

## East Sussex Healthcare NHS Trust

RXC

# Community health inpatient services

## Quality Report

### CQC Registered Location

### CQC

#### Location ID

Rye, Winchelsea and District Memorial Hospital

RXCX2

Bexhill Hospital

RXC03

Crowborough War Memorial Hospital

RXCX1

Lewes Victoria Hospital

RXCLV

Uckfield Community Hospital

RXC18

Tel: 01424 755255

Date of inspection visit: 9 to 12 September 2014

Website: <http://www.esht.nhs.uk/>

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

# Summary of findings

## Ratings

Overall rating for Community health inpatient services

Good



Are Community health inpatient services safe?

**Requires Improvement**



Are Community health inpatient services effective?

Good



Are Community health inpatient services caring?

Good



Are Community health inpatient services responsive?

Good



Are Community health inpatient services well-led?

Good



# Summary of findings

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# Summary of findings

## Overall summary

Overall, this core service was rated as 'Good. We found that community health inpatient services were effective, caring, responsive and well-led. However, we considered that some elements of the service, where it came to safety, required improvement.

East Sussex Healthcare NHS Trust delivers community inpatient services in five locations throughout the county of East Sussex. During our inspection, we visited all five community hospitals comprising the community inpatient service. We spoke with approximately 32 patients, three relatives, 13 operational managers – including ward sisters and matrons – two doctors, eight staff nurses, five healthcare assistants, five therapists and 13 members of support staff.

Our key findings were as follows:

- We found that the systems used to identify patients at risk of deterioration were not used effectively.
- We found that some aspects of medicines management needed improvement, although, generally, patients received their medicines safely when they were prescribed.
- The facilities were well maintained in a clean and hygienic condition and staff employed recognised infection control practices.
- There were adequate numbers of suitably qualified and experienced staff to meet patients' needs, and to keep them safe. We had some concerns about the availability of a dietician and speech and language therapy services. Patients received adequate medical supervision, although doctors told us that at busy times they felt pressured at Bexhill Hospital.
- There were robust systems for assessing and mitigating risks. When incidents did occur, there were well understood systems for reporting and investigating these, and changes were made to practice in light of the lessons learnt.
- Patients received care that followed latest published guidance and best practice and outcomes were in line with national averages.
- Patients received adequate pain relief.
- Patients were supported to eat and drink suitable food in sufficient quantities.
- Staff received adequate training to safely undertake their role, and their performance was appraised.
- Patients received their care from a multidisciplinary team who worked cohesively to deliver care that met their needs.
- Patients were positive about their experience. They were treated with compassion and their privacy and dignity were respected. We had some concerns about the lack of privacy in some therapy treatment areas.
- The service was well placed to meet the diverse needs of patients and was committed to providing care as close to home as possible. The care environment could be made more dementia-friendly.
- Admissions to the service were well managed to minimise risks to patients. Discharge from the service was well planned to ensure the needs of patients would continue to be met.
- There was a shared vision and philosophy of care in the service, with a strong rehabilitative ethos within the service. Senior leaders were visible and staff were supported by their immediate managers to provide high quality services.

We saw some good practice, including:

- Compliance with national infection control guidance.
- A strong ethos of promoting independence and rehabilitation.
- Multidisciplinary team working between nursing, therapy and social care staff.

However, there were also areas where the trust needed to make improvements.

Importantly, the trust must:

- Reconsider the implementation strategy of the national early warning score (NEWS).
- Make arrangements for the accurate recording of medicine deliveries.
- Ensure that medicines are stored in suitable temperatures.

# Summary of findings

- Take steps to ensure the accurate recording of medicine administration at Crowborough War Memorial Hospital.
- Ensure that workforce considerations are fully integrated into service relocation plans.

The trust should:

- Ensure that medicines given on an 'as required' basis are suitably evaluated.
- Consider pain assessment strategies for those with dementia or learning disabilities.
- Ensure there are suitable supervision arrangements and appraisal mechanisms in place, especially for staff with managerial responsibilities.
- Take action to make the care environment more dementia-friendly.
- Consider arrangements that ensure the effective utilisation of on-site diagnostic facilities.
- Ensure that therapy treatment areas afford sufficient privacy for patients.
- Ensure that the contribution of support staff is recognised.
- Consider the arrangements by which patients are made aware of their individual rehabilitation plans.
- Consider arrangements for public and patient engagement in the service.

# Summary of findings

## Background to the service

### Background to the East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust provides community inpatient services in five locations throughout the county of East Sussex. These are Bexhill Hospital, Crowborough War Memorial Hospital, Lewes Victoria Hospital, Rye, Winchelsea and District Memorial Hospital and Uckfield Community Hospital. Inpatient services provided vary from location to location, but include intermediate care, palliative care and rehabilitation. The regulated activities

carried out across the five hospitals are diagnostic and screening procedures and treatment of diseases and disorder and injury. In some locations, the additional regulated activities of surgical procedures, family planning and accommodation for persons requiring personal or nursing care are carried on. Patients are admitted to community inpatient services from their own homes, or from acute hospitals. At Bexhill Hospital, care is consultant-led and at the other locations medical services were provided by local GPs.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

**Head of Hospital Inspection:** Tim Cooper, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on 10, 11, 12 September and the team of five who visited the

two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

## Why we carried out this inspection

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

East Sussex Healthcare Trust was rated as a band one risk in the July 2014 CQC intelligent monitoring data, (where band one is the highest risk and band six is the lowest risk).

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We carried out an announced visit between 10 and 12 September, 2014. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use the services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use the services. We met with people who use the services and carers, who shared their views and experiences of the core service.

# Summary of findings

## What people who use the provider say

We spoke with approximately 32 patients during our visits. Feedback we received was positive. Comments received included:

“If I didn’t have a home to go to, I’d be quite happy here.”

“The staff were amazing, they are genuinely interested in people.”

“Great attitude of staff, they get to know what you like.”

“All the staff have been excellent and looked after me really well.”

“They are good, young staff who are really caring. I feel able to keep my dignity even when needing help in the shower.”

“There are plenty of clean toilets; I have a choice.”

“The food is good, I’ve no complaints.”

“You can see the staff work together helping each other no matter the grade; it’s good to see.”

“It’s first class care, even throughout the night when I requested tea and biscuits.”

“I feel well cared for and have been involved in my care.”

“Last night, I was hot and a member of staff really put himself out to make sure I was comfortable – I could not have asked for more.”

“Staff took the time and trouble to explain to me why I had to stay in bed until my blood pressure returned to normal.”

“The atmosphere here is amazing and that is down to the staff.”

Less positive comments were few in number, but included:

“Physio, there could be more.”

“They are not always there when needed.” (In relation to helping patients to go to the toilet.)

## Good practice

We judged the following to represent areas of good practice:

- Compliance with national infection-control guidance.

- A strong ethos of promoting independence and rehabilitation.
- Multidisciplinary team working between nursing, therapy and social care staff.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve

- Reconsider the implementation strategy of the national early warning score (NEWS).
- Make arrangements for accurate recording of medicines deliveries.
- Ensure that medicines are stored in suitable temperatures.
- Take steps to ensure the accurate recording of medicine administration at Crowborough War Memorial Hospital.
- Ensure that workforce considerations are fully integrated into service relocation plans.

### Action the provider **SHOULD** take to improve

- Ensure that medicines given on an ‘as required’ basis are suitably evaluated.
- Consider pain assessment strategies for those with dementia or learning disabilities.
- Ensure there are suitable supervision arrangements and appraisal mechanisms in place, especially for staff with managerial responsibilities.
- Take action to make the care environment more dementia friendly.
- Consider arrangements that ensure the effective utilisation of on-site diagnostic facilities.
- Ensure therapy treatment areas afford sufficient privacy for patients.

# Summary of findings

- Ensure the contribution of support staff is recognised.
- Consider the arrangements by which patients are made aware of their individual rehabilitation plans.
- Consider arrangements for public and patient engagement in the service.

East Sussex Healthcare NHS Trust

# Community health inpatient services

**Detailed findings from this inspection**

The five questions we ask about core services and what we found

**Requires Improvement** 

## Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

### Summary

Overall, we judged that safety in community inpatient services required improvement.

Referrals and admissions to the community inpatient services were generally well managed to ensure that the needs of people admitted to the service could be safely met.

Medical cover was provided in-hours by local GPs and we found that patients were regularly reviewed. Out-of-hours medical cover was provided by GP on-call services and staff told us that this arrangement worked well and that they could access medical assistance if required. However, at Bexhill Hospital in-hours medical cover was provided by resident medical officers (RMOs) under the supervision of a consultant. We had some concerns relating to the amount of time the consultant was able to be present at the hospital and the level of support that could be afforded to

the RMOs. This meant that at Bexhill Hospital there was a potential risk that patients' with complex medical needs may not have these safely met, especially during peak periods.

The national early warning system (NEWS) had been implemented. This is a system to identify patients whose condition is deteriorating. We found that the early warning scores were regularly calculated, but not always accurately. We found numerous examples where the escalation processes described in NEWS had not been followed and saw examples where nursing records did not reflect these risk scores or describe any action taken. This meant that patients whose conditions were deteriorating may not have been identified at an early stage with the risk that their care may not have been escalated appropriately.

We found that, generally, patients' medicines were well managed and people received their medicines safely, as prescribed. However, we found that rooms where medicines were stored did not have their temperature

monitored, which meant staff could not be sure that medication was stored in optimum conditions. We found examples at Crowborough War Memorial Hospital of missed doses not accounted for.

We found that nursing staffing levels had been reviewed and were maintained at an agreed level that enabled staff to meet the needs of patients safely. There had been recent service reconfigurations within the organisation and found that there had been insufficient workforce planning to ensure that the caseloads of the RMOs and therapy staff remained manageable.

There was a robust electronic system in place for the reporting of clinical and other incidents. Staff were aware of this system and told us they were confident in its use. We saw that incidents were investigated appropriately and the technique of root cause analysis was used for reviewing serious incidents. There were good mechanisms for feeding back the outcomes of investigations to individual staff and to staff teams. We saw that lessons learnt were widely disseminated and we saw examples of when practice had been changed. This demonstrated that there was an effective system for the management of critical incidents. Hospitals we visited were clean, hygienic and we observed that the fabric of the buildings and equipment were well-maintained. We observed that practice conformed to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, issued by the Department of Health in 2010.

All staff we spoke with were aware of local safeguarding procedures and their responsibilities in relation to these. Additionally, all staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and we saw evidence that, where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

We saw that there were systems in place to identify, monitor and manage risks to patients. Risks were identified and recorded on risk registers. We saw examples of risk assessments that were regularly reviewed and noted that the control mechanisms identified were in place. There was a system for disseminating national safety alerts and ensuring that these were reviewed by the appropriate staff. This showed there was a proactive approach to managing risks that was well embedded in practice.

The organisation had major incident and business continuity plans in place. Staff could clearly tell us their responsibilities in the event of a major incident. This showed that there were contingency plans to ensure patients remained safe in case of a major incident.

### **Detailed findings**

#### **Incidents, reporting and learning**

- During the period August 2013 to June 2014, there were four serious incidents requiring investigation reported. There were no Never Events reported in the past year. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The community inpatient services used an electronic incident reporting system. All staff we spoke with were knowledgeable about the process and could tell us how and when to report incidents.
- We were told that a development group had been established to review and standardise the reporting of incidents. Staff confirmed that this would ensure that there were standardised guidelines on what incidents were to be reported. For example, we found that, at Lewes Victoria Hospital, late admissions to the ward after 9pm were reported as an incident, while at Bexhill Hospital this was not considered to be a reportable incident as it was a usual occurrence.
- Staff told us they received feedback when they reported an incident. We looked at minutes of staff meetings and noted that there was a standing agenda item where reported incidents and their outcomes were discussed with ward based teams. At Crowborough War Memorial Hospital, we saw that staff had identified falls as a concern and had introduced the use of non-slip 'slipper-socks' for patients as a risk reduction measure. Staff could demonstrate this had reduced the number of falls.
- A system of identifying patients at risk of falling using "the falling leaf" signage was used at Bexhill Hospital and Lewes Victoria Hospital and we found that these initiatives had been shared with other community hospitals. This meant that learning was shared across sites.
- We noted that there were some unplanned readmissions and we also noted that there was no formalised system for recording these and for analysing these events. This meant there was no mechanism to identify any common themes.

- We saw that a root cause analysis (RCA) investigation was performed for serious incidents. We saw examples of these investigations and saw they were comprehensive and detailed. They all contained an action plan. We followed up an RCA action plan in four hospitals and found that the action plans had been implemented and that staff were aware of the incident and the associated learning. For example, at Rye, Winchelsea and District Memorial Hospital, we found that changes to information regarding patients' mobility needs at handovers had been modified following a serious fall.
- Staff told us they received regular summaries of incidents and changes in practice that had been made throughout the trust in the Listening into Action™ publication, which we saw displayed on noticeboards at Bexhill Hospital, Crowborough War Memorial Hospital and Lewes Victoria Hospital.
- Managers told us they received regular reports of incidents in their areas and were thus able to identify themes and trends.
- Infection control training formed part of the mandatory training programme. We saw records that showed that there was an overall training compliance rate of 77.6% (ranging from 60.4% to 91.8%).
- We saw that staff used personal protective equipment when appropriate. We saw that staff decontaminated their hands in line with the World Health Organization's guidelines ('Five Moments for Hand Hygiene'). Hand hygiene audits were carried out on a monthly basis and an overall average score of 99.6% was achieved during the period of August 2013 to June 2014.
- There were few outbreaks of infection in the community inpatient services. There had been no instances of MRSA or E. coli bacteraemia and one incidence of C. Difficile and Norovirus infection since October 2013. Each service had access to adequate patient isolation facilities and staff could discuss when it was appropriate to use these.
- We observed that single-use or single patient equipment was used appropriately. Equipment that was shared between patients was clearly labelled as having been decontaminated and ready for use and we observed staff cleaning shared equipment using appropriate methods.
- We saw there were appropriate systems and arrangements for the segregation and disposal of domestic and clinical waste. Disposal of 'sharps' met 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'.

### **Cleanliness, infection control and hygiene**

- We found practice conformed to guidance issued by the Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2010).
- We saw that the community inpatient premises were clean and hygienic. Patients we spoke with commented positively about the cleanliness of the environment. Patient-led assessments of the care environment (PLACE) earlier in 2014 achieved cleaning scores ranging from 95% to 99.1%.
- We saw records that cleaning standards were audited monthly and that scores showed a satisfactory level of performance. We noted that remedial actions were identified at the time of audit and were followed-through. This meant that cleaning standards were monitored and corrective actions were taken when elements of cleaning were deemed to be unsatisfactory.
- Cleaning and nursing staff clearly understood their responsibilities in relation to cleaning. We saw schedules and checklists, which clearly set these out. We were shown checklists completed by cleaning staff and nurses that showed when designated tasks were carried out and these were consistently completed.

### **Maintenance of environment and equipment**

- We saw that community inpatient services premises and grounds were well maintained. The surroundings were pleasant and we did not identify any obvious safety risks for staff, patients or visitors.
- PLACE assessments earlier in 2014 awarded scores in 'condition, appearance and maintenance', with a range of 89.7% to 96.3%.
- We were shown quarterly health and safety site inspection reports, which had been carried out. We saw that these reports identified any actions that were taken to address any identified deficiencies. We looked at an inspection carried out at Bexhill Hospital in August 2014 in detail and noted that there were four potential risks identified, one of these was rated negligible, two minor and one moderate. We saw that actions were being progressed, but noted that the two moderate priority items were first reported in November 2013.

- Staff received health and safety training as part of the mandatory training programme. However, compliance in this area was significantly below that of other training areas, with an overall average of 42.3%. Training rates at Lewes Victoria Hospital were the lowest, at 10%.
- Staff described systems for reporting concerns and repairs to us and told us that problems were addressed in a timely manner. For example, at Bexhill Hospital we followed the process that staff had used to report repairs required to a damaged ceiling. We saw from records how this had been recorded and reviewed to ensure that the work was completed by the maintenance staff.
- We saw records that showed that equipment was regularly checked and maintained. At Crowborough War Memorial Hospital, we noted that hoist maintenance was two weeks overdue, but found that a visit from an engineer was imminent.
- We found there were arrangements for checking mattresses to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients. We saw checklists that showed mattresses were checked regularly and removed from use if found to be inadequate.
- Staff also described how electrical medical equipment (EME) was checked and maintained by the trust's EME department. They told us that any faults or concerns were responded to quickly.
- We saw staff induction records, which showed that new staff were trained, and had their competency assessed, in the use of equipment found in their work area. In each area, staff had access to a current, site-specific management of medical devices manual for reference. This meant staff were able to use equipment safely.

## Medicines management

- Overall, we found that there were adequate systems for the safe supply, storage, administration and disposal of patients' medicines, although we found some issues that required improvement.
- We saw induction records that showed that new nurses' competency in medicines administration was assessed, but there were no arrangements for competency to be reassessed on a periodic basis. Training records showed a total of 105 staff had attended formal training in medicines administration and transcribing of prescriptions. This meant that, although new staff demonstrated competency, the available training was not compulsory and ongoing competency was not re-evaluated formally.
- Community inpatient services were served by a pharmacy service with registered pharmacists and pharmacy technicians visiting the clinical areas. We saw that pharmacy technicians visited at least weekly to ensure that stock levels were maintained and provided advice regarding medicines management to both staff and patients. Registered pharmacists also visited the wards and provided a clinical pharmacy service that ensured that the delivery of patients' medicines was optimised. This meant that community inpatient services had access to a comprehensive pharmacy service.
- Stock medicines were obtained from the trust pharmacy service. Individual patient medicines were generally obtained from local pharmacies. We saw examples of orders being made and delivered promptly. However, we found an example at Crowborough War Memorial Hospital, where there had been a four day delay in obtaining a patient's medicine from a local pharmacy. This meant a patient had an unacceptably long break from their treatment, due to supply problems.
- We saw records that showed deliveries were signed for. However, at Crowborough War Memorial Hospital, deliveries were not always signed for and delivery records were blank, ticked or dated and not signed. At Crowborough War Memorial Hospital, this meant that there was no robust audit trail of stock deliveries, as in the case identified.
- Medicines were stored securely in locked cabinets or trolleys. We observed that these storage facilities were locked and that access to keys was controlled by the nurse in charge.
- The ambient temperature of rooms where medicines were stored was not checked, and staff we spoke with were not aware of this requirement. This meant that medicines could be stored at inappropriate temperatures, which could adversely affect their efficacy. Medicines that required it were stored in locked, designated refrigerators to ensure they remained in good condition. The temperatures of the refrigerators were checked, although, at Crowborough War Memorial Hospital this was not done consistently.
- We observed nurses administering medication and found that they complied with 'Standards for medicines

management' issued by the Nursing and Midwifery Council (NMC). We checked patients' medicine prescriptions and administration records and found that they met legal requirements.

- We generally found administration records to be accurate and complete with the reasons for any omissions recorded. However, at Crowborough War Memorial Hospital we looked at three patients' administration records and found two of these contained unaccounted missed doses. In the period between August 2013 and June 2014, there were 91 medication errors reported in community inpatient services and 39 of these related to missed doses. There were no medication errors that caused serious harm reported. These demonstrated that the recording and accounting for missed doses of medicines required improvement.
- We observed there were adequate arrangements for the disposal of unused or unwanted medicines. These medicines were stored in distinctive bins with blue lids while awaiting collection by a suitable waste contractor. Staff we spoke with could describe systems in our discussions with them.
- Controlled drugs (CDs) are medicines which are subject to additional controls as they are liable to be misused. We found that ordering and delivery systems for CDs met legal requirements, that CD registers were accurately maintained and that CDs were stored appropriately and balances were regularly checked. Unwanted CDs were destroyed with a member of pharmacy staff using denaturing kits, which we saw were available.

## Safeguarding

- Staff received appropriate training in safeguarding adults and children as part of the mandatory training programme. Training rates for adult safeguarding across sites averaged at 87% (ranging between 77.2% and 94.8%).
- Staff we spoke with were aware of the principles of safeguarding and could describe what action they would take if they suspected abuse. We saw that safeguarding policies agreed with local authorities were available for staff to reference.
- We were given examples of safeguarding referrals and the sequence of events that followed to ensure people were protected from abuse. Social care staff we spoke

with praised the engagement of community inpatient service staff in safeguarding procedures. This demonstrated that staff worked collaboratively with social care colleagues to protect people at risk of abuse.

- Patients we spoke with told us they felt safe.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as part of the mandatory training programme. Training completion rates were 92.3% for the Mental Capacity Act 2005 and 88% for Deprivation of Liberty Safeguards.
- All staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and we saw evidence that where people did not have the capacity to consent, the provider acted in accordance with legal requirements.
- We viewed do not attempt cardio-pulmonary resuscitation (DNACPR) orders that had an integral capacity assessment completed and were compliant with the requirements of the Mental Capacity Act 2005.
- Staff were able to describe how they would organise a best interest meeting if needed, and gave us examples of such meetings being held and their outcomes. We saw from patient records that these meetings had been appropriately recorded.
- We saw information available about an advocacy organisation that provided Independent Mental capacity Advocates (IMCA) to the community inpatient services displayed. There had been two referrals to IMCA's from Lewes Victoria Hospital in the past month. There had been no Deprivation of Liberty Safeguards applications made from community inpatient services.

## Records systems and management

- We found that records were stored securely, but were accessible to staff when they needed them.
- We saw that patients transferred from acute hospitals arrived with adequate information to inform their ongoing care. However, it was reported to us that staff needed to be vigilant in ensuring that patients arrived with their old records and sufficient assessment data.
- Staff were aware of their responsibilities in relation to information governance and 83% had completed training in this area.

- We viewed patient records and, overall, found them to be complete, current, accurate and fit for purpose. However, we had some minor concerns relating to some specific records, such as fluid charts.
- We found that other records, such as checklists were consistently completed and retained. Staff records were stored securely and were only available to those who needed to see them.

### **Lone and remote working**

- We observed that community inpatient services were secure, with controlled access out-of-hours. We confirmed this when we visited Uckfield Community Hospital out-of-hours and needed to use an intercom to gain admittance.
- Night staff told us they could access a private security firm if needed and in the past had received a prompt response when they needed to do this.
- At Uckfield Community Hospital, staff showed us personal alarms, which allowed them to summon help in an emergency. They told us these were tested weekly.

### **Assessing and responding to patient risk and managing anticipated risks**

- Quality and risk panel meetings occurred every six weeks where local managers met with senior leaders. These included discussion and analysis of incident reporting data. This meant there were systems to identify and mitigate any emerging safety risks.
- We saw that there were systems to identify, monitor and manage risks to patients. Risks were identified and recorded on risk registers. Staff were aware of local and organisational risk registers and referred to these during our discussions.
- We saw examples of risk assessments that were regularly reviewed and noted that specific control mechanisms, identified on these assessments, were in place.
- The community inpatient services collected data for the national Safety Thermometer programme, which enabled us to judge their performance and inform future practice in relation to minimising patient harm.
- There was a system for disseminating national safety alerts and ensuring that these were reviewed by the appropriate staff. There were no outstanding safety alerts requiring action from quarter one of 2014. This showed there was a proactive approach to managing risks.

- We saw that the service had responded appropriately to the national alert 'Safer ambulatory syringe drivers' and had ensured that all its syringe drivers met the recommendations of this alert.
- We saw there was adequate emergency equipment, including automated defibrillators, airway management equipment and oxygen readily available and staff could tell us its location. Staff knew there was a system for checking equipment to ensure it remained ready for immediate use and we saw completed checklists, which showed this practice was well embedded.
- The national early warning score (NEWS) had been implemented, but required improvement. This is a system to identify patients whose conditions may be deteriorating. We found that the early warning scores were regularly calculated, but not always accurately. This meant that patients whose conditions were deteriorating may not have been identified at an early stage – with the risk their care may not have been escalated appropriately.
- We found numerous examples where the escalation processes described in NEWS had not been followed and saw examples where nursing records did not reflect these risk scores, or describe any action taken. Staff we spoke with expressed a view that the NEWS escalation protocols were not applicable in a community inpatient setting.
- During our visit to Crowborough War Memorial Hospital, we were aware that a patient's condition was deteriorating and causing concern. We observed that their care was appropriately managed and escalated with urgent review being sought from the GP, who visited promptly. At Uckfield Community Hospital, we saw in the records that a patient had been transferred to an acute hospital the previous day. Staff were able to describe how they had recognised the patient was becoming unwell, had used the NEWS score to objectively describe their concern to the GP and to arrange a transfer to a more appropriate care setting. Staff we spoke with told us that if they had concerns regarding a patient's condition they had the option of calling 999, and gave us examples of when they had done this. This demonstrated that, if a patient's condition is deteriorating, staff took appropriate action.

### **Staffing levels and caseload**

- We saw that nursing staffing levels, including those for community inpatient services, had been agreed at an

organisational review of staffing levels. Nurse to patient ratios were at about 3:5 during the day and 1:5 at night, exceeding National Institute for Health and Care Excellence (NICE) guidelines. We noted that registered to unregistered staff ratios were maintained as at least 1:1 and that two registered nurses were on duty nearly all the time. At Rye, Winchelsea and District Memorial Hospital, staff described that, occasionally, they chose to work with one registered nurse in case of short notice absence, as this allowed them to use unregistered staff that were familiar to them and the service.

- We checked staffing rotas and saw that agreed staffing levels were maintained. Staff confirmed they rarely worked with less than their agreed template. We looked at the staffing rates for August 2014 and found that overall 98.8% of nursing hours were filled. However, we noticed that other night shifts at Lewes Victoria Hospital and Bexhill Hospital had fill rates significantly below this average. Night shifts at Lewes Victoria Hospital achieved a fill rate of 79.9% and, at Bexhill Hospital, 81.5%. Staff we spoke with felt that, generally, there were sufficient nursing staff to meet patient needs.
- Most patients we spoke with felt that their needs and requests for help were responded to promptly. However, some patients commented that they were surprised at the length of waits for assistance to use the lavatory.
- Vacancy rates at community inpatient services ranged from 0.8 to 3.39%. Managers told us that they were actively recruiting into vacant posts and we saw evidence of new staff who were waiting to start employment.
- Members of a temporary workforce were used to cover gaps in rotas. Most of these staff were members of staff working additional hours, or 'bank' staff familiar to staff and the service. We saw that very few agency staff were employed, although the level of usage was higher at Crowborough War Memorial Hospital. In the period September 2013 to August 2014, temporary staff accounted for 1.1% of total workforce (in a range of between 0.5 and 2.7%). Overall, 80% of requests for temporary staff were filled.

- We were told there were no arrangements to cover junior therapists' annual leave, which led to a reduced service to patients.
- Some therapy staff were required to provide cover to the trust's acute hospitals. They told us that they were often pulled away from their commitments in community inpatient services, as the acute hospital work was seen to be a greater priority. They felt that, although this did not impact of patients' immediate treatment, it meant that work relating to service development was delayed and not progressed.
- Recent service reconfigurations had led to stroke services being relocated to Eastbourne District General Hospital. We had concerns that, at Bexhill Hospital, this had impacted on the levels of consultant cover available for medical staff there. Staff told us that this meant that, when reviewing patients with complex medical needs, consultants were restricted on the time they were able to spend with medical staff. We saw that, at Lewes Victoria Hospital, six specialist beds had been designated specifically for the rehabilitation of amputees, but no additional therapy staff had been allocated. Staff reported that this had impacted on their ability to effectively manage the amputee pathway of care. This showed that the manpower implications of service changes had not been fully considered.

### **Major incident awareness and training**

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

# Are Community health inpatient services effective?

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

## Summary

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

We saw that patients' needs were assessed and care was planned to meet those needs. We also saw that there was a range of patient risk assessments performed including malnutrition and pressure damage.

We saw examples of care, which reflected current national guidance from the NICE and learned societies. However, we found that systems for disseminating and reviewing new guidance, and for assessing the impact of new guidance on clinical practice, and for monitoring change, were not sufficiently formalised. This meant there was risk that new guidance may not be implemented promptly.

Patients we spoke with told us that they were provided with adequate pain relief. However, we found that there was limited use of objective pain scoring systems, including those specifically for people living with dementia. The effectiveness of pain relief given on an 'as required' basis had not been adequately recorded or evaluated.

We found that patients' nutritional needs were assessed, and that they were provided with choices of nutritionally balanced food and drink, in sufficient quantities, to meet their individual needs. Food provision met the Hospital Caterers' Association Better Hospital Food (BHF) programme (2006) guidance.

The community inpatient services all participated in the national patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages. We saw that there were plans to display performance information in a common format on ward areas for staff and patients to see.

The community hospitals took part in the organisation's mandatory training programme. We noted that staff were attending mandatory training and relevant updates. They also told us that they could access further training as part of their personal development plans.

We found that junior staff had an annual appraisal. However, there was an issue with operational managers

accessing ongoing supervision and this staff group told us that their appraisals were ineffective. This meant that the performance and development of operational managers was not well managed and could result in patients receiving poor services.

We saw that some sites were using telemedicine technology, such as movement sensors. We attended discharge planning meetings where patients were referred to community services for the installation of telemedicine systems. This showed that the hospitals were aware of, and used, new technologies to improve patient care.

Generally, we found that patients could access the full multidisciplinary team, including social care staff from the local authority. We observed that staff worked in a cohesive team and they demonstrated a strong commitment to multidisciplinary working. We also found that there was a strong ethos of promoting independence and rehabilitation. However, we noted the input of medical staff into multidisciplinary team reviews and discharge planning meetings was inconsistent. We found that access to speech and language therapy and a dietician was sometimes delayed.

On-site x-ray and scanning facilities at Lewes Victoria Hospital and Bexhill Hospital were not readily accessible to inpatients. This necessitated lengthy waits for an ambulance or other transport to take them for their diagnostic procedures at an acute hospital. This presented a risk that appropriate care and treatment could be delayed and represented a poor patient experience.

We saw examples of care pathways being used to ensure that patients received evidence-based care at the right time. We saw the stroke pathway in use at Bexhill Hospital, and ambulatory pathways for cellulitis and rehydration in use at Uckfield Community Hospital.

# Are Community health inpatient services effective?

## Detailed findings

### Evidence-based care and treatment

- We viewed records that demonstrated patient needs were assessed when they entered their service, and those assessments were regularly reviewed. We saw that there were plans of care that were designed to meet patient needs.
- We saw that a range of standardised, validated risk assessments were used to determine specific patient risks and to inform an appropriate response. Risk assessments were updated at regular intervals. Risk assessments included the Waterlow risk assessment score (to determine risk of pressure damage), venous thromboembolism (VTE or blood clot) risk assessments and dementia screening tools. Local risk assessment tools were used to assess the risk of falls and those associated with the moving and handling of patients.
- We saw that relevant NICE guidance, relating to Falls (CG161), Infection prevention and control (QS61) Medicines adherence (CG76), Pressure ulcers (CG179) and VTE (QS3) were all being broadly followed.
- At Uckfield Community Hospital, we saw care pathways for intravenous (IV) rehydration and cellulitis that were evidence-based, with the relevant literature clearly referenced.
- At Bexhill Hospital, we saw a stroke pathway in use and when we reviewed a sample of patient records we saw how multidisciplinary teams had been involved, including therapists, stroke nurses, and discharge coordinators. This meant that patients received care using evidence-based treatment pathways.
- We found that staff and managers could not clearly describe robust, systematic arrangements for disseminating and reviewing new guidance, for assessing the impact of new guidance on clinical practice, and for monitoring required change. We judged that systems were not sufficiently formalised. This meant that there was a risk that new guidance may not be implemented promptly.
- There were no records indicating any staff had been trained in the use of audit techniques. Some audits of care and treatment effectiveness had been performed at an organisational level that included community inpatient services. We saw an example of the impact of

the falls reduction initiatives being monitored through audit methodology at Crowborough War Memorial Hospital. Community inpatient services had not participated in any national audits in the past year.

- We were shown documents that demonstrated that the actions resulting from audits were tracked to ensure progress was made. For example, we saw actions from the 'Audit of Community Services in Rehabilitation for Patients Admitted Between December 2012 and January 2013' were clearly set out with the person responsible and it was confirmed when they were completed.

### Pain relief

- Patients we spoke with told us that they were provided with adequate pain relief. We looked at records, which demonstrated that patients were given pain relief when it was required.
- We found that objective pain scoring systems were available and were included on observation charts. Staff did not use, or show awareness of pain assessment tools that have been developed for people living with dementia or learning disabilities. This presents a risk that for these people; their pain could be poorly assessed and inappropriately managed.
- We tracked the records of patients who had been given analgesia as required, and sometimes high-strength medicines. We found that the reason for administration was seldom recorded and was never specific. We found examples of patients who had been given pain relief described as "no complaints of pain verbalised". We also found that evaluation of analgesia as required was rarely made. We found one example where a patient was receiving pain-relief several times a day for an extended period, yet this had not been converted to a regular prescription, nor was the effect evaluated in their nursing record. This meant documentation of pain relief as required did not allow staff to analyse the effectiveness of treatment and presented a risk that patients may receive suboptimal pain control.

### Nutrition and hydration

- We found that the provision of food and fluid met the Hospital Caterers' Association Better Hospital Food programme (2006) guidance, the National Patient Safety Association document 'Nutrition and Hydration' (2008) and NICE guidance 'Nutrition Support in Adults' (QS24).

# Are Community health inpatient services effective?

- Patients we spoke with were positive about the quality of food. Typical comments were, “The food is good, I’ve no complaints,” and, “It’s better than being at home for the food.” Patient-led assessments of the care environment (PLACE) earlier in the year had scored community inpatient services in a range of between 84.7 and 90.7%. This demonstrated that patients were satisfied with the quality of food provided.
  - The community inpatient service was able to provide a full range of therapeutic diets and also diets that met the individual religious or cultural needs of patients.
  - When required, food charts were kept and maintained. Fluid charts were in use, but were not well maintained. They lacked target amounts for fluid intake and were rarely totalled. They were not referenced in nursing records, where general comments such as “drinking well” was the only evaluation documented. This meant that objective information to assess patients’ nutritional status was not utilised.
  - Patients were risk assessed for possible nutrition using the malnutrition universal screening tool (MUST) within 24 hours of admission and at least every seven days thereafter. An audit of MUST scores looking at data from December 2013 to July 2014 showed that, on average, 92.3% of patients were assessed within 24 hours and 92.3% had been reviewed in the previous seven days. When we reviewed patient notes we found that MUST assessments were usually accurate and completed in a timely way. This showed that patients’ nutritional needs were regularly assessed using a validated tool.
  - We looked at patient notes and found that, when patients were assessed as being ‘at risk’ we found the correct processes had been followed. We did find some examples of a delayed referral to a dietician, and were told that as the dietetic service did not always respond promptly, ward staff managed the risk themselves. While not ideal, we did note that, in these cases, patient care was appropriate.
  - We observed meal services. We saw that food was tested to ensure it was at the correct temperature. There was a choice of menu options. Meals appeared well presented with a choice of portion size. Patients were encouraged to eat in a dining room and they told us they enjoyed this. We observed there were sufficient staff available to help patients eat and to encourage them when necessary and we saw them doing this. Appropriate equipment was available to help patients and promote their independence when eating. A red tray scheme was in use to alert staff to patients who required additional help with their food. However, this was not so effective when people ate in the dining room.
  - We observed that staff encouraged people to drink adequate fluids throughout the day. The patients we spoke with appeared adequately hydrated.
  - Staff told us that patients could access food and drink at any time on request. Patients we spoke with confirmed this.
  - As part of rehabilitation assessments and plans, the occupational therapist was able to carry out functional feeding assessments and provide adaptive cutlery, if required. Weekly breakfast clubs were used as part of rehabilitation plans where patients prepared and ate breakfast together under the supervisor of therapy staff, as part of a rehabilitation strategy. This meant that nutritional care was integrated into rehabilitation plans.
  - We found there were shortages of support from the dietician and the speech and language therapist. This resulted in delays in treatment. We were told of an example earlier in the year of a patient who waited six weeks for a swallow assessment from a speech and language therapist. At Crowborough War Memorial Hospital, we were told that, during a service reconfiguration, some 18 months ago a dietician was moved to the community rehabilitation team and this had resulted in reduced access to their advice and input.
  - We found that there were inconsistencies of manpower resources for catering across community inpatient services. For instance, at Rye, Winchelsea and District Memorial Hospital, a chef worked single-handedly to provide freshly cooked food for staff and patients and an associated care home, while at Crowborough War Memorial Hospital, the housekeeping assistant’s role, working the same hours, was to regenerate food delivered from another site.
- ### Telemedicine
- We found that staff were aware of how new technologies could be used to improve the care and safety of patients. We observed the use of sensor mats and movement alarms at Crowborough War Memorial Hospital.
  - We attended a multidisciplinary team meeting at Rye, Winchelsea and District Memorial Hospital, where

# Are Community health inpatient services effective?

patients' suitability for various telecare solutions on discharge was discussed and referrals organised. Staff were familiar with the technologies available and demonstrated an understanding of when their use would be appropriate.

## Patient outcomes and performance

- The community inpatient services all participated in the national patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.
  - Using Safety Thermometer data, we found that 92.2% of patients experienced harm-free care in community inpatient services during the year July 2013/2014. This is below the national target of 95%. In this same period, 98.8% were free from pressure damage and 10.1% were cared for with a urinary catheter in situ; about 1% of these contracted a catheter-associated urinary tract infection. 0.6% developed a venous thrombosis and about 0.9% of inpatients experienced a fall, but none of these resulted in serious harm.
  - We saw that there were advanced plans to display performance information, including staffing levels, incidences of harm, such as falls, pressure areas and patient feedback. It was planned that information would be in an easily understandable and common format displayed prominently on ward areas for staff and patients to see. We saw mock-ups of the format and were told delivery was imminent. Some hospitals, such as Rye, Winchelsea and Memorial Hospital and Uckfield Community Hospital, were already displaying this information in their own format.
- ## Competent staff
- The community hospitals took part in the organisation's mandatory training programme. We noted that staff were attending mandatory training and relevant updates. Staff we spoke with confirmed they received mandatory training either online, or face-to-face and were supported to attend. Training records showed that overall compliance rates were 73.8%, but we noted that compliance at Lewes Victoria Hospital was lower than at the other sites.
  - We found that junior staff participated in an annual appraisal. Overall appraisal rates were 82.2% (ranging between 60% and 92%). Junior staff told us that they could access further training as part of their personal development plans.
  - The operational managers' group told us that their appraisals were not as effective as they could be. We found examples of people in post for over a year who had received no initial review. Staff told us that they had development plans, but felt these were not sufficiently specific to assist their development. One staff member told us, "I feel I am good clinically at my job, but I've not had enough development in a managerial role. I've been in post over a year and no PDR yet and it seems it had been cancelled twice." They also told us that there were no reviews of these plans between appraisals.
  - There seemed to be variation in clinical supervision across the service. Some staff reported that they had regular 1:1 meetings with their managers while others said that, although they had informal conversations frequently with their managers this was not recorded in a systematic way. The trust told us that no central supervision records were held, as any records kept were personal to that individual. Operational managers had difficulties accessing ongoing supervision. This meant that the ongoing performance and development of staff was not well formalised and could result in patients receiving poor services.
  - We saw there were systems in place to ensure that staff registered with the Nursing and Midwifery Council (NMC), maintained active registration which enabled them to practice. We saw an instance where a nurse was being supported through a return to practice nursing programme to enable them to update their registration with the NMC.
  - We saw an example of a registered nurses' induction programme. The staff member told us they had attended both trust and local inductions, which they had found both useful and effective at preparing them to do their job well. The induction was recorded in a preceptorship booklet, which we saw was well maintained and clearly documented the activities and competency assessments the staff member had undertaken as part of their induction programme. Other staff we spoke with also indicated they had received appropriate trust and local inductions.
  - We saw that an agency nurse working at Crowborough Memorial Hospital during our visit had received an orientation to the ward and had had key skills observed. This induction was recorded and retained. This meant that temporary staff were adequately prepared to work in the service.

# Are Community health inpatient services effective?

- Staff we spoke expressed confidence in the abilities of the staff caring for them. One commented, “Staff are confident in what they are doing”.
- During multidisciplinary meetings and handover we observed that staff demonstrated sound knowledge of their patients’ conditions, their individual circumstances and their care preferences. They showed they were aware of current best practice and the theoretical basis underpinning their practice. All staff showed knowledge of the local resources that would benefit patients and their families in the short, medium and long term.

## Use of equipment and facilities

- We found that at Lewes Victoria Hospital and Bexhill Hospital, there were on-site x-ray and scanning facilities. However, due to the age and layout of the buildings this presented limitations to access and meant that these facilities were not readily accessible to inpatients. This necessitated lengthy waits for ambulance or other transport to take them for their diagnostic procedures at an acute hospital. For example, we were told that it had taken five hours for a patient at Lewes Victoria Hospital to have an x-ray. The majority of this time had been spent waiting for transport. This presented a risk that appropriate care and treatment could be delayed and represented a poor patient experience.

## Multidisciplinary working and coordination of care pathways

- Generally, we found that patients could access the full multidisciplinary team, including social care staff from the local authority.

- We observed that staff worked in a cohesive team and they demonstrated a strong commitment to multidisciplinary working. Staff demonstrated a sound understanding of each other’s roles, and staff commented that all staff were treated with respect.
- Therapy staff praised the skills of nursing staff in relation to rehabilitation. There were no competencies for rehabilitation skills for registered or unregistered staff working in community inpatient services.
- At Crowborough War Memorial Hospital, it was brought to our attention that all the advertised rehabilitation groups did not take place.
- All community inpatient service sites held weekly multidisciplinary meetings to discuss the ongoing care and treatment plans of patients, which meant care was planned and coordinated. Although patients did not attend these, their views were sought beforehand and there was feedback given to them and their families. We also found that, when planning complex discharges, discharge-planning meetings were convened. However, we noted that the input of medical staff into multidisciplinary team reviews and discharge-planning meetings was inconsistent.
- We found access to speech and language therapy and a dietician was sometimes delayed. We heard examples of long delays in these staff being able to respond to referrals, which meant that there was a risk that patient care was compromised.
- A patient told us, “You can see the staff work together helping each other no matter the grade; it’s good to see.”

# Are Community health inpatient services caring?

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

## Summary

Overall, we judged that community inpatient services were caring and rated them good in this domain.

Patients were overwhelmingly positive about their experience. Patients told us that they were treated with kindness and compassion and that their dignity was maintained and privacy upheld. We were told of instances where patients felt that staff had treated them especially well. A typical comment received was, “The staff were amazing, they are genuinely interested in people.”

During our visit, we observed care practices that ensured patients’ dignity, with their care needs being met in a sensitive and discreet way.

Patients told us they were included in discussions and decisions relating to their care and treatment. We saw that discussions concerning patients’ treatment plans were documented in their records. Staff were aware of the need to obtain patient agreement and consent to deliver care and we observed this in practice. This meant that patients understood and participated in decisions about their care and treatment, and they were asked for their consent when appropriate.

## Detailed findings

### Compassionate care

- During our inspection, we observed that patients were treated kindly and with respect. During conversations with each other, staff talked positively about patients and their circumstances.
- The community inpatient services administered the NHS Friends and Family Test to gauge patient satisfaction. Average scores from August 2013 to July 2014 were: Crowborough War Memorial Hospital – 72%, Bexhill Hospital – 58%, Lewes Victoria Hospital – 68%, Rye, Winchelsea and District Memorial Hospital – 67% and Uckfield Community Hospital – 80%. However, caution is required in interpreting these results, as often sample sizes were small.
- Patients were overwhelmingly positive about their experience. Typical comments received were, “The staff were amazing, they are genuinely interested in people,” and: “All the staff have been excellent and looked after me really well.”

### Dignity and respect

- We observed that patients were treated with dignity and their privacy was maintained. We saw staff using people’s preferred names. We saw that care was given in private and conversations, especially those relating to personal care, were discreet. One patient said, “They are good, young staff who are really caring. I feel able to keep my dignity, even when needing help in the shower.”
- There were no instances of mixed sex accommodation reported in quarter one of 2014.
- Patient-led assessments of the care environment (PLACE) earlier in the year awarded scores for privacy, dignity and welfare – 78.4% for Bexhill Hospital, 75.8% for Crowborough War Memorial Hospital, 75.9% for Lewes Victoria Hospital, 76.9% for Rye, Winchelsea and District Memorial Hospital and 76% for Uckfield Community Hospital. We noted that these scores represented a slight deterioration from those of the previous year, but still represented an acceptable standard.

### Patient understanding and involvement

- Patients told us they were included in discussions and decisions relating to their care and treatment. We saw that discussions concerning patient treatment plans were documented in their records.
- We saw that staff were aware of the need to obtain patient agreement and consent to deliver care and we observed this in practice. This meant that patients understood and participated in decisions about their care and treatment, and they were asked for their consent, when appropriate.

### Emotional support

- We reviewed records that showed that nursing staff provided emotional support to patients and their families. Details of conversations were recorded.
- At handovers we attended, staff discussed the emotional needs of patients, and the strategies they would use to support them.
- We saw that patients had access to spiritual advisers and chaplaincy, if they requested it.

## Are Community health inpatient services caring?

### Promotion of self-care

- We observed that there was a strong ethos of promoting independence and rehabilitation in the service. We saw that staff encouraged patients with patience and kindness to undertake tasks for themselves where this would aid their recovery.
- Although patients received general information relevant to their rehabilitation, there were no patient-held rehabilitation plans setting out personal goals and how these might be achieved, or a timetable of planned therapy sessions and activities. This meant that patients and their families could not easily be sure, or remind themselves, of the rehabilitation plans.

# Are Community health inpatient services responsive to people's needs?

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

## Summary

Overall, we judged that community inpatient services were responsive to patients' needs and rated them 'good'.

There were systems in place to manage referrals and ensure that the services were effectively utilised for the benefit of the local population. Referrals were managed through a centralised clearing house: Integrated Community Access Point (ICAP). We saw that ICAP provided basic referral information, but that service managers needed to liaise further to ensure that inappropriate admissions were minimised. Overall, the bed occupancy rates were in line with national recommendations.

However, at Bexhill Hospital staff told us they were concerned that at periods of peak activity they felt pressurised to admit patients who did not meet the agreed admission criteria. This presented a risk that their complex medical needs may not be met. We reviewed a selection of patient notes identified as inappropriate admissions, but found no evidence to support the assertion that inappropriate referrals had been accepted.

There was facility to increase capacity during periods of peak demand to ensure patients' access to services was not delayed. There were provisions to increase nursing staffing if additional capacity was opened. However, at Bexhill Hospital, we were told that there was no mechanism for increasing the cover by the RMOs, who felt this increased the risks to patients.

The community hospitals prioritised admissions for patients with a local GP, or connection in order to provide services as close to home as possible. The community hospitals had a target of 60% admissions coming from patients' homes to prevent admission to the acute hospital, but we were told that, at that time, transfers from the acute sector represented the majority of their admissions.

We found there were facilities and resources available to meet the diverse needs of patients. This included the provision of adaptive equipment, mobility aids, bariatric equipment and interpreting services. We saw that some specific measures were in place to meet the needs of people living with dementia, but observed that the environment was not dementia friendly as defined by best practice guidance produced by the University of Sterling.

We were told that there had not been any environmental audit of the ward areas regarding dementia friendliness and that none was scheduled. At Crowborough War Memorial Hospital and Rye, Winchelsea and District Memorial Hospital, the therapy facilities did not support the provision of treatment in private.

We found that there was an appropriate emphasis on discharge planning and observed good practice in this area. Patients, their families, and outside agencies were engaged in discharge-planning processes. This meant patients were discharged safely and their needs continued to be met after they left the hospital.

There were some delayed transfers of care, and staff told us that this was usually due to awaiting NHS-funded continuing healthcare assessments, awaiting local authority funding or a lack of local availability in care homes. These situations are beyond the control of the trust, but remain within their sphere of influence and we found that staff worked hard to minimise any delays.

We found there were clear procedures for receiving, handling, investigating and responding to complaints. Patients we spoke with all knew how to raise a concern, and we saw information about the complaints process was made available to patients and their families. We saw that concerns and complaints were discussed at team meetings and that action plans were formulated and implemented in response to these.

## Detailed findings

### Service planning and delivery to meet the needs of different people

- Overall, the bed occupancy for the service was 86%, which was in line with the national recommendation of 85% for effective management of hospital services. However, occupancy at Rye, Winchelsea and District Memorial Hospital and Lewes Victoria Hospital was consistently below this average at 80% and 78.9%. The average length of a patient's stay was 22.6 days. The inpatient community services were operating a pathway with a 14 to 21 day length of stay; however, there was confusion as to whether the current pathway was 14 or 21 days. This meant that length of stay was above that planned and commissioned.

# Are Community health inpatient services responsive to people's needs?

- Not all beds were commissioned, for example there were 24 available beds at Crowborough War Memorial Hospital but the local Clinical Commissioning Group had only commissioned 14 of those. This meant that there was scope to increase capacity during periods of peak demand. Staff told us that had happened during the winter, and that staffing levels had been revised upwards to manage the increase in demand. However, at Bexhill Hospital, we were told that there was no mechanism for increasing the cover by the RMOs who felt this increased the risk to patients.

## Access to care as close to home as possible

- The community hospitals prioritised admissions for patients with a local GP, or connection, in order to provide services as close to home as possible. We saw there were arrangements to ensure those who did not have a local GP were cared for as a temporary resident.
- The community hospitals had set themselves a target of 60% admissions coming from patients' homes to prevent admission to the acute hospital, but we were told that, at that time, transfers from the acute sector represented the majority of their admissions. This showed there was a commitment from the service to enable people to be cared for close to home.
- We found that patients were referred to appropriate community services to ensure their needs continued to be met in their own homes. This included referral to community rehabilitation teams to ensure patients' rehabilitation continued post-discharge and that they were supported to achieve their full rehabilitation potential.

## Meeting the needs of individuals

- We found that the therapy facilities at Rye, Winchelsea and District Memorial Hospital and Crowborough War Memorial Hospital did not enable therapy to be delivered in private. At Rye, Winchelsea and District Memorial Hospital, the therapy gym was used by a commercial company and patients from the service had to travel through this area, with waiting outpatients, to their treatment. Also the occupational therapy assessment kitchen was an integral part of the therapy area and afforded no privacy to patients receiving assessment or treatment in that area. This layout also meant that patients using the occupational therapy kitchen could be disturbed and distracted and, therefore, not gain the full benefit from their treatment

session. However, we were assured that plans were being drawn up to e-design the therapy area to obviate these issues. At Crowborough War Memorial Hospital, therapy parallel bars and practice stairs were located in the reception area and we observed one patient receiving his treatment in public. At Uckfield Community Hospital the therapy area was a shared communal area, but we were assured that it was not used by patients or their visitors when therapy was in progress.

- We saw that some specific measures were in place to meet the needs of people living with dementia, but observed that the environment was not dementia friendly as defined by best practice guidance produced by the University of Sterling. For example, flooring was shiny and uniform, lavatory seats were not of a contrasting colour and signage and way-finding cues were not present. We were told that there had not been an environmental audit of the ward areas regarding dementia friendliness and that none was scheduled. This meant that the environment did not support people living with dementia to gain the most from their care and treatment.
- At Rye, Winchelsea and District Memorial Hospital, staff told us that access to older people's mental health Services was via a GP referral, which resulted in delays for specialist input for those living with dementia or mental health needs. Previously, they had been able to access the liaison staff from the acute hospital, and felt the present service was less responsive.
- We found there were facilities and resources available to meet the diverse needs of patients. This included the provision of adaptive equipment, mobility aids, including hoists. Bariatric equipment could be obtained and we were told of cases where admission was delayed until the appropriate equipment was in place.
- Although no referrals had been made to interpreting services in the past year, staff were all aware of how to access these should they be needed.
- The service cared for few patients with learning disabilities. Staff told us they could access specialist support if they needed to and showed us a resource folder they could reference.
- We saw that community inpatient areas were accessible for people with disabilities or limited mobility.
- Facilities for patients' visitors were satisfactory. We found that waiting areas were pleasant and comfortable. There were adequate parking facilities. Due to the size of individual sites, not all had an on-site

# Are Community health inpatient services responsive to people's needs?

shop for patients and their visitors. Catering facilities were understandably limited for visitors, but there were vending machines where they could obtain drinks and snacks.

## Discharge, referral and transition arrangements and access to the right care at the right time

- We found there were systems in place to manage referrals and ensure that the services were effectively utilised for the benefit of the local population. Referrals were managed through a centralised clearing house, Integrated Community Access Point (ICAP). ICAP summarised the medical assessment and care needs of patients prior to referral to ensure they were appropriate for care in a community inpatient setting. We saw that ICAP provided basic referral information, but that service managers needed to liaise further to ensure that inappropriate admissions were minimised. We found that at Lewes Victoria Hospital and Crowborough War Memorial Hospital, staff were particularly vigilant in ensuring that patient needs were in line with the organisation's intermediate care beds admission criteria before they were admitted.
- At Bexhill Hospital, we were told that nursing and medical staff felt pressurised to admit patients with complex medical needs that, in their opinion, were outside of these criteria, which states: "The primary reason for admission must be for rehabilitation, reablement or therapeutic non-medical management." This criterion was dated 29 November 2010 and although marked for annual review staff told us this was the most up-to-date version. We had concerns that inappropriate admissions had been made and were told that this resulted in patients being returned to the acute hospital in order to meet their care needs. Staff told us that in the previous month, two patients had been transferred back to acute care. We asked for a selection of patient records identified by staff as inappropriate to be available from hospital archives. We reviewed these and found no evidence in this sample to support the assertion that inappropriate referrals had been made.
- We were told that there were minimal delays in accessing a bed in the community inpatient service, although occasionally a waiting list was operated by ICAP during periods of peak demand. During our inspection, we found that there was capacity that allowed for admission once referral had been accepted and agreed.

- We found that there was an appropriate emphasis on discharge planning and observed good practice in this area. Patients, their families, and outside agencies were engaged in discharge-planning processes. This meant patients were discharged safely and their needs continued to be met after they left the hospital.
- We saw that, where appropriate, discharge-planning meetings were held to plan the discharge of patients with complex needs. We saw that a wide range of assessments by the multidisciplinary team were performed, including home assessments and access visits.
- We saw evidence that demonstrated staff were aware of the availability of NHS continuing healthcare funding and the process for ensuring people were assessed for this as part of their discharge planning. We were assured that, when appropriate, patients were referred and received an assessment to establish their eligibility for this funding.
- There were some delayed transfers of care, and staff told us that this was usually due to awaiting NHS-funded continuing healthcare assessments, awaiting local authority funding or a lack of local availability in care homes. These situations are beyond the control of the trust, but remain within their sphere of influence and we found that staff worked to minimise any delays.
- The trust reported non-acute delayed transfers of care as a percentage of occupied bed days. The overall average from August 2013 to July 2014 was 14.4%. No delays were reported at Rye, Winchelsea and District Memorial Hospital, or Crowborough War Memorial Hospital, although staff at these sites told us that the patients' discharges were often delayed. Staff told us that as delays were non-chargeable, in theory they were not reportable. This meant there was some concern that trust data in this respect may not be complete and accurate.

## Complaints handling (for this service) and learning from feedback

- We found there were clear procedures for receiving, handling, investigating and responding to complaints. Patients we spoke with all knew how to raise a concern, and we saw information about the complaints process was made available to patients and their families.

## Are Community health inpatient services responsive to people's needs?

However, at Crowborough War Memorial Hospital, we were told this information had been removed as part of a deep clean and replacement materials had been ordered.

- From April 2013 to June 2014 inpatient community services received 14 complaints. From August 2013 to July 2014 a total of 228 plaudits were received by the service. This showed there was a low level of formal complaints.
- We saw meeting minutes, which showed that concerns, complaints, and plaudits were discussed at team meetings and that action plans were formulated and implemented in response to these.
- Ward areas displayed 'You said, we did' information. For example, we saw that Uckfield Community Hospital had received comments about its visiting hours, so information about the ability to be flexible had been publicised. Staff we spoke with told us how they made sure that patients' families knew who to contact to discuss out-of-hours visiting if they felt this was required. This showed that actions were taken as a result of concerns raised, and patients and their families made aware of a response.

# Are Community health inpatient services well-led?

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

## Summary

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

We observed that the trust values were prominently displayed. Staff we spoke with showed an awareness of these values in our discussions with them. We saw that individual ward areas had local philosophies of care and staff told us that they were formulated and owned by the ward team.

At community inpatient service level we found there were robust governance arrangements in place.

The services had been subject to a number or reorganisations in the past few years. We were told by a manager that staff perceived this as a problem and said, "Too much change, too much pace and with poor communication."

Staff we spoke with told us they felt supported by their immediate managers to provide good quality care, and felt that their manager was approachable and visible. Senior leaders visited the ward areas and staff knew who they were. Staff told us that they participated in Listening into Action events and found these useful. However, some support staff we spoke with felt that they were not appreciated and their contribution to the service was not fully recognised. We had some concerns regarding the support afforded to doctors and the quality of medical leadership at Bexhill Hospital.

There were vacancies for key therapy leadership roles, but the organisation was recruiting into these. This restricted the development of therapy services at the time of our inspection and meant that therapists we spoke with did not feel fully supported.

We observed that staff all exhibited a positive attitude in relation to their jobs, and patients noticed this and commented on it. In our discussions we noted that, among nursing staff, morale was high. We saw that staff worked collaboratively, and staff told us that they valued the good teamwork and peer support they enjoyed at work.

There were active 'Friends' organisations (local voluntary groups supporting and fundraising for the hospital) at each site – independent charitable and voluntary organisations that support a wide range of hospital departments and facilities. However, there was no forum for a formal public engagement within the service.

## Detailed findings

### Vision and strategy for this service

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

### Governance, risk management and quality measurement

- At community inpatient service level we found there were robust governance arrangements. We saw minutes of ward meetings where there was a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated.
- We were also told about the quality risk panel meeting, which ensured that quality and safety matters received due consideration and that actions were agreed and progress monitored.

### Leadership of this service

- Staff we spoke with told us they felt supported by their immediate managers to provide good quality care, and felt that their managers were approachable and visible.
- Senior leaders visited the ward areas and staff knew who they were. The chief executive's weekly message was generally well-received and staff appreciated the opportunity to be kept up to date with organisational developments. One manager said, "They provide

# Are Community health inpatient services well-led?

succinct messages and show he wants positive, effective change.” However, other staff told us they found the messages repetitive, but still read them to keep in contact with trust developments.

- However, some support staff we spoke with felt that they were not appreciated and their contribution to the service was not fully recognised by their managers. We were concerned to hear that some support had been told not to engage with inspectors. We heard individual stories that indicated support staff felt undervalued and perceived they were treated less favourably than clinical colleagues.
- We found there were discrepancies relating to the introduction of new shift patterns. At some sites, staff had been compelled to change their shift patterns and we were told that some people had resigned as a result. However, at other sites, this change had been voluntary and some staff had continued their original working patterns without detriment to the service.
- A manager told us they were currently being supported by the trust to undertake an accredited, external leadership programme to improve their skills and make them more effective in their role. At Rye, Winchelsea and District Memorial Hospital, two managers had recently undertaken a course entitled ‘Leading Through People Toolkit’. However, other staff we spoke with were unaware of any leadership training that they could access, although they agreed it would be useful for their development. This meant that some leadership training was currently available, but that staff were not all aware that they could access this.
- We had some concerns regarding the support afforded to doctors and the quality of medical leadership at Bexhill Hospital. Recent reconfigurations of stroke services to Eastbourne meant that consultants were constrained in the levels of time available for supporting staff outside of general ward rounds.
- There were vacancies for key therapy leadership roles, but the organisation was recruiting into these. This restricted the development of therapy services at the time of our inspection and meant that therapists we spoke with did not feel fully supported. For example, at Lewes Victoria Hospital therapy staff reported that the additional focus on the provision of specialist amputee rehabilitation beds was not reflected in their ongoing development needs or staffing levels.

## Culture within this service

- The services had been subject to a number of reorganisations in the past few years. We were told by a manager that staff perceived this as a problem and said, “Too much change, too much pace and with poor communication.” However, staff seemed aware of the latest reorganisation that had occurred and could usually name their managers.
- Equality and diversity training formed part of the mandatory training programme. 54.4% of staff had completed this (ranging from 30% to 72.2%). Although the community inpatient services did not serve a particularly diverse population, staff were aware of the need to recognise and celebrate diversity.
- Community inpatient sickness rates were 5.5%, slightly above the trust average of 4.5%. Stress-related sickness rates were not significant, as was suggested by a rate 0.2%.
- We observed that staff all exhibited a positive attitude in relation to their jobs, and patients noticed this and commented on it. In our discussions, we noted that, among nursing staff, morale was high. We saw that staff worked collaboratively, and staff told us that they valued the good teamwork and peer support they enjoyed at work.

## Public and staff engagement

- We saw minutes that confirmed that site team meetings took place, which afforded staff the opportunity to discuss both local and wider organisational issues and to be kept updated with service developments.
- Staff told us that they participated in Listening into Action events and found these useful. We saw reports of these events displayed at Crowborough War Memorial Hospital and Lewes Victoria Hospital.
- We saw that each site had an active Friends organisation and staff could tell us about the financial support they received to purchase equipment and to improve facilities. We saw advertising materials about the Friends organisations displayed throughout the service.
- However, we discovered that there was no formal forum for patient or public engagement within the community inpatient service.

# Compliance actions

## Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA 2008 (Regulated Activities)  
Regulations 2010 Management of medicines

The provider did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The provider must make arrangements for accurate recording of medicines deliveries. Additionally, the provider must ensure that medicines are stored in suitable temperatures. Further the provider must take steps to ensure the accurate recording of medicine administration at Crowborough War Memorial Hospital.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing

The provider did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The provider must make arrangements for accurate recording of medicines deliveries. Additionally, the

# Compliance actions

provider must ensure that medicines are stored in suitable temperatures. Further the provider must take steps to ensure the accurate recording of medicine administration at Crowborough War Memorial Hospital.

## Regulated activity

Treatment of disease, disorder or injury

## Regulation

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services

The provider had not ensured that, at all times that the planning and delivery of care meets individual needs.

This is a breach of Regulation 9 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider must reconsider the implementation strategy of the national early warning score (NEWS).