St Oswald's Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Overall rating for this service

Community inpatient services	

Summary of findings

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Summary of findings

Overall summary

Okeover Ward is a 24 bedded facility within St Oswald's Hospital. This inpatient service provides general rehabilitation, end of life care and post-operative rehabilitation for adults following discharge from acute hospitals or from home.

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Safeguarding procedures were in place and staff received an appropriate level of training. Learning took place as a result of serious incidents, and staff described changed that had come about following a serious incident relating to maladministration of insulin. However, we saw that patient records were not all accurate in recording that people had received their medication as prescribed.

Patients and their relatives were positive about the care and treatment they had received. Patients told us, "I'm very happy with staff, they don't rush us" and, "Care is excellent." Patients and their families were involved in making decisions about their care and the support needed. Patients were assessed on admission and risks identified and managed appropriately. Staff completed two hourly safety rounds and used a range of equipment to reduce the risk of harm to patients. Staff were passionate about providing good quality care to patients.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multi-disciplinary team (MDT) to support the planning and delivery of patient centred care. The care on Okeover Ward was responsive to patients' needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multi-disciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. The Trust Board members were visible and the Chief Executive communicated weekly via email with all staff. The majority of staff we spoke with felt well supported at a local level within the ward and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

We saw that the majority of the care provided during our inspection was safe. Staff were confident about reporting serious incidents and providing information to the senior staff on duty if they suspected poor practice which could harm a person. Patients were assessed for risks on admission and appropriate measures were put in place when potential risks were identified. However, we saw that patient records were not all accurate in recording that people had received their medication as prescribed.

Are services effective?

Care was effectively delivered through the use of evidence based guidance and nationally recognised recording tools. Care plans and risk assessments were reviewed and updated as required. Two hourly safety rounds were carried out to ensure that patients were kept safe. Effective rehabilitation was provided to facilitate discharge back into the community. Sufficient staff were provided to care for patients, although the ward had a number of vacancies, which were being actively recruited to.

Are services caring?

We observed patients and visitors being treated with dignity and respect. One patient said, “Staff look after me well.” Another told us, “Staff have everyone’s care at heart.” Patients told us they felt involved in their care. Comments included “Staff tell me what is going on”; “Staff are keeping me informed” and “Staff keep me informed of what they are doing and how long it will take.”

Are services responsive to people’s needs?

Patients’ need were assessed on admission and reviewed throughout their stay. Discharge plans were discussed daily to assess progress towards meeting the discharge plan. The discharge and transfer of patients was well managed. Effective systems were in place to ensure that discharge arrangements met the needs of patients. The multi-disciplinary team (MDT) worked effectively to support the planning and delivery of patient centred care. Weekly MDT meetings ensured the patient’s needs were fully explored

Are services well-led?

Staff were aware of the Trust’s vision, the ‘DCHS way’ and were able to describe what this meant in practice. Staff told us they well supported and that they could raise any concerns at a local level. The Trust Board members were known to staff, and the Chief Executive communicated with all staff via a weekly email.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Safeguarding procedures were in place and staff received an appropriate level of training. Learning took place as a result of serious incidents, and staff described changed that had come about following a serious medicines incident.

Patients were assessed on admission and risk identified and managed appropriately. Staff completed two hourly safety rounds and used a range of equipment to reduce the risk of harm to patients. Staff were passionate about providing good quality care to patients.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multi-disciplinary team (MDT) to support the planning and delivery of patient centred care. Patients and their relatives were positive about the care and treatment they had received. Patients and their families were involved in making decisions about their care and the support needed.

Okeover ward was responsive to patients' needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. The Trust board were visible and the Chief Executive communicated weekly via email with all staff. The majority of staff we spoke with felt well supported at a local level within the ward environment and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

Summary of findings

What people who use the community health services say

Derbyshire Community Healthcare Trust had implemented the Friends and Family Test in April 2013. We reviewed the most recent figure for October 2013 which placed the Trust's inpatient scores in the top 25% for England.

Patients and their relatives were positive about the care and treatment they had received. Patients told us, "I'm very happy with staff, they don't rush us" and, "Care is excellent."

Areas for improvement

Action the community health service SHOULD take to improve

- Medication records should demonstrate that patients have received their medication as prescribed.

Good practice

Our inspection team highlighted the following areas of good practice:

- The multi-disciplinary team worked closely together to ensure the best outcome for the patient.

St Oswald's Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare Foundation Trust

Head of Inspections: Ros Johnson, Care Quality Commission

The team included a CQC inspector, a community nurse and two experts by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we inspected.

Background to St Oswald's Hospital

St Oswald's Hospital is managed by Derbyshire Community Health services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. St Oswald's Hospital is registered to provide the regulated activities: Diagnostic and screening procedures; and Treatment of disease, disorder or injury.

St Oswald's Hospital was built as a state-of-the-art facility in 2010 and houses a community hospital, a GP Practice and a two storey health centre.

St Oswald's Hospital has not previously been inspected by the CQC

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team looked at the following services:

- Community inpatient services

Detailed findings

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider.

We carried out an announced inspection to Okeover Ward, St Oswald's Hospital on 25 February 2014. We looked at how the inpatient services operated. During our visit we held focus groups, we observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We circulated an electronic survey to community and voluntary organisations in the area of the Trust. We also sent comment cards to be distributed around Trust locations. We reviewed all the information received in this way and information sent to us by patients and local people following a press release and publicity about our inspection. We also reviewed information from comment cards completed by people using the services.

Community inpatient services

Information about the service

Okeover Ward is a 24 bedded facility within St Oswald's Hospital. This inpatient service provides general rehabilitation, end of life care and post-operative rehabilitation for adults following discharge from acute hospitals or from home.

Okeover Ward is located on the first floor of the hospital and is easily accessible by lift or stairs. The ward had a kitchen where occupational therapy assessments were carried out. The areas we visited were free from clutter and obstacles.

During our inspection we spoke with 12 patients and a number of visitors. We spoke with the ward manager, an advanced nurse practitioner, a staff nurse and a health care assistant. We held a focus group meeting with eight qualified staff from four community hospitals within the Trust.

We reviewed patient records, observed care being delivered and reviewed information we had received from the Trust.

Summary of findings

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Safeguarding procedures were in place and staff received an appropriate level of training. Learning took place as a result of serious incidents, and staff described changed that had come about following a serious medicines incident. However, we saw that patient records were not all accurate in recording that people had received their medication as prescribed.

Patients and their relatives were positive about the care and treatment they had received. Patients told us, "I'm very happy with staff, they don't rush us" and, "Care is excellent." Patients and their families were involved in making decisions about their care and the support needed. Patients were assessed on admission and risks identified and managed appropriately. Staff completed two hourly safety rounds and used a range of equipment to reduce the risk of harm to patients. Staff were passionate about providing good quality care to patients.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multi-disciplinary team (MDT) to support the planning and delivery of patient centred care. The care on Okeover Ward was responsive to patients' needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multi-disciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. The Trust Board members were visible and the Chief Executive communicated weekly via email with all staff. The majority of staff we spoke with felt well supported at a local level within the ward and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

Community inpatient services

Are community inpatient services safe?

Safety in the past

We found that community inpatients were protected from abuse and avoidable harm as staff were confident about reporting serious incidents and informing senior staff on duty if they suspected poor practice which could harm a person. Staff were aware of the safeguarding policy and had received training at the appropriate level on safeguarding vulnerable adults.

Information highlighted by the NHS Safety Thermometer assessment tool (used to measure a snapshot of avoidable harms once a month) showed fluctuation in the number of new pressure ulcers between December 2012 and December 2013 for the over 70's group. However, the percentage of patients with new pressure ulcers has tended to fall in line with the national trend. The provider reported no occurrences of grade 3 or 4 pressure ulcers on the ward between December 2012 and November 2013.

We looked at the current medicines storage arrangements and found that medicines in the ward were stored safely. Medicines administration records were available for the prescribing and recording of medicines. However, the records did not demonstrate that patients were given their medicines as prescribed. On the two medication records we looked at there were a number of occasions when medication had not been signed as given, nor a code used to record the reason for non-administration.

Daily recording of the temperature of the refrigerator used to store medicines was undertaken and recorded. This meant that staff took appropriate action to check that refrigerator temperatures were appropriate and to ensure the effectiveness of medicines was not affected.

Learning and improvement

Staff were familiar with the reporting system for all incidents. Staff spoken with told us that all staff were responsible for reporting incidents and completing the electronic system. Staff were aware of the importance of reporting incidents and told us they were actively encouraged to do so. Staff told us that root cause analysis investigations were undertaken when incidents occurred and action plans developed and implemented as required. Staff told us they received feedback relation to incidents that had been reported, both in relation to their inpatient area and from across the Trust.

Staff shared with us the learning that had taken place following a serious medicines incident when insulin was not given safely. They told us following this incident, additional training had been provided, and the procedure for drawing up and administering the medication had been changed. They told us that two registered nurses were always involved in the drawing up and administration of insulin to all patients.

A customer experience report was produced quarterly for the Board and provided an overview of customer experience across all locations. This report included an update on actions to date relating to issues raised from compliments, patient questionnaires, comment cards, websites, complaints and the Friend and Family Test. Complaints were categorised into four levels, level four being the most serious. The report outlined trends and themes, and identified priorities for the Patient Experience Team

Systems, processes and practices

The majority of staff reported that their managers were supportive. They told us they were able to raise issues without fear of negative consequences.

The provider had policies and processes in place regarding incident reporting which were available for staff to refer to. On the ward, staff routinely monitored quality indicators such as falls and pressure ulcers, known as the 'four harms,' through the NHS safety thermometer. Incidents of concern were reported by staff on the electronic incident reporting system.

The 2013 - 2014 Pressure Ulcer Prevention Plan acknowledged there was still progress to be made to address the delays in reporting grade 3 and 4 pressure ulcers and completing the review / action plan within the set timescales. By March 2014 the provider expected to achieve an internal organisational target of completing and implementing action plans within 10 days of the incident report date for 100% for community hospitals and 95% for community based services.

Patient records were kept securely and we were able to follow and track the patient care and treatment easily as the records we reviewed were well kept, up to date, and accurately completed. In addition staff were able to easily locate and obtain any additional notes we required when conducting our patient record review.

Community inpatient services

Staff were aware of current infection prevention and control guidelines, and told us they completed an infection control work book as part of their induction, and infection control training was also part of their essential training. We observed that hand washing facilities and alcohol hand gel were available throughout the ward areas. We noted that the ward area was clean and personal protective equipment, such as gloves and aprons, were available to all staff. Domestic staff wore colour coded aprons depending on which area of the ward they were cleaning. Monthly hand washing audits were carried out, and the ward achieved between 90 and 100%.

Monitoring safety and responding to risk

Patients were allocated to beds according to the level of observation they required. For example, patients who were identified to be at risk of falls were accommodated in beds closest to the nursing station so that they could be closely observed and monitored. Two of the single rooms could not be easily observed from the nurses' station, and these rooms were used for patients ready for discharge or requiring end of life care. Staff were organised into teams of one qualified nurse and two health care assistants to care for 12 patients on the early shift. There were sufficent staff on duty to meet the needs of the patients.

Anticipation and planning

The staff we spoke with reported that they had received essential training in areas such as safeguarding children and vulnerable adults, moving and handling, and health and safety.

Staff carried out safe care assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and personal handling. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care. Waterlow and Malnutrition Universal Screening Tool (MUST) assessments were carried out within six hours of admission and included a full skin assessment.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

We observed that care provided was evidence based and followed recognised and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. For example, staff were using tools such as the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs. Policies were available electronically via the intranet and staff had access to these.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005. Training was being provided for all staff who worked on the ward. Information relating to mental capacity and Deprivation of Liberty Safeguards (DoLS) was displayed on the ward. None of the patients whose care records we looked at lacked capacity to make decisions about their treatment.

Monitoring and improvement of outcomes

We saw care plans and risk assessments were reviewed and updated within the required timescales. Appropriate action was taken if patients were identified as at risk, for example, provision of pressure relieving equipment. Staff were completing venous thromboembolism (VTE) assessments and following the guidance regarding prophylactic measures.

Staff told us they carried out two hourly safety rounds. During these rounds they ensured that the patient was safe, could reach their call bell, had access to food and fluids, and were encouraged to stand or move for pressure area care.

Sufficient capacity

On the day of our inspection we found that staffing levels and skill mix supported safe practice. Staff told us that agency and bank use was high due to staff vacancies on the ward. Staff told us the staff team were supportive of each other, and would cover shifts whenever they could. At the time of our inspection, there were vacancies for 3.9 full time equivalent qualified staff, and 2.5 full time equivalent

health care assistants. Interviews for qualified staff took place on the day of our visit and we were told that three people had been offered posts. The health care assistant posts had already been recruited to.

Medical staff cover was provided by local general practitioners, the only exception being out of hours cover, which was provided by the local Out of Hours Service. In order to improve the service offered to patients, an advanced nurse practitioner had been appointed to work on Okeover ward. They told us their role was similar to that of the medical staff, although they were trying to move away from the medical model. They said they had identified areas for improvement, for example training for both staff and patients to improve chronic disease management. They were also developing the skills of the qualified nurses on the ward, so they were confident in dealing with the range of situations that may arise in the absence of medical staff.

Staff were positive regarding the recent changes that had been made to the induction process. The induction programme had been expanded to five days, and new staff commenced their employment at the same time during the month, and attended their induction during their first week before going on the wards. One recently recruited member of staff commented that the recruitment process had taken three months from interview to start day, and they did not receive updates from the Human Resources department during this time.

Staff told us they were required to complete essential training, which was a mixture of e-learning (computer based) and face to face training. They told us this included moving and handling, fire safety, pressure area care, information governance, and health and safety. Staff were able to request additional training, such as venepuncture and leadership courses. Staff told us it could be difficult to find the time to complete the e-learning. However, staff told us they were up to date with their essential training, and this was reviewed as part of their annual appraisal. Staff told us they all had an annual appraisal. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. They told us they were able to access external training, if their essential training was up to date. They told us the provider was supportive of training, and usually provided the funding and study time to attend courses.

Multidisciplinary working and support

Whilst care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Weekly MDT meetings ensured the patient's needs were fully explored.

Patient records that detailed current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs.

Medical staff cover was provided by local general practitioners, the only exception being out of hours cover, which was provided by the local Out of Hours Service. Staff told us that on occasions there had been delays in medical staff attendance out of hours, particularly when patients had been admitted to the ward during the evening and these were reported through the reporting system. If a patient was acutely ill, staff told us they would request an ambulance to transfer the patient to the local acute hospital.

Are community inpatient services caring?

Compassion, dignity and empathy

We observed all staff treating patients and visitors with dignity and respect. One patient said "Staff look after me well." Another told us "Staff have everyone's care at heart."

Compliance with same-sex accommodation guidelines was ensured through single rooms and single sex bays. Doors were closed prior to the delivery of care and discussions with patients in regards to their care

Involvement in care

Patients and their families were involved in and central to making decisions about their care and the support needed. Patients comments included, "Staff tell me what is going on"; and, "Staff keep me informed of what they are doing and how long it will take."

We found that relatives and/or the patient's representative were involved in discussions around the discharge planning process. For example, relatives were informed of potential discharge dates and patients and relatives had discussions with members of the multi-disciplinary team to ensure a smooth transition home.

Community inpatient services

Where a 'Do Not Attempt Resuscitation' (DNACPR) decision was in place in the case of a life threatening event, we saw that discussions had taken place with both the patient and family and their wishes recorded.

Trust and respect

We observed staff treating patients with dignity and respect when attending to care needs or providing support. We observed the serving of the lunch time meal. Staff were offering patients support if required and remained in the vicinity throughout but their presence was unobtrusive.

Patients commented that they were treated with respect. One patient told us "Staff are very respectful. I need a lot of physical help and they never make me feel awkward." Staff told us that effective communication and collaboration between all members of the multi-disciplinary team ensured trust and respect in those delivering prescribed treatment and care.

Emotional support

We saw from care records that staff identified patients who required additional emotional support. For example, staff observed and recorded that one patient was presenting with a low mood. They had completed the geriatric depression scale for this patient. As a consequence they had referred them to the older people's mental health team for assessment and support.

One patient, whose health could deteriorate quickly, told us, "My doctor and staff have worked well to deal with my bad chest quickly; they had the medication on standby ready for me." This reassured the patient that any deterioration in their condition would be dealt with promptly, which helped to manage their fears and stresses.

The ward had a communal day room and a separate dining room. The dining room was arranged with small tables which seated four patients, and provided the opportunity for patients to socialise at meal times. However, the chairs in the communal day room were arranged around the walls which limited the opportunities for patients to interact socially with each other.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

There was evidence from staff we spoke with that staff were meeting the needs of patients admitted for rehabilitation and palliative care. For example, there were good mechanisms for information sharing between in-patient and community teams and a willingness to engage with other service providers, such as social services, to ensure that all care needs were met.

Staff were knowledgeable regarding the community in which they provided services, and commented that they felt like they were giving something back to the community.

Patients were complimentary about the meals provided to them. One the day of our visit patients had the choice of five main courses and two desserts. Although patients had chosen their meal prior to lunch time, staff were flexible if patients wished to change their selection. This meant patients were provided with suitable and nutritious food and drink based on what they would currently like to eat.

Staff told us about a Trust initiative 'Making Every Contact Count'. They described this as taking every opportunity to discuss health promotion with people, not just patients, to encourage a healthier lifestyle. They told us the driver for this was patient public involvement, and engaging and involving people in their own health to assist them to remain in their own homes.

Access to services

Patients could access the ward by referral from the local acute Trusts, or directly via their GP, community nurses or single point of access team. Staff told us all referrals were reviewed by the multidisciplinary team to ensure that patients met the criteria for admission. The system in place meant that patients with specific needs could be admitted in a timely manner to receive appropriate care.

Accessibility to the ward was good as services were provided on the first floor level with lifts and stairs and free car parking available on site.

Vulnerable patients and capacity

The Trust was actively promoting dementia awareness within the staff group. Staff told us that training was being

arranged but the ward had difficulty releasing staff for training at short notice. They told us that the Dementia Nurse Specialist also provides basic training on dementia awareness. Training on the Mental Capacity Act 2005 was also provided.

Staff told us that if patients were vulnerable due to the risk of falls, they were cared for in areas of the ward where they could easily be observed, and a sensor care system alerted staff when patients moved.

Leaving hospital

The discharge and transfer of patients was well managed. Effective systems were in place to ensure that discharge arrangements met the needs of patients. Staff were able to describe the system in place, and how this worked in practice.

Discharge planning commenced at the point of admission for all patients. Discharge meetings were held every weekday morning, where each patient was discussed and what progress needed to be made before the patient could be discharged. Multi-disciplinary team (MDT) meetings were held weekly where patient progress towards discharge was discussed. Staff told us patients were only discharged when the patient was medically fit and had been checked as safe by physiotherapy and occupational therapy; in addition, the home environment needed to be assessed as safe (e.g. heating on, keys available, someone to meet the patient) and any care packages had been arranged. Staff told us there were rarely delays with discharges, but when they occurred it was usually due to care packages not being in place or waiting for a bed in a care home.

Staff told us patients and families were involved in the discharge process. The majority, but not all patients were aware of their discharge plans. One patient told us "The doctor has been very clear on what was happening, social services have visited and seem to understand the medical as well as helping with discharge." Another said "It's unclear when I will be going home, but support for when I go home has been set up."

Learning from experiences, concerns and complaints

Patients told us they had no complaints about their care or treatment during their stay. However, patients were aware of the complaints procedure and told us they were confident they would be listened to and their concerns acted upon.

The Trust used the Friends and Family Test, which asks patients whether they would recommend the ward to their friends and family if they required similar care or treatment. The score for all inpatient facilities provided across the Trust averaged a high score of 88 during the period April to September 2013.

Are community inpatient services well-led?

Vision, strategy and risk

Staff we spoke with were aware of the Trust's vision, the 'DCHS way', which has three elements: Quality Service, Quality People and Quality Business. Staff described this as putting patients first, providing safe care with privacy and dignity, and supporting staff. Information about the DCHS Way was on display around the hospital.

Staff told us the Board and particularly the Chief Executive maintained a visible presence and were approachable. They said members of the Board visited ward areas, often when carrying out quality audits. A newly recruited member of staff told us the Chief Executive had attended their induction programme to introduce herself to new staff. Information was cascaded to staff through a variety of channels including emails, the Trust newsletter 'The Voice', and team meetings.

The last assessment by the NHS Litigation Authority (NHSLA) was in 2012. The NHSLA handles negligence claims made against NHS organisations and assesses the processes Trusts have in place to improve risk management .The Trust was assessed at level 1 in 2012 which meant they had policies in place which described the actions staff were required to follow. We saw that staff were familiar with the incident reporting system and confident that any incidents reported would be investigated.

Community inpatient services

Quality, performance and problems

The quality and safety of inpatient care was monitored at all levels within the organisation. The Board received regular reports and the results of audits undertaken to measure the quality of care being provided.

We received statistical information from the NHS Safety Thermometer prior to our inspection. The thermometer is used to monitor the four common harms to patients, development of pressure ulcers, falls with harm, catheters and urinary tract infections and venous thromboembolism. The data for the Trust showed decreases in all areas of harm.

Leadership and culture

Staff were aware of the members of the Board, and felt that they were approachable. The majority of staff we spoke with felt well supported at a local level within the ward and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

The delivery of care was led by the nursing staff. We saw there was effective communication between all the members of the multidisciplinary team to support patient centred care and rehabilitation. Staff felt that they were part of a good team, and were passionate about providing good quality care to patients.

Patient experiences and staff involvement and engagement

Communication about changes in the Trust were cascaded to staff through a variety of routes. The Trust issued a weekly bulletin, The Voice, and the Chief Executive wrote a weekly update email to staff. Ward managers from the different community hospitals met on a regular basis and relevant information was discussed with staff at the ward team meeting. We were told that minutes of the ward meetings were emailed to each member of staff to ensure everyone received the same information.

Patients were positive about the care and treatment they received. Patients were aware of how to make a complaint and were confident they would be listened to and their concerns acted upon

Learning, improvement, innovation and sustainability

New staff were provided with an induction into the Trust. This had recently been improved so that all new staff attended induction at the beginning of their employment before they commenced on the wards. This meant that staff had completed some of their essential training and were aware of important policies and procedures prior to delivering patient care.

Staff told us they had good access to training. In addition to the essential training staff received they were able to access other training they identified to support their role. Training was recorded electronically, and was flagged in red when due for update. Ward managers told us they received the prompts for their staff team and outstanding training was discussed at appraisals. This showed the provider ensured staff had the right skills, experience and support to deliver safe efficient care.