were told that re-admissions back to the community hospital were extremely rare. This was because after the patient was discharged, if they then became unwell, they would be cared for in the local acute hospital.
- Physiotherapists employed at the hospital arranged their appointments through a daily list. The daily list was compiled by night staff. There was then a 'hot sheet' produced, which showed staff when and where patients would be seen by the therapists. The hot sheet was not final and could be updated and amended to meet the needs of the patients.
- Either family or friends provided patient transport. If more specialist transport was required, this would be provided by the local NHS ambulance patient transport service. There were also plans in place for patient transport to be sub-contracted to St John's Ambulance if necessary.

Good

Are services responsive to people's needs?

- Each ward in community hospitals had a dependency assessment sheet. This showed the patient's dependency on nursing care. Areas including the ability to eat and drink, use the toilet, move and pressure area care were scored on a scale on one to four with one being independent and four being highly dependent. When the areas were assessed and the scores added together, a dependency score was given. This meant that staff had ready access to information about all patients on the ward and the level of care received and required.
- In all wards patients were separated by gender in same-sex bed bays or side rooms to avoid mixed-sex breaches, which are against national NHS England guidance. There were no mixed sex breaches in the year preceding the inspection visits.
- AHPs completed a social history assessment of each patient as part of rehabilitation planning. We saw this in practice and it was used to establish the contributing factors to the patient's current condition and whether social issues contributed to this. Staff used this to plan rehabilitation and ensure it was delivered in a holistic way that took into account diverse social needs.

Equality and diversity

- Staff were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that staff could communicate effectively with all patients where English was not there first language.
- Staff could access information leaflets in other languages if needed and we saw information on the back of patient information leaflets signposting patients to these.
- The kitchen at Milford Hospital was able to cater for patients with specific religious / cultural dietary requirements as well as other health related dietary requirements.
- There was a multi faith prayer room off the dining room. This had a sheet that clearly displayed the times that it must be made available for those that wanted to use it. Holy Texts for the major religions were available.
- Hospital chaplains visited the wards and could signpost or contact ministers from non-Anglican traditions and other religions on request.
- At the entrance to the physiotherapy gym there were signs in a number of different languages that advised patients that interpreting services were available.
- At the time of the inspection VCSL had a draft version of a Diversity Inclusion Strategy. The main driver for the implementation of this strategy was ensure the organisation allowed colleagues to bring their 'whole selves' to work every day so that they and their patients 'felt the difference'.

Meeting the needs of people in vulnerable circumstances

- Milford Hospital had a courtyard garden in the middle of the inpatients building with a number of benches, tables and other seating areas. This area was rarely used during the winter months but we were told it would be used regularly at other times of the year. The garden was looked after by the 'friends' of the hospital. All items were in good condition although the hard surfaces were uneven. Any patients wanting to use the garden would be accompanied by a member of staff or a family member/friend to reduce the risk of falls.
- Milford Hospital was visited regularly by a charity that engaged the patients in various activities including reminiscence painting, arts and craft sessions and quizzes. The service that was provided could be done in groups or in one to one sessions.
- Every other month a group that used pets for therapeutic purposes would visit. This would allow patients to have contact with animals. We were told how this was especially beneficial for those patients that had previously had pets but had become unable to care for them any longer. Families and friends were able to attend the hospital garden with their dogs so patients could sit in the garden with them.
- There was a shared dining room for both Holly and Oak wards at Milford Hospital. Patients were encouraged to eat meals in the dining room although they were able to eat in their room or at their bed. Patients had a choice between cereals or porridge for breakfast. Menus were available for patients to choose from, including an option of two main courses and three desserts for lunch. The menu was changed daily and was on a two week cycle. This meant that patients had a varied choice of meals. Patients were offered soup, a selection of sandwiches or a hot meal for supper. Patients ordered their food at the time they sat down rather than in advance, which staff said had been introduced to provide a restaurant-style experience. Snacks were provided to patients throughout the day if required.

Good

Are services responsive to people's needs?

- The hospitals did allow patients relatives or friends to bring in food and drink for the patients although staff did discuss with friends and family whether what was being brought in was suitable.
- The dining room at Milford Hospital had a small hand held bell that patients could use if they wanted to summon the help of staff should they require assistance.
- There was a trolley of games, books and a CD / cassette player available for the patients to use as well as board games in the hospitals.
- The hospitals were visited every other week by a dietitian from the local acute NHS hospital to provide advice and assistance to the patients. A speech and language therapist also attended every other week to carry out swallowing assessments.
- A notice board, specifically provided for patients, friends and families of those who had had a stroke contained a comprehensive set of information leaflets, contact details for support groups and practical advice to assist with the patient's rehabilitation.
- There was a board at the entrance to the gym that showed a picture of all the therapy staff with their names underneath. There was also a wide range of information for patients, friends and family provided by national charities as well as specific information about a range of conditions.
- A recent Dementia Strategy was created from listening to stories of people affected by dementia, reviewing innovations in place with other providers nationally and staff consultation. The provider had set up a Dementia Community with people from across the services with a dedicated page on the intranet signposting staff to resources. The group had reviewed the screening tool and training programme and there was a current recruitment programme for dementia champions from within the staffing complement and an audit across services to ascertain how Dementia Friendly the services were.
- One member of staff had undertaken a dementia fellowship course to help inpatients with dementia 'feel the difference'. Specifically, they had recruited knitters who could knit a type of sensory hand muff. People with dementia often have restless hands and like to have something to keep their hands occupied.
- Patient-led assessments of the care environment (PLACE) put patient views at the centre of the assessment process and areas included privacy and dignity, cleanliness, food and general building maintenance. In addition, the building's suitability for dementia sufferers who sometimes have difficulties with identifying contrasting colours such as doors and door frames unless these are clearly marked. Scores for dementia in Farnham, Milford were better than the national average of 75% with results of 80% and 76%.
- Staff were able to give us examples of caring for people living with dementia and the adjustments made, for example, taking time to talk to patients, using simpler language and involving carers.
- VCSL have committed to supporting John's Campaign, an initiative championed through the Carers Forum to allow family carers the right to stay with their relative who is living with dementia, when they are in hospital.
- Ward environments had been adapted to help orientate patients living with dementia. The dining room had a dementia friendly calendar and clock. The clock had large digital number with the day and date next to it. This was situated at eye level when patients were sitting at the dining tables. In addition, bathroom doors had dementia-friendly signs on them.
- Each ward had a display of the staffing team, including photos and their job title. This made it easier for patients and visitors to identify key staff.
- There was a patients' occupational therapy kitchen at Haslemere Hospital that was for the use of patient therapy assessments. The kitchen was fitted with a cooker, microwave, fridge, toaster, pots and pans. The hospital had a courtyard garden which was maintained by the friends of Haslemere Hospital. The wards had dementia friendly clocks with large digital numbers telling the time as well as clear words saying the day and date.

Access to the right care at the right time

- The hospital did not assess patients for dementia as they would have been diagnosed by the acute hospital. However, if staff had concerns that a patient had dementia, they could send the patient to the acute hospital for scanning and diagnosis.
- The therapy teams at the hospital ran various groups to assist in the rehabilitation of patients. These were a falls groups, a balance group and a renablement group
- The occupational therapists had access to a fully equipped kitchen. It contained a sink, gas and electric ovens toasters, microwaves, fridges and pots and pans.

Good

Are services responsive to people's needs?

This was for the exclusive use of the patients and the OT's to assess a patients ability to prepare food and drinks themselves safely. The environment and equipment was all clean and in working order.

- Between August 2016 and January 2017 the average length of stay for patients in Milford Hospital was 21 days.

Learning from complaints and concerns

- The Complaints Policy stated complaints should be acknowledged within three working days and fully investigated. The complainant should be kept informed throughout the process and a time frame given.
- All complaints received were sent to the Customer Service Team (CST), who provided central support and sent an acknowledgement letter and confirmed a response date. The complaint was then forwarded to the service manager to begin any necessary investigation.
- An open and transparent response that addressed all the points raised was encouraged with staff being supported to offer face to face meetings whenever possible.
- The clinical lead for each business unit was responsible for oversight of all complaints and telephoned complainants personally. The sign off for all complaint letters was the business unit (regional) director.
- The CST also monitored social media and feedback sites for any new comments and responded to these as they would more formal complaints and comments.
- The overall level of complaints was very low across all VCSL adult community services.
- The complainant was informed to take the complaint to the independent Parliamentary and Health Service Ombudsman if they were not satisfied with the way the complaint had been dealt with by VCSL.
- In the 12 months prior to our inspection, there had been a total of seven complaints made about community inpatient services. Five complaints had been made about Farnham Hospital, one complaint had been made about Milford Hospital and one complaint had been made about Haslemere Hospital
- We reviewed four complaints that were received by VCSL relating to community inpatient services. The responses were comprehensive and demonstrated that the complaints had been thoroughly investigated. It was also clearly demonstrated that areas for learning were identified and acted upon. For example, the dining room had equipment that kept plates warm. This was purchased following complaints that hot meals were being served on cold plates. This showed us that the provider responded to concerns raised in complaints and took action to address the concerns.

Outstanding

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

- The leadership, governance and staff culture were highly developed and used to drive and improve the delivery of high quality person-centred care. There was evidence clinical governance processes resulted in improved practice, such as in better information governance training and systems following a series of data incidents.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a clear governance structure and assurance framework with effective and clear communication to and from the executive team.
- There were effective systems in place for providing assurance to the Board about the safety and quality of the services provided. Data collated as part of the assurance and governance framework was used to drive service improvements.The governance structure was comprehensive but not unduly complex and encouraged operational staff to take responsibility for the services they delivered. The clinical governance structure included a range of clinical groups and committees and management groups that worked together to ensure services were delivered safely and benchmarked against national best practice.
- Leaders exuded a strong sense of shared purpose, strove to deliver and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Staff felt supported by their line managers and felt confident to raise concerns with them. There was a strong visible local and national leadership who, together with the staff, were committed to improving patient care.
- We saw staff and managers shared the same vision and strategy. The organisation was pro-active in celebrating staff achievements. There was an overarching vision and strategy that all of the staff we spoke with understood. Where one group of staff had indicated through a staff survey they felt they could be more empowered and involved, the senior team acted on this.
- The leadership drove and supported continuous improvement and staff were accountable for delivering change. Safe innovation was encouraged and celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Staff felt empowered to make positive changes. The provider actively recognised innovation and rewarded staff for contributions and achievements. Teams also sought recognition from external bodies. For example, the tissue viability nurse team had been shortlisted for a National Patient Safety Award for their publication of a pressure ulcer audit in an international clinical journal.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. The senior team proactively sought out and acted on patient and staff feedback and used this to improve services through a 'you said, we did' programme. For example, enlarged assessment and therapy materials had been provided so more patients could use them.
- Senior staff had engaged with a series of 'back to the floor' sessions aimed at making them more visible and accessible to staff who worked on the ward. Staff spoke variably about how engaged and consulted they felt with regards to changes in their services. This included a recent reduction in nurse and healthcare assistant staffing in which staff at one hospital said they had been consulted and staff at another hospital said they had not.

Governance, risk management and quality measurement

- Virgin Care Services Limited had a very clear governance structure that fed up to Virgin Healthcare Holdings Limited, the parent company through their monthly meetings.
- The VCSL Executive team led the services provided and received assurance both from the Virgin Care Clinical Governance Committee and directly from the Health and Safety Committee and Information Governance Committee.

Outstanding

Are services well-led?

- At VCSL Clinical Governance Committee meetings, the executive team shared learning, monitored key performance indicators and the clinical strategy with each business unit (regional) director and clinical lead.
- The VCSL Clinical Governance meetings were chaired by the medical director.
- Reporting directly into the VCSL Clinical Governance Committee were four sub committees – Infection prevention and control, research governance, medicines management and safeguarding adults and children. The sub committees each had representation from each business unit and were multidisciplinary to enable concerns and ideas to be considered from a wider perspective.
- Sitting under the VCSL Clinical Governance Committee and with information passing in both directions were the Business Unit Clinical Governance Committees (Clinical Quality and Risk; Integrated Governance Committees). These business unit meetings were chaired by the business unit head.
- Providing arm's length, higher level challenge and assurance was a Quality Committee that provided additional organisational assurance on clinical governance, quality and safeguarding. This group received reports from the VCSL Clinical Governance Committee and also the Health and Safety and Information Governance Committees. The role of this group was to provide 'Blue Sky' thinking, to consider innovative ideas and to ask strategic questions that arose from the assurance reports.
- For each business unit, there was a monthly Business, Clinical Quality and Risk Meeting (BCQRM) where a monthly clinical quality report was shared, which addressed all clinical quality & safety including safeguarding, complaints, compliments and friends and family test (FFT) data.
- The clinical quality report was comprehensive and we saw the minutes for September and October 2016. The July 2016 BCQRM showed concerns were addressed. In addition, targets and actions identified in relation to risks to patients, staff and the organisation.
- Staff understood and felt involved in governance processes.
- Quality outcomes were recorded in a clinical quality report, which was shared with leaders of the organisation at the BCQRM. This meant that there was a process in place for sharing information on quality outcomes with leaders of the organisation.
- A business unit clinical quality and risk group led the objectives of providing strong clinical governance to deliver recognisably and demonstrably high standards of care, transparent responsibility and accountability for those standards and a constant dynamic of improvement.
- This group looked at the organisation's performance with regards to patient safety, patient experience and clinical effectiveness.
- The group was formed of:
  - The Business Unit Head of Operations (Chair)
  - Operational Leads
  - Quality and Clinical effectiveness Lead
  - Leads for each service within the business unit
  - Leads on medicines management, non-medical prescribing, information governance, safeguarding and infection control.
- A clinical lead chaired a monthly clinical governance meeting, contributed to the hospitals steering group and also led appraisals for the medical team. This represented an embedded governance structure that enabled the clinical lead to maintain oversight of incidents, clinical practice, patient outcomes and complaints. This framework enabled clinicians to expand practice and improve governance arrangements in specialist areas. For example, a virtual falls group took place monthly where doctors treating patients at this provider's hospitals liaised with clinical specialists elsewhere to review individual cases and plan complex care.
- Four committees provided oversight and scrutiny in specific areas of clinical governance, including infection control, research, medicines management and safeguarding. The four committees reported into the clinical governance committee, which contributed to overall organisational assurance through an overarching quality committee.
- The service had identified a need for improved information governance training and practices following a series of incidents that involved breaches of confidentiality, poor document management and the use of unsecured e-mails. In response the provider reviewed its information sharing policy and instructed each department to conduct a data flow mapping exercise to identify how staff shared data. Information governance formed part of the mandatory training for

all staff. In February 2017, an average of 95% of staff were up to date with training. This included 100% of staff on Haslemere ward and Oak ward at Milford Hospital.

- Services completed a RAG rated Clinical Governance Scorecard monthly. The individual scores were collated into a comprehensive dashboard that allowed trends over time and comparisons to be made.
- As part of the assurance framework, the provider had introduced Internal Service Reviews (ISR) a comprehensive account of the way services were provided, completed by each team every six months. The web based tool used the CQC five key questions and Key Lines of Enquiry as a basis for assessing each area of care provided by VCSL. Staff were required to complete the very comprehensive assessments, with supporting evidence to the governance team for analysis and benchmarking against other services. Where services rated themselves as anything other than 'Good' based on the responses to the questions and using a scoring matrix, then a review of why the score was less than 'Good' was held and the team were supported to make improvements.
- The Board saw the ISR as both a monitoring tool and a development tool. Front line staff had worked with subject matter experts to create the review tool.
- Where services were new in scope, additional support and resources were made available to enable them to reach the benchmark of 'Good'.
- The provider had a Risk Register Policy that was used effectively locally and at Board level. Each service and business unit had its own Risk Register that it was responsible for. High scoring risks were escalated to the Virgin Care Clinical Governance Committee and upwards to the VCSL executive team. Significant corporate risks were escalated to the parent company.
- The risk register was discussed at each BCQRM and we saw evidence of this in meeting minutes. The register was up to date, identified the risk, the impact to the patient or service user, the controls in place, with a nominated lead for each risk.
- Individual executives, business unit directors and clinical leads were able to talk to us about the most serious risks within their remit. Examples were given of how the provider had responded and mitigated against risks.
- The senior team for each business unit monitored risks to the service using a risk register. This enabled an accountable individual to lead on minimising and resolving risks. At the time of our inspection there were two risks classified as 'high' that affected inpatient services. This included a change in the electronic referral system used by NHS acute providers and an increase in the number of bariatric patients admitted. There was evidence staff had acted to mitigate the risks, including convening a strategy meeting to consider how to ensure referrals were still acted upon and providing staff with specialist training in caring for bariatric. All risks relating to this service had been reviewed in October 2016.
- The provider had achieved the Cybersecurity Standards of the General Data Protection Regulation (GDPR). This legislation will apply in the UK from 25 May 2018. There were 22,000 data flows across the organisation that were mapped to check the provider was GDPR ready.
- The Caldicott Guardian was the clinical director.

Service vision and strategy

- VCSL had very clear strategies and an explicit service vision supported by Virgin Care Values. There were clear shared goals that were known to staff.
- The Virgin Care Values were, "Think, Care, Do". The values formed part of every staff member's appraisal, were included in the welcome packs for staff and were on display throughout services.
- The provider had a Nursing Strategy that was under review at the time of the inspection visits. It had been identified that whilst nurses formed the majority of frontline professional staff, there were therapists and other staff groups who needed to be included. Going forward the Nursing Strategy was to become the Health and Care Strategy; the organisational values were being mapped to the professional codes of conduct, which formed the basis of the strategy document.
- Each service also had their own Service Vision that was owned by staff. For example, following a Community Nursing innovation Programme in 2015, the vision for community nursing in Surrey was agreed as, "To create a resilient, sustainable and innovative 21st century community nursing service that provides the best care and is highly respected by patients, carers, professional partners and the public.

Are services well-led?

- The Quality Strategy focussed on implementing and operating quality systems that supported a culture of empowerment, quality management, shared learning and continuous improvement.
- Within the strategy and assurance framework were clear accountabilities, structures and systems for reporting and monitoring. Clinical leaders worked alongside and in partnership with managers.
- There was an organisational belief that clinicians in operational roles were best placed to improve services and this led to there being a relatively small executive team and few central support roles.
- The new strategy going forward was created to allow for a 'Strategy on a page', a working tool rather than an exhaustive very thick document. There was a decision to keep it simple and to connect the strategy to the values and behaviours. "To attract the BEST practitioners, to have the BEST systems, and to deliver the BEST outcomes….providing the tools and creating the environment where quality flourishes, demonstrated through Outcomes such that everyone feels the difference".
- Virgin Care Services Limited had values which they believed helped them to 'Stand out from the crowd', they were unique to who VCSL were. They were said to be the moral compass of VCSL and defined the way VCSL were.
- The services had a vision focused on a culture of compassionate care that included nurses, midwives and the care team. The vision directed staff to deliver care and treatment with compassion, competence, communication, courage and commitment. Most nurses we spoke with recognised this but five individuals said they felt this was a corporate approach to health and they did not feel involved in its ethos or delivery.
- Allied Health Professionals (AHPs) we spoke with were positive about the vision and strategy of the organisation and said they understood how this applied to their roles and the patients they were responsible for.

Leadership of this service

- The executive team were approachable and accessible. Their contact details were known and staff were encouraged to raise concerns direct with members of the executive, if they felt they were not getting sufficient or appropriate responses at a local level.
- The executive team knew their services well and were able to describe examples of good practice, learning and incidents from across their services which were correlated with what operational staff told us. They talked about individual named members of staff, knew the buildings and could tell us about any particular challenges services and individual staff members were facing. They spoke with genuine warmth and respect for the staff and were clearly proud of the achievements of teams from across the country.
- The executive team made regular floor visits and all services had been visited over each year. Some executive members worked alongside teams where governance systems had raised concerns. The Chief Nurse had recently spent time with one team where an incident report raised concerns about the quality of pressure area care being provided. The Chief Pharmacist oversaw 'Deep Dives' where a potential cross service risk was identified.
- Business unit managers and clinical leads also spent time with the teams that reported to them. Over the year they visited all services and also provided a regular drop in session when they were available to meet with staff. Their mobile phone number was included on the business unit newsletter, so staff could call them directly.
- Credit for all achievements was given to the front line staff. Good practice was recognised and celebrated. There was support and opportunities for learning but limited tolerance of poor standards. One senior manager we spoke with talked about their staff having the freedom to act, and staff ownership of the care they provided. They also said, "People are encouraged to work to the top of their grade, 'just good enough' isn't really acceptable".
- All managers from business unit level upwards were required to obtain 360 feedback as part of their appraisal, annually. This allowed staff the opportunity to comment on their manager's performance and relationships.
- Managers we spoke with appeared knowledgeable about their service user's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. We saw that managers at all levels were visibly upset at losing their staff through transfer of the contracts to other providers. Senior managers specifically asked the inspection team to be mindful of the transfers that were happening and the impact this had on staff and their line managers.

Are services well-led?

- Senior leaders were supported to complete the Virgin Inspire leadership programme, after successful attendance at an assessment centre.
- VCSL had invested in developing the management skills of the senior district nurses as part of the Community Nurse Innovation Programme. In 2015, they introduced a nurse development programme for 56 senior community nurses where they were taught about managing teams effectively, customer service, 'The Virgin Way' and conducting root cause analysis investigations. The lead for the programme was awarded the Nurse Leader of the Year award by the Royal College of Nursing Institute for their contribution to this programme.
- There was a Band 6 development programme available to staff who wanted to develop their leadership skills.
- In Surrey hospitals, a senior community hospital matron, supported by ward matrons and ward sisters led nursing care on the wards and a therapy lead provided leadership to physiotherapists and occupational therapists on a cross-site basis.
- Staff told us they felt matrons were readily accessible and could be contacted at any time for support or to escalate a concern.
- An on-call manager rota was in place at weekends and out of hours through the week and staff told us the manager had always been contactable when they had needed to reach them.

Culture within this service

- Staff spoke about the visibility of and support from the executive team. For example, some individuals knew who was part of the executive team and said they visited the ward regularly.
- The culture in the ward teams encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned.
- We spoke with staff about the organisation culture and all of them reported that they enjoyed their jobs and felt valued.
- Every member of staff we spoke with said the matron was approachable and proactive in helping them. One nurse said, "I feel really well looked after. We've got an excellent matron who will point us in the right direction whenever we need help."
- Staff told us they felt ward and multidisciplinary teams were cohesive and inclusive. One therapies member of staff said, "There is a fantastic atmosphere here. Everyone is approachable and there's no attitude." Physiotherapists and occupational therapists said they felt there was no obvious hierarchy, which meant staff worked as equals and formed a coordinated team.
- There was a commitment to supporting staff from diverse backgrounds and to ensure equality for staff with protected characteristics. This included attendance at London Pride, a Diversity and Inclusion space on the VCSL intranet, a Mental Health Wellbeing toolkit, a Pledge for Parity and engagement with Stonewall.
- The provider had three 'Freedom to Speak up' Guardians, one whom was the legal counsel for the organisation. The guardians were supported by an anonymous online system. There is no requirement for providers of independent healthcare services to have Freedom to Speak Up guardians but VCSL felt it was the right thing to do.
- Staff were also encouraged to make direct contact with Board members if they felt their concerns warranted senior intervention or they felt they were not getting an adequate local response.
- The provider had invested £250, 000 training over 20% of the workforce in the People Flourish programme so that they can support colleagues to transform services, work better together and reduce sickness absence. Since the programme started there had been a 5% reduction in reported stress, increased staff retention and improved morale. The programme was credited with saving £160, 000 in recruitment costs because of lower staff turnover.

Public engagement

- The hospital participated in a 'you said, we did' initiative with community inpatients. This initiative allowed patients to raise any issues they wanted to be changed. For example, one comment was from patients requesting visible clocks. These clocks had been provided and are described in the responsive section of this report. Another suggestion was that staff did not have clear name badges. This mainly applied to agency staff. The hospitals had raised this with agencies who had now issued clearer name badges with a photograph of the member of staff on them. In addition, enlarged assessment and therapy materials were provided to help patients with reduced eyesight.

Are services well-led?

- Hospital Friends groups volunteered and raised funds for items to improve patient experiences. Friends of Farnham Hospital held events such as buying and distributing Christmas Presents for all in-patients at Christmas and delivering strawberry cream teas in the Summer. Purchases have included mobile ward telephones and anatomical models for the physiotherapy department. The Haslemere League of Friends had installed Wi-Fi access on the wards and maintained and enhanced the patients' garden. At Milford Hospital, the League of Friends had arranged regular performances by a ukulele group, provided Christmas presents for patients and held an annual summer garden party.

Staff engagement

- VCSL had a yearly staff survey called 'Have your say' with a 'Pulse check' six months later. Four main themes were identified in the most recent business unit four (October 2016) 'Have your say' these included equipment and "tools to do the job", communication, morale and training. VCSL developed an action plan to address the issues identified within the 'Have your say' with a member of staff nominated, which ensured the action was taken.
- VCSL business unit four had a band 6 staff development programme this provided this staff group a dedicated programme, which explored the band six role, vision, values and expectations. This meant all band 6 staff shared the same vision and values and knew what was expected of them.
- Staff were nominated for 'Star of the year awards', which were presented at the yearly 'Big Thanks' Christmas parties. One staff member told us she had won an award, other staff were aware of the awards and other staff had received nominations.
- Staff who won major awards had been taken out to dinner in a roof top restaurant in London.
- We saw there were Surrey wide newsletters, professional meetings and 'away days' held in many of the community services. VCSL produced a monthly 'Something for the weekend' newsletter which contained routine but important information, compliments 'shout outs' for staff, awards nominations and occupational health information. Staff we spoke with were positive about the newsletter as it was 'user friendly'.
- All staff had access to VCSL intranet 'the Jam' where policies, information and activities could be accessed.
- Staff had a VCSL 'Tribe card' which offered discounts on many products.
- As an independent provider VCSL were not required to employ a Freedom to Speak Out Guardian. However, the provider had appointed three guardians nationally. Data relating to staff seeking the support of the guardian (numbers and themes) were reported to the Executive via the Quality and risk meetings.
- Ward meetings took place monthly and the minutes and outcomes were e-mailed to the whole team. This meant staff who could not attend were able to stay up to date with changes in the unit. Staff we spoke with said they felt this was a useful process and that they felt involved. For example, a healthcare assistant said they received an invitation with two weeks' notice and were asked to contribute to the agenda. If staff knew in advance they could not attend, the matron asked them for topics of discussion so they could still contribute.
- Senior staff had engaged with a series of 'back to the floor' sessions aimed at making them more visible and accessible to staff who worked on the ward.
- As part of team meetings and the governance process for physiotherapists and occupational therapists, one individual was asked to prepare and present a talk on an initiative they had been involved in or about a specific case study. This enabled the team to benefit of the learning and experiences of each individual.
- A weekly multidisciplinary ward management meeting allowed all staff involved in providing care and running the wards to contribute to developments and to stay up to date. We saw changes were made as a result of this system. For example, an AHP told us they were always asked what they thought was working well and what they could suggest as an improvement. They raised the issue of patient privacy at Farnham Hospital and in response privacy, notices were provided on each bedroom door that staff used to indicate when a patient was receiving personal care.
- Feedback from the staff survey in September 2016 indicated ward sisters wanted more opportunities for professional development. In response the provider implemented a new band six nurse development programme that aimed to develop leadership skills and better connect staff with the organisation's values.

Innovation, improvement and sustainability

Outstanding

Are services well-led?

- Staff could apply to the 'Feel the difference' fund to help with ideas and innovations. Staff felt innovation was encouraged. This was a £100, 000 fund that seed funded local initiatives suggested by staff that focussed on patient experiences. The bids could be suggested by any staff and were approved by a peer panel. There was an option for very small bids to be fast tracked. Innovations so far have included standing desks, body blocks and a body mapping system.
- In Surrey, we were told about the discharge to assess process that the hospital was piloting. We were told that this process had been established as patients were being assessed in the hospital environment which was not always reflective of the patient's home environment. At the time of the inspection the hospital were concentrating on getting the patient medically fit, complete one form rather than a form a separate form for each member of the multi -disciplinary team. A comprehensive assessment will then be carried out in the patient's home. At the home assessment the team will decide what each of them will need to do to and produce a clear plan to provide ongoing care for the patient.
- The clinical lead was increasing the scope of the clinical governance framework to develop a more multidisciplinary model. This included developing more regular collaboration between hospital doctors and GPs, such as through video conferencing, to be able to plan care for patients with increasingly complex needs.
- The therapies team in Surrey recognised the need for sustainability and staff development and provided students with opportunities to remain involved with the organisation. For example, we met two former student physiotherapists who had undertaken placements at the hospitals and then successfully applied to join the permanent teams after they qualified.
- Staff were proactive in identifying areas for improvement, including through establishing and participating in pilot schemes. For example, a physiotherapist had implemented a pilot scheme at Haslemere Hospital that involved lunchtime handover sessions. The handovers were used to review the activity level of each patient, review opportunities for movement in the afternoon and ensure that the whole clinical team were involved in this.
- The AHP team had secured funding as part of a 'Feel the difference' programme that was used to provide equipment and resources to help patients continue therapy outside of planned sessions. This included equipment for exercises and to keep patients engaged and the therapies team developed a programme of bed-based activities patients could safely complete without their supervision. This equipment also provided patients with more support during routine tasks, such as body blocks to help patients elevate their legs during dressing changes and bandaging.