Staffordshire & Stoke-on-Trent Partnershp NHS Trust

R1E

Community health inpatient services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Staffordshire & Stoke-on-Trent Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Staffordshire & Stoke-on-Trent Partnership NHS Trust and these are brought together to inform our overall judgement of Staffordshire & Stoke-on-Trent Partnership NHS Trust

Summary of findings

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Overall summary

We undertook this unannounced inspection in response to a number of whistle-blowing letters we had received from staff. The letters highlighted a number of concerns to us, around safe staffing levels and organisational culture; these areas have been our focus for this inspection. Additionally, following these letters, the Trust Development Authority agreed with our concerns.

We concentrated particularly on two of CQC's five key questions – safety and leadership. Given this visit was not a comprehensive inspection we are not providing ratings on the trust.

We inspected two sites during this unannounced inspection - Haywood Hospital and Bradwell Hospital. We visited Grange ward at Haywood and Oak ward at Bradwell. We spoke with two senior managers, the interim director of nursing, 13 trained staff including two ward managers, five ancillary staff, one bank nurse, four patients and three visitors.

We found that patient safety and ward performance was being measured. Ward managers were responsible for ensuring that ward data was registered on the safety dashboard and reported to the trust senior managers on a monthly basis. We saw that where results had shown a risk appropriate action had been taken to address the issue. An increase in staffing levels had improved the observation of patients and reduced the reported falls. Patients told us they felt safe and well looked after.

The wards we visited were led by caring and responsive managers; their staff told us they felt well managed and listened to. We heard examples of positive 6C's team work which had resulted in achievement awards being presented to Oak ward. Staff vacancies were covered by substantive or bank staff, on rare occasion's agency staff was booked. The closure of two community wards had reduced staffing deficit although the trust still held 17 vacancies. Senior staff told us that staffing was on their worry list.

We heard many examples of innovative plans being put in place such as the introduction of ward buddies to improve patient transfer and discuss poor/good transfers and review situations that were less effective than others between acute wards and the community.

Summary of findings

Background to the service

Staffordshire and Stoke on Trent Partnership NHS Trust provides community health services in four hospitals in Stoke on Trent. The hospitals largely provide rehabilitation/intermediate care following an acute hospital admission and direct admissions from home to prevent an admission.

Haywood Hospital has 130 inpatient beds on six wards, a day unit and therapy services. Bradwell hospital had 73 inpatients beds on three wards and offers short term stay for rehabilitation and assessment of long term needs.

Cheadle Hospital has two wards with a total of 47 beds, including one supportive therapies day case bed. Leek Moorlands Hospital has two wards, with a total of 44 beds and also has a minor injuries & illnesses unit. Services provided at Leek Moorlands Hospital include specialised nursing care for the elderly, physiotherapy, occupational therapy and speech therapy.

Currently Longton Hospital wards are both closed to address staffing shortages and protect patient safety.

Our inspection team

Our inspection team was led by Tim Cooper, Head of Hospital Inspection.

The team of 8 included CQC inspectors and senior nurses with specialist experience of community nursing teams. We did not include experts by experience in this inspection.

Why we carried out this inspection

We undertook this unannounced inspection in response to a number of whistle-blowing letters we had received from staff. The letters highlighted a number of concerns to us, around safe staffing levels and organisational culture; these areas have been our focus for this inspection. Additionally, following these letters, the Trust Development Authority agreed with our concerns

How we carried out this inspection

As this was a focused inspection we did not cover all of the five key questions across all core services. The main focus of the inspection was on the safety of current nurse staffing levels and the culture and leadership of the organisation.

Due to the specific focused nature of the inspection, we have relied on the trust to provide us with key

performance metrics and we have reviewed all the information held by CQC about this trust. We have also liaised with the Trust Development Authority (TDA) and NHS England.

We inspected two sites during this unannounced inspection - Haywood Hospital and Bradwell Hospital. We visited Grange ward at Haywood and Oak ward at Bradwell.

What people who use the provider say

As this was a focused inspection we did not collect service users views of the provider.

Summary of findings

Good practice

- The trust employs a Cultural Ambassador for Change. Their remit is to provide help, support and advice for staff wishing to raise concerns. The Ambassador reports directly to the Chief Executive and the Chair. The trust also has a dedicated telephone helpline and email address for staff to raise concerns.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Review the internal communication arrangements for the Ambassador for Change to ensure transparent lines of communication and staff feel reassured that the role is organisation wide, not part of the management process.

- Review the methods currently used for communicating and engaging with staff to ensure there is a mechanism for the trust to monitor and measure the effectiveness.

Staffordshire & Stoke-on-Trent Partnershp NHS Trust
Community health inpatient services

Detailed findings from this inspection

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

Are community health inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

Safety thermometer and quality dashboards were reported on monthly to look for trends and safety issues. The staff we spoke with understood the purpose of the data collection and was looking forward to displaying it on the boards. Patients told us they felt safe and well cared for. Relatives also confirmed this.

An identified increase in falls had been addressed, with improved staffing levels and improved observations of patients.

A robust recruitment process was in place and the trust were continually working to address the shortfall of permanent staff.

Incidents, reporting and learning

- Safety performance was measured on a 'ward assurance dashboard' (previously known as matrons' quality dashboard). Dashboard results were displayed at the entrance of most wards. The hospital manager told us they were aware that further work was required to fully embed the dashboards. Corporate display boards were currently being sought but most ward managers had developed their own temporary display area.

- Dashboard results were recorded and monitored for the four community hospitals. In September 2014, 10 of the 11 dashboard scores ranged between 80 to 100%. The 11th score for dementia ranged from 33 to 88%. An action plan was in place to improve the inpatient dementia care; staff training and the introduction of ward based dementia champions had commenced.

- We saw minutes from the matrons' monthly quality dashboard meeting for September. During these meetings the dashboard results were discussed, action plans were initiated and five 'random' sets of patient notes were reviewed to ensure standardisation and correct recording of information was adhered to.

- We reviewed the safety thermometer data on Oak ward which showed 100% no harm; no falls and no acquired pressure ulcers had been reported.

- Staff told us they were encouraged to raise concerns, record and report safety incidents and fully understood their responsibilities. They told us that safety of patients was the number one priority and they had attended 'raising concerns' training, which was now mandatory. Staff told us they did get feedback from incident reporting and specific ward issues were discussed at team meetings. We saw the minutes of ward meetings which followed a set agenda.
- Appropriate action was taken by the trust when safety data had increased to amber or red. When falls with harm had increased the trust responded with immediate implementation of "bay tagging" for staff to be in attendance in bays at all times, the cohort where possible of high risk patients, the introduction of Wanderguard alerts and the purchasing of pressure sensor alarms. The results showed a reduction in falls and falls with harm.
- The trust had registered with 'NHS Sign up to safety' (SutS). SutS was designed to help make the NHS the safest healthcare system in the world by creating a system of continuous learning and improvement. SutS aimed to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

Nurse staffing levels and skill mix

- The trust had introduced NICE safe staffing guidelines. The 'planned' and 'actual' staffing numbers were monitored daily through manager's telephone meetings. On the wards we visited the name of the nurse in charge was displayed along with the actual staff numbers.
- We were told that a trust transformation team was working on guidelines for benchmarking at the hospitals. This was evidenced as we observed a policy 'Improving and supporting staff' which enabled ward managers to spend 50/50 of their workload on clinical and admin work.
- Staffing levels continued to be top of the 'worry' list for most senior managers.
- Staffing was recorded electronically and stored in a shared area with full access by the managers. Rostering guidelines were followed to ensure staffing numbers were adhered to and the minimum four weeks duties were available. The trust had a standard operating procedure in place to support this.

- The ward staff and occupational therapy team looked at the level of assessed needs of the patients and then staffing was provided according to the needs and levels of patient dependency.
- 50/50 ratio 'tipping point' was in place to ensure wards were staffed with at least 50% substantive staff.
- Substantive, bank and very occasionally agency staff were currently covering shifts for 17 whole time equivalent vacancies across the four hospitals. 26 staff had been recruited at the September recruitment day that was managed by an external recruitment company. A robust recruitment system was in place where all staff pre-employment checks were made prior to an appointment and a robust induction programme was in place.
- The use of agency and bank staff had reduced since the recent closure of two wards at Longton Hospital. However, staff redeployment had not been without its problems with some last minute staff sickness causing staffing levels to be below planned numbers.
- At Haywood Hospital, the sickness absence rate for the year to date was 4.35% which was below the trust average of 4.64%. However, at Bradwell the rate was 8.77%.
- We were told by the ward managers that the bank and agency staff were given appropriate induction and an introduction to the ward check list was signed by the new member of staff. Block booking of some agency staff had been arranged to ensure consistency for patients and substantive ward staff.
- We spoke with one bank nurse who told us they had received an induction but they were waiting for some new uniform.

What is the impact of staffing on caring and responsiveness?

- Community hospitals inpatient survey received feedback from 123 users achieving a net promoter score of +75.63. 79.34% of patients were extremely satisfied with the quality of care they had received. The inpatient discharge survey received feedback from 83 users with a net promoter score of +83.58.
- An increase of in-patient falls had been an on going concern during the summer months, with cognitive issues of the patients being identified as the cause. To

meet the increased patient need, the staff had been utilised to their full potential including cohorting of the appropriate patients to improve their observation and night time staffing numbers had been increased.

- Patients told us they were well cared for and felt safe. Patients were risk assessed on admission and their safety monitored. We saw that patients had their call bells and the ward areas were clean, tidy and free from trip hazards. We heard call bells answered promptly.

- At hand over an 'up to date' print out of the patients names, status and plan of care was given to all staff to ensure that they had the information they needed. On one ward we were told that this had been discontinued.

- Benchmarking was carried out using the trusts own standards protocols, NICE guidelines and the NHS skills for competency levels.

Are community health inpatient services well-led?

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

Summary

We heard and saw many examples of good leadership at the two hospitals. Staff told us they felt well managed and listened to. Development of trained staff was being embedded with the introduction of leadership programmes relevant to the nurse banding.

Senior staff had a good understanding of the governance framework and ward level priorities such as reporting of audit and safety thermometer scores. We were told of the 'take action attitude' that was being promoted and welcomed by the staff rather than the historic 'blame' culture. Staff told us they were confident to raise concerns and report incidents.

Vision and Values

- Ward manager understood the organisation's vision and values and were able to discuss how each value was incorporated in to staff appraisals.
- Junior staff was less aware of the vision and values however they fully understood their own roles and responsibilities. They were clear that they gave good quality care for all patients but could not explain if or how this fitted into the overall picture. Ward staff told us they had not been included in the development of the trust vision.
- The staff on Oak ward showed us that they had won 6 C's award which was part of the trusts vision and values. We saw the evidence folder that was submitted to achieve this award.
- Ward staff were supportive of all senior management and felt they were empowered to take appropriate decisions and stated they were comfortable in expressing concerns and points of view.
- Trained staff leadership programmes had commenced for band seven and above. A bespoke core skills development programme had been developed for band six's and band fives.

Governance, risk management and quality measurement

- Senior staff had a good understanding of the governance framework and ward level priorities such as

reporting of audit and safety thermometer scores. We were told of the 'take action attitude' that was being promoted and welcomed by the staff rather than the historic 'blame' culture.
- There was an annual appraisal system in place for all staff but regular formal supervision was not undertaken and as a result of this it appeared that only staff that was not considered competent had individual support. The ward managers acknowledged that there was a formal supervision policy within the trust.
- The ward managers divided their time between managerial duties and clinical work on a 50/50 basis. Since the staffing levels had increased this was now possible for most ward managers. This gave them more capacity to monitor quality and risk.
- We saw that robust planning through multi-disciplinary meetings (MDT) meetings ensured that the patients' needs were monitored and their care appropriately planned. Daily board rounds and ward rounds took place before and after MDT each weekday. Relatives we spoke with told us they had been updated about the care being given and possible discharge date.
- We were told that community occupational therapy staff had been moved onto the wards when there were staff shortages. We were told that they were not aware if moving staff from community was having an impact on the workload or pressure on the remaining community team members.

Leadership of the service

- We found there to be strong leadership and management on the wards. The trained staff told us they felt supported by the ward managers and they were given help and support when needed. Health care staff told us they felt supported by the trained staff and they taught them new ward based skills. All the staff we spoke with were confident to approach their manager with any problems or requests as they know they will be listened to.
- We were told that the board members had been to the hospital sites but the ward staff were not aware they had visited the wards.

Are community health inpatient services well-led?

- Staff told us they understand their role in promotion of good care and completion of ward audits which were carried out on a regular basis.
- Monthly leadership meeting were held with case discussion taking place to ensure learning from certain incidents was shared across all sites.

- The leaders do have the support of their managers and the Matron is very supportive.
- We heard of staff teams working well and the open and honest culture within the wards. The managers were happy to talk with any staff and were visible on the wards and helping with clinical teaching and supervision.