Humber NHS Foundation Trust

RV9

Community health inpatient services

Quality Report

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

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

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

Summary of findings

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Summary of findings

Overall summary

Staff on the community inpatient wards at East Riding and Withernsea Community Hospitals were dedicated to providing a high quality service to patients. This was reflected in the comments made by patients and their relatives.

We found that care on the wards at both hospitals was safe. There was evidence to show that staff recorded and reported incidents, and completed risk assessment and risk management plans. Patient risks were assessed and plans were developed to reduce them. In addition, there was a daily multidisciplinary review of patient risks and their progress, to make sure that planned care was still relevant and that patients were making suitable progress.

The trust had set up a dashboard to monitor the quality of care provided. It also provided clinical skills training for staff, as well as additional managerial support. There were temporary arrangements in place at Withernsea Community Hospital to provide medical cover for the ward. Interim arrangements were also in place at East Riding Community hospital. However, the trust had advertised a tender to contract permanent medical cover for the ward.

The care patients received was effective. We saw that regular audits were undertaken and that any issues identified were addressed or escalated. Staff completed assessments for all patients, if appropriate, and recorded the outcomes in their care records.

While both wards worked well together as a multidisciplinary team, there was limited access to therapy support, especially at Withernsea Community Hospital. This affected the discharge of some patients. There were also some problems with accessing medicines through the local pharmacy services.

Patients and their relatives were all positive about the care they or their relative received. We saw staff were respectful towards patients, and made sure that they were treated with dignity. Patients were involved in decisions about their care where possible, for example, taking part in the multidisciplinary team meetings. We also saw staff took families' needs into consideration.

Patients with individual needs were given the support they required. In addition, members of staff were identified as leads, for example, in diabetes, learning disabilities and dementia. Staff were trained in safeguarding and mental capacity procedures, and were able to apply and discuss these appropriately. Discharge was discussed with patients on their admission. Staff updated patients if their discharge was going to be delayed, and the reasons for this. Any complaints were handled in line with the trust's policy.

Both hospitals displayed information about the provider's vision and values and staff demonstrated that they understood these. Staff were aware of the structure of the organisation and said that they were supported by their matrons, senior staff and, at East Riding Community Hospital, the service manager. Both of the wards had risk registers, however the completion of the register at Withernsea Community Hospital was inconsistent.

Summary of findings

Background to the service

The community inpatient wards at East Riding and Withernsea Community Hospitals provide diagnostic and screening services, and care for people with long-term conditions. The inpatient facilities at Bridlington Hospital provide end of life care and are not included in this section of the report.

The ward at Withernsea Community Hospital had 12 beds, with one male and one female bay. The ward at East Riding Community Hospital provided 17 rehabilitation beds, nine overnight beds (where people were staying for less than 10 days) and four day care beds (for planned treatment, falls and for palliative care patients).

Our inspection team

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leader: Cathy Winn, Inspection Manager, Care Quality Commission (CQC) and Surrinder Kaur, Inspection Manager, Care Quality Commission (CQC).

The community inpatient inspection team included: a CQC inspector, a specialist nurse and a community hospital manager.

Why we carried out this inspection

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

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

We visited the community inpatient services of Humber NHS Foundation Trust on 20 to 23 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with nurses and allied health professionals. We spoke with a range of staff at different grades, including nurses, matrons, service managers, support staff and the senior management team. We also talked with over 20 people who had used services, observed how people were being cared for and reviewed their care or treatment records.

During the inspection, we visited Withernsea Community Hospital and East Riding Community Hospital.

How we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot for mental health and community health services inspection programme.

Summary of findings

What people who use the provider say

Patients and relatives we spoke with were positive about their care and treatment, including admission and discharge procedures, privacy and dignity, and intentional rounding (regular checks with patients at set intervals) within the wards.

Good practice

- Patients were treated with compassion, dignity, respect and were spoken with and listened to promptly.
- The quality dashboard at East Riding community hospital gave real-time information on the completion of appropriate risk assessments and documentation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should review access to therapy support within community inpatient services, especially at Withernsea Community Hospital.
- The trust should review the process for updating the risk register at Withernsea Community Hospital.
- The trust should review the arrangements within community inpatient services, for obtaining medication outside the designated delivery times.

Humber NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

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

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found that care on the wards at both hospitals was safe. There was evidence to show that staff recorded and reported incidents, and completed risk assessment and risk management plans. Patient risks were assessed and plans were developed to reduce them. In addition, there was a daily multidisciplinary review of patient risks and their progress, to make sure that planned care was still relevant and that patients were making suitable progress.

The trust had set up a dashboard to monitor the quality of care provided. It also provided clinical skills training for staff, as well as additional managerial support. There were temporary arrangements in place at Withernsea Community Hospital to provide medical cover for the ward. However, the trust had advertised a tender to contract permanent medical cover for the ward.

Detailed findings

Incidents, reporting and learning

There were systems in place to report incidents that may affect the safety, health and welfare of patients. Staff were familiar with the reporting system and could give examples of what they would report. We looked at three of the electronic records of incidents reported and saw that these corresponded with details in individual patient records. All incident reports were seen by the matrons and any emerging trends were identified. For example, they monitored the number of falls reported during a specific period. Information about incidents was shared with senior managers and reported at board level. The matrons told us about regular meetings to discuss lessons learned from incidents. Staff told us that they had received feedback about learning from incidents through supervision, shift handovers and team meetings.

Staff had taken steps to reduce the reoccurrence of incidents, including the development of comprehensive patient assessments.

Are services safe?

There had been no never events or serious incidents attributable to inpatient services within the last 12 months.

Cleanliness, infection control and hygiene

We observed appropriate practices to protect patients against the risks of acquiring infections. This included provision of hand washing facilities for patients, staff and visitors, and staff following hand hygiene guidance. An infection control lead nurse had been identified and we saw audits had been undertaken on hand hygiene.

There were suitable arrangements for management, storage and the disposal of waste, including clinical waste. The areas of the hospital we saw looked clean.

Maintenance of environment and equipment

Risks to the safety and welfare of patients were identified and managed. This included environmental risks, such as fire safety risks on both wards. Risks were monitored by regular checking and review.

We saw appropriate equipment to ensure effective care was avilable. Portable appliance testing was current on all equipment inspected.

Medicines

There were effective arrangements for safely managing medicines, including medicines prescribed 'as required' and controlled drugs. We saw that patients' care plans included details of when 'as required' medicines should be offered to patients. Medicines were stored securely and were administered by qualified nurses. We looked at the records of administration of medicines for four patients and found these were completed correctly.

Safeguarding

We spoke with members of the multidisciplinary team and they were confident staff knew how to respond to allegations or signs of abuse. Staff we spoke with were all aware of the phone number and procedure for escalating concerns. There had not been any safeguarding alerts raised by the ward in the last 12 months.

Records

Admission procedures included comprehensive assessment of key areas of health needs including tissue viability and nutrition screening, assessment of personal care needs included infection and continence and risk assessments for falls and venous thromboembolism.

Patient records showed consent had been gained before treatment or support was given. This was confirmed by patients.

All patient care was reviewed daily within the multidisciplinary team (MDT) meeting. The MDT meetings resulted in a joint plan of care for each patient.

A quality dashboard used at East Riding community hospital gave real-time information on the completion of appropriate risk assessments and documentation.

Staffing levels and caseload

Staff on both wards felt nurse staffing levels were sufficient to allow them to provide safe care to patients. They all recognised the importance of safe staffing and the impact it had on providing care. The safe staffing toolkit was actively being used in both wards and we found staffing levels were in accordance with the required levels; staff absences were actively covered through the use of agency staff arrangements.

On both wards the matron told us that staffing was adjusted according to patients' needs and the level of care, treatment and observation they required. Where vacancies had been identified there were plans in place to actively recruit and, in the short term, to cover these through agency and other local arrangements.

The trust had identified that there had not been adequate levels of medical input to ensure patient safety, particularly at East Riding Community Hospital. There had been an increase in the bed base of the ward, an increase in the acute presentation and the early transfer of patients from the acute trust. Temporary arrangements had been put in place to provide medical cover at both hospitals. At East Riding Community Hospital a Senior House Officer was employed and arrangements were in place for daily telephone supervision from a Consultant. A tender had been advertised to contract permanent medical cover for the wards to replace the current temporary arrangements.

Assessing and responding to patient risk

The trust had set up a dashboard to monitor the quality of care provided. The matron collated information on ward performance and introduced measures to address concerns. This had included the introduction of intentional rounding to improve patient observation and reduce the risk of incidents occurring for example patient falls. The contact was recorded within the patient's records.

Are services safe?

We saw that appropriate risk assessments were completed when patients were admitted. This included the risk of fallsand of developing pressure ulcers. We saw that the risk assessments were regularly reviewed according to the level of risk. Appropriate action was taken in response to the risks identified. We saw patients were monitored throughout their stay through the use of a range of tools, such as the early warning score. We found that the rate of reported venous thromboembolism (VTE) for the provider was above the England average for the period April 2013 to April 2014. This measure records whether or not a patient is being clinically treated for a VTE of any type. Patients were assessed on admission for their risk of developing VTE. On the two wards inspected, we saw that the VTE assessments had been completed in the patient records.

There was a daily multidisciplinary review of patient risks and their progress, to make sure that planned care was still relevant and that patients were making suitable progress.

Deprivation of Liberty safeguards

Staff received training at induction on safeguarding and mental capacity. Records showed that staff had received recent training in the Mental Capacity Act 2005. Staff were able to discuss the Mental Capacity Act 2005 appropriately and we saw that deprivation of liberty safeguarding was applied, where appropriate.

Major incident awareness and training

There was a documented business continuity plan for teams. Staff received mandatory training in fire safety and health and safety. There were clear instructions in place for staff to follow in the event of a fire or other major incident.

Are services effective?

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

Summary

The care patients received was effective. We saw that regular audits were undertaken and that any issues identified were addressed or escalated. Staff completed assessments for all patients, if appropriate, and recorded the outcomes in their care records.

While both wards worked well together as a multidisciplinary team, there was limited access to therapy support , especially at Withernsea Community Hospital. This affected the discharge of some patients. There were also some problems with accessing medicines through the local pharmacy services.

Detailed findings

Evidence based care and treatment

Staff had access to the trust's policies and procedures in both paper form and electronically using the intranet. Local policies were written in line with this and were updated every two years or if national guidance changed.

The matron at both hospitals undertook regular audits (for example, hand hygiene, records and falls). We saw that action was taken where issues were identified, for example increased staffing and introducing link roles.

Patients were assessed on admission to the wards using recognised assessment tools. Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included venous thromboembolism (VTE), pressure ulcers, falls and infection control risks. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care.

Pain relief

We saw nurses administered pain relief as required in accordance with pain assessments. A pain assessment tool was used and documented as part of the care pathway.

Nutrition and hydration

Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. These assessments were detailed and used the Malnutrition Universal Screening Tool (MUST). Care pathways for nutrition and hydration were in place and had been comprehensively completed. Patients were able to access suitable nutrition and hydration including special diets. Dietician advice and support was available if a patient was at risk of malnutrition.

Patient outcomes

Assessments were undertaken at admission and discharge and evaluation completed on the clinical effectiveness of health initiatives and support provided during inpatient treatments. We saw records from the therapy teams that considered health assessments from GPs and nurses on the ward, including timescales and plans for treatment or discharge which were linked to the frequency and intensity of therapy offered.

Daily multidisciplinary team meetings ensured practice was shared and patient care was discussed and reviewed as required.

Performance information

The ward at East Riding Community Hospital had implemented a quality dashboard to give real time information on the completion of appropriate risk assessments and documentation to monitor the quality of care provided e.g. completion of relevant risk assessments, national early warning scores (NEWS), nutrition and falls assessments.

This showed a high level of compliance with key indicators and demonstrated there were processes in place to address any identified issues promptly. These initiatives are currently being rolled out to staff on the ward at Withernsea Community Hospital.

Competent staff

All staff reported they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The mandatory training matrix displayed on the wards confirmed staff had attended required mandatory training. Information from the Department of Health Information Toolkit confirmed the trust had mandatory training procedures in place and all staff were appropriately trained.

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff told

us they were supported by their managers to attend training days and to complete online training. Staff said the training they had received was appropriate and relevant to their work role. A comprehensive clinical skills training course had been developed and was currently being rolled out.

Nursing staff had received appraisals within the last twelve months which included discussion of their personal development and training needs. Revalidation processes for nursing and medical staff were in place and up to date. Staff told us they had regular clinical supervision described as protected time for staff to reflect on their practice in order to learn from experience, develop and maintain competence.

Multidisciplinary working and working with others

Both wards had developed multidisciplinary team (MDT) working that allowed shared decision making on the most appropriate care and treatment for patients. Daily MDT meetings were held where each patients care was discussed. Within the wards, members of the MDT had agreed a shared way of working based on each member's professional and clinical background. The MDT meetings served to address issues as they arose.

Delays in discharge were discussed and problems addressed. All members of the team remained clear as to when discharge was expected and any additional support required from any specific team was actioned. This included an assessment for equipment, continuing health care or access to additional support networks. The team worked together to ensure the patient was only discharged when their needs for discharge were met.

Staff at Withernsea Community Hospital told us it was difficult to obtain therapists input at times; one patient told us his discharge had been delayed because he was waiting for a physiotherapist consultation.

Both wards had arrangements with local pharmacy services for accessing medication. These arrangements caused difficulties obtaining medication outside the designated delivery times. We were told staff had to take prescriptions and collect medications themselves from pharmacies outside delivery times.

Co-ordinated integrated care pathways

Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care. We saw effective collaboration and communication amongst members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. MDT meetings, involving the patient, families and carers, nursing staff, therapists and doctors, ensured the patient's needs were fully explored. This included identification of the patients' existing care needs, relevant social and family issues, mental capacity, and any support needed from other providers on discharge, such as support from community nurses. We saw evidence of the outcomes of these meetings in patients' records.

Are services caring?

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

Summary

Patients and their relatives were all positive about the care they or their relative received. We saw staff being respectful towards patients, and making sure that they were treated with dignity. Patients were involved in decisions about their care where possible, for example, taking part in the multidisciplinary team meetings. We also saw staff taking families' needs into consideration.

Detailed findings

Compassionate care

Throughout our inspection at both hospitals we observed patients were treated with compassion, dignity and respect. Patients were spoken and listened to promptly. We received universally positive comments from patients at both hospitals regarding their care and treatment. Patients told us care was "very good", "excellent" and they had been "fully informed" and the staff were "absolutely wonderful". All patients spoken to commented positively on the dedication and professionalism of staff and the high quality of care and treatment received. Patients gave examples where staff had responded to their individual needs e.g. moving their bed closer to the nurse's station. Patients we spoke with told us they felt safe on the wards.

Dignity and respect

We observed patients being kept informed throughout their time on the wards and saw all staff introduced themselves appropriately and curtains were drawn to maintain patient dignity. We asked patients and visiting relatives if they felt they were treated with respect and everyone confirmed they were.

We observed staff interacting with patients in a respectful manner. Staff were observed speaking to patients in a caring and empathetic way designed to encourage them to engage with staff and other patients, particularly at meal times.

Patient understanding and involvement

Patients we spoke with all said they felt they were involved with their care. We saw within patient records they had been asked key questions and plans had been developed where possible in a person centred way. All patient care was reviewed daily within the multidisciplinary team (MDT) meeting. The MDT meetings resulted in a joint plan of care for each patient. The plan was agreed or amended in discussion with the patient.

Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the nurses and doctors looking after them. Matrons were visible on both wards so that relatives and patients could speak with them. Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.

We contacted 20 patients who had used the hospital previously and were now living at home. We were told staff on the wards had kept them fully informed about their care and treatment and discharge arrangements. Support had been provided on the wards until staff were sure people could cope on their own.

Patient-Led Assessments of the Care Environment (PLACE) for 2013 showed both East Riding Community Hospital (98.76%) and Withernsea Community Hospital (99.20%) scored highest for cleanliness.

Emotional support

We spoke with patients and relatives and were told they had been involved with the support they had received. We were told they felt their needs had also been assessed when the wards decided on the support their family members needed when they got home. One of the wards had the facility for relatives to stay with patients prior to discharge to assess any particular needs.

We spoke with patients who had been discharged back to their own homes and were given examples where a patient's discharge date was revised pending conversations with community nursing, therapy services and social services to help allay any patient anxiety.

Patients said that the felt able to talk to ward staff about any concerns they had either about their care or in general and patients did not raise any concerns during our inspection. There was information within the care plans to

Are services caring?

highlight whether people had emotional or mental health problems. We saw patients were able to access counselling services, psychologists and the mental health team if appropriate.

Promotion of self-care

We saw staff supporting and encouraging patients to be as independent as they could.

Are services responsive to people's needs?

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

Summary

Patients with individual needs were given the support they required. In addition, members of staff were identified as leads, for example, in diabetes, learning disabilities and dementia. Staff were trained in safeguarding and mental capacity procedures, and were able to apply and discuss these appropriately. Discharge was discussed with patients on their admission. Staff updated patients if their discharge was going to be delayed, and the reasons for this. Any complaints were handled in line with the trust's policy.

Detailed findings

Service planning and delivery to meet the needs of different people

Multidisciplinary teams (MDT) were committed to meeting the needs of the people who used the ward. Support was available to meet the needs of different people, for example patients living with dementia and learning disabilities. Wards had dementia and learning disability champions designated, responsible for ensuring staff were aware of the needs of individual patients

Access to the right care at the right time

People told us the service was what they needed at the time of admission. This was the case for patients admitted from home and patients from an acute hospital. Bed occupancy at the inpatient hospitals, particularly at Withernsea Hospital was low, therefore patients could access a bed at the right time. People who had been discharged from the inpatient wards all said the process had helped to give them extra confidence to remain independent. The discharge planning process commenced at the admission stage. Services, equipment and community packages of care were all in place for the patient when they returned home.

Meeting the needs of individuals

We checked 12 patient care records and found all records had a completed learning disabilities assessment and mental capacity assessment, where appropriate. This meant care and treatment planned accounted for the individual needs of patients.

The inpatient wards completed a dementia assessment with every new patient. The assessment gave staff the information they needed to refer the patient onto specific support services.

Patients on the ward who lacked capacity were supported appropriately through best interest assessments and decisions. There were enough senior staff trained to undertake best interest assessments.

A translation service was in place and advertised throughout the hospital and policies were in place to ensure patients following different religions were treated with dignity and respect.

Moving between services

Each ward had identified staff to undertake discharge planning and this was begun as soon as patients were admitted. Discharge was discussed with patients on admission; this gave patients and staff ideas about expectations and anxieties. Comprehensive assessments were completed by each member of the MDT and progress was discussed within the daily MDT meetings and communicated in a timely manner with the patient and their family.

Each team had dedicated referral routes for continuation of specific support as required. This included the outreach team supplied by the trust, extended therapy or rehabilitation and adult social care support provided by the local authority. Access to equipment was arranged during inpatient provision and the outpatient team ensured everything was set up and understood by the patient on discharge. This type of organisation at discharge helped ensure a smooth transition from inpatient unit to independent living. A discharge summary was sent to the GP on discharge from the wards. This detailed the reason for admission and any investigation results and treatment undertaken.

An average, 8.5 patients' transfers of care were delayed each month based on data from October 2013 to March 2014, ; all reported delays were for non-acute patients. We discussed discharge arrangements with patients still on the wards and those who had returned home. All said they had no concerns about their discharge; they were kept informed of any delay and understood the reasons for this.

Are services responsive to people's needs?

Complaints handling (for this service) and learning from feedback

Information was available for patients and their families about how to make a complaint or raise concerns, including an easy to read format for patients who needed this. Patients told us they would go to the ward staff if they were unhappy about anything. Both wards also sought patient feedback within ward rounds and daily discussions.

Nine complaints had been received about community hospital services between April 2012 and March 2013. The complaints were handled in line with the trust policy.

Patients or relatives making an informal complaint were able to speak to individual members of staff or the matron. Staff described the complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospitals and wards informing patients and relatives about this process. Themes from both formal and informal complaints were collected and discussed in staff meetings, when appropriate, although some staff were unable to identify improvements made.

Are services well-led?

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

Summary

Both hospitals prominently displayed information about the provider's vision and values. Staff demonstrated that they understood these. Although both of the wards had risk registers, the completion of the register at Withernsea Community Hospital was inconsistent. Staff were aware of the structure of the organisation and said that they were supported by their matrons, senior staff and, at East Riding Community Hospital, the service manager.

Detailed findings

Vision and strategy for this service

Information about the provider's vision and values was prominently displayed in both hospitals and wards. The trust vision was visible throughout the hospital in wards, clinics, staff rooms and corridors. In addition staff were able to repeat the vision and discuss its meaning with us at focus groups and during individual conversations.

Guidance, risk management and quality measurement

Risk registers were in place on both wards. Risks, impact, controls, gaps in control, assurance, gaps in assurance and mitigating actions had all been identified at East Riding Community Hospital. The register at Withernsea Community Hospital had recently been developed and did not include raised, review or completion dates. The individual member of staff with responsibility for taking action was also not identified. It was unclear how risks have been mitigated as no residual risks ratings had been added to any of the risks. The completion of this risk register was inconsistent.

Risks at ward level were identified and monitored. This included risks specific to individual patients, such as moving and handling and self-harm. Environmental risks were included, such as fire safety, infection control and security. The matrons told us they had overall responsibility for monitoring and managing risks, though this was shared by delegation to specific members of staff.

Clear governance procedures and structures were in place and these included a local governance framework, quality circle and clinical network supported by local management teams, business management teams, governance and compliance committees, organisational risk committee and the trust board. Minutes of these committees showed regular discussion and action took place regarding audit, patient experience, management and quality dashboards, incident management and risk. In focus groups and individual discussions staff were able to express the same concerns as those in more senior positions within the wards.

Complaints, incidents, audits and quality improvement projects were discussed at regular staff meetings and we saw 'quality' boards displayed throughout the wards. Feedback from these meetings was given to matrons. Managers could provide examples of where they had identified issues and had taken action to address these. Examples were given of learning from root cause analyses (falls), risk reduction measures (infection control) and learning from incidents. Wards and clinics used a quality dashboard and safety thermometer to measure their performance against key indicators.

Leadership of this service

Most staff were aware of the structure of the organisation although some did express concern about the amount of change that had happened and planned. Staff at East Riding Community Hospital told us they had good support from their service manager. This was not the view expressed at Withernsea Community Hospital; staff expressed concern about the lack of involvement of the service manager and this had been included in the local risk register.

Culture within this service

Staff on both wards said that the matrons and senior staff were approachable and there was good team working. Every staff member expressed pride and commitment to their role and the care of the patients using the service; staff at East Riding Community Hospital said the ward had greatly improved over the last twelve months. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience was a priority and everyone's responsibility.

We saw staff worked well together and there was respect between disciplines. We saw good team working on the

Are services well-led?

wards between staff of different disciplines and grades. Staff at Withernsea Community Hospital did not feel well engaged with the rest of the trust and expressed geographical and managerial "isolation".

Public and staff engagement

Patients, relatives and carers were universally positive about the care and treatment provided on both wards. Patients and their families were provided with opportunities to raise concerns or complaints. Patients told us they would speak to staff if they were unhappy. Patient views on their experience were sought at ward level and used to inform changes and improve care.

Staff were able to share ideas and raise concerns through team meetings, supervision, shift handovers, and informally with their managers. Staff told us they were asked for their opinions on new ideas being trialled, such as changes to documentation and the development of the quality dashboard.

Innovation, improvement and sustainability

The matrons, service manager and staff told us they were supported to try new ways of working to improve the effectiveness and efficiency of the wards. Notice boards on the wards displayed patient experience data, safety and staff welfare. Staff meetings identified good practice and were held regularly. The quality dashboard had been developed and was planned to be rolled out across other services.