London North West Healthcare NHS Trust

R1K

Community health inpatient services

Quality Report

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 020 8864 3232
Website: www.lnwh.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1K05	The Denham Rehabilitation In-Patient Unit	In patient Hospital	HA3 5EG
R1K06	Willesden Centre for Health and Care	In patient Hospital	NW10 3RY
R1K07	Clayponds Hospital	In patient Hospital	W5 4RN

This report describes our judgement of the quality of care provided within this core service by London North West Hospitals NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by London North West Hospitals NHS Trust and these are brought together to inform our overall judgement of London North West Hospitals NHS Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall, the service provided by London North West Hospitals NHS Trust for community health inpatient services requires improvement because;

- The Denham unit did not have enough nursing staff to keep people safe all the time. There were not enough full time registered nurses which meant too many agency nurses were being used.
- The community hospitals were not always ensuring that patients with memory needs were being identified and their care was not being adapted to meet their individual needs.
- Services, processes and standards were variable across the three community hospitals. There was no single clear process of management and clinical governance. There was no clear trust plan for developing the service.
- The trust had good systems and processes in place for keeping patients safe. They ensure that patients are well enough to be cared for in the unit and that if patients deteriorate this is identified and the patients were transferred to an acute hospital if needed.
- Community health inpatient services were effective. Care and treatment was evidence based and staff were competent. There were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently.
- Multidisciplinary teams worked well together to provide patients with good outcomes. In particular, physiotherapists and occupational therapists were well integrated and showed leadership in ensuring patients achieved their recovery goals.
- All the patients and families we spoke with were very positive about the care they had received in the community hospitals. One person told us, " They have been great. I have got all the care I needed". Another said, " The nurses are nice and they have been trying to get me well enough to go home".
- Community services were caring. Staff were dedicated and worked hard to ensure that patients received the best treatment and support possible. Patients were involved in decisions and understood the services being delivered to them. Emotional support was available to patients who were dealing with difficult circumstances.
- Staff generally reported good supportive leadership at local level and we met some committed and enthusiastic managers who were working hard to develop and improve their own specific services.

Summary of findings

Background to the service

Information about the service

This report includes all inpatient and day case wards in community hospitals. Examples of the care provided include: Inpatient rehabilitation;Inpatient intermediate care;Inpatient nursing and medical care for people with long-term conditions, progressive or life-limiting conditions or for those who are elderly or frail.

This report does not include; other community health services that the provider runs from a community hospital site, such as community nursing or therapy clinics or outpatient services. These services are included in the community health services for adults' core service. End of life care provided to people on community inpatient wards. This care is covered by the community end of life care core service.

Any services run out of the location but provided by other providers, such as walk-in centres.

The trust had three community inpatient hospitals; The Willesden Centre for Health and Care, Clayponds Hospital and the Denham Rehabilitation In-Patient Unit.

Willesden Centre for Health and care had three wards; Fifoot Ward (20 beds), Furness Ward(20 beds), and Robertson Ward (20 beds).

Clayponds Hospital had two wards; Jasmin Ward (15 beds), and Rosemary Ward (25 beds).

The Denham Rehabilitation In-Patient Unit had 30 beds.

The primary purpose of the community hospitals was to care for patients who are not accutely ill. Most patients are tranfered from one of the trusts three acute hospitals and spend a few weeks receiving intense physiotherapy and other treatment to enable them to go home or move to a care or nursing home.

During our inspection, we spoke with 29 patients, seven familiy members, and 63 members of staff. We visited and observed every inpatient community ward.

Our inspection team

Chair, Dr Richard Quirk, Medical Director, Sussex Community NHS Trust

Inspection lead: Nicola Wise (David Harris supporting) CQC

The inspection team was made up of a CQC inspector and specialist advisers.

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 the trust we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 19 and 23 of October 2015. During the visit spoke with a range of staff who worked within the service, such as managers, nurses, and therapists. We observed how people were being cared for and we talked with parents and reviewed a small number of treatment records of people who use services.

During our inspection, we spoke with 29 patients, seven family members, and 63 members of staff. We visited and observed every inpatient community ward.

Summary of findings

Good practice

The availability and Input of dedicated psychologists as part of the MDT at the Willesden Centre for Health and Care provides patients with improved long term outcomes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

The provider must ensure that the Denham Unit has sufficient nursing staff to keep patients safe at all times.

The provider should Increase the number of full time registered nurses and decrease the number of bank and agency nurses.

The provider should ensure patients with memory need are identified and they receive personalised care according to their needs.

The provider should develop a single vision and set of operating procedures across the three community hospitals.

London North West Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

All the community hospitals vacancy rates for registered nurses were too high, this meant that too many agency nurses with less knowledge of the patients and the unit were being used. There were not enough staff at the Denham unit to keep patients safe.

The trust reported low numbers of incidents. Those incidents that did occur were consistently properly investigated and the outcomes fed back to staff.

The community hospitals were effective at making sure only suitable low risk patients were admitted. The hospitals had a clear process for identifying and responding to deteriorating patients. Patients who had deteriorated had been identified and transferred to the acute environment if necessary.

Safety performance

The trust reported low numbers or pressure ulcers.

The number of patient falls was low throughout the year, the trust had a target of no more than seven falls per 1,000 bed days. The latest figures for the trust in August 2015 indicated that the number per 1,000 was seven for Ealing, one for Brent, and six for Harrow.

Ward managers maintained a quality dashboard by the entrance to the ward where it could be seen by staff and patients. The board contained up to date information on key safety issues such as; staffing levels, urinary tract infections, pressure ulcers, falls, deep vein thrombosis and infections outbreaks.

Incident reporting, learning and improvement

Staff knew how to use the electronic incident reporting system that was in place and there was a system for ensuring the trust picked up reports and investigated them appropriately.

The community services generally reviewed and investigated incidents. There was evidence of local learning

and changes had been implemented as a result of incidents that had occurred. For example, staff talked about an incident where a Health Care Assistant (HCA) had been left alone on the ward and a patient had fallen.

The hospital did not always ensure that staff received feedback on the incidents they reported. For example, staff at the Denham unit were not aware of the circumstances or any possible learning from an unexpected death that had occurred there.

Hospital matrons held meetings which included reviewing incident trends, root cause analyses (which are investigations to determine how and why patient safety incidents happened) and learning.

Safeguarding

Staff were aware of the correct safeguarding process to follow and were able to outline the policy and methods for escalating concerns. Staff gave examples of recent safeguarding alerts they had

made. For example, they described a fall that had occurred and then how they ensured the patient received one to one care to prevent it happening again.

Falls risk assessments identified patients who were at risk of falling and the hospitals used an orange wrist band so that staff knew who to provide with additional support.

Staff applied the principles of the Duty of Candour legislation, although they did not recognise the term. Staff demonstrated an attitude of transparency and openness.

The trust had made safeguarding part of its mandatory training programme with a target of 90% compliance. Latest trust figures from April 2015 indicated that Ealing was reaching only 84%, Brent 86%, and Harrow 83%.

Medicines

The community services managers monitored medication errors monthly as part of the performance dashboards. The vast majority of medicines were administered correctly.

Clinical staff had correctly maintained drugs charts and we found that; allergies were documented on each drug chart, there was a pharmacist review of each drug chart, the patients drugs history had been completed, VTE risk assessment completed. We found that missed doses were recorded but occasionally no reason had been identified.

A pharmacist and pharmacy technician attended Clayponds every weekday morning. The pharmacists were correctly reconciling and issuing medicines to patients. We found one emergency pack, including oxygen out of date, which was removed by staff during our inspection. All drugs including oxygen in the Resuscitation trolley were in date and had been checked.

At the Denham unit the clinical room, where medicines are stored, is very small and not fit for purpose, the fridge, all cabinets and CD cupboard were locked. Keys are held by the nurse in charge and by the unit pharmacist.

The fridge temperature was monitored and recorded daily. At the Denham unit the pharmacist was based on the ward Monday to Friday, 9am – 5pm The matron ensured that both admissions and discharges are planned and timed to ensure that the doctor and pharmacist are on site and can clerk the patient and complete medicines reconciliation.

The Denham unit pharmacist had implemented staff training around medicines for nursing staff and the nurses were included in the trust wide SMART training which included a section on medicines management. Wall mounted oxygen cylinders were available throughout the unit and were labelled as flammable.

Environment and equipment

The trust was too slow at dealing with repairs or replacing broken equipment. For example, a bath chair at Clayponds had not been fixed in a month. And a bath at the Denham Unit had been out of service for more than a year.

We found that Jasmin ward at Clayponds was in need of refurbishment with plaster missing from the walls in some places.

The community services made sure that sufficient equipment was available to meet patients' needs. The trust correctly checked and maintained equipment.

The trust had ensured that each hospital had a suitable room where staff could talk to families and patients in private and comfort to discuss their treatment.

Quality of records

We examined patients' notes in all of the wards for the three hospitals. Overall, we found that notes were well

completed with documented care plans including, consent, risk assessments and NEWS scores. We found some examples where doctors had not always made a note or it was difficult to read and understand.

Cleanliness, infection control and hygiene

We observed during our inspection that the clinical environments were visibly clean and tidy. Staff applied infection control principles and were seen to wash their hands and use hand gel appropriately.

Staff at the Denham Unit did not have access to dedicated hand wash sinks They used the sinks in patients' rooms, which were not standard utility sinks and did not comply with infection control policy. Managers had installed additional hand sanitisers to reduce the increased risk of infection created by the poor hand washing facilities.

The community services had provided ample personal protective equipment which we observed being used. The trust completes an infection control audit for each hospital on a quarterly basis.

Mandatory training

Mandatory training included safeguarding, manual handling, information governance, fire safety and diversity.

The trust had a target of 90% compliance for mandatory training. The compliance with mandatory training for the period May 2015 to July 2015 ranged from 74% to 80% for Ealing staff, 63% to 64% for Brent staff and 66% to 69% for Harrow staff.

Assessing and responding to patient risk

Nursing assessments and risk assessments were undertaken and, where risks were identified,

appropriate action plans were mostly in place.

The hospitals had a clear process for identifying and responding to deteriorating patients. The hospitals used the National Early Warning Score (NEWS) system to provide a tool based on the patients' respiration, pulse, oxygen saturation, temperature, blood pressure and level on consciousness. If the patients had a poor score then a doctor or ambulance would be called.

Staff used the recognised situation, background, assessment and recommendation (SBAR) system for reporting information on deteriorating patients.

Charts showing the National Early Warning Score (NEWS) for ill patients were in place and completed appropriately. During our inspection, we saw staff recognise and respond appropriately to the deterioration of a patient.

The community services management had ensured that all staff had been trained in basic life support which included CPR and using a defibrillator.

Staffing levels and caseload

The community services managers had made sure staffing levels were planned according to patient need and recent acuity assessment had been completed for each hospital. The hospitals generally had one registered nurse to each eight patients (1:8) This met the acuity needs of the patients at Clayponds and Willesden who are generally well and was achieved the vast majority of time. At the Denham Unit the nursing establishment was not sufficient to meet the needs of its patients.

We found a number of examples where additional nursing staff were called in to provide 1:1 support for vulnerable patients. For example, those who were very likely to fall or who needed intensive psychological support.

The community services managers were using too many agency staff. All the units had high vacancy rates for registered nurses (RNs) at Clayponds the vacancy rate for RNs had been 40% but was now 31%.

The Denham Unit had an establishment 11.85 RNs of which nine posts were filled. The establishment for Health Care Assistants (HCAs) was 14.23 HCAs of which 13.9 post were filled.

The community services managers had completed a recent acuity assessment for the Denham unit which stated that the unit needed an establishment of 21.85 RNs. The manager informed us that the local CCG had agreed to fund the additional number but that it would not happen until the planned move of the unit in January 2016. There are not enough nurses to meet all the needs of the patients at the Denham unit, patients are kept safe but their recovery is likely to be delayed.

The community managers are using too many agency RNs because they have been unable to fill full-time vacancies. This means that staff will be less knowledge about local procedures. There were a few shifts at the Denham unit

where both the night duty registered nurses were not fulltime staff. Managers we spoke with said that these staff were regular attenders at the unit and some had been former fulltime staff.

The community services managers had undertaken activity to increase fulltime staff although they had found this much easier for HCAs than RNs. However, data provided by the trust indicated that the number of staff had been decreasing and the percentage of the salary bill spent on agency staff had become a higher proportion between May 2015 and August 2015.

The community services managers made sure the hospitals had enough medical cover to keep patients safe all the time. When there are no doctors on duty the nursing staff are able to obtain medical support and know the correct process for sending the patients to an acute hospital.

The consultant at the Denham unit undertook three ward rounds a week on Monday, Wednesday and Friday but was willing to come out at other times if patients needed to see a doctor.

Managing anticipated risks

Business continuity plans were in place and staff were aware of these. Fire risk assessments had been carried out and evacuation protocols agreed.

Fire alarm tests were carried out weekly.

Major incident awareness and training

The trust had made sure that major incident and business continuity plans were in place. Staff received information on these and their role during induction.

Staff had completed fire drills in the last 12 months and knew their roll in the case of a major incident. For example, staff at the Denham unit knew they might receive minor injury casualties in the event of major incident in the area.

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 in the all hospitals were following NICE and other clinical guidance to ensure patients achieved the best possible outcomes.

Multidisciplinary teams worked well together to provide patients with good outcomes. In particular physiotherapists and occupational therapists were well integrated and showed leadership in ensuring patients achieved their recovery goals.

Staff understood their responsibilities regarding consent for patients who may lack mental capacity and the actions that could be taken to prevent unnecessary restraint.

Evidence based care and treatment

Staff had access to evidence-based policies and guidance on the trust's intranet site. Current

guidance and information was also displayed on the staff noticeboards.

National Institute for Health and Care Excellence (NICE) guidance was shared in team meetings and new

information and guidance was disseminated from trust level by the matron. For example, we observed nurses following the NICE guidance on falls.

Clinical staff used care pathways, such as the fractured neck of femur pathway, to inform care. We found that staff used skin care bundles to reduce the risks of pressure ulcers.

Doctors had undertaken clinical audits, for example, they were able to talk through the findings and changes they had made following a stroke patient audit.

Nursing staff had recently completed an annual record keeping audit and were undertaking the national audit of intermediate care.

Pain relief

A pain assessment tool was in place and all patients had a pain assessment completed and were offered

analgesia when they reported pain.

Patients we spoke with told us they were given support in managing their pain.

Nutrition and hydration

The hospital used a purple flower symbol to identify those patients who needed support with eating and drinking.

The hospitals had protected mealtimes at 8.30am – 9.30am, 12.30pm – 1.30pm, and 5.30pm – 6.30pm. This ensured that patients were able to eat their meals without interruption and staff were able to support them without having to be interrupted by visitors. However, staff were also clear that friends and families could support patients to eat and drink during the protected times.

Patients were generally positive about the quality and quantity of the food. To support their recovery, patients were encouraged to cook some of their own meals under the supervision of an occupational therapist. Food and snacks were available and specialist diets, such as texture modified diets, were available

At all of the inpatient sites, patients were provided with fresh food cooked on site seven days a week. Hospital staff encouraged patients to eat their meals in the dining room, which helps to encourage social skills and reduce any feelings of loneliness.

Patient outcomes

Staff on Rosemary ward at Clayponds provided recovering stroke patients with group education sessions to ensure they understood how best to make a fuller recovery and deal with any symptoms of the stroke.

Clinical audits were carried out regularly with good levels of compliance recorded. For example, an audit of

Clinical notes was completed across the community hospitals. undertaken in March 2014. An action plan was implemented to address shortfalls.

The matrons undertook a programme of monitoring on a monthly basis which informed ward-level quality dashboards. This included information on falls, infections, pressure ulcers, and VTE risk assessment audits.

Good

Are services effective?

Patients had individual assessments and care plans that specified the aims of care based on enabling people to become more independent. These were individually monitored and evaluated. Multidisciplinary meetings were held to discuss patients' progress and plans for discharge.

Competent staff

The community services managers had ensured that staff, including bank staff, had received trust and local induction training.

The clinical care on Jasmin ward at Clayponds is nurse led supported by a very junior doctor from Monday – Friday 9am-5pm. As the only doctor working on this ward and with no senior presence, this means there is no opportunity for the junior doctor to observe more senior colleagues and improve their medical practice.

Staff said they had all been appraised within the last 12 months and had been given the opportunity to develop. For example, one HCA said she had asked for and been given a course in taking blood samples.

Staff used the trust's online training system ELMS (E-Learning Management System) to log training and to complete online training courses. Managers informed us that they used ELMS to monitor which staff members had outstanding mandatory training.

Multi-disciplinary working and coordinated care pathways

We observed the therapy handover on Jasmin ward. Both therapy and nursing staff had a good knowledge of the patients' needs and had visited their homes to carry out detailed assessments.

Psychologists saw most patients at least once a week and a psychologist could be contacted for all patients if they were needed. A permanent psychologist was available on Furness ward at Willesden to provide patients who were dealing with issues such as dementia, delirium and depression additional support and treatment.

Wards had a morning 'board round' where nursing, medical and therapy teams would discuss the progress with the patients.

Ward staff had formal MDT meetings once a week which would also include social services and the patient's consultant. The Willesden unit told us that Harrow local authority had withdrawn its social worker on 14 August 2015 which had meant patients were taking longer to be discharged.

Clinical staff provided a good level of multidisciplinary working across all the hospitals. Therapy staff, such as physiotherapists and occupational therapists, were present on each of the wards and were keys members of the care team.

Standardised information boards in each bedroom showed patients' individual progress and plans, for example, to be able to make a meal and dress.

A permanent psychologist was available on Furness ward at Willesden to provide patients who were dealing with issues such as dementia, delirium and depression additional support and treatment.

The therapy teams provided high of support in all the hospitals. Every patient was seen by a physiotherapist or occupational therapist every day and often twice a day. Patients achieved good outcomes, such as being able to walk with little or no support and being able to return to independent living.

Referral, transfer, discharge and transition

There was clear admission criteria for patients. Staff said this was followed and they were able to meet patients' needs.

The trust had too many patients staying too long at the community hospitals. Most of these patients were as a result of delayed transfers of care (DTOC). The community services had a target that only 2% of bed days should be as a result of DTOC patients latest figures for the trust in August 2015 indicated that the number was 8% for Ealing, 5% for Brent, and 7% for Harrow.

Access to information

The multidisciplinary teams had access to the information they required to support patient care.

The community teams, including the inpatient hospitals, had recently introduced a new computer system called System One. This meant that all community staff were able to share information with each other but the system was

Good

Are services effective?

not linked to the three acute hospitals in the trust. When a patient is transferred from the acute hospital the full set of notes travels with them and a short electronic discharge summary is available on the system.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Clinical staff at all hospitals involved patients in their care and obtained verbal consent before carrying out any interventions.

We found no patients requiring Deprivation of Liberty safeguards during our inspection. Staff we spoke with were aware of the correct procedure and supporting documentation that would have been required.

Staff understood their responsibilities regarding consent for patients who may lack mental capacity and the actions that could be taken to prevent unnecessary restraint.

Good

Are services caring?

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

Summary

All the patients and families we spoke with were very positive about the care they had received in the community hospitals. One person told us, " They have been great. I have got all the care I needed". Another said, " The nurses are nice and they have been trying to get me well enough to go home".

Patients are fully involved in their care planning. The MDT team agree individual recovery goals for each person so that they are able to achieve as independent living as possible.

We observed that staff were caring and provide patients with emotional support. This also included professional psychological support for a number of patients.

Compassionate care

We spoke with 17 patients and seven relatives during our inspection. They all spoke positively about the care they had received while at the community hospitals. Staff answered call bells promptly when they were pushed by patients.

Patients told us they were treated with kindness, dignity, respect and compassion. We observed this during our inspection. One patient said, "I can't see anything wrong with this place". Another commented " I thought the treatment was exemplary".

Understanding and involvement of patients and those close to them

The clinical staff agreed goals with patients and they were written onto a white board in the patient's room. We saw examples such as "to be independent" and " to wash and dress independently".

Staff could access interpreter services when required. There was minimal literature provided in languages other than English but staff were aware of the process for obtaining translated copies.

Clinical staff involved patients in decision-making and patients demonstrated that they understood the care

planned and provided. One person told us, "The nurses and doctors are kind and explain everything. I can't praise them enough".

Emotional support

The hospital provided a chaplaincy service which visits each ward at least once a week. Staff were not aware of external support groups that could support patients during their stay or after they were discharged.

We observed staff providing emotional support in response to patient needs.

Patients felt emotionally supported. One patient told us about an event that had upset them and had described how the ward staff had supported them.

Good

Are services responsive to people's needs?

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

Summary

The community hospitals were willing to take all the patients who were physically well enough to be admitted. They were willing to take patients who needed high levels of support including psychological support.

The community hospitals were not always ensuring that patients with memory needs were being identified and their care was not being adapted to meet their individual needs.

Complaints and other forms of feedback were taken seriously by the community hospital. Changes were made as a result of patient feedback.

Planning and delivering services which meet people's needs

Most beds at the community hospitals were commissioned by one of the three CCGs for Harrow, Ealing and Brent. Local managers told us that only patients with GPs registered in those boroughs could use the relevant bed paid for by their CCG. As a result, there are often empty beds at community hospitals even when the acute hospitals were full and had patients who were suitable to be moved to a community bed. This meant patients were not always in the best environment. For example, they should have been starting intensive physiotherapy which is only available at community hospitals. Managers told us that this should not be the case and patients should go into any free beds and the CCGs have a cost recovery agreement.

Staff demonstrated a good understanding of the local populations which varied from hospital to hospital. For example, staff at Willesden had responded to their local Asian and Afro-Caribbean populations by always making sure that rice was a menu option every day.

Staff told us and we observed that there were no leaflets available in other languages at any of the three locations we visited.

Equality and diversity

Patients were treated as individuals and families were welcomed to the ward environment. Patients never expressed concerns that they had been treated unfavourably.

Premises were accessible and we saw that people who used wheelchairs or had other mobility needs were supported appropriately.

Meeting the needs of people in vulnerable circumstances

Staff undertook a memory assessment for all patients who were over 65 to identify if they needed additional support. Staff were not clear about how they would treat people with dementia differently to adapt to their circumstances. Figures provided by the trust indicated that only 33.5% of patients over 65 were being screened. Managers were aware of the needs of dementia patients and there were robust plans to improve.

We saw some examples of the environment being modified to meet vulnerable people's needs. But given the fact that many patients stay at the hospitals for many weeks, we saw few examples where rooms had been personalised with personal pictures and items from the patient's home.

There were two terminally ill patients on Furness ward during our inspection. We were told by staff that the trust Palliative care team does not cover patients in the community hospitals.

Staff at the Willesden unit were willing and able to take patients with complicated emotional, social and psychologically issues. This ensured that those patients who need intensive support are also cared for.

Where patients had particular needs, staff gave examples of liaising with specialist workers.

Nursing staff were aware of which patients in their care were at a high risk of developing pressure ulcers. Staff had undertaken Waterlow scoring (a tool to identify the risk of a patients developing a pressure ulcer) and had taken the correct action based on the score. For example, we found patients who needed them were provided with special pressure relieving mattresses.

Good

Are services responsive to people's needs?

Access to the right care at the right time

Admissions and discharges were organised and managed by the single point of contact within the trust

bed management service in liaison with local managers and ward staff. Different hospitals and wards had different criteria but generally patients had to be well and likely to be able to be discharged within a few weeks.

Staff generally had 24 hours to assess a patient before their potential admission. If patients who are too ill are admitted from the acute hospital environment to community care, then they were at risk should their condition deteriorate as community hospitals did not have the competent staff to deal with acutely ill patients. Claypond and Willesden ensured that patients were suitable by visiting them before admission to ensure they met the admission criteria. The manager at the Denham unit did not visit patients and this increased the risk of unsuitable patients being admitted.

The trust bed and discharge team held a conference call which included a staff member from each community hospital at 9am each day. This allows the trust to know which beds are available at 9am but does not give them live information throughout the rest of the day. During our inspection, Rosemary ward had three vacant beds although the acute hospitals were full.

Learning from complaints and concerns

Each ward had a 'You Said and We Did' notice board where patients can see how the hospital has responded to feedback. For example, one board had the following written on it; You said " the choice and flavour of some of the food was not a high standard" We Did " we meet with our food suppliers to review the choice available".

Patient feedback was encouraged on discharge and the patients told us that they were comfortable with asking questions or raising concerns with staff.

Formal complaints and patient advice and liaison service (PALS) enquiries were recorded on the ward quality dashboard.

There were very low numbers of complaints with the trust recording no complaints in most months. Data provided by the trust indicated that complaints were responded to within the set time limits.

Learning from complaints was shared at the team meetings by the matrons.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We found that the Trust, community leadership team and in patient hospitals all worked in isolation. We found no focus or plans to improve integration at all levels.

Services, processes and standards were variable across the three community hospitals. There is no single clear process of management and clinical governance.

There was a lack of clarity over medical leadership in the community hospitals. Doctors at Willesden and the Denham unit told us that they reported to the trust medical director but doctors at Clayponds said they reported to the clinical director for the medical division.

The vast majority of the staff we spoke with were proud of the care they gave to patients and were proud to work in their own hospitals. They did not share the same pride in working for the trust.

Service vision and strategy

The vision and strategy varied from each hospital. Each hospital had a slightly different set of admission criteria and the services available in each hospital also varied. For example, only Willesden had a fulltime psychologist but it was unclear how this fitted into the vision of the community hospitals.

Staff had some knowledge of the vision for their particular unit but there was no single vision of strategy for the trust.

The community hospitals' strategies were different and were based on the relationships they had with their individual CCGs. Services were often based on what was funded rather than what patients needed.

Governance, risk management and quality measurement

The community managers had a governance and risk meeting for each of the boroughs but there was no single meeting across the trust.

There was a monthly clinical risk meeting at Clayponds hospital chaired by the matron but no doctor attended the meeting.

The community services division had a tri-borough risk register. On looking at the most recent register dated 16 October 2015, we found that there were no inpatient risks recorded in it. We would have expected risks, such as poor staffing and hand hygiene at the Denham unit, would have been recorded with the relevant mitigating actions.

Leadership of this service

There was a lack of clarity over medical leadership in the community hospitals. Doctors at Willesden and the Denham unit told us that they reported to the trust medical director but doctors at Clayponds said they reported to the clinical director for the medical division.

The trust community managers are operating three very different models of medical support at each of the three hospitals. This means that some patients have high levels of medical input and some have very little. There was no community strategy setting out how medical cover was assessed and established.

Matrons and Ward Managers provided good leadership on the wards. Staff told us they felt supported by their ward managers and matrons.

Senior managers at divisional and trust level were not seen as visible or supportive.

Culture within this service

The vast majority of the staff we spoke with were proud of the care they gave to patients and were proud to work in their hospitals. They did not share the same pride in working for the trust and were focused on their boroughs and nearest acute hospital.

Staff felt they looked after patients well and were proud of their part in helping patients to regain their independence after being in hospital.

Staff said they felt empowered and supported to provide good quality and effective care. They told us that they are encouraged to put the patient at the centre of everything they did.

All staff we spoke with exhibited an open, honest and transparent culture.

Requires improvement

Are services well-led?

Public engagement

Managers we spoke with were not aware of how their hospitals were scoring in the Friend and Family test. Individual feedback was sought but there was no strategy or process for obtaining an overall picture of the publics issues and concerns.

There had been no public engagement over the planned proposal to close the Denham unit and move it to a location outside of the borough.

Staff engagement

The managers of the community division did not involve staff in the decisions that affect them. Staff told us they were told about major decisions after they had been made and had no opportunity to contribute to the decision making process.

The trust had decided to close the Denham Unit on 4 January 2016. In the minutes of the Community Services Performance Meeting of 20 July 2015 there was a note saying, "Notice to close has been submitted. Process for a managed and phased closure to be put in place". However, at the time of our inspection staff had not received written notice of the trust intention to close their unit. The senior managers of the community divisions had met with staff the week before our inspection but staff had not been given any information on what options they would have for future employment with the trust.

The managers of the community division had not supported staff during the major organisational changes that had occurred over the last few years. As a result, staff felt devalued and demotivated. One member of staff told us, " Moral is low, we love looking after our patients but we never know what is going on".

Senior managers had little knowledge of how the community staff had responded in the NHS staff survey and no plan about how they would respond to the survey.

The matrons at each of the hospitals held a monthly meeting with their staff to discuss keys issues such as; staffing, patient safety and staff development.

Innovation, improvement and sustainability

We examined a copy of the community strategic development improvement plan for 2015/2016 dated 10 April 2015. The plan does not set out any specific plans for the community hospitals.