Oxford Health NHS Foundation Trust

RNU

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/unit/ team)
RNUX3	Abingdon Community Hospital		
RNUCE	Bicester Community Hospital	<Placeholder text>	<Placeholder text>
RNUCK	Didcot Community Hospital	<Placeholder text>	<Placeholder text>
RNUX2	Oxford City Community	<Placeholder text>	<Placeholder text>
RNU28	Townlands Community Hospital	<Placeholder text>	<Placeholder text>
RNUDJ	Wallingford Community Hospital	<Placeholder text>	<Placeholder text>
RNUDK	Wantage Community Hospital	<Placeholder text>	<Placeholder text>
RNUDM	Witney Community Hospital	<Placeholder text>	<Placeholder text>

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires Improvement O

We rated Oxford Health NHS Foundation Trust as requires improvement overall for its community health inpatients services.

Improvements were required to ensure safe, effective and well-led inpatient services. We found staff were caring and compassionate and treated patients with respect and the trust provided a responsive service.

Our key findings were:

- We were concerned that when patients' appeared to have difficulties in their ability to swallow ; their drinks were routinely thickened to try to reduce the risk of choking without a clear assessment of the risk or assessment by a speech and language therapist.
- Most staff were aware of safeguarding and what constituted abuse. They were able to explain the types of concerns which would result in a safeguarding alert being raised.
- The process for assessing risks such as pressure ulcers, falls and malnutrition were mostly completed and care plans were developed to manage them effectively. However there was a lack of pain assessments or documentation.
- All hospitals used a recognised tool to determine if patient's health was at risk of deterioration. However, staff did not always follow the procedures such as escalating concerns.
- Not all staff showed awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were no assurances in place that the code of practice was being followed and some managers did not have a clear understanding of the process. Therefore patients were at risk of being detained unlawfully.
- We found documentation consisting of paper and computer notes was not contemporaneous or stored in one place. We found variation in the completion of risk assessments and care plans.
- Equipment, including emergency equipment was available. In general equipment was maintained though there were a number of pieces of equipment that required portable electrical testing.
- There were a high percentage of delayed discharges and patients experienced long lengths of stay in hospital, which could have a negative impact on their welfare and wellbeing. The trust was monitoring patietnes length of stay and delays to discharges and was working with partners to address some of the issues.
- Processes for monitoring the quality of the inpatients' service and those to ensure risks are identified and managed were not sufficiently robust with risks not always managed effectively. There was monitoring of performance and quality using a trust wide dashboard but limited evidence of local audit of the service or patient care.
- Medicines were available to patients and were managed effectively and according to medicines guidance.
- Appropriate staffing levels were maintained at most hospitals and agency and bank staff covered shortages. There were adequate staff to meet the needs of patients in a safe and consistent way.
- We found there was strong ethos of multi-disciplinary working. Multi- disciplinary team meetings were held on a regular basis.
- Infection control procedures were followed and overall standards of cleanliness were good in the community hospitals.

Summary of findings

Background to the service

Information about the service

Oxford Health NHS Foundation Trust provides adult inpatient services from 145 beds in nine wards over eight locations. The eight community hospitals are Abingdon community hospital, Bicester community hospital, Didcot community hospital, Oxford City community hospital, Townlands community hospital, Wallingford community hospital, Wantage community hospital and Witney community hospital. All of the community hospitals undertake focussed rehabilitation. Sub-acute and stroke rehabilitation patients are admitted to Witney and Abingdon community hospitals only.

Abingdon community hospital has two wards. Ward 1 has 12 beds which are shared between patients admitted for rehabilitation and specialist rehabilitation following a stroke. Ward 2 has 20 beds which provide care for rehabilitation patients and patients admitted from the community through Emergency Multidisciplinary Units. Bicester community hospital has one ward with 12 beds; Didcot community hospital has one ward with 12 beds; Oxford City community hospital has one ward with 17 beds; Townlands community hospital has one ward 12 beds; Wallingford community hospital has one ward 16 beds and Wantage community hospital has one ward 12 patients. Witney community hospital has 30 beds which are shared between patients admitted from the community through Emergency Multidisciplinary Units, specialist rehabilitation post stroke and patients admitted for rehabilitation.

Our inspection team

Our inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader Lisa Cook Inspection Manager

The team of 36 inspecting the community services included CQC inspection managers and inspectors. They were supported by specialist advisors, including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a pharmacist, safeguarding leads, speech and language therapists, a consultant specialising in care of the elderly, an Advanced Nurse Practitioner - Urgent Care, a urgent care doctor, a palliative care consultant and palliative care nurses. Two experts by experience who had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The inspection team for inpatient services comprised of Care Quality Commission inspectors, specialist advisors including: a consultant specialising in care of the elderly, senior nurse, and physiotherapist. The team included experts by experience; these are people who have personal experience of using or caring for someone who uses this type of care service.

Why we carried out this inspection

We inspected the inpatient community hospitals as part of our on-going comprehensive inspection programme.

Summary of findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting Oxford Health NHS Foundation Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an announced visit on 29 and 30 September and 1, 2 and 3 of October 2015

During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use 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 services. We met with people who use services and carers, who shared their views and experiences of the core service.

For this core service:

- We visited eight community inpatient hospitals
- We spoke with 31 patients and their family.
- We spoke with 54 staff members; including doctors, nurses, and support workers, healthcare professionals such as therapists, volunteers, and domestics.
- We Interviewed senior managers with responsibility for these services
- We attended and observed 4 multi-disciplinary team meetings.
- We reviewed 67 care and associated records of patients
- We looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

We spoke to 28 patients and five visitors who all told us that the care they received from staff was excellent and that patients felt safe and cared for, during their stay. Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered. We observed staff speaking to patients in a sensitive and compassionate manner

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

The trust MUST ensure that-

- Emergency equipment is fit for purpose and available in all areas at all times.
- All staff are trained in basic life support to deal with emergency situations
- Comprehensive and contemporaneous notes are maintained at all times for all patients.
- The track and trigger system is used correctly and that there is early escalation of concerns if a patient's condition deteriorates.
- Systems and procedures for the recording and assessing of patients' pain are reviewed.
- Due process is followed regarding Deprivation of liberty
- There is a clear system for the management and assessment of patients with swallowing difficulties.
- Governance processes across inpatient services are robust, risks are managed effectively and there are arrangements for monitoring and improving safe quality care.

Summary of findings

The trust SHOULD ensure that-

- Equipment servicing and checks are carried out regularly and a record kept that they are safe for use.
- Service strategies are clear and communicated effectively
- Discharge planning processes are proactive and well-coordinated with social services to reduce delayed transfers out of hospital.
- The effectiveness and purpose of the multidisciplinary team meetings is reviewed.

Oxford Health NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

We judged safety as requires improvement:

Patients were not always adequately protected from avoidable harm. The trust used a tool known as 'track and trigger' to identify patients whose condition might deteriorate, this was not always completed or acted upon.

Resuscitation equipment was available at all community hospitals. However, the resuscitation trolleys were not maintained securely and at one community hospital we found items missing from the trolley which had not been replaced.

There was a variety of equipment which was serviced at regular intervals; these were maintained safely and were ready and available for patients. However, we found several items that were not tested for electrical safety.

Medical records were not always complete or concise and the management of patients' risk was not well documented. We found variation in the completion of risk assessments and care plans. Although most staff were aware of their responsibilities in relation to safeguarding, there were some staff that did not have a clear understanding of the process.

Medicines were available to patients and were managed safely in accordance with medicines guidance.

On all wards, minimum and maximum temperatures for the fridges where medicines were stored were monitored. However, in some areas the temperatures were not being correctly monitored and therefore there was no assurance that medication was stored correctly at all times.

Ward environments were clean, tidy and clutter free in all areas. All staff followed infection control principles. Personal protective equipment was available and used.

Nurse staffing levels met national requirements but there had been staff shortages for nurses and therapists and a high number of vacancies.

Staff knew how to report incidents, and reported incidents were investigated and lessons learnt were shared.

At all community hospitals staff were aware of the Duty of Candour. Statutory and mandatory training was undertaken via e-learning or face to face. Most staff had completed their mandatory training.

Requires improvement

Are services safe?

Medical cover was provided on weekdays by a consultant, GP or an associate specialist in elderly medicine. Out of hours medical cover was accessed from the local GP out of hours service.

Detailed findings

Safety performance

- From April 2014 to June 2015 there had been five serious incidents reported; three incidents of slips, trips and falls, one medication incident and one assessing risk in patients.
- The trust used the NHS Safety Thermometer for recording levels of harm free care but it was not displayed on any ward. The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. Not all staff were aware of the safety thermometer data relating to their ward or department.
- Patients and visitors were made aware of each ward's performance with regard to safety issues by

the 'Productive Ward' dashboard which was displayed in each hospital. This showed how many days had elapsed since a patient had experienced any of the above. The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.

- Grade 2 pressure ulcers and above developed in the community hospitals reached a high of five in July 2015. There were two grade 2 pressure ulcers reported in February and March 2015.
- The number of recorded falls with harm fluctuated over the year, with a peak of three falls in January 2015.
- The incidence of catheter related urine infections and new urinary tract infections (UTIs) had varied throughout the year. A high of three was seen in the months of October 2014, January 2015 and March 2015.
- Patients were assessed for risks of venous thromboembolism or blood clots. There had been no cases of venous thromboembolism (VTE) recorded from January to June 2015.
- The community hospitals reviewed all inpatient deaths in conjunction with Oxford University Hospital NHS Foundation Trust gerontology teams using the Mortality and Morbidity process. The reviews were held at Oxford University Hospital NHS Foundation Trust, senior staff from the community hospitals were invited to attend. We saw minutes of these meetings for April, May and September 2015.

Incident reporting, learning and improvement

- Staff in all community hospitals were able to describe the processes of reporting an incident via the electronic reporting system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls.
- Staff we spoke with had reported an incident. However some staff said they had not received feedback once they had reported an incident.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, following an incident where medication went missing in one of the hospitals. A root cause analysis was undertaken which resulted in a change in practice. This was that all community hospitals now monitor this medication as part of their daily controlled drug checks.
- We found that serious incidents were reviewed and investigated by other departments within the trust unrelated to where these incidents had occurred to support transparency and learning. Senior staff told us about the learning that was shared following a serious incident investigation, where two patients condition deteriorated and had not been acted upon in a timely manner. The outcome and learning was shared with all staff on the ward and we were shown action plans.
- At a local level there were systems in place to feedback to staff learning from incidents. This was in team/ward meetings, handovers, newsletters and electronic communication.
- The trust had produced a monthly bulletin called trust wide-key learning and good practice which shared learning and outcomes and was emailed to all staff.
- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the

patient, and any other relevant person, within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Duty of Candour was well known to all staff; staff knew what the duty was and followed its principles. A ward manager described an incident where they had been open and honest with a patient and their family when the patient had received the wrong medication.

Safeguarding

- Most staff we spoke with were aware of their responsibilities in relation to safeguarding of adults at risk. However, there were some staff that did not have a clear understanding of the process of escalating or reporting to the social services safeguarding team. The trust had dedicated safeguarding leads who would provide advice.
- All medical, nursing and ancillary staff were required to complete safeguarding training. Staff received training in protecting people in a vulnerable situation which was part of the trusts mandatory training programme. The data provided by the trust demonstrated training rates for adult safeguarding across hospitals. Completion rates by staff were generally good, and varied between: Abingdon community hospital at 79% and Wantage community hospital at 96%. The trust target was 90%.
- Staff on the wards, including non-clinical staff, were aware of what constituted abuse and the actions they would take to protect the safety of patients from abuse. Staff were able to explain the types of concerns which would result in a safeguarding alert being raised.
- Patients we spoke with told us they felt safe.

Medicines

- Medicines were ordered, stored and used safely in line with regulations at all of the eight community hospitals.
- The trust was trialling a new system called the Medicines – a Patient Profile (MaPP) system in the community hospitals. This provided bespoke medicines information leaflets for patients.
- Medicines should be kept according to manufacturer's guidelines which, includes the correct temperature to ensure they remain fit for use. On all wards, the fridge minimum and maximum temperatures were recorded. In some areas the temperature of medicine fridges were being incorrectly monitored and temperatures outside the expected range were not identified or actioned. This meant staff were not aware if the fridge temperature was either above or below the safe range. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients.
- We found all medicines rooms were locked and we saw evidence of temperature monitoring of these rooms on all wards. This meant that medicines were being stored at the temperature as per manufacturer's guidance.
- We checked the controlled drugs stock levels in four hospitals and all drugs were accounted for. Staff followed medicines management protocols and trust policies on the storage and administration of controlled medicines.
- We observed medicine rounds at Oxford City, Wallingford and Didcot community hospitals. All used drug trolleys and staff wore tabards to indicate they should not be disturbed while undertaking medicines rounds, to minimise errors. Staff carried out appropriate checks to ensure medication was given to the correct patients and followed the trust's Medicines Management Policy March 2012.
- Systems were in place for staff to record medicines' errors. Information provided by the trust showed 98 medication incidents had been reported between March and August 2015. Staff we spoke with confirmed they knew how to report medicines' errors. At Abingdon community hospital there had been a series of recent recording errors. This had been proactively addressed by the ward team and they had changed the procedure to include a second nurse to check prescription charts for any omissions after each drug round.
- The pharmacy technician visited each area three times a week and the pharmacist twice a week, to check patient's medications and stock levels. Arrangements were in place in case medicines were needed outside of standard working hours.
- At Abingdon community hospital the pharmacist had placed posters around the ward detailing when they would be available if any patient wished to discuss their medication.

Environment and equipment

- Resuscitation equipment was available on all the wards. We found gaps in the daily checks of the resuscitation equipment in some of the community hospitals. In

Requires improvement

Are services safe?

Wallingford community hospital we found items missing from the resuscitation trolley which had not been replaced. This posed a risk of these not being available if needed.

- Resuscitation trolleys were not tamper evident to identify unauthorised access to equipment and potentially drugs. This could place people at risk if equipment had been removed
- The portable appliance testing (PAT) on the resuscitation suction equipment at Witney community hospital and Wantage community hospital had expired in August 2015 and at Oxford City community hospital in April 2015. This meant that if required in an emergency situation that staff could not be assured that it was safe to use.
- Across all eight community hospitals we found 16 pieces of equipment that was not within its servicing date or tested for electrical safety, this meant that equipment may not have been fit for purpose.
- At Abingdon community hospital we observed that the domestic's storage cupboard was left open and several large cupboards containing equipment e.g. needles and syringes which had information displayed on the outside of the door was accessible to patients and visitors.
- All of the community hospitals, achieved higher than the England average scores for condition, appearance, and maintenance scores of 90% in Patient Led Assessment of the Care Environment (PLACE) audits of privacy, dignity and wellbeing. The highest scoring hospital was Bicester community hospital (98%) and the lowest scoring was Didcot community hospital (94%). This showed that the environments were maintained to a satisfactory standard and met the needs of patients.
- The wards had sufficient moving and handling equipment to enable patients to be cared for safely such as hoists, adjustable beds and walking frames.
- Equipment such as commodes, bedpans and urinals was readily available on the ward.
- We observed elements of dementia friendly design were incorporated into the ward areas, for example a colour coding system was used for different bays and there was pictorial signage.
- Ward staff told us they had good access to equipment needed for pressure area care. Pressure relieving equipment was readily available to all community hospitals.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps, in clinical environments.

Quality of records

- We reviewed 36 sets of medical, nursing notes and other associated records. The trust used electronic records for nursing and multi–disciplinary notes and paper records for the medical team. Medical and nursing staff made entries in separate sets of patient records. This meant there was a risk that staff might not find information due to inconsistent approaches to completing records. The trust recognised this on their risk register and had plans to introduce electronic patient's records for all staff to access and use.
- Staff raised concerns and frustration around multiple records being in use and not all staff being able to access each system. We found that patients' medical and nursing records were difficult to track as information was not clearly documented in one place.
- The trust used a number of agency nurses who were responsible for patients' care on the wards. Agency staff did not have access to the computerised record system. They were not able to review patient care and treatment needs or add to records directly. As a result patient records may not have been current. Agency staff documented care given on paper and asked substantive staff to input this on patients records. In some instances agency staff used substantive staff logins.
- The quality of documentation in patients' records was variable. At three community hospitals, records of care were detailed and reflected the patient's current needs. However some patients' records lacked details of actions taken and evaluations of treatment. There was a risk to patients if staff did not record vital information including any deterioration or changes to care and treatment.
- Care records included information, about patient care and treatment needs for example risk assessment, care plans, case notes and test results. We found there was limited information on admission details or comprehensive risk assessments completed.
- We saw in all community hospitals that medical records were stored securely in locked trolleys.
- At all the community hospitals staff maintained a daily diary for the medical team which they recorded patient changes or concerns.

Requires improvement

Are services safe?

- The trust completed a documentation audit from January to March 2015 to monitor the quality of records, all community hospitals were rated as good or excellent overall. This looked at the completion of risks assessments and care plans.

Cleanliness, infection control and hygiene

- All wards we visited were visibly clean and well maintained. Domestic staff were seen on the wards with cleaning trolleys and they used a colour-coded system to minimise the risk of cross infections.
- There was clear process for the management and prevention of infection at the locations we visited. We observed staff adhered to the 'bare below the elbows' policy, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves. This included different coloured aprons for meals and personal care. Hand sanitizer gel was available at the entrance to wards, along corridors, and at the bottom of each patient's bed.
- The trust's infection prevention and control team completed an infection control audit from April to July 2015. The audit showed Abingdon community hospital ward one, Oxford City and Townlands community hospitals failed to achieve the trust target score of more than 85%. At Abingdon community hospital we saw action plans that had been put in place.
- Patients who required 'barrier nursing' (this was where they were nursed in a side room) had gloves and aprons available outside their rooms. We observed staff that followed instructions to use this equipment when entering the rooms.
- Equipment had 'I am clean stickers', these indicated that the piece of equipment was clean and ready for use. The exception was Witney community hospital where these were not evident on the ward. This posed a risk of cross infection, as staff could not be assured equipment had been cleaned between use.
- Daily and weekly equipment cleaning schedules were completed consistently.
- The percentages of staff that had completed the infection control training varied across the community hospitals. The data provided by the trust demonstrated that staff statutory training rates ranged between 69% to 93%. The trusts target was 90%.
- The trust performed bi-monthly hand hygiene audits across all community hospitals. The hand hygiene observational audit tool for May 2015 covered hand hygiene at the 'point of care', for example, before and after patient contact, and the bare below the elbows policy. The audit did not identify any issues or concerns.

Mandatory training

- Statutory and mandatory training was undertaken via e-learning or face to face. Most staff had completed their mandatory training, for example: fire safety, manual handling, health and safety. However, the uptake varied across the eight hospitals. Staff received an electronic reminder when the training was due.
- Trust data showed a high proportion of nursing staff had completed their moving and handling practice training. Completion rates were: Wallingford and Townlands community hospitals 73%, Oxford City community hospital 74%, Witney community hospital 76%, Abingdon community hospital Ward 1 85%, Bicester community hospital 86%, Abingdon community hospital Ward 2 88%, Wantage community hospital 92%, Didcot community hospital 93%. Lack of necessary moving and handling training may pose risk of injury to patients and staff.
- There was an induction programme for all new staff. This covered all the key statutory and mandatory training.
- Patients suffering a cardiac arrest would be reliant on nursing staff to provide basic life support (BLS) until medical assistance arrived. Out of the eight community hospitals five had achieved 80% or more for staff training in BLS. At Oxford City community hospital only 69% of staff was up to date with BLS training.
- We saw that staff were given an opportunity to complete mandatory training at work or at home.

Assessing and responding to patient risk

- The track and trigger', scoring system which identifies patients at risk of deterioration or needing urgent review was in use in all community hospitals. This tool helps to identify where there may be a potential for deteriorating standards of care, so treatment could be initiated in a timely manner. At Wantage and Bicester community hospitals, records showed the tool had not been used correctly and advice from doctors had not been sought in line with the tools escalation procedure.
- Allergies were clearly documented on medication charts making them easy to be seen by all staff.

Requires improvement

Are services safe?

- In the 35 notes reviewed, we saw malnutrition universal screen tools (MUST) assessments, falls assessments, intentional rounding and Braden scale (pressure ulcer assessments). Not all of these were completed in a consistent way which meant there was a risk to patients care and treatment. For example we found one patient with a pressure sore who did not have any documentary evidence of size, depth or progress of wound healing.
- Staff at Didcot community hospital were piloting the five steps to prevent and treat pressure ulcers referred to as the 'SSKIN bundle'. This encourages staff to consider the five steps defined as surface, skin inspection, keep moving, incontinence and nutrition to monitor patients' pressure risks and skin conditions.
- At Wantage community hospital we reviewed six medical notes and were unable to see a clear medical, functional, social or discharge plan, this could have impacted on patients' care.
- A dictation machine was used at nursing handover for every shift so that all staff could listen to the recording. We heard staff sharing information about the care patients had received such as changes to care plans, current clinical or social issues. Staff handed over changes in patients conditions which ensured that actions were taken to minimise any potential risk to patients.
- Patients with a known risk of falls were accommodated in bays closest to the nurses' station for close observation and to minimise risks of falls. The community hospitals had access to seat cushions and bed alarms that were activated to alert staff when a patient stood up from their chair or bed.
- The trust had a protocol that if a patient became unwell, they had a direct line to the out-of-hours emergency call centre. Staff told us this could result in a doctor's visit, or advice to call an ambulance.
- Therapists were involved in the moving and handling assessments, detailed plans were developed and equipment was available to patients as needed.
- We saw intentional rounding had been implemented. Intentional rounding is a structured process where nurses on wards regularly checked patients.

Staffing levels and caseload

- Since January 2015 the trust had gradually reduced the number of beds from 194 to approximately 145 across all of the community hospitals. It had closed one ward at Witney community hospital in order to maintain safe staffing levels.
- Nursing numbers were assessed using an acuity tool and there were minimum staffing levels identified. The safe staffing levels were displayed on all wards, including planned and actual numbers. All wards were well staffed according to safer staffing (requirements for the minimum levels of staff on an adult inpatient ward)
- There is now nationally agreed minimum guidance on safe staffing levels for community or intermediate care inpatient units. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014). Direct Care Measurements (NHS England, January 2015). The actual staffing levels against these established (also known as expected level) were reviewed weekly and reported monthly to the board of directors.
- The bed occupancy rate for quarters three and four in 2014/2015 was 95% which was higher than the England average of 88%. It is generally accepted that when occupancy rates rise above 85%, there is an increased risk to the quality of the care provided to patients and the orderly running of the hospital.
- Data provided from the trust showed staff vacancies as of September 2015 varied from an over staffing of 3.2% at Oxford city community hospital, and an understaffing of 25.7% at Abingdon community hospital Ward one and 31.8% Witney (Wenrisc) community hospital.
- The trust was aware of the high staff vacancy levels on Abingdon community hospital ward, one of which had a registered nurse vacancy rate of 60%. The vacancies were filled with agency staff on short and long-term contracts. This meant there was staff continuity despite the high vacancy rate.

Staff were able to request additional nursing staff when it had been identified that a patient required enhanced support.

- We reviewed the nursing rota for Abingdon community hospital Ward one, between the months of June and August 2015, and found that planned staffing levels were met for the majority of shifts. Bank staff were employed to cover shortfalls in staffing if required.

Requires improvement

Are services safe?

- Staff we spoke with felt supported by senior nurses and matrons and did not express any concerns around staffing numbers and skills.
- The trust employed physiotherapists and occupational therapists to support inpatients rehabilitation. There were dedicated speech and language therapists and dieticians employed on the stroke rehabilitation wards.
- The trust provided sickness rates for January to September 2015. Abingdon community hospital had the lowest at 0.6% and Bicester community hospital had the highest sickness rate at 16%.

Managing anticipated risks

- Staff were aware of the safety procedures they would follow in case of emergencies such as fire or flood. Evacuation procedures were in place for responding to emergencies. Staff at Wantage community hospital gave us an example where a fire alarm was sounded accidently and they had to evacuate the ward of patients and staff.
- Staff we spoke with were unaware of any plans being developed for the upcoming winter pressures.

Requires improvement

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.

We rated effectiveness as requires improvement because:

We were concerned that when patients' appeared to have difficulties in their ability to swallow ; their drinks were routinely thickened to try to reduce the risk of choking without a clear assessment of the risk or assessment by a speech and language therapist.

Not all staff were able to demonstrate an awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). There were no assurances in place that national guidance was being followed and some managers did not have a clear understanding of the process. Therefore patients were at risk of being detained unlawfully.

Care assessments were not always person centred so did not include the full range of individual needs. Goal settings and monitoring of outcomes for individuals was inconsistent and participation in audits was limited. This meant that outcomes of treatment and care could not be adequately monitored.

We found that the community hospitals did not have policies in place for pain management or documentation to assess patient's pain.

There was evidence of multidisciplinary working, with weekly meetings attended by nurses, therapists and social services at all hospitals. However, the effectiveness of these meetings varied according to the levels of attendance and standards of documentation.

Food and fluids were within patients' reach and patients told us they enjoyed the food provided. Patients who required assistance with eating and drinking were well supported. The community hospitals had introduced a coordinator to supervise mealtimes and staff in this role were identified by green tabards. Staff involved patients in their care and obtained verbal consent before carrying out any interventions.

Staff received performance appraisal, although compliance varied in differing community hospitals. Staff were positive about the quality of their appraisals and the support they received in relation to gaining competencies. Staff had access to learning and development nurses, clinical supervision and one to one support.

Evidence based care and treatment

- Staff followed guidelines for the prevention and management of pressure injury in line with national guidelines. Most patients had a Braden score, which is a standardised assessment for risk of pressure injury completed on admission. However, there were inconsistencies in reviewing these records which meant patients risked developing pressure ulcers.
- The trust conducted local audits, such as falls, cleanliness and hand hygiene. Action plans were developed and implemented and these were used to improve patient care. The falls audit from April to June 2015 had resulted in referrals to the falls team within 24 hours after a patient had fallen a second time.
- Venous thromboembolism (VTE) assessments were completed in accordance with National Institute for Health and Care Excellence (NICE) clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital'.
- Patients who were assessed to be nutritionally at risk were referred to a dietician. This was in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- The trust participated in Catheter-associated Urinary Tract Infection (CaUTI) project with the Academic Health Science Network to reduce catheter, associated urinary tract infections.

Pain relief

- Staff were not aware of any formal process or documentation for managing pain. We found that there were no pain records, or care plans in use. Patients' pain was not regularly assessed or managed.
- Patients told us that when they requested analgesia, that their pain needs were discussed and managed appropriately.

Requires improvement

Are services effective?

Nutrition and hydration

- Staff routinely thickened food and fluids when patients developed swallowing difficulties. Staff told us they had been informed to do this by the speech and language therapists. Most nursing staff we spoke with were not trained in swallowing assessments. If food or fluid was not of the correct consistency, there was a high risk of aspiration.
- When patients were identified as needing to see a speech and language therapist they were referred, however, the response time was at least two weeks.
- Food and fluids records were not always fully completed and staff could not be assured that patients were having their food and fluid correctly monitored.
- Patients had access to fluids, including beverages. They said they were given choices for food. However, one patient told us that they had run out of his preferred choice. We were told by staff that they could cater for all diets including vegan, vegetarian, halal and kosher. There were limited choices available for soft diets.
- The trust's patient led assessment of the care environment (PLACE) score for food on most wards was 91%, which was higher than the England average for similar trusts. The lowest score was at Witney community hospital (76%) and the highest score was achieved by Wallingford community hospital (95.5%).
- We observed lunch being served at Didcot, Abingdon and Oxford City community hospitals. Patients were offered a choice of drinks first. People were supported with their meals in a respectful way. Meals were not rushed. Occupational therapists were involved in mealtimes as part of patient's rehabilitation.
- All eight hospitals participated in "protected" mealtimes. The purpose of this was, to allow patients uninterrupted time to eat their meals and to enable staff to focus on providing assistance to those patients unable to eat independently.
- All of the community hospitals had introduced a food coordinator for mealtimes. They ensured patients received the food of their choice, provided assistance if required and recorded details in patient's records. Food coordinators wore a green tabard, so they could be easily identified.
- At all of the community hospitals, patient food allergies were identified on a notice board in the kitchens. This meant that care and domestic staff were able to access the information quickly when helping a patient to order food or serving them their meals. These minimised risks of giving patients foods they were allergic to.
- A colour-coded tray system was used in all hospitals to identify patients who needed help with eating and drinking. Staff were seen to offer support to patients at mealtimes. We observed all patients were able to reach their fluids.
- Patients were assessed for malnutrition and referred to a dietician appropriately.

Patient outcomes

- We looked at the performance dashboard used by the hospitals which reported against a range of trust-wide targets. These included number of falls, patient and staff satisfaction, direct care time, infection control, and length of stay, pressure ulcers, safety thermometer and protected mealtime audit. This was not completed consistently across all hospitals.
- Productive Ward Releasing time to care was introduced in 2014 and evident in all areas. The productive ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.
- We found that there was no evidence of goal setting and little measurement of patient outcomes at four of the hospitals we visited. It was difficult to track the goals and outcomes from the notes, and no evidence was seen that this was audited.
- We saw the functional independence measure tool being used. This measured the level of a patient's disability and indicated how much assistance was required for the individual to carry out activities of daily living. Patients and staff were able to assess improvements in mobility from admission and to plan discharges effectively.
- Abingdon and Witney community hospital Stroke Units participated in the initial Sentinel Stroke National Audit Programme (SSNAP). The SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence-based standards, national and local benchmarks.

Competent staff

- Staff received annual performance appraisals; however, there were differences in appraisal rates between staff groups in different hospitals. For example in Oxford City

community hospital 13 members of staff (31 %) were overdue their appraisal, whereas in Didcot community hospital only two staff required their appraisal. The appraisal rate at Abingdon community hospital Ward 2 was 94%. The trusts performance target was 100%.
- Staff we spoke with found appraisals were effective and relevant to their work environment.
- Senior staff reported that the lack of skilled and experienced nurses at some hospitals meant patients were not able to receive therapy intravenously (IV), for example antibiotic therapy or IV fluids for dehydration.
- Each community hospital employed a clinical development nurse who supported all staff in their training and clinical skills. The clinical development nurse also offered support to staff following any performance related issues.
- We saw evidence that there was some good clinical supervision taking place with senior staff but this was not embedded with the staff nurses and healthcare assistants.
- There was an induction process for agency staff to ensure that they were aware of relevant procedures and processes. Agency staff we spoke with confirmed this.
- Most staff said that they were given time to perform training for competencies and were given blocks of time (a morning or an afternoon) dedicated to e-learning or training as required. This allowed them to maintain concentration without being distracted. Access to training was available at home.
- There was a good ethos, encouragement and access to individual learning and development in all areas. Staff told us there were opportunities to study for further qualifications and develop themselves. One staff member said they had been encouraged and supported to complete their nurse prescriber's course.

Multi-disciplinary working and coordinated care pathways

- Medical care at Witney community hospital and Abingdon community hospital was provided Monday to Friday by two part time consultants, a specialist registrar and two foundation grade doctors.
- Wallingford and Oxford City community hospitals had medical cover provided by a GP with support from a gerontologist from Oxford University Hospital NHS Foundation Trust.
- Medical cover provided at Didcot, Wantage, and Townlands and Bicester community hospitals was one hour a day this was through an agreement with local GPs.
- All evening and weekend medical cover was provided by the Out-of-Hours (OOH) GP service.
- There was an expectation that a GP would review a patient within 24 hours of admission. At other times GPs were dependent on nurses identifying issues and notifying them of any serious concerns.
- There was evidence of multi-disciplinary working across all the hospitals we inspected. This included the involvement of physiotherapists, social workers, occupational therapists and ward staff.
- All of the eight community hospitals had daily handovers and once or twice weekly multidisciplinary meetings. These did not always include all members of the multidisciplinary team.
- We observed a weekly multidisciplinary meeting at Wallingford community hospital and Bicester community hospital. In attendance was a senior nurse from the ward, occupational therapist, physiotherapist and social worker. Each patient was discussed in detail which included discharge plans and support required. There was no medical input and no clinical decision made. The outcomes were documented in patient notes.
- Support was available from a physiotherapist and occupational therapists but this was not a seven day service.

Referral, transfer, discharge and transition

- At Witney community hospital they had introduced integrated nurse therapists who liaised with families, patients and staff to promote a smooth transition to home.
- Seven of the community hospitals did not have a discharge co-ordinator. Staff we spoke with believed this increased the length of stay for patients.
- There was some evidence of active discharge planning in patients' records. However, we found at Bicester, Oxford City, Didcot and Wantage community hospitals that patients were not always aware of the discharge pathway and when they were due to leave the hospital.
- We found that staff were encouraged to complete the continuing healthcare checklists on the majority of patients, who were ready for discharge. We were told in one hospital that of ten patients only one could be

eligible for funding. This checklist is a tool to help practitioners identify people who need a full assessment for NHS continuing healthcare funding. Anyone not eligible could have a delayed discharge for up to two weeks.

- There were delayed discharges from all eight hospitals due to delays in referrals being actioned and care packages in the community being set up. This was supported by the trust's data which showed that community inpatient services continuously exceeded the target dates for discharges. The target was 16 days: from March to August 2015 the average length of stay was 34 days.
- Physiotherapy and occupational therapy input at the community hospitals was limited due to staff vacancies. Community therapists covered some of the shortfalls. The staff we spoke with told us this reduced patient rehabilitation particularly for those with mobility issues, thereby impacting on their length of stay in hospital.

Access to information

- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received. A copy was given to the patient on discharge. Ward staff told us these were always sent and faxed within 48 hours following patient discharges. This ensured that GPs were aware about their patient's discharge and could offer adequate community support if required.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent was obtained and documented in patients' records including consent to share information about them with other organisations involved in their care. During the inspection we saw staff asking for patients consent before commencing interactions.
- Staff were able to describe how they would support patients to make decisions for themselves wherever possible.
- The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The trust made 27 Deprivation of Liberty Safeguards (DoLS) applications between 1st May 2014 to 30th April 2015 across the inpatient community hospitals.
- There were no assurances in place to ensure once an application for DoLS had been submitted that processes were followed in line with national guidance. We were given an example of a patient who had been discharged home and they had received notification that the application had been refused a few months later. This example demonstrates that the trust did not have a robust system in place when authorisation for DoLS is not responded to by the local authority and urgent authorisation may be expiring.
- Resource packs about DoLS and MCA, to inform staff practices were available. However, some ward managers did not have a clear understanding of DoLS, how to maintain accurate records and the requirement to review patients once DoLS had been granted.

Good

Are services caring?

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

We rated caring as good because:

We spoke to 28 patients and five visitors who all told us that the care they received from staff was excellent and that patients felt safe and cared for during their stay.

We found caring staff across all the community hospitals, staff treated patients with kindness, respect and demonstrated that they had a good understanding of their differing needs. Where patients were not fully able to participate in their own care, their family were involved as appropriate.

The multi-disciplinary team shared information with patients and their relatives and involved them in the

decision making.

We saw positive interactions between staff, patients and their families. Patients 'privacy and dignity were respected.

Detailed findings

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed multiple examples where staff demonstrated compassionate and kind care when providing support to patients.
- One patient stated "staff always come quickly when I press my buzzer, there has never been an occasion when they've never came quickly".
- We observed a nurse knocking before entering a room, introducing themselves, explaining their role, and the medication they were offering the patient. They assisted the patient to take the medication appropriately; they were kind and respectful and gave the patient time to speak. Consent was gained before intervention.
- All patients and relatives spoke positively about the care and support they had received.
- Due to the staff to patient ratio at most of the community hospitals, nurses and healthcare assistants had time to spend with their patients on a one to one basis. Good interactions were observed.
- We saw good interactions between the nurses and patients during our inspection at Oxford City community hospital and we saw staff engaging with a group of patients playing bingo.
- We observed four patients in Bicester community hospital using the short observational framework for inspection (SOFI) a tool used to capture the experiences of people. We saw good communication and positive interactions between patients, staff and volunteers. Staff engaged with patients and visitors in a friendly and considerate way.
- A Patient Led Assessment of the Care Environment (PLACE) audit of privacy, dignity and wellbeing showed that Didcot, Abingdon, Wallingford and Wantage community hospitals were performing below the England average of 86%. The lowest score was Didcot community hospital (79%) and the highest score was Bicester community hospital (93%).

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed and doctors and nurses discussed their care with them and their family as appropriate.
- One patient expressed to us how pleased they were that their daughter sometimes changed her bandages on her legs. This was done under the supervision of the nurses.
- A relative spoke of their involvement with their relative's discharge plans and how the staff had treated them both with respect.
- One relative we spoke with was complimentary of the service provided by the staff at the hospital. She said that "since my husband has been here he has received excellent care and attention". She went on to say "the multidisciplinary approach has helped him to recover to good health."
- At Abingdon community hospital we observed an exercise class with therapists with good staff and patient interactions. The staff knew the patients' ability and their limitations.
- We observed doctors, nurses and therapists sharing information with patients and taking time to ensure it

was understood. Therapists for example explained the process for carrying out a home environment assessment prior to discharge in order for any equipment to be put in place.

- In the corridors at Wantage community hospital we saw information available to carers and relatives. There was advice on being 'dementia friendly', nutrition and hydration, learning disabilities, communication and infection prevention.

Emotional support

- Positive interactions were seen between staff and patients at all the hospitals. Staff took time when supporting the patients to listen to what and how they communicated.
- One patient told us "I am kept informed and consulted all the time".
- Within community hospitals spiritual & pastoral care services were overseen by trust chaplains and referrals were received via ward staff. Each community hospital had slightly different visiting arrangements depending on what resources were available locally. For example, at Witney community hospital they were visited by a chaplain, at Wallingford community hospital members of the local clergy and at Abingdon and Townlands community hospitals a trust chaplaincy volunteer.

Good

Are services responsive to people's needs?

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

We rated responsive as good:

We found that patients experienced long lengths of stay in the community hospitals and were not being discharged in a timely way. There was a disparity in therapy services across all of the community hospitals.

The daily community teleconference provided operational staff with an overview of patient flow to and from community hospitals.

Reasonable adjustments had been made to ensure the premises at all the hospitals were accessible to all. This included access and toilets for the mobility impaired person. Adjustments had been to the environment to make it more suitable for patients with dementia. "Knowing Me" document was being used to improve care for patients who were not able to communicate their specific needs and preferences.

Complaints were managed well and there was a robust methodology for investigating these. Most complaints were investigated and resolved at a local level.

Detailed findings

Planning and delivering services which meet people's needs

- The average length of stay in the community hospitals was 34 days between March 2015 and August 2015. The hospital with the shortest average stay was at the Abingdon community hospital ward two with 21 days and the longest average stay was Wantage community hospital with 41 days. The trusts target was 16 days.
- There were systems and processes in place to monitor and act on delays to discharge. These included multi-disciplinary meetings and the capturing of information to show agreed expected date of discharge using patient status at a glance boards, patient journey database and when a multi-disciplinary team agreed 'fit' date had been set. There was an agreed approach when carer's choice was contributing to the delay. A weekly 'Delays to Transfers of Care' review meeting took place to validate declared delays, discusses each patient, and allocates a primary delay reason.
- We found the effectiveness of multi-disciplinary meetings varied between the community hospitals, dates for discharges were not always being set and ownership of discharge planning was not always obvious. Staff we spoke with told us that a there were delays in referrals being actioned and care packages in the community being set up, by social services.
- The inpatient community service was a bed-based model. There were plans for this to be reviewed to establish the best model for the different areas within the county. The trust was developing a more integrated locality model.
- The criteria for admission to the community hospitals had been updated in May 2015. We found that staff were aware of its existence but not familiar with its content. The criteria for admission to the community hospitals were that patients required one of the following, sub-acute medical care, bed based rehabilitation, end of life care or specialist rehabilitation following a stroke. The community hospital beds provided care to patients which could not be safely delivered in the patient's own home.
- The trust was a validated stroke provider and provided beds for patients who had suffered a stroke at Witney and Abingdon community hospitals. They primarily received patients, from the local acute trust.
- Staff at Witney community hospital said they had a minibus to take patients home or for home visits. This was driven by trust staff, and was an in-house initiative to help their patients get home quicker.
- There was a variety of information available to patients. At Abingdon community hospital they had produced a welcome pack which contained information such as contact details, visiting advice, the rehabilitation process and arrangements for home assessments.

Equality and diversity

- Staff told us the trust could cater for patients who required an alternative diet due to their religious or cultural needs, for example, Halal meals were available. No patients at the time of our inspection were receiving an alternative diet because of their cultural or religious beliefs.

Good

Are services responsive to people's needs?

- Care practices observed showed staff were aware of people's diverse needs and supported them with respect.
- At all the hospitals we visited, reasonable adjustments had been made to ensure the premises were accessible to all. This included access and toilets for the mobility impaired person.
- Information leaflets were available written in English. There was information on the back of the leaflets in different languages explaining how the leaflet would be obtained in that language.
- Interpretation services were available and staff knew how to access the service when needed.

Meeting the needs of people in vulnerable circumstances

- We received several examples of negative feedback. One relative we spoke with said that they waited all day for a physiotherapist. They also felt the nursing staff failed to keep them informed about the delay.
- The trust was participating in the 'Dignity Plus' Programme led by Oxfordshire County Council. We saw examples of this, which included pictures of nature (animals, plants, scenery) that served as points for conversation and reminiscence.
- All of the hospitals we visited had one bedroom which had "heal well lighting" which mimics natural day/night cycles, creating a restful sensory experience. This was used for patients with dementia.
- In Wantage community hospital they had a quiet room for relatives. Different hospitals had their own arrangements for providing relative rooms.
- The "Knowing Me" document aims to improve care for people who may not be able to communicate their specific needs and preferences. We saw evidence of "Knowing Me" being completed this contained information about the patients' likes and dislikes; previous life history and hobbies. Staff said they found this useful and used these in their practice.

Access to the right care at the right time

- Patients had access to doctors at each community hospital but the cover arrangements varied.
- There was a disparity in therapy services across all of the community hospitals. At Bicester community hospital the occupational therapist was employed one hour a day and physiotherapy was not available every day. Didcot community hospital provided therapy six days a week. Staff at Bicester community hospital told us that this increased risks for patients who were unable to mobilise and in some cases resulted in longer stays in hospital.
- The daily community teleconference was set up to provide operational staff with an overview of patient flow to and from community hospitals. This meant staff were able to discuss: patient flow, potential and agreed admissions, agreed and predicted discharges, staffing and capacity issues and bed availability. It was facilitated by the Single Point of Access service and attended by the coordinators of community hospital wards, emergency multidisciplinary units and matrons.
- To avoid admittance to an acute setting, patients could be admitted to Witney or Abingdon community hospitals via the emergency multi-disciplinary unit and were provided with intensive nursing, medical and therapeutic interventions.
- The community hospitals were not all commissioned to provide the same level of care and there are differences in the levels of training of nursing staff; for example, stroke rehabilitation is provided in Abingdon and Witney community hospital. In order to meet the needs of this group of patients the nurses at these locations are trained to undertake some additional roles that nurses in other locations do not undertake, such as the administration of intravenous antibiotics. Patients who required intravenous medication were unable to be admitted to Bicester, Didcot, Oxford City, Townlands, Wallingford or Wantage community hospitals.This meant that when patients were discharged from an acute hospital their choice of community inpatient care wards could be limited.

Learning from complaints and concerns

- Staff followed the trust's complaint policy and reported any complaints from patients to the senior nurse or matron.
- Senior staff told us that were very few formal complaints because they were mostly dealt with at a local level. Data from the trust indicated there had been seven formal complaints over the last 12 months.
- Complaints were handled in line with trust policy; staff showed us that patients were given information on how to complain. Staff directed patients to Patient Advisory Liaison Service (PALS) if they were unable to deal with their concerns directly and advised them to make a formal complaint.

Good

Are services responsive to people's needs?

- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.
- A representative from PALS visited all the wards unannounced on a monthly basis. They reported back to staff any complaints or concerns.

Requires improvement

Are services well-led?

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

We rated well-led as requires improvement because:

Processes for monitoring the quality of the inpatients service and those to ensure risks are identified and managed were not sufficiently robust with risks not always managed effectively. There was monitoring of performance and quality using a trust wide dashboard but limited evidence of oversight and challenge when the information as not completed or below the expected.

The trust wide vision and messages were not widely known or understood by staff. The vision and strategy for community inpatient beds was not fully developed.

We saw good local leadership in all of the community hospitals and this was reflected in the positive culture shown by staff, who said that the visibility of managers was good. The trust board were well known to community hospital staff from face to face visits. There was evidence of the service engaging with local communities and using feedback from patients. At the hospitals the league of friends had worked to build and develop dementia friendly outdoor areas.

Detailed findings

Service vision and strategy

- In general, staff were not aware of a vision for community inpatients which linked to the trust wide strategy. Discussions around the review of service provision and the strategy were taking place with senior staff and the clinical commissioning group. How to involve in staff in the process was under consideration.
- The clinical directors told us that their organisational risks and strategic targets for the service were the workforce, leadership and giving patients a choice for their preferred place of care.
- Most staff at a local level were not able to tell us about the trust strategic vision. However, they were passionate about providing care and serving the local community.
- Staff were able to share with us the trusts' values of caring, safe and excellent.
- The service leads told us the future strategy was to decrease the reliance on inpatient community beds with more emphasis on community care delivered in people's own homes. This was the case at Townlands community hospital where they had plans to close the ward and staff the new community care hub.

Governance, risk management and quality measurement

- There had been a revised governance structure included in a recent review of the older people's directorate. This introduced a quality and governance assurance framework in April 2015, which proposed a structure based on two sub committees. These committees had met once and although the inpatients service was a member of the committee, a review of the minutes showed they were not represented.
- A monthly directorate governance group was attended by locality managers. Local governance meetings were held once a week, where quality issues such as complaints, incidents and audits were discussed.
- There was not a sufficiently robust audit programme, resulting in the identification and management of risk across the hospitals. Audits were undertaken but did not always identify areas of risk and instigate action to improve the quality and safety of services. For example, the Business; Performance & Quality report for August 2015 stated that weekly checks on completion of care plans were not consistent.
- The service leads told us they met every week to discuss any complaints, capacity issues or any safety issues. Ward managers and deputy ward managers held meetings regularly.
- We saw and reviewed risk registers held by the directorate and by each individual community hospital. The community inpatient services risk register updated in September 2015 highlighted 12 areas of concern. Three of these were staffing issues and the trust had put actions in place to try and resolve them.
- The process for checking of equipment was not robust and could impact on the safety of patients. This had not been recognised as a risk and so no action had been taken to address it.
- The trust had developed a clinical dashboard with a red amber green (RAG) traffic light system, rating against

quality and performance information. This could be interrogated to ward level but the information and data on quality metrics was not complete and there was no evidence of oversight and challenge, this was not effective.
- Safety Thermometer information was used in all eight hospitals to monitor the quality of care.
- Most of the hospitals had regular team meetings at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.

Leadership of this service

- Occupational and physiotherapy therapy staff at one community hospital told us they felt unsupported and lacked leadership, however the team worked hard to provide the best service and worked well together.
- Although the clinical lead nurse for the community hospitals had only been in post for eight weeks we saw visible signs of good leadership at the community hospitals we visited. Staff generally spoke highly of this leadership influence.
- Senior nurses told us they met with the service director regularly.
- Staff across the community inpatient services that we spoke with said that board members did walk rounds and visited the community hospitals.
- Staff at most hospitals described their line managers as being approachable and having 'an open door policy.
- Middle management staff said they did not feel listened to by the trust board and there was lack of action. Service leads acknowledged that this was an area that required improvement.

Culture within this service

- Staff told us there were a good team spirit and a positive atmosphere. There was good team work and support from the matrons and the clinical lead, so the morale was high with professional respect evident between team members.
- Staff at all the hospitals we visited were caring and passionate about the service and the care they provided to people.
- Staff worked well together, and there was obvious respect across various disciplines. Staff said they felt valued team members.

Public engagement

- The trust was in consultation with Age UK to consider the role of voluntary organisations and determine whether they were equal partners with community health and social care in supporting the individual to meet their needs.
- The trust was part of a pilot project delivered by Age UK Oxfordshire, called Circles of Support which worked with Oxfordshire Clinical Circles of Support Commissioning Group, Oxfordshire County Council and Oxford University Hospitals Trust. It was one of seven pilot projects across England awarded funding last year by the cabinet office and the national tripartite group. It had been awarded a grant from Oxfordshire clinical commissioning group. Circles of Support project worked alongside local health and social care teams in Oxfordshire, it helped keep people with on-going health needs out of hospital, smoothed their passage through hospital and ensured safe discharge.
- The trust had systems in place to gather information from patients, and had records about people's experience from patient surveys. These were displayed on the wards as "what you said" and "what we did, showing how staff had made changes in response to feedback.
- We saw some examples of public engagement across the community hospitals. For example at most of the hospitals we saw the league of friends had worked to build and develop dementia friendly outdoor areas.
- One of the trusts' four priorities for the year 2015 to 2016 in their quality account was to improve and capture patient and carer feedback.
- Friends and family was not embedded and some staff were unaware of its value this reflected in their response rate where some hospitals had limited responses.

Staff engagement

- The trust had a staff health and wellbeing group with membership from across the organisation. The purpose of the group was to actively promote and create opportunities for wellness by considering the social, physical, emotional and psychological needs of staff. The chief executive stated in the trust staff health and wellbeing guide that in the past year the group has had a very positive impact on staff health both physically and mentally.

Requires improvement

Are services well-led?

- The results of the 2014 NHS staff survey were published on 25 February 2015. Only 32% staff contributed to the staff survey compared with a response rate of 50% in 2013.
- The trust score for staff ability to contribute towards improvement at work; was 73% which was above the national average of 72%. Staff recommendation of the trust as a place to work or receive treatment was within the national average of 3.6. The staff motivation at work score was similar to the national average of 3.8
- Staff at Bicester community hospital said they were happy with the introduction of the new electronic staff rostering system as they were able to make plans with their family and it was easy to create fair rosters.

Innovation, improvement and sustainability

- The trust informed us they were involved in a Catheter-associated Urinary Tract Infection (CaUTI) project with the Academic Health Science Network to reduce catheter associated urinary tract infections.
- As recruitment of experienced, senior nurses was difficult, the service was considering offering junior nurses developmental opportunities.
- At Didcot community hospital they were currently piloting "SSKIN" pressure ulcer care and this was to be rolled out across all community hospitals.
- At Witney community hospital they had an integrated nurse who had been liaising with patients, families and the multi-disciplinary team to facilitate discharges.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (Regulated Activities) Regulations 2014 Person-centred care** **How the regulation was not being met: People's pain was not assessed and monitored. Regulation 9 (1) (b), (3) (a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment** **How the regulation was not being met: Service users were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5).**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 HSCA (Regulated Activities) Regulations 2014 Meeting Nutritional and hydration needs**

This section is primarily information for the provider

Requirement notices

How the regulation was not being met: The nutritional and hydration needs of service users not being met because Assessment and Management of swallowing was not in the service user's best interests Regulation 14 (2) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 14 HSCA (Regulated Activities) Regulations 2014 Good governance

How the regulation was not being met: Accurate, complete and contemporaneous records were not maintained Regulation 17(2) (c)

Governance processes across inpatient services were not robust, and risks were not managed effectively and that there were not robust arrangements for improving the quality of care Regulation 17(2) (a) (b)