The Mid Yorkshire Hospitals NHS Trust

Community health inpatient services

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Community health inpatient services

Inspected but not rated

We carried out this short unannounced, focused inspection at the same time as CQC inspected a range of urgent and emergency care services in West Yorkshire. To understand the experience of patients accessing the intermediate care unit in Wakefield we asked a range of questions in relation to urgent and emergency care. The responses we received have been used to inform and support system wide feedback. As part of this focused inspection we looked at the Wakefield team who are located at Pontefract hospital and considered how they were supporting the wider urgent and emergency care pathway.

This inspection was not rated

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Inspected but not rated

Mandatory training

Staff, including medical staff, healthcare support workers and therapy staff received and kept up to date with their mandatory training. At April 2022, the compliance rate for staff in this service was 98.8%, which was above the trust target of 90%.

Our findings

The mandatory training was comprehensive and met the needs of patients and staff. However, we did not see compliance rates for staff training in responding to patients with mental health needs. This mandatory training was something the trust told us they had introduced as part of their new mental health strategy but not all staff had completed it yet.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. As well as access to specific training, staff had access to a specialist care team that supported them with advice and guidance for patients with complex mental health needs. During the pandemic, patients had access to emotional support to help deal with any trauma they might have experienced as a result of COVID-19.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw that team leaders received email notifications when staff needed refresher training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. All staff, including healthcare assistants and therapy staff received training in safeguarding adults and children. At April 2022, the compliance rate for staff training in adult and child safeguarding was 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff received mandatory training in equality, diversity and human rights. Staff gave us examples of how they protected patients that might be at risk of discrimination from other patients because of their ethnicity.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The staff we spoke with were knowledgeable about how to identify abuse including emotional and domestic abuse. They had access to specialist guidance from a trust-wide safeguarding team where they needed it.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had not made any safeguarding referrals in the previous 12 months, but we did not find any evidence that they should have done.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Patients could reach call bells and staff responded quickly when called. The patients we spoke with confirmed that staff responded quickly when they needed assistance.

The design of the environment was not suitable for patients with rehabilitation needs. For example, there was no dedicated therapy space so most therapy took place in patients' rooms. There was no space for groupwork, and the trust had stopped the staff using some round tables on the ward because of their concerns about infection control and COVID-19.

Our findings

Staff carried out daily safety checks of specialist equipment. We also check maintenance logs for equipment and saw they were complete.

Staff told us there was nowhere for families to speak with staff in private, but following the inspection, the trust confirmed that patients' families did have access to suitable facilities off the ward if relatives needed to speak with staff without the patient present. The trust told us that staff could facilitate a temporary bed to enable carers and/or family to be with their relative overnight if needed.

The service had enough suitable equipment to help them to safely care for patients. For example, there were enough hoists and other mechanical aids to help move patients safely. This included enough equipment for patients with bariatric needs. Following assessment, patients had access to pressure mats and pressure relieving mattresses. All patients had access to anti-slip footwear.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a nationally recognised early warning score to identify deteriorating patients and they received training in how to use the tool. Patients in need of emergency treatment were sent to the trust's emergency department but there was no separate pathway in place to facilitate this. Staff had to call the emergency services and wait for an ambulance.

Staff knew about and dealt with any specific risk issues. Staff assessed all patients regularly for falls risks and risk of developing pressure ulcers. They used a screening tool to identify patients at risk of sepsis. This was because these were identified as particular risks with this patient group, but staff carried out other risk assessments such as nutrition and hydration.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The trust had an agreement in place with the local mental health trust, such that staff could refer patients for specialist mental health support and/or assessment if they were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff could refer to the local mental health trust in these situations and, during office hours, they also had support from a trust-wide specialist team that could provide advice and direct support for staff working with patients with complex mental health needs.

Staff shared key information to keep patients safe when handing over their care to others. They held safety huddles every morning to share information about patient risk.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Our findings

The service had enough nursing and support staff to keep patients safe. Two nurses were on each day shift supported by one assistant practitioner and four health support workers. On the night shift, there were two nurses supported by two health support workers. An additional nurse manager worked the day shift and they could be counted into the numbers if required. Other health professionals, such as physiotherapists and occupational therapists, were also on shift during the day, including at weekends.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers used the trust's safe care tool to calculate the numbers of staff needed on each shift.

The ward manager could adjust staffing levels daily according to the needs of patients. For example, they requested extra staffing to care for a patient with bariatric needs.

The number of nurses and healthcare assistants matched the planned numbers. We checked data on the trust's website to confirm that from October 2021 to March 2022, the average fill rate for nursing staff on both the day and night shifts never fell below 90% and there were only two occasions when the fill rate for other care staff fell below 90%.

The service had low and/or reducing vacancy rates. At inspection, staff told us they did not have any vacancies, and this was confirmed by the trust.

The service had low turnover rates. Following inspection, the trust sent us data to confirm this.

The service had low and/or reducing sickness rates. They monitored this monthly and, where possible, they had cover arrangements in place for some posts, for example, therapy posts.

The service had low and/or reducing rates of bank and agency nurses used on the wards. The service did not use agency or bank staff. Managers had access to staff from other community health nursing services from across the trust.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe, but there was no agreed medical cover arranged during the day for when the doctor was on leave. Out of hours, the trust had a contract with a local medical service who could attend the unit to assess a patient if needed. It was not often that patients required additional medical care because they were medically optimised when admitted. For example, in March 2022, staff called for out of hours medical support on four occasions and managers told us this was about the norm.

Managers could not access locums when they needed additional medical staff. When the regular doctor was on leave, staff did not know who was covering so they had to escalate requests for medical support to the trust. This meant additional pressures on staff who were already busy caring for patients. The trust told us there was some scheduled medical cover in the form of an identified consultant from the trust's stroke service, but staff were not aware of this arrangement.

The service did not have a consultant on call during evenings and weekends. The service was a nurse and therapy staff led service with access to on-call GP services.

Our findings

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. All patient care except observations and handovers were recorded on the electronic patient record that nurses and therapy staff had access to. The doctor recorded medical care on another electronic system but unit staff including health support workers had access to these notes.

When patients transferred to a new team, there were no delays in staff accessing their records. Ward staff in the acute hospital could access observation and medical notes made by the intermediate care unit staff because they used the same system. Referrals into the intermediate care unit were made via a central care hub using a trust-wide electronic records system. This meant there was a good flow of information when patients had to be transferred to and from the intermediate care unit.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The service had very few medicine errors and, within the last 12 months, there were no errors that caused harm to patients.

Staff completed medicines records accurately and kept them up to date. We checked a sample of patient medicines records to confirm this.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Patients were not admitted to the unit from the acute trust unless they had the correct medicines on their drugs chart. Staff told us about one incident where this had not happened but an on-call doctor in the trust had been able to rectify this.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

All staff knew what incidents to report and how to report them. When we spoke with staff, we confirmed that staff reported any patient care incidents including where patients were admitted without the correct medicines or where there was no doctor cover so patients could not be admitted or discharged.

Staff reported serious incidents clearly and in line with trust policy. In the last 12 months, the service had no serious incidents and no never events in this service.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust circulated a regular bulletin for staff that contained information about lessons learned from adverse events.

Is the service effective?

Inspected but not rated

Our findings

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, but therapy staff were not able to deliver groupwork due to the limitations of the environment. Most therapy had to take place in patient's bedrooms because the therapy room was used to store equipment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. At inspection, we observed a handover and multidisciplinary meeting. We saw how staff provided holistic care to meet the emotional needs of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients were weighed regularly so staff know whether patients were not eating properly. Where needed, staff monitored patients' intake of fluid and nutrition and escalated any concerns to nursing and medical staff.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw examples in multidisciplinary meeting notes where patients had been assessed by a trust-wide speech and language therapist. Therapists at ward level could assess patients for swallowing difficulties where required. Dietitians provided specialist advice to patients and staff and diet plans were recorded in patient records.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients received pain relief soon after requesting it. We confirmed this when we spoke with patients who were on the unit at the time of our inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Some audits had been paused during the pandemic, but we looked at a recent audit where staff had made improvements in pressure care. The audit showed a significant reduction in pressure ulcers in March 2022 compared with previous months.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Our findings

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. In addition to nursing and medical staff, the team consisted of clinical leads, occupational therapists, physiotherapists, a social worker, a technical instructor and health support workers. Together, they provided care that met the mental and physical needs of the patients referred to them.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with a member of staff that had returned from an extended period of absence to confirm this. The staff member was supernumerary for three weeks and had a structured induction timetable in place. This process was followed by the unit manager for all new starters.

Managers supported staff to develop through yearly, constructive appraisals of their work. At April 2022, the compliance rate was 93%.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. We received data from the trust to confirm that the compliance rate for the period May 2021 to April 2022 was over 90%.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that the unit manager identified learning needs for staff and organised appropriate training via a trust-wide clinical education team.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Following our inspection, we looked at a sample of team meeting minutes to check this.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We confirmed this when we spoke with staff at inspection.

Managers supported volunteers to support patients in the service. The trust was re-launching their volunteer workforce strategy following the pandemic. This meant staff on the intermediate care unit could support volunteers in a befriending role which was something they did prior to the pandemic.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. At inspection, we observed a multidisciplinary meeting with nursing and therapy staff. We saw how they worked together to help patients achieve their therapy goals and work towards discharge in a timely way.

Staff referred patients for mental health assessments, as necessary, when they showed signs of mental ill health. We saw how staff worked effectively with the local community mental health team with a patient experiencing depression.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Our findings

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients had a comprehensive mental and physical health assessment on admission to the unit. Nursing, therapy and social work staff worked together to provide patients information and advice about healthy living. The service had relevant information promoting healthy lifestyles and support on the unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with showed a good understanding of the principles of the Mental Capacity Act and how to apply them in practice. We saw some strong examples where staff had supported patients to make and communicate their own decisions about how they wished to be supported.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available, and they clearly recorded consent in the patients' records We saw this when we looked at a sample of patient care records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw how staff worked with a patient's family to establish their wishes when they lacked capacity to make a specific decision.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At April 2022, the compliance rate for this training was 100%.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spent time on the unit observing the way staff interacted with patients and their families. We also spoke with patients separately to confirm this.

Patients told us staff treated them well and with kindness.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We confirmed this when we looked at patient care records and notes from multidisciplinary meetings.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Our findings

Staff gave patients and those close to them help, emotional support and advice when they needed it. We confirmed this when we spoke with patients and carers.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with patients and carers who confirmed that staff explained their care to them in ways they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback about the service in a variety of different ways, and staff discussed patient and family feedback at their team meetings. Overall, patient feedback was very positive with little negative feedback.

Patients gave positive feedback about the service. We spoke with five patients who were on the unit at the time of our inspection. They all gave very positive feedback about the staff and the ward environment. We also spoke with one carer who gave positive feedback about their experiences.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The trust planned and organised services so they met the changing needs of the local population, but staff told us the service could only take referrals from the acute trust, which meant there were no step-up facilities for patients in the community. A step-up facility is a pathway for people who have a care need that cannot be managed in their own home but may not require admission to an acute hospital.

Since our last inspection of this service, in 2017, the unit had moved and was situated within Pontefract hospital, but the number of beds had reduced from 26 to 22. We were unclear whether this was based on the needs of patients or the capacity of the unit they had moved into.

Facilities and premises were not appropriate for the services being delivered because there was no communal space for patients to socialise with each other and no dedicated space for therapy activities to take place. Patients had most of the therapy in their bedrooms and, due to lack of space, one piece of therapy equipment was situated at one end of a corridor. There was small therapy room, but this was used for storage of equipment. The provider had plans for patients to access the gym facilities at the site and to reconfigure the layout of the ward to create a communal space for patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Our findings

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff gave us an example of how they had cared for a patient with a learning disability, working in partnership with their carers to provide an individual package of support.

Despite the deficiencies in the environment, staff provided care that was person centred and focused on the needs of each individual patient. Patients had access to therapy every day including at weekends.

Wards were not designed to meet the needs of patients living with dementia. Although the unit did not take referrals of patients with severe dementia, they did have patients with mild symptoms of dementia or cognitive impairment. The environment was not dementia friendly, but ward areas were well-lit and clutter free. Staff were knowledgeable and skilled in providing assistance to such patients and they could request support from a local community organisation that would provide volunteer befrienders.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust had a complex care team that could support patients with communication aids where needed. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and, on the whole made sure patients could access services when needed and received treatment within agreed timeframes.

The service sometimes had a waiting list, but there was a dedicated admissions and discharge coordinator to monitor patient flow. When we inspected the service, there were no patients waiting to be admitted but, when the trust faced pressures on other wards, they required staff in the unit to admit patients outside their standard referral criteria if they had available beds. This meant patients that did fit the referral criteria sometimes had to wait longer. We asked the trust to provide average admission wait times for patients, but they were unable to provide this data.

Sometimes, a patient could not be admitted because there was no planned cover for the ward doctor when they went on leave. However, the trust told us that in the last 12 months, there had been no incidents where a patient could not be admitted to the ward because there was no doctor.

On the whole patients were admitted during the day when the doctor was available but one patient, we spoke with was admitted at 2 a.m. When this happened, staff reported this as an incident. Following the inspection, we asked the trust for data on how often this happened, but they could not supply this information within the timescales we requested.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay for the period, April 2021 to March 2022 was 19.3 days. This was in line with guidance from the National Institute for Health and Care Excellence, (NICE), who say intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks.

Managers and staff started planning each patient's discharge as early as possible. We looked at patients records and minutes from multidisciplinary team meetings to confirm that patients had concrete discharge plans in place.

Our findings

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff had good partnerships with social work and community teams to ensure patients had the right support in place when they were discharged from the unit. Prior to discharge, therapy staff carried out visits to patient's homes to assess any needs for specialist equipment.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Despite the lack of planned medical cover, staff worked hard to ensure patients discharge was not delayed. They had social work input into regular multidisciplinary meetings and access to temporary reablement provision where needed.

Staff supported patients when they were referred or transferred between services. A patient told us how staff had supported them to attend a hospital appointment by organising transport. There were other examples including where staff supported a patient with sensory needs following discharge from the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. When we spoke with patients and relatives, they confirmed they would be comfortable raising concerns with staff. None of the patients or relatives we spoke with at inspection had any concerns or complaints.

The service clearly displayed information about how to raise a concern in patient areas. The ward areas had trust complaints leaflets which gave clear information about how patients could provide feedback including how to make a formal complaint. Staff understood the policy on complaints and knew how to handle them.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff had requested the trust to have equipment fitted into each patient's bedroom so they could watch live television. Although patients had access to tablet computers, staff responded to feedback from patients that they would like access to live television.

Staff could give examples of how they used patient feedback to improve daily practice. We saw how the manager had put together a proposal to install televisions in each patients' bedrooms following feedback from patients that they were sometimes bored.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Our findings

A clinical nurse team leader and a matron managed the wards on a day to day basis. They were both experienced and knowledgeable about the issues faced by staff and patients. The staff we spoke with told us managers were visible and approachable. They supported staff with further training and development to enhance their skills, for example, there were assistant practitioners on the ward that could help out with some of the nursing tasks.

Vision and Strategy

The service had a vision for what it wanted to achieve but there was no strategy to turn it into action.

At ward level, managers wanted to create a step-up facility so that patients could be admitted from the community. At the time of the inspection, the trust were not commissioned to provide this service but told us that this would be re-considered in future system planning work.

The trust had an operating plan for the service, but this did not specify how patients' needs for rehabilitative group therapy would take place on the ward, nor did it specify how the doctor's work would be covered when they were on planned annual leave. However, the trust ensured there was a mental health strategy in place which meant that staff at ward level had access to support and training to work effectively with patients with mental health needs.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported and valued by their immediate line managers and they were focussed on the needs of patients. They were doing their best with the resources they had and despite the deficiencies in the ward environment, they were delivering as much rehabilitative therapy as they could. There was an open culture where staff and patients could raise concerns and they would be listened to. However, some staff felt that higher managers were not responsive to their concerns about the ward environment and the lack of planned cover for when the ward doctor was absent.

Governance

Leaders did not always operate effective governance processes, throughout the service. However, Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Overall, the service had the right number of staff with the right skills to meet the needs of patients and to help them progress through to discharge. The trust had the right pathways and joint working arrangements in place to ensure patients had effective support once discharged, but, sometimes patients had to wait for a bed on admission. This was because the trust admitted patients outside of the unit's referral criteria in order to relieve pressure on other wards. At times when the ward doctor was not available, there were no planned cover arrangements in place meaning that staff had to take time away from patients by trying to find another doctor to cover the work.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not identify actions to reduce their impact. They did not always have plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

Although staff at ward level escalated their concerns, the trust did not have a contingency plan for how they would cover the doctor's work if they were on leave or unexpectedly absent. Insufficient medical cover was noted as risk on the trust's risk register but the trust had no control measures in place. This meant higher managers did not have any concrete plans to mitigate the potential risk to patients when their regular doctor was on leave or otherwise absent.

Our findings

Areas for improvement

- The trust should ensure they continue with their plans to improve the ward environment to meet the rehabilitation needs of patients and provide a suitable communal space for them.
- The trust should ensure arrangements are in place to provide patients with adequate medical cover when the ward doctor is on leave or otherwise absent
- The trust should ensure that staff are aware the ward has suitable facilities for carers and families who may need to speak in private with staff.
- The trust should evidence that staff have received training in supporting patients with mental health needs including learning disabilities and autism.
- The trust should consider ensuring the ward environment is suitable for patients with dementia.

Our inspection team

Our inspection team consisted of two CQC inspectors, and two specialist advisors. One specialist advisor was a nurse and the other was an occupational therapist.

On site, we spoke with:

- five patients and one carer
- twelve staff including nurses, doctors, therapists and health support workers
- spoke with the unit manager and the matron
- Attended a multidisciplinary meeting and a handover
- Looked at four care records
- Looked at the quality of the environment and saw how staff were caring for patients.