

Derbyshire Community Health Services NHS Foundation Trust

RY8

Community health inpatient services

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RY8Z2	Babington Hospital	Baron Ward	DE56 1WH
RY8NT	Bolsover Hospital	Hudson Ward	S44 6DH
RY8Y8	Cavendish Hospital	Fenton Ward	SK17 6TE
RY8Y7	Clay Cross Hospital	Alton Ward	S45 9NZ
RY846	Ilkeston Hospital	Hopewell Ward, Heanor Ward and the Day Treatment Centre	DE7 8LN
RY8Y4	Ripley Hospital	Butterley Ward	DE5 3HE
RY8Y3	St Oswalds Hospital	Okeover Ward	DE6 1DR
RY8Y1	Whitworth Hospital	Oker Ward	DE4 2JD

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

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

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

Summary of findings

Ratings

Overall rating for the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Good	●

Summary of findings

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Summary of findings

Overall summary

Overall, we rated the community health inpatient service as good, with outstanding for caring.

We found:

The service protected patients from avoidable harm and abuse. There was an embedded system in place to keep people safe and a good level of staff knowledge on how to safeguard patients from abuse. There was evidence of an open and transparent culture in relation to the reporting of incidents and we saw evidence of staff learning from investigations. All of the areas that we visited were visibly clean and staff actively participated in keeping their patients safe from infections. There were well embedded systems in place to recognise a deteriorating patient and we saw evidence where escalation of treatment was correctly identified and acted upon. All wards had good staffing levels with proposed staffing always matching the planned staffing. On occasions where additional staffing was required, staff told us that they were supported to increase the staffing.

The trust participated in local and some national audits, and was also looking into participating in other national outcome audits. All local policies and guidance were evidence-based and followed National Institute for Health and Care Excellence (NICE) guidance. Staff comprehensively assessed patients to produce individualised care plans. Care plans accounted for patients' physical, mental and clinical needs. Staff were competent to undertake their roles and responsibilities and the trust supported staff to continue their professional development. We saw evidence of staff providing a cohesive team approach to patient's care involving all members of the multi-disciplinary team, including discharge planning and transferring to other teams. Staff had knowledge and understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

We observed patients being treated with the upmost respect and dignity during their admissions. Staff valued patients as individuals and empowered them to become partners in their care. Feedback during the inspection was positive from patients with words including 'excellent' and 'brilliant' often being used. Staff welcomed the relatives of patients to also become involved in their care and we saw evidence of where the staff involved the relatives in decision making. Staff empowered the patients and their relatives to have a voice and realise their own potential.

People's individual needs and preferences were central to the planning and delivery of the services. The service was proactive in its approach to understanding the needs of different groups of people and delivered care in a way that met the needs of patients. We saw evidence during our inspection where staff made considerable efforts to meet the needs of vulnerable patients and those with complex needs. Waiting times and cancellations were minimal and staff took appropriate action to rebook procedures for patients in the event of cancellations. There was a well-established complaints procedure which was well publicised and patients felt comfortable in raising complaints and concerns.

There was a clear vision and set of values which was publicised by the trust. All staff we spoke with were aware of the 'DCHS Way' which reflects the vision and values. There was a good governance structure in the service and there was a flow of information that went both ways. Risk was assessed at all levels and residual risks were held on a trust risk register, which all staff had access to. There was positive leadership in the service and staff demonstrated high levels of satisfaction stating they felt appreciated and supported in their roles.

Summary of findings

Background to the service

Derbyshire Community Health Service provides community inpatient services for the population of Derbyshire, which is estimated at over one million people. Services are provided across both urban and rural areas and varying levels of deprivation, and affluence. The majority of patients are admitted from one of the nine surrounding acute hospitals with a smaller number of patients admitting straight from their own homes via their GPs.

There were a total of 164 declared inpatient beds for patients in 10 wards spread across nine community hospital locations. Inpatient services were provided at Babington hospital, Bolsover hospital, Cavendish hospital, Clay Cross hospital, Ilkeston hospital, Newholme hospital, Ripley hospital, St Oswalds hospital and Whitworth hospital. Services provided to patients admitted into these hospitals include rehabilitation, nursing and medical care for people with long term conditions and end of life care.

During our announced inspection we visited Baron Ward at Babington hospital, Hudson ward at Bolsover hospital, Fenton ward at Cavendish hospital, Alton ward at Clay Cross hospital, Hopewell and Heanor wards at Ilkeston hospital, Butterley ward at Ripley hospital and Okeover

ward at St Oswalds. As part of the unannounced inspection which took place on Sunday 22 May, we visited Oker ward at Whitworth hospital. We did not inspect Rowsley ward at Newholme hospital during this inspection as this was temporarily closed for refurbishment.

The wards are all nurse led with input from rehabilitation specialists including physiotherapists, occupational therapists (OTs) and rehabilitation assistants. Medical input is either reliant on visiting GPs at some locations or provided by DCHS employed doctors from 9am until 5pm. Out of hour's medical cover was provided by the local out of hour's service, which all wards had a direct contact number for.

The service has a day treatment centre (DTC) located at Ilkeston which completed 3,262 procedures in the last 12 months. They provide procedures from eight surgical specialities including general surgery and colorectal surgery, gynaecology, dermatology, ear, nose and throat (ENT) surgery, ophthalmology, trauma and orthopaedics and podiatry. Endoscopy procedures were also provided at the DTC until 27 May 2016 when the trust decommissioned the service. Surgeons who complete procedures at the DTC are employed by local acute trusts.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health

Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 9 and 13 January 2016. During the visit we held focus groups with a range of staff who worked in the service, such as nurses, doctors, therapists. We talked with people who use services. We observed

how people were being cared for using the Short Observation Inspection Framework (SOFI) and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 22 May 2016.

During the inspection we spoke with 45 staff members, 40 patients and 14 relatives. We also reviewed 10 complete sets of records, seven additional medication administration records (MARs), an additional four malnutrition universal screening tools (MUST) records and four additional GULP (dehydration assessments) records. We also attended four multidisciplinary team meetings (MDT), patient handovers and focus groups.

What people who use the provider say

People who used this service said:

- Patients told us they felt safe and well cared for. They felt reassured if they needed assistance quickly; this would happen as they witnessed the staff answering buzzers quickly. Staffing was good in the wards which also made them feel safe.
- Patients commented on how clean and tidy the hospital wards and noted staff were always around cleaning. This extended to the ward staff cleaning items of equipment after they had used them and also cleaning their hands.
- The food and drink provided for patients was plentiful and there was always a suitable choice for patients. Patients acknowledged staff were very accommodating of them if there was nothing on the menu they would like or if they decided to change their selection of meal. Patients were also

complimentary about the provision of drinks. Even if it was between planned drinks rounds, the staff would be happy to provide additional drinks for patients and their relatives on request.

- Patients noted all staff seemed to know what they were doing and demonstrated competent skills. They were very professional at all times, but they also had the ability to put you at ease by using humour and empathy. Patients would often use exemplary words to describe the staff and the care they provided.
- Staff always communicated with patients about their care and treatment plans, and if there was anything which was not fully understood, they went over it again until it was understood.
- No faults could be found at all about the care and treatment provided by the staff working for the trust in

Summary of findings

any of the wards. If there were any concerns or complaints that the patient or families had, they would raise this with the ward manager, and they would feel comfortable doing this.

Good practice

- The community inpatient services had worked hard to provide a service which was dementia friendly. There were activities being provided across the trust and work had begun to update the wards where possible to be suitable for patients living with dementia. They had also invested in the staff to become dementia friends and complete external training to increase their knowledge and competence in providing care for patients living with dementia.
- The pharmacy service provided on the wards was outstanding and integral to the patients' discharge planning.
- Patients were left with comment cards on Oker ward so that they could write down any questions that they may have about their care and treatment. The staff on the ward would regularly review these cards and answer the patient's questions.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should continue to identify relevant national audits which can be completed to benchmark the quality of care provided
- The trust should review the provision of therapy on a weekend to maximise a patients rehabilitation programme
- The trust should consider how the confidentiality of patient information can be guaranteed when notes are stored at the end of a patient's bed.
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- The trust should monitor the number of patients that are transferred to an acute trust following care and treatment at the day treatment centre.

Derbyshire Community Health Services NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

We rated the safety of the community inpatient services as good because patients were protected from avoidable harm and abuse. We found:

- There was a proactive culture on safety and incident reporting across the community inpatient services. Safety performances were good with low rates of acquired pressure ulcers and low healthcare acquired infections.
- The environment was fit for purpose and we observed good levels of infection prevention and control practice with staff showing that they were not afraid to challenge others to maintain safety in their wards.
- Medicine management was safe and patients were encouraged where appropriate to self-administer their medications as part of their rehabilitation.
- Records we reviewed were comprehensive, clear and legible. The risk assessments completed on patients were completed and reviewed in a timely manner.

- There was a good amount of equipment provision throughout the community inpatient services which enabled staff to complete their jobs safely. Staff cleaned and stored reusable equipment appropriately after use.

However, we found:

- Detailed nursing notes were kept at the end of the patient's beds which could breach confidentiality.

Safety performance

- The community inpatients services of Derbyshire Community Health Services (DCHS) NHS Foundation trust participated in the NHS safety thermometer programme which is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Data is collected on a specific day each month to indicate performance in four key safety areas which are new pressure ulcers, catheter related urinary tract infections (CAUTI), venous thromboembolism (VTE) and falls.

Are services safe?

- The data provided by the trust for the period January to December 2015 showed there had been one new pressure ulcer, three new VTE harms and 12 falls with harm. No information was supplied in relation to CAUTI.
- Between April 2015 and February 2016 the rate of harm from care averaged at 91.7% for the community inpatients service, this was below the trust target of 94%.
- The information on harm free care was displayed on each ward that we visited. Wards displayed information near to the entrance where this was visible to all staff, patients and visitors to the ward.
- The trust reported no Meticillin resistant Staphylococcus aureus (MRSA) bacteraemias in the past 12 months. MRSA is a bacterium that is resistant to a number of widely used antibiotics.
- The trust had reported six cases of Clostridium difficile (C. difficile) in the past 12 months, however after root cause analysis (RCA) of each case; all six cases were not in association with lapses in care. C. difficile is a bacterium that can infect a person's bowels. It is also commonly associated with people who have had courses of antibiotics but can also be easily transmitted to other people.
- There had been no never events reported for the trust since the previous inspection conducted by the Care Quality Commission in 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Incident reporting, learning and improvement

- Data provided by the trust showed inpatient services, including the day treatment centre (DTC) at Ilkeston hospital, reported a total of 1673 incidents for the period of January to December 2015. Of these incidents, 52 were of a moderate, major or catastrophic nature, all of the other incidents reported were low or no harm.
- Root cause analysis (RCA) investigations were completed on all serious incidents. Ward managers usually took the lead on the investigations; however, they tried to involve all relevant staff members in the investigation process.
- Staff at all locations used the trust wide electronic reporting system. All staff we spoke with knew of the

incident reporting system and felt encouraged to report any incidents or near misses. All staff told us that if they submitted an incident report, they received feedback about the outcome of the incidents.

- Staff in the day treatment centre (DTC) were encouraged to complete incident reports. The senior manager at the DTC said they would rather staff report incidents than not report them and there be an issue. When asked by the inspection team around a scenario involving a patient having a lens inserted into the wrong eye, not all staff were aware immediately that this would qualify as a never event, however they would raise this as an incident through the trust incident reporting system.
- All wards we visited held regular monthly ward meetings where incidents, local and trust wide, were discussed. Actions and learning identified through the investigation process were shared with staff. An example of this provided by one member of staff involved security issues at another service in DCHS, but as this had implications for the whole of the trust, this was discussed in depth at a meeting.
- All ward meetings were followed up with an email about the key learning points, involving incidents and the learning surrounding them. This was sent to all staff members including any regular attenders of the ward including any doctors. This made sure that all staff had the opportunity to review any key learning points from incidents. During our inspection, we saw examples of the emails sent with key information from ward meetings.
- Staff who worked in the DTC at Ilkeston Community Hospital also liaised with other local NHS acute trusts to try and improve their service by learning from serious incidents involving surgical procedures. Managers told us they had discussed the most recent never event which occurred at the local acute hospital and how they could implement actions to reduce the likelihood of it occurring at the DTC.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify and apologise to patients (or other relevant persons) if there have been mistakes in their care that have led to moderate or significant harm. All staff told us the trust had a very open and honest culture and they were aware of their responsibilities to be open and honest with patients

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about incidents. All staff at all levels demonstrated an awareness of the duty of candour, with more senior staff being able to provide examples and a more in-depth explanation of what the duty of candour legislation involves.

- One ward manager told us they applied the duty of candour approach to all incidents raised on their ward, even if there was low or no harm. Examples of where this had been conducted included medication errors and falls. Staff discussed details of these incidents with the patient or relevant person and then an apology was made.
- On Hudson ward, we saw a 'duty of candour' folder which contained guidance for staff to follow when dealing with incidents where this applied. This allowed a consistent approach to the way in which staff on that ward dealt with incidents and provided assurance that staff applied duty of candour principles.

Safeguarding

- Safeguarding level one training for adults and children was mandatory for all staff working in the trust and was part of the trusts mandatory training programme under essential learning. Compliance with mandatory training was 94.6%.
- Staff working in inpatient wards and the DTC were required to complete level two safeguarding children training. The trust target for compliance with was 95%, at the time of the inspection trust compliance with level two safeguarding adults training was 94% and trust compliance with level two safeguarding children training was 89%.
- The trust were due to implement a new training matrix shortly after the inspection which meant registered staff working in the ward areas would have to complete adult safeguarding training to level three.
- All staff we spoke with about safeguarding had a good understanding of what constituted abuse and the actions they would need to take if they suspected a patient required safeguarding. Some staff also included an awareness that this may also extend to any vulnerable persons who may be visiting a patient. One staff member gave an example of where they had called the safeguarding team to discuss a vulnerable person who was visiting a patient on the ward. In this case, they did not have to complete any formal referral however, they were aware of the process required had they needed to.

Medicines

- Staff told us in the ward areas; some staff had received training and had been certified as competent to transcribe medications. This involved staff writing on a medication administration record (MAR) the medications which they were discharged from an acute hospital with, including doses, route and times. Another member of staff acting as a second checker will then review this.
- Data provided by the trust showed 51 staff had completed the transcribing training across five wards which were Hudson ward, Fenton ward, Hopewell ward, Okeover ward and Alton ward. The trust also told us the requirement for staff to complete the transcribing course had decreased due to the availability of ANPs.
- During our inspection, the pharmacy team visited and found Hudson ward and Okeover ward had safe protocols in place for ordering medicines, storing medicines and safe medicine administration.
- During our inspection, all drugs fridges checked had evidence logs of robust temperature checking. All temperatures were in acceptable ranges. Staff we spoke with were aware of the actions required if temperatures were not in the acceptable ranges. All drug fridges were locked as per trust policy.
- We checked 17 MARs; all of the records had the required information contained in them, including all allergies documented. We found there was low incidence of omitted doses on drug charts we checked which demonstrated staff had worked hard to apply the actions from recent trust omitted doses audits.
- During our inspection, we observed staff giving patients medications including controlled drugs. Staff administered medication in accordance with local policy and professional standards including two people going to the bedside when administering a controlled drug. Staff wore red 'do not disturb' tabards while completing medication rounds. This stopped any unnecessary interruptions which could affect safety. All registered staff involved in drug administration were required to complete drug assessments prior to being certified competent. Data provided by the trust showed variable compliance with completing the drug administration assessment. Hudson ward, Hopewell

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ward and Alton ward all had 100% compliance. Fenton ward had 99% compliance and Okeover Ward had 63% compliance. The trust did not provide data on the remaining five wards.

- Staff appropriately completed daily checks of controlled drugs (CD) record books. We saw staff completed them appropriately as per trust policy. Staff recorded patient's own supply of CDs in a separate book so that these were not confused with the wards supply of CD medications. There was also evidence of patients own CDs being checked under the same conditions as the wards supply of CD medications.
- FP10 prescription pads which are prescriptions pads that a doctor would write a prescription for medicines on for a patient and the CD order books were all stored appropriately in the CD cupboard in line with the trust policy as these items are considered as controlled stationery. This prevented them from being used inappropriately/abused.
- The trust employed their own pharmacy staff, including pharmacists and pharmacy technicians. The pharmacy technicians were responsible for monitoring the wards stock of medications and reordering where required. The pharmacy technician was also responsible for making sure all patients had a two-week supply of medications in their patient own drugs (PODs) cupboards in case they were discharged. It was trust policy that all patients discharged from the trust had a two week supply of medications.
- A pharmacist we spoke with at the Cavendish hospital told us that they were responsible for medicine reconciliation; checking prescriptions were accurate, looking for possible contraindications (a condition or factor which may cause harm if certain medicines are administered) with medicines prescribed and also monitoring patients' renal and liver functions. If there were any concerns with the medicines prescribed or with possible medications causing altered results, they would advise on steps that staff would need to take.
- As part of the patient's initial admission assessments, staff risk assessed all patients for self-administration of medicines. Level one patients' would continue to have their medications administered by the ward staff, level two patients were deemed to be able to self-administer with supervision and education, level three patients were deemed to be able to self-administer their medication with no supervision.
- All patients discharging home should be at a level two before discharge with only minimal supervision from ward staff, unless they were due to have carers administering medicines on discharge. As all patients are encouraged to be self-administering medications when they returned home, pharmacy staff provided an example of where they had tried to support a patient preparing for discharge by setting up an alarm on their phone to remind them when their medication was due.
- Pharmacy staff covering the Cavendish hospital said if carers were administering medication to patients at home, they provided a MAR as part of the discharge paperwork. This meant carers were aware of what medications the patient should be receiving.
- Oxygen provision for the service was through the use of oxygen cylinders. All oxygen cylinders were stored in an appropriate way and in rooms with doors labelled accordingly in line with medical gases requirements.
- The trust completed regular audits on omitted doses, treatment cards and controlled drugs administration. The inpatient ward areas all participated in these audits and the results showed there was inconsistent practice across the community inpatient wards. The CD audit for storage and record keeping showed that Fenton ward and Alton ward were consistently achieving high standards; however Ilkeston theatres and Okeover Ward were consistently failing to meet the standard set. The treatment card audit also demonstrated inconsistent practice with only 50% of the wards achieving the set standard. Both of these audits had action plans for those areas not achieving the standard. The trust will complete a re-audit later in 2016 to see if there have been any improvements.
- All medicines that were no longer required or out of date were destroyed in accordance with trust policy.

Environment and equipment

- Across the inpatient services, the environments ranged from older/listed buildings to more modern environments which considered the relevant building guidance. In some wards, there was evidence of ongoing improvements made to the environments.
- All of the wards we visited appeared safe with restricted access to the wards through the use of a pass system. For visitors wishing to visit the wards, staff would have to let people in. This also meant there was a controlled access out from the wards which reduced the likelihood of patients who may be confused absconding from the

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ward. We also checked six windows on Oker ward and found that all six had window restrictors in place reducing the risk of serious incidents involving patients falling or trying to leave this way.

- On Alton ward at Clay Cross hospital, the ward had a single en-suite room called the cedar room which was away from the main area of the ward which meant the patient was not visible to the staff. The nurse in-charge of the ward, told us risk assessments were completed to make sure that suitable patients were allocated to the room.
- We observed clinical and domestic waste was correctly segregated and waste bins provided for the wards were compliant with health technical memorandum (HTM) 83 as they were fire retardant as well as being enclosed and foot operated which are requirements under the larger waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy.
- All ward areas had standardised resuscitation equipment which had security tabs present. Systems were in place to check all equipment on a weekly basis and we saw documented evidence of staff completing these checks. The trust had recently taken steps to standardise all resuscitation equipment and the checks made on the equipment. All staff we spoke with said they had not identified any problems.
- There was plenty of equipment for staff to use for safe moving and handling of patients. This also included ceiling tracked hoists which were located in some bays in the inpatient services as well as the regular hoists and standing aides.
- On Butterley ward at Ripley Hospital, staff said they regularly nursed bariatric patients. Bariatric is the medical term used for patients who are clinically obese. Bariatric frames and commodes were readily available, additional equipment could be ordered if required.
- Pressure ulcers were identified as one of the top risks for the trust. Staff told us that they had adequate equipment for patients who were identified as at moderate or high risk of developing a pressure ulcer. This included a range of mattresses and cushions for patients to use whilst as an in-patient.
- All wards had access to pressure/sensor equipment which was used to detect movement in patients who were at high risk of falls. Nursing staff on the wards told

us that they had adequate amounts to meet patient needs. If they had an increase in patients who required these devices they would be able to order these items in.

- All electrical equipment we inspected had been checked annually as per portable appliance test (PAT) recommendations.
- All staff we spoke with told us they did not have any problems with the amount of equipment they had to enable them to do their job. If they did have a requirement for an item of equipment, there was a contract in place, which enabled them to request the equipment, which was usually delivered to them the same day.

Quality of records

- We reviewed 10 sets of completed patient records across the service. These were all paper-based records as the new electronic system had not been implemented across the inpatient services.
- All 10 sets of records we reviewed showed evidence of thorough risk assessments, this included but was not limited to nutrition and hydration assessments, falls risk assessments, moving and handling assessments and pressure ulcer risk assessments. These were completed in a timely manner after the patient had been admitted and we saw evidence they were regularly reviewed.
- We saw evidence of individualised care plans for each patient, based on the outcomes of risk assessments. Care plans had documented notes detailing the patient's progression or regression with their care and were up-to-date and completed to a good standard in accordance with professional standards by both nursing and medical professional bodies.
- There were separate records for nurses, doctors, advanced nurse practitioners (ANPs) and therapists. This did not appear to create confusion as to where to document important knowledge.
- All of the patients' risk assessments and care plans were located at the end of the bed with the patients medication administration record (MAR), the separate records of the ANP, therapists and doctors were stored in a notes trolley in a lockable office. Although confidentiality was maintained for the medical notes, the same could not be assured for the notes which were kept at the end of the bed. There was evidence of personal details being documented in these notes as well as personal details about the care being received.

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- Staff assured us that printed handover sheets were all collected in at the end of a shift and shredded as confidential documents; however, we did not see any document control in relation to these items. There was no method used to identify which number document staff had been given and before we left the ward, we offered the staff our handover sheets back, we were not asked for them by the staff. All handover sheets are stored electronically in case there are any incidents in the future which require investigation.
- During our inspection, 50% of the staff commented on the poor quality of the documentation by some of the attending practitioners from the out of hours service which provided medical cover. Their concerns mainly centred around the admission documentation and their documentation on the medication administration record (MAR).

Cleanliness, infection control and hygiene

- All areas we visited during our inspection were visibly clean. This was supported by most recent patient led assessment of the care environment (PLACE) data which demonstrated a high compliance rate of cleanliness in the ward areas of 99.70% which is above the national average of 97.50%.
- Staff demonstrated knowledge of the standards for good hand hygiene and were not afraid to challenge other staff and visitors. An example of this was on Butterley Ward at Ripley Hospital where members of the inspection team were asked to decontaminate their hands when entering the care environment.
- The average hand hygiene compliance for inpatient services was 99% for May 2016. All wards and the DTC achieved 100% apart from Okeover Ward and Fenton Ward who scored 95%. Actions have been identified for these wards to try and increase compliance including monthly hand hygiene audits until they consistently score 100%.
- Although the inpatient services demonstrated high compliance with hand hygiene, during our inspection, we observed mixed compliance with the World Health Organisations (WHO) five moments for hand hygiene. The WHO five moments for hand hygiene are guidelines for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene. During a five minute period of observation, there were six opportunities where staff should have performed hand hygiene. Staff took up only 50% of the opportunities. The moments missed were before patient contact, after patient contact and after contact with the patient's environment.
- During our inspection, we saw all patients were encouraged to clean their hands prior to eating their meals through the use of hand wipes placed on their meal trays.
- Infection prevention control (IPC) champions were identified for each ward environment. Those identified as a champion received a more in-depth educational package from the IPC team. The champions were responsible for conducting hand hygiene audits on their wards.
- During our inspection, Oker ward at Whitworth Hospital had closed temporarily due to a confirmed norovirus outbreak. The ward staff had worked swiftly with the IPC team to contain the outbreak and prevent further transmission to other patients and visitors.
- There was a provision of side rooms on all wards, which staff prioritised for known or suspected infectious patients. Some of these side rooms had an en-suite facility. If infectious patients were in a side room with no en-suite facility, bathrooms were designated for sole use by that patient. During our inspection, there were no infectious patients using the side rooms.
- We saw evidence of regular flushing of all water outlets on the wards, which was in line with the requirements of health technical memorandum (HTM) 04-01 the control of Legionella, hygiene, "safe" hot water, cold water and drinking water: part A. All documents used to record the flushing were scanned and stored electronically.
- The IPC team had recently changed the MRSA screening policy for patients. The new policy only required patients who were admitted for surgery at the DTC in Ilkeston, patients transferred out of the wards for further procedures or patients with a previous history of MRSA to be screened. MRSA screening results for the trust showed that there is 100% compliance with trust policy.
- There had been no cases of MRSA bacteraemia in the last 12 months, although the lead for the IPC team did tell us that they had seen four MRSA infections between April 2015 and May 2016. As MRSA infections have the potential to escalate in seriousness, the IPC lead asked the ward to complete root cause analysis (RCA) investigation on them. The outcomes of the RCAs conducted identified no lapses in care.

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- There had been six cases of *C. difficile* infection between April 2015 and May 2016. No lapses in care were identified in any of the six cases following a detailed RCA. Despite there being no lapses of care identified, the IPC team continued to work hard in the management of patients with diarrhoea, including the regular use of Bristol stool charts to help staff identify earlier if patients were developing diarrhoea. A Bristol stool chart is a chart which documents the type and frequency of stools/faeces a patient is passing.
- We saw evidence of a well embedded process for recognising when items of equipment are clean. All ward areas that we visited during our inspection used the 'I'm clean' stickers for items of equipment once they were decontaminated following use. During a visit to Hudson ward at Bolsover hospital, we observed staff decontaminating items of equipment immediately after patients used them.
- We observed adequate amounts of wipes used for decontaminating items of equipment around the ward areas which were readily available for staff to use.
- We observed staff using personal protective equipment (PPE) appropriately during our inspection. The IPC team did not complete regular audits of PPE compliance however, information provided by the trust showed the team regularly visited the ward areas and challenged non-compliance and provided additional on-site support to staff if this was required.
- The trust IPC team told us about the successful way in which Fenton ward at Cavendish Hospital had cared for patients who were colonised with Carbapenemase producing Enterobacteriaceae (CPE) without any further transmissions of this organism (bug). CPE is an organism which is highly resistant to a wide range of antibiotics including Carbapenems which are usually used to treat serious infections and can be easily spread between patients if careful infection control practices are not carried out.
- The cleaning of the inpatient areas was completed by an in-house service. Their cleaning schedules and audit compliance was set in line with the National Specifications for Cleanliness in the NHS. Cleaning audit data provided by the trust demonstrated compliance with the 95% target for high risk areas in the inpatient ward areas. Data provided by the trust showed that the DTC had achieved 93% in their April 2016 cleaning audits which is an improvement since their March 2016 audit which showed 86.3% compliance. As this is considered a very high risk area, their target compliance should be 98%. No action plan was submitted in regards to how this gap in compliance will be addressed.
- There was a rolling deep clean programme for all the inpatient ward areas and DTC. Staff on the wards told us this happened every six months, however we saw no documented evidence of this. If they had an infectious patient in the side room which required a deep clean after the patient had left, there were hydrogen peroxide fogging machines which all house keepers were trained to use.
- The domestic staff regularly cleaned the carpeted area that was in the therapy room on Hopewell ward. On our inspection we saw that it was clean and stain free.
- During our inspection, we found on one ward there were many clinical waste bags left in the corridors of the ward. This provided not only a potential infection risk to staff, patients and visitors, but also presented as a trip/fall hazard too which is a significant risk to those patients who are especially there on a rehabilitation programme.

Mandatory training

- Mandatory training consisted of essential learning for clinical staff, fire and information governance. The trust set a target of compliance at 95%, the inpatient services currently demonstrated 96.2% compliance with fire safety and 96% compliance with information governance. Resuscitation training was part of the mandatory programme which all staff must complete. The trust compliance target was set at 95%, however data provided by the trust showed that this target was not being met as only 90% staff had completed this training.
- Essential learning is training which all clinical staff must complete as part of their mandatory training. This package consisted of health and safety, infection prevention and control, safeguarding children level 1, safeguarding adults level 1 and moving and handling. The trust set a target of compliance at 95%, the inpatient services were at 94.6% compliance at the time of our inspection.
- All wards provided data about their compliance with mandatory training as part of their Quality Always assessments. Staff told us although it was the individuals responsibility to make sure they were up-to-

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date with their training, ward managers would also be aware of when staff were coming up to their renewal date and would prompt them to book on to the required training.

Assessing and responding to patient risk

- All patients who were located on inpatient wards had observations completed at least once per day. Staff then completed an early warning system (EWS) assessment to identify if a patient's condition was changing or deteriorating. The EWS system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance.
- Staff told us if they had a patient with a higher EWS, they would highlight this to the GP/ANP or if it was out of hours, to the DHU practitioner. Staff completed a situation, background, assessment and recognition (SBAR) form to provide more information on the patient's condition. The forms assisted the reviewing practitioner with identifying if further treatment was required. During our inspection, we saw evidence of where SBAR forms had been used for patients who required transfer to an acute facility.
- Staff said they would arrange for an immediate transfer to the local acute hospital for patients suspected of having sepsis, as they were not able to provide the level of care that would be required. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. A senior ANP told us although they would be unable to administer any antibiotics, they would cannulate the patient (insert a small tube into the patient's vein) and administer intravenous (IV) fluids to help stabilise the patient prior to them being collected by an ambulance.
- If patients required other risk assessments not covered by those in the self-care assessment book, nursing staff would complete individualised risk assessments for these patients. During the inspection, we saw evidence of staff completing assessments for patients with hospital anxiety and depression and geriatric depression.
- All staff were issued with a printed handover sheet which contained details of the patient's current medical

status as well as any previous medical history, if they were for resuscitation, and the current status of the care being provided, including any indicators for reviewing relevant risk assessments.

- During a multidisciplinary team (MDT) meeting, we observed staff discussing each patient and the risk assessments conducted for each patient. The discussions focused around reviewing status of risks and if any further input should be given to mitigate those risks.
- For patients at risk of falls, staff used the boards behind their beds (Pippa boards) to highlight this to all other staff members by using a red 'F' card. These patients would also have a movement sensor or cushion to alert staff if they were about to stand or move unattended. Patients deemed at a high risk of falls would be allocated a bed that was near to the nurse's station so that staff could monitor them.
- During our inspection of the DTC at Ilkeston hospital, we observed staff using stop the line effectively and appropriately and felt assured that systems were safe in the theatre department. Stop the line was an initiative focused on safety which empowers all staff to be able to stop proceedings if they believe that an activity being conducted could lead to patient harm.
- We also saw evidence of individualised care rounds records being kept for patients. This was a checklist which staff completed on a regular basis, dependent on the patient's need and assessment of risk. Activities included on these checklists included skin checks, continence or toileting checks, repositioning checks and fluid checks.

Staffing levels and caseload

- Across the inpatient wards and the DTC, there was 11.74 whole time equivalent (WTE) vacant posts for registered staff and 0.56 WTE vacant posts for unregistered staff. Staff told us there was an active recruitment programme in place for the vacant posts.
- Between May 2015 to April 2016 data provided by the trust showed Okeover Ward at St Oswalds Hospital had a higher rate of permanent staff sickness for both registered and unregistered staff. Rowsley ward also reported a higher rate of permanent staff sickness for both registered and unregistered staff.
- There were three wards which had been highlighted as having a higher than trust average for staff turnover, these were Baron ward at Babington Hospital, Hopewell

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ward at Ilkeston Hospital and Okeover ward at St Oswalds Hospital. Hudson ward also reported a higher staff turnover which was in relation to a reorganisation of staffing on the ward.

- Staff on most wards we visited told us staffing was stable with few staff leaving and minimum long periods of staff sickness.
- There was no national established guidance for community inpatient services staffing ratios. The chief nursing officer (CNO) had used the Royal College for Nursing (RCN) guidance on safe nurse staffing levels in the UK for establishing a minimum staffing level. During the day, there would be a ratio of 1:8 (one nurse to eight patients) with support from unregistered staff. During a night shift the CNO was keen for wards to have a minimum staffing ratio of 1:11 (one nurse to 11 patients) with support from unregistered staff. Whilst setting these minimum staffing levels the CNO was keen to make sure the wards had the right number of staff not only for patient reasons, but also because a large number of the hospitals were located in quite isolated areas and therefore appropriate staffing numbers of wards was required for safety reasons for both staff and patients.
- During our inspection, we found all wards had details about their required staffing and their actual staffing numbers. All wards were showing that they had the number of staff that they had planned for.
- There was an established use of an acuity tool across the inpatient services. An acuity tool is a tool which is used to assess the dependency of patients admitted so that nursing managers can make decisions about staffing levels and skill mix required to provide safe care. Ward managers told us that they updated this three times per day.
- There was a strict admission criteria which empowered ward managers when it came to making decisions on accepting patients. Occasionally, some wards would accept patients who did not fully meet the admission criteria if their current acuity levels were low, but this would be on a case by case basis and would include discussion with senior managers.
- The overall usage of agency staff in the trust was below 2%. In the inpatient services, there was varied usage of agency staff. On the whole, most ward staff told us that they hardly used agency staff. Other ward areas said that their agency usage was variable with some wards experiencing high agency use because of staff sickness or absence.
- During our unannounced inspection, Oker ward at Whitworth Hospital had two bank nurses in-charge of the shift who were supported by healthcare assistants (HCAs) who were regular staff from that ward. Both of the bank nurses had completed a small number of previous shifts on Oker ward and other wards in DCHS. This could be problematic due to the bank nurses not having the in-depth working knowledge of the ward and there may be differences in the day-to-day running of the wards, however this did not pose a risk to patients.
- We saw documented evidence that agency and bank staff underwent a local induction to enable them to be familiar with wards they were working in. We spoke to an agency member of staff who confirmed they had received an in-depth local induction which included being shown where the resuscitation equipment was located, where the fire exits were and a demonstration of the emergency buzzer.
- There were advanced nurse practitioners (ANPs) who worked on all of the wards covering from 9am until 5pm, Monday to Friday. On Baron ward at Bolsover Hospital, they also had a doctor covering the ward until 5pm, Monday to Friday. This doctor also covered Clay Cross Hospital. The out of hours cover for the ward areas was provided by an external agency from 6pm Monday to Friday. They also covered all day Saturday, Sunday and Bank holidays. Doctors and ANPs recognised there was an hour each Monday to Friday when there would be no cover for the ward areas. The ANPs we spoke with told us that they would be flexible with the hours that they worked so that this hour would be covered by either themselves or the doctors employed by the trust. There had been no reported incidents between this hour.
- In the community hospital wards, GPs from medical practices in the local community visit the wards to review patients. Staff on Fenton ward at Cavendish Hospital told us they usually had visits from GPs twice a week. On Oker ward at Whitworth Hospital, staff there told us they had visits from local GPs four times per week. The service level agreement with the local GP practices also provided cover and support to the community hospitals between the hours of 5pm and 6pm Monday to Friday before the out of hours service took over.

Are services safe?

- During our inspection, staff told us on some of the wards, they had consultant input from local acute hospitals who would attend the wards once a week to complete a ward round. We asked the trust for further information about consultant visits to the inpatient ward areas but this was not provided.
- There was a mixed response from therapy staff about the staffing numbers. Some therapy staff stated there was enough staff to provide the required therapy for the patients, however other members of therapy staff were not as positive. One member of staff said that there were not enough staff to provide all the required classes and breakfast clubs which would usually be provided in a rehabilitation setting.

Managing anticipated risks

- The trust had an in-depth business continuity policy, which covered what actions would be implemented, for

example, in adverse weather conditions. Due to some of the locations of the hospitals, this was taken very seriously by the wards and all staff we spoke with were aware of the policy with some staff telling us when the policy had been implemented. When asked, staff could demonstrate where they would find this policy on their intranet.

- There was a policy available for staff to follow for transferring out of patients who had been identified as deteriorating in their condition. All staff that we spoke with were aware of this policy.

Major incidents awareness and training

- Most of the staff we spoke with were aware of regular fire training. They also told us about practice ward evacuations that were conducted as part of this training.

Are services effective?

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

We rated the effectiveness of the community inpatient services as good.

We found:

- We found positive examples of evidence-based practice used throughout the hospitals.
- Staff regularly assessed patients for pain and responded to those reporting that they were experiencing pain in a timely manner.
- The nutrition and hydration of patients was appropriately assessed and actions taken where necessary. The food provided by the wards scored above the national average on the Patient-led Assessments of the Care Environment (PLACE) audit conducted in 2015.
- There was a well-established process for patients who had failed to recover adequately following their day treatment procedure to be transferred to the operating surgeon's acute hospital.
- There was evidence of good multi-disciplinary team working.
- Staff were encouraged to attend further training and conferences as part of their continuous professional development (CPD).
- Although there is limited opportunity for the service to participate in national audits, there was evidence of the service participating in those audits deemed relevant.

However we found:

- There was minimal data on patient outcomes being collected which was therefore making it difficult to identify if patients were improving following the care they received.
- Admissions and discharges were generally well planned although this still resulted in significant delayed discharges attributed to delays in organising ongoing care which was beyond the control of the wards.

Evidence based care and treatment

- Staff worked towards National Institute for Health and Care Excellence (NICE) guidelines for the assessment and treatment of pressure ulcers. The lead nurse for the tissue viability service told us that the policy and tools

used by the trust were all based on this national guidance. All inpatients had a pressure ulcer risk assessment on admission with a regular review of at least weekly and we saw evidence of the completed reviews.

- Staff provided evidenced based care in line with NICE guidance for falls in older people. Risk assessments and management strategies implemented in inpatient ward areas were in keeping with national guidance.
- National Safety Standards for Invasive Procedures (NatSSIPS) have been created to bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses in a set of recommendations that will help NHS organisations to provide safer care to their patients. Local Safety Standards for Invasive Procedures (LocSSIPS) were produced locally in the DTC as per the national guidance. Staff were linking in with the local acute hospitals to further work on their local guidelines and training of staff in the department.
- In the DTC, all staff used the World Health Organisation (WHO) safe surgery checklist. This is a document based on best practice which aims to reduce the risk to patients who are having surgery. The DTC regularly completed local audits for compliance with the checklist. Data provided by the trust showed for the past 12 months, the DTC had 100% compliance with the WHO checklist.
- We saw evidence of staff conducting comprehensive assessments of patients on admission which covered most health needs including physical, mental, emotional and spiritual health as well as any clinical needs. These risk assessments formed the basis for individualised care plans which were completed for all patients and were regularly reviewed.
- Each patient had a white board at the head of their bed. Signs were used to indicate, for example, whether a patient was at risk of falling, were living with a dementia or if there were any specific dietary requirements including the use of thickener for fluids. We saw that these boards were well used and updated regularly.

Pain relief

Are services effective?

- All patients were assessed for pain during their regular observations and individualised care rounds. Staff used the pain score of zero to three and documented this on patient records. Staff used a specific pain assessment tool for patients who had cognitive impairment and were unable to verbalise their pain. This tool used a scale of zero to three.
- During a patient's admission, if they were experiencing pain regularly, an individualised care plan was completed to try and meet the patient's goals of either being pain free or having well controlled pain. These care plans were reviewed regularly and documentation of the patient's progression made.
- During our inspection, we observed staff completing pain assessments for patients and responding to patients in pain in a timely manner by administering analgesia (pain relief).
- Feedback from patients about pain management was good. One patient told us they receive regular medication for pain, but if they needed more, staff were quick to provide it.
- We saw evidence of assessments forming the basis for individualised care plans for patients in relation to nutrition and hydration, with staff regularly reviewing these care plans and documenting patient progress.
- We saw evidence of actions taken for patients where there was a medium or high risk. This included the use of the orange lidded water jugs and orange cups to identify the patient required additional prompts or assistance with drinks.
- The kitchen on Fenton ward at Cavendish Hospital had a folder with details of allergens contained in the meals which were being offered to patients. If staff were unsure about a meal which a patient had chosen, this folder was used to answer any potential concerns. This folder also contained details of meals from the menus which were considered as 'mashable' for any patients who were on a soft diet.
- On the ward, there were signs displayed that informed staff, patients and visitors that meal times were protected. This meant that patients were not to be interrupted by staff for any procedure which they might require. During our inspection, we saw meal times were protected.

Nutrition and hydration

- All inpatient wards we visited used and completed the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. The MUST tool is a five-step screening tool which is used to identify patients who are malnourished, at risk of malnutrition or are classed as obese. We reviewed 14 MUST assessments and all had been completed in 24 hours of the patient's admission, and all patients had weights recorded on each assessment.
- All of the inpatient wards we visited completed a hydration risk assessment for patients as part of the admission process. The tool used by all wards, was called the 'GULP' tool. Staff had to gauge the patients 24 hour oral intake, look at the colour of the patients urine, look for any signs and symptoms of dehydration and then plan ahead for what additional input was required in the patient's treatment plan to overcome the risk of dehydration (gauge, urine, look, plan). We reviewed 14 GULP assessments and saw staff were completing the assessments as directed to by the GULP guidelines.
- Where patients were identified as requiring additional nutrition and hydration support through the use of the MUST and GULP, we saw evidence of staff referring them to dietitians as directed by the trust policy.
- All of the inpatient wards we visited encouraged all patients to take their meals, except breakfast in the dining rooms which were located on the wards.
- During our inspection, we saw patients being offered drinks regularly. This included the regular hot drinks rounds which the staff completed usually including biscuits or cake, as well as staff regularly refilling patients' water jugs.
- Patients who required assistance with eating were given orange rimmed plates and orange handled cutlery. This reduced the time taken for staff to identify which patients required assistance so they were not waiting for help whilst their food was going cold.
- We observed staff using fluids thickener for patients who had been identified as having difficulty with swallowing.
- Patients who were identified as at nutritional risk were offered a wide range of supplements. We observed staff encouraging patients to take their supplements which were written on their medication administration records (MAR).
- All of the patients we spoke with were complimentary about the choice of food and the amounts of food that they were offered with one patient telling us that they had not been hungry at all during their admission as there was always enough food on offer.

Are services effective?

- Results from the 2015 PLACE audit showed the trust achieved 94.20% overall for their food and hydration assessment which was above the national average of 88.94%. They scored 95.42% for their ward based food assessment which is also above the national average of 89.27%. Looking at the individual results for the inpatient wards, only Bolsover Hospital failed to individually achieve a result which was above the national average, scoring 87.79% for the overall food and hydration assessment and 82.48% for the ward based food assessment.
- During our inspection, we observed staff serving food to patients. Staff checked food prior to being served to assure it was a correct temperature. All staff wore appropriate personal protective equipment (PPE) while serving food which they discarded if they went to do another task. The food looked of an acceptable standard with a choice of vegetables for patients to choose. Staff told us that if a patient changed their mind, there would always be extra available so they could accommodate this.
- Not all of the food provided for the patients was cooked on site; most of the patients' food would be warmed up on site. However, the kitchen staff working on the wards had access to fully functioning kitchens in which they could bake fresh cakes and biscuits, or hot breakfast food including porridge. During our inspection we observed a member of the staff from Baron ward at Babington Hospital bringing out some freshly cooked shortbread biscuits in time for the afternoon tea round.
- Patients could help themselves to a bowl of fresh fruit.
- Patients had access to literature surrounding healthy eating so they could make informed decisions about the food they wished to select from the menu.
- At the DTC at Ilkeston Hospital they followed the guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for pre-operative fasting. Patients who attended for a procedure were required to be fasting from midnight but allowed clear fluids until 6am if they were on a morning list. If they were attending for an afternoon list, they were required to fast from 8am but allowed clear fluids until 11am. During our inspection, we observed patients who had recovered from their procedures being offered food and drink.
- At the time of our inspection the trust was in the process of acquiring reminiscence therapy software. Reminiscence therapy software is an innovative tool which supports communication, interaction and engagement with people who may have memory problems. Staff told us about how this would improve the care they can provide patients living with dementia.

Patient outcomes

- The trust reported they completed the patient reported output measures (PROMS) national audit for hernia repairs. Data received by the trust for 2015/16 showed 72.7% of patients reported an improvement in their condition compared to the England average of 36.8%. No previous data was received by the trust for comparison due to poor participation rates in previous years.
- Staff from the DTC recognised that it was difficult to participate in national patient outcome audits due to the low numbers of patients treated in comparison to larger acute hospitals.
- Each month, the DTC completed local audits of the use of the WHO safe surgery checklists. Data provided by the trust showed 100% compliance each month. This meant staff at the DTC were maintaining a safe pathway for all patients receiving surgery.
- There was a comprehensive audit of the transfers out of the service for patients who were identified as deteriorating in their condition. This audit showed that staff assessed patients effectively leading to the correct decision to transfer patients out to local acute hospitals for further treatment.
- The physiotherapy staff utilised the Borg Scale of perceived physical exertion with rehabilitation patients in their care. Other outcome measures which the physiotherapists used were the Derby outcome measure. This is an outcome measure used to objectively determine the baseline function of a patient at the beginning of their treatment. This tool is then used to continually record the progress being made by the patient. Between January 2016 and March 2016, 72% of patients reported an improvement in the patient's outcome compared to a trust agreed local target of 65%.
- Staff from the inpatient wards completed local audits and data gathering for the commissioning for quality and innovation (CQUIN) on dementia care. The most recent report from quarter three of 2015/16 shows there

Technology and telemedicine

Are services effective?

was still more work to be done when it comes to data collection. However the trust were achieving their target for training of staff to provide improved care for patients living with dementia and also the support that staff were providing to the carers of patients living with dementia.

- During our inspection, we asked occupational therapy (OT) staff if they had any way of measuring patient outcomes. They did not record patient outcomes for patients receiving OT input.
- Up until June 2014, podiatry outcomes had been measured for Hallux Valgus (bunion) surgery and internal fixation irritation. Both of these demonstrated high patient outcomes (above 80%) and satisfaction with the outcome of the procedures. We requested data for 2015 but this was not provided by the trust.

Competent staff

- Data provided by the trust showed 19 out of 22 doctors employed by the trust had completed revalidation. Three of the doctors employed by the trust had been deferred due to insufficient evidence. The doctor who we spoke with on Hudson ward told us that they had completed their revalidation.
- The trust had provided training and support for registered nursing staff on revalidation with the nursing and midwifery council (NMC). The trust electronic staff record system had the ability to highlight to ward managers when staff from their wards were due to revalidate three months in advance. To date, seven nurses had completed the revalidation process.
- All wards displayed high compliance with appraisals, with the majority of wards showing 100% (Baron ward, Alton ward, Rowsley ward, Okeover ward, Oker ward and the DTC). The trust target for compliance with appraisals is 100% however the inpatient services including the DTC at Ilkeston were achieving 97.6% at the time of our inspection. One ward manager who had recently returned to the trust following maternity leave had only just become out of date for their appraisal, but was already in the process of arranging their appraisal. Another ward was addressing the small number of outstanding appraisals following ward leadership changes in the previous year.
- Advanced nurse practitioners (ANPs) were reviewing their appraisal process with their line managers and human resources (HR) so that they became more meaningful to them. Due to their job descriptions, the

regular appraisal didn't cover all aspects of their role which is why as a cohort of advanced practitioners they were forming a working group to create a system that would meet their requirements.

- During our inspection, ward managers spoke about an additional process which they completed as part of the appraisal system which required them to gather 360° feedback. This is a system where staff receive anonymous feedback on their performance and behaviours from people that they work with including managers and peers. The managers who we spoke with about this said that they found this a useful system.
- Trust policy stated all staff should be completing quarterly sessions of clinical supervision. Staff feedback during inspection showed variation in achievement. Therapy staff experienced difficulties completing these required sessions because they did not have access to enough qualified supervisors. Ward staff said they were managing to receive clinical supervision, with health care assistants (HCAs) completing a less formalised session known as reflective meetings. ANPs did not have any difficulties in achieving their required clinical supervision sessions and told us they had access to clinical supervisors from a wide range of services. One ANP said they preferred to access a clinical supervisor that was not in their field of healthcare as this aided a more objective session.
- Some members of staff told us that as well as the formalised clinical supervision mandated by the trust; they also sought their own peer support too. One of the ward managers told us the ward managers regularly met for peer support sessions. Another member of staff told us they sometimes felt clinically isolated from other members of staff in the same clinical field as them. To rectify this, they regularly went to members who covered the community side of therapy to receive clinical peer support.
- The occupational therapy (OT) staff we spoke with told us they completed group continuous professional development (CPD) sessions relevant to their area of work. This included the introduction of a journal club where they would take it in turn to present a journal article to the rest of the group which could influence how they worked.
- Staff told us that they were encouraged to develop their skills and knowledge by attending additional training and conferences. Some members of the therapy staff told us they were encouraged to complete the Bobath

Are services effective?

- course (a course on the assessment and treatment of individuals with disturbances of function, movement and postural control) and external fall training. The results of the NHS staff survey supported this with the trust scoring better than average for staff answering questions surrounding relevant training and the quality of the non-mandatory training they are able to access.
- The inpatient services had champions for specific services which included infection prevention and control, tissue viability, safeguarding, dementia, privacy and dignity and falls. These champions received a package of mainly in-house training to develop education and knowledge in their specific area. One ward manager told us those who had become dementia champions were prioritised to complete the external dementia friends training.
 - Staff on Alton ward at Clay Cross hospital had regular student nurses training on their wards. At the time of our inspection they had five members of staff who had completed their mentorship training and two members of staff who were sign off mentors. One of these members of staff had just completed a review.
 - Staff from the DTC told us about an apprenticeship programme which had recently run in collaboration with an acute trust. Four individuals had joined the apprenticeship where they received regular training at the acute hospital, but worked as a supernumerary member of staff alongside a buddy in the theatre environment at the DTC. At the end of 12 months, one of these individuals had been employed for a full time position. Staff told us this was a great opportunity for not only the apprentices, but also the DTC staff. It was an opportunity to 'grow their own' staff by giving them experience of working in a theatre department so they would be more ideal candidates if they applied for a job in the department in the future. This experience was extremely positive for the DTC and the managers of the department told us they hoped to repeat this again.
 - Most of the staff we asked felt they had a good understanding of each other's roles and reiterated that they worked well as a team. All members of staff we spoke with were aware of who had the overall responsibility of the patient.
 - We observed four MDT meetings during our inspection on different wards. Staff nurses, ward managers, occupational therapists (OT), physiotherapists, ANPs, discharge co-ordinators and community care workers attended these meetings. No medical staff attended the meetings that we went to however members of the MDT team told us they did attend meetings if work patterns allowed. All patients on the wards were discussed in a professional and respectful manner with regard to their current status; progress made and plans for discharge. In one meeting we observed, the MDT used the 'JONAH' method for discussing patients in relation to discharge planning. JONAH is a software supported methodology for proactive and timely management of patient discharge, focusing on constraints methodology in patient pathways. The use of this methodology has improved lengths of stay and efficient use of resources.
 - Members of the MDT on Butterley ward at Ripley Hospital had daily JONAH board rounds which reviewed patient's plans and actively looked for any actions that required chasing to improve the whole pathway for that patient. If the members of the MDT could not resolve these issues, they would escalate to senior staff for resolution.
 - Staff regularly liaised with social workers and social care providers in relation to the patients in their care. If complex cases were due to be discussed, the social worker involved in the patients care would be invited to attend.
 - The inpatient wards had access to additional members of the MDT which included but were not limited to, speech and language therapists (SALT), dietitians, community oxygen therapists, tissue viability specialists, infection prevention and control specialists, continence nurse specialists and cardiac nurse specialists. The presence of these staff would be dependent on patient need.
 - Physiotherapy and OT staff did not work weekends, however staff told us that there was an on call system for therapy staff.

Multi-disciplinary working and coordinated care pathways

- During our inspection we observed good multi-disciplinary team (MDT) working throughout the whole inpatient service. However, some of the therapy staff we spoke with told us that inpatient care was nurse led and they felt it should have been more rehabilitation focussed. Despite their opinions, this did not interfere with the way in which they worked as a team.

Referral, transfer, discharge and transition

Are services effective?

- The referral process into the inpatient hospitals was usually through a waiting list system from the acute hospitals. There was a total of nine acute hospitals that referred patients into the community hospitals in the trust. Other referrals for community inpatient services came from the GPs, although the majority of the referrals were from the acute hospitals.
- When patients were admitted into a community hospital, all patients were given an estimated discharge date of 10 days from their admission. This was reassessed at the earliest opportunity and if this was not feasible, a new estimated date of discharge was given.
- Staff from some wards told us they had a small waiting list for their beds. Butterley ward had three patients waiting to come in at the time of our inspection and Alton ward were discharging a patient and another patient was already identified to come over from the acute hospital. Waiting lists were regularly reviewed by the trust to ensure that each ward was making the best use of their beds. We asked the trust for further information about their waiting lists for the inpatient wards, but this was not provided.
- Discharges from the inpatient wards in the trust were completed any day of the week if the patient was discharging to their own home and the MDT worked well to ensure that if discharge is imminent, all paperwork and medications were completed in good time. If further packages of care were arranged, staff would liaise with members of the community team to make sure that all aspects of the care package was in place prior to leaving the ward. If a patient was discharged to another care facility, staff would discuss the appropriate time and day for the patient to be transferred.
- Discharge paperwork was completed in advance so that any documents the patient required to take with them was available. This was especially important if the patient continued having a programme of care in the community. A copy of their discharge paperwork was also forwarded to the patients GP in 48 hours of discharge to reduce any delays in continuation of care.
- Staff told us patients were transferred into their hospitals in the day time usually between lunch and dinner. However, all wards had experienced late transfers to them from the acute hospitals, with some wards receiving patients as late as 10pm. One staff member had recently experienced this and had complained as this requires the staff to call the out of hours doctors to come and complete admission documentation for the patients. All staff commented on how they felt it was not acceptable for patients to be transferred to a new environment at that time as it can cause some anxiety and orientation issues with some patients. We asked staff if they monitored late transfers from the acute hospitals but they all told us they did not do this and they did not complete incident forms for late transfers.
- The trust subsequently informed us they do monitor late transfers from acute hospitals data centrally as part of their quality contract, however we did not see this data during our inspection and staff were unaware of this.
- Staff at the DTC told us patients who did not recover well from surgery would be transferred to the operating surgeon's acute trust. This was agreed in a standard operating procedure (SOP). Staff told us of occasions when patients had been transferred acute hospitals. However there was no process to monitor the number or reasons for these transfers. One manager thought it had happened approximately four times in the last 12 months. This meant that they had no assured process for monitoring patient outcomes and would not be able to benchmark quality standards for their department.
- The policy for the patients admitting on to one of the inpatient wards was that they had to be reviewed in 24 hours of admission and their admission documentation had to be completed along with their nursing assessments. If a patient had a do not attempt cardio-pulmonary resuscitation (DNACPR) order whilst in the acute hospital, the doctors or ANPs had up to 48 hours to complete a new trust form for this patient. This allowed the community staff to have a sensitive conversation with the patient and their families. Records that we reviewed all conformed with this.
- If there was a patient who required care and treatment that could not be provided by the inpatient wards in the trust, the SOP for transferring patients back to acute hospitals was well established and staff on the wards were very aware of their roles and responsibilities in completing this. Staff told us as part of the SOP, they would keep the bed available for 24 hours if they thought that a patient only required short term input.

Access to information

- Staff told us they had good access to information. Staff used the trust intranet regularly to locate all policies. Staff also told us that they regularly received updates

Are services effective?

from their immediate managers by emails. Some staff told us that they also received newsletters. During the inspection, we saw evidence of newsletters being produced for staff which contained important information.

- All wards that we visited had a prominent white board which featured heavily in MDT meetings and contained information about patients and their care programme. This system provided relevant 'at a glance' information for staff and would be updated daily by the ward staff and helped staff to progress discharge planning.
- Patients who had been transferred from an acute hospital would be accompanied with detailed notes about their care. These files were stored in a separate filing system in MDT staff rooms. Some staff told us not all patients were accompanied with their records and this could be a problem, especially if these patients were transferred out of hours. The staff had escalated their concerns at the time through their senior managers.
- Staff on Baron ward at Babington Hospital told us a trial of an electronic notes system did not meet the requirements of ward staff. Information could not all be contained on the electronic system due to issues with some of the tools and paperwork used by staff. This led to a confusing filing system for patients, so the trial was abandoned until a smoother system could be devised. During our inspection we saw all areas using paper files for patients and this system was effective.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Most staff had a good level of knowledge about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) in all ward areas that we visited.
- We asked the trust to provide details on staff training for MCA and DoLS however this was not provided for us.
- During our inspection we observed many patients who were using a sensor cushion or attachment due to their risk of falls. Staff told us all patients who were using these items had a DoLS application completed. Unfortunately, due to the large number of DoLS applications, not all applications had been reviewed by the reviewing authority. Staff were also able to talk about other patients where they had made a DoLS application.
- A ward manager told us about their regular 'best interest' meetings with a patient's next of kin where they discussed application for DoLS. A 'best interest' meeting is a meeting which discusses decisions being made in the best interest of a patient who may lack capacity to make a decision. During an MDT meeting, a patient had been identified as potentially lacking in capacity and would therefore require assessment. The staff at the meeting requested that a best interest meeting was also set up with the patient's family.
- We saw evidence of verbal consent being obtained before care was delivered. One of the examples we witnessed was a member of staff asking a patient if they could complete a scan of their bladder. The staff member had fully explained what this non-invasive procedure would entail as part of the consent process. Another example of this was a staff member asking for the patients consent to complete a blood pressure observation.
- In the DTC, we followed two patients on their journey through the surgical pathway. Both patients gave their consent following in-depth explanations about their procedures. Along the pathway, checks were made by the staff that the consent form had been completed and the patient was asked to confirm it was their signature on the form.



Are services caring?

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

We rated caring for the community inpatient services as outstanding.

We found:

- All patients we spoke with were overwhelmingly positive about the care and treatment they had experienced. Comments including 'excellent' 'outstanding' 'wonderful' and 'brilliant' were often used to describe the care received from all of the staff working in inpatient services and patients believed staff went the extra mile for them. This included house keeping and domestic staff, not just clinical staff.
- Patients felt involved in their care and they were treated with dignity and respect throughout their admissions. There was a strong, visible, person centred culture demonstrated on all wards that we visited.
- Friends and Family Test (FFT) data reported a consistently high percentage of patients would recommend the service to their friends and family.
- Data from the two Short Observational Framework for Inspection (SOFIs) that were completed was positive. SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us. Many positive patient and staff interactions were observed throughout both SOFIs.
- Patients and their relatives were shown the highest level of compassionate care and emotional support during their admission and this was embedded in the provision of the care and treatment they provided.
- Staff identified ways in which they could provide care and support to patients when they had been discharged.
- All staff were committed to providing high quality patient centred care. Staff took their time to provide patients with all the relevant information about their care and answered questions that patients and their relatives had with sensitivity and patience.

Compassionate care

- During our inspection, we spoke with 40 patients and 14 relatives about their experience with the service. All patients reported overwhelmingly positive experiences about their care and told us how happy they were with

the way staff treated them despite acknowledging that at times staff were busy. Comments made by patients included the words such as 'excellent' 'wonderful' 'brilliant' and 'cannot find any fault'. One patient in particular could not speak highly of the services they received and made a point of stating that they had experienced many different hospitals. This was reflected in comments made about all staff involved in the care of a patient, from cleaners to matrons.

- The trust used the NHS Friends and Family test (FFT) to obtain feedback from patients. The FFT is a single question survey which asks patients whether they would recommend the NHS service to their friends and family.
- The most recent FFT results from March 2016 showed that 99% of patients who responded would recommend the community inpatient services to their friends and family. This is above the England average and trust target of 95%. Results of the FFT were consistently between 98 to 100% for community inpatient services between April 2015 and March 2016. On all of the wards we visited, we saw they had the results of their FFT on their Quality Always boards.
- Staff told us they did not complete their own individual satisfaction surveys; however we did observe wards collating information about all comments, concerns and compliments they received from patients and their relatives. Data on the number of compliments and concerns was displayed alongside the FFT results on the Quality Always boards.
- All patients told us staff maintained their privacy and dignity at all times when they were providing care. During our inspection we observed staff maintaining patient's privacy and dignity whilst providing care by closing the curtains around their beds. Patients who we spoke with also told us staff were very respectful towards them as well.
- During our inspection of the Day Treatment Centre (DTC) we followed two patients on their surgical pathway. At all stages of their journey, the patients had their privacy and dignity maintained.



Are services caring?

- The Patient-Led Assessments of the Care Environment (PLACE) results from 2015 showed the inpatient wards achieved 87.44% for their privacy and dignity assessment which was above the national average of 86.03%.
- Staff were observed maintaining a patient's confidentiality by lowering their voices when discussing confidential or potentially embarrassing matters with the patient.
- Patients continuously told us the staff were very responsive to their needs including if they were in pain or needed general assistance. We observed staff answering the call bells promptly and approaching patients in a calm and reassuring manner.
- We saw staff assisting patients down to the dining rooms where assistance was required as well as helping patients with any condiments they required.
- During the inspection, we carried out two Short Observational Framework for Inspection (SOFIs) at Bolsover and Ilkeston hospital. SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us. The evidence from these observations showed staff were very quick to respond to patients needs and did so in a professional and caring manner. The interactions were all very positive between staff and patients, with staff demonstrating empathy towards patients and reassuring those who required it. We also observed staff and patients interacting in a happy and jovial way whilst sharing a joke.
- Staff assessed patient's individual needs and preferences. An example of this was on Alton ward where a husband and wife had been admitted on to the same ward. As part of their preferences and requirement for supporting each other, staff had allocated them in a bay together.
- Patients told us all members of staff encouraged them to be independent and were very patient with them, however if they required help they were very accommodating and warm whilst helping them.
- On the wards we visited we saw call bells and water jugs were all in reach of patients. Comments made by patients reinforced that staff would regularly check to make sure they had enough water as well as being able to reach it.
- During our inspection, we saw not only evidence of compassionate care being provided for patients, but also to their relatives and visitors. A relative told us staff always asked how they were feeling and always offered to wheel them to the entrance of the hospital as they themselves were not very mobile. Another relative told us about the care they had received during the five weeks their husband had been admitted and summarised it with "they have been angels to both me and my husband".
- Another example of where staff had provided compassionate care for both the patient and their family was during Christmas when they had supported the family of a patient to decorate their room to make the patient feel at home on the ward. The relatives commented on how they had felt part of the ward as the staff had been so supportive of them.
- On Baron ward, staff told us they were nominated for a care and compassion award by a patient that had been nursed by them.
- We saw evidence of staff respecting patients' social needs. Patients were encouraged to socialise with other patients during their time on the ward. An example of this was on Hudson ward where patients were encouraged to engage in the activities on the ward. Patients told us how much they valued having this available to them as it gave them something to do and keeps their minds active. They also appreciated the extra lengths the activities co-ordinator went to, to meet their social needs. We also saw staff being respectful of patients' wishes if they did not wish to join in.

Understanding and involvement of patients and those close to them

- We saw nurses and therapy staff taking time to clarify patients' understanding of their care and treatment. This was also supported by comments made by the patients we spoke with. One patient told us about the sensor alarm they had. The patient could give us with a clear explanation as to why they had been given this sensor due to their risk of falling. Another patient was able to provide a clear reason why they required a soft diet. A patient also told us that they are always kept fully informed as to what is going on with their care and treatment.
- If patients had not understood fully what was going on with their care and treatment, patients and their relatives were confident to ask staff questions. One patient told us that it's never too much trouble for staff to spend the time with you and to explain things again if necessary.



Are services caring?

- We observed staff providing family members with an update of their relative's condition when there had been a significant change. They were very respectful and supportive of the relatives and also acknowledged the patient during this interaction rather than talking about them.
- On Oker ward all patients were left with cards which they could note down any questions that they thought of to ask the staff. Staff would then review them regularly and answer any questions they could.
- Many of the patients and relatives we spoke with made reference to staff involving them by asking them for their permission and consent before doing something. Comments made for example were "staff do not just do it, they involve you and ask you first" and "staff always ask if they can do something they never assume".
- The staff were very respectful of the patients and all patients told us staff never just went ahead and completed an aspect of their care or treatment without their consent. All staff treated patients in a dignified manner. This also extended to the relatives of patients. The caring did not just stop with the patient, it extended to the whole family. Comments made by relatives demonstrated this by relatives providing examples where staff checked on their welfare when they visited the patient.
- All wards we visited were promoting the Johns Campaign which encourages the involvement of relatives and carers in the care of patients living with dementia. This encourages the relatives and carers to work with the ward staff so they can be available at all times of the day to help meet the patient's needs. To make it easier for relatives and carers to be involved the wards gave them passes so that they could access the ward at times convenient for the patient and they were offered food and drinks along with the patient. This demonstrated to them that staff understood the importance of having those close to them with them at all times.
- We saw evidence of staff recognising when patients required additional support to help them to communicate. We saw one example where a staff member was helping a patient who was hard of hearing to communicate. They were speaking to the patient in a way which made it easy for them to understand through lip-reading. There were also examples of staff using pictorial cards to help patients to select what they would like to eat.
- We saw therapy staff helping patients to be involved in their discharge planning by taking photographs during their home visits which they then discussed any issues with the patient in regards to functional needs and based any further therapy around so they will be safe on discharge.

Emotional support

- During our inspection, we observed a relative who had been found in tears in the corridor by a member of staff. The member of staff went over to them and took them to a more suitable environment on the ward and provided them a drink and the opportunity to discuss with them their concerns and feelings.
- A patient told us during our inspection that if they required emotional and spiritual support, staff had told her that they have regular access to members of all religious faiths. The trust had access to a chaplain who worked part-time that could be contacted on patients' request. On Butterley ward in Ripley Hospital, staff told us that they had a good relationship with the local vicar who regularly visited the ward. They also had access to other faith leaders should they be required.
- The service had clinical nurse specialists available to provide patients with additional support and advice if required. Examples of most commonly used specialist nurses on the ward included palliative nurses, the dementia specialist nurse and cardiac nurses.
- We observed staff providing emotional support and reassurance to patients who were distressed or confused by sitting with them and talking to them calmly and reassuringly
- On Fenton ward, a patient told us staff had taken all the steps to make sure that she would be safe to manage her own care at home which included making her room as realistic to her home surroundings as possible and helping to input reminders on her phone for when she would need to take her medications. She told us her care had been excellent and could not have had more support from staff.
- We observed staff signposting patients and their relatives to appropriate organisations where further support could be accessed if they felt that they required it. An example of this was staff signposting a patient and their relatives to the Parkinson's association.



Are services caring?

- Pet therapy was used on the wards where patients living with dementia were accommodated. The pets usually invited into the wards were dogs. Pet therapy calmed patients living with dementia, but also brought out a more social and interactive response from the patient.

Are services responsive to people's needs?

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

We rated the responsiveness of the community inpatient services as good.

We found:

- There was a proactive approach to understanding the needs of different groups of people including those who were considered in vulnerable circumstances. Actions had been taken in all wards to try and provide care for all groups of patients which was individualised.
- Significant actions had been taken to improve the care and treatment provided for patients living with dementia.
- Patients were able to access the service in a timely manner and care and treatment was co-ordinated well with other providers.
- Staff were encouraged to resolve complaints and concerns locally, which was reflected in the low numbers of formal complaints made against the service in the last 12 months. Learning from complaints was evident.
- Cancellations for surgical procedures were low. Patients who had their operations cancelled were quickly re-booked for another day which suited them.
- Bed occupancy rates for 2015/16 had dropped by over 10% from the previous year and were recorded at 74.6% at the time of our inspection.

However we found:

- Patients told us they were not aware of the correct procedure for raising a complaint or concern; however they would still feel confident about raising concerns and complaints to the ward manager or matron if they had any.
- There was confusion amongst staff as to what the target length of stay was for patients.
- The bed capacity for the wards was reducing and staff were unsure as to why this was.
- Therapy staff were not available at weekends on the wards.

Planning and delivering services which meet people's needs

- Services were planned and delivered in a way that met the needs of the local population, but were also flexible

to deliver services which met individual patient's needs. An example of this was on Alton ward where staff had planned for a patient from Wales to have care provided at their hospital because they were due to be discharged to their relatives house, but would still require therapy input in the community. This enabled continuity of the patients care and enabled a relationship to build prior to discharge.

- The trust worked with four main clinical commissioning groups (CCGs) to plan and deliver services across the population of Derbyshire.
- All of the inpatient wards had reduced the number of beds open. Regardless of their total capacity, all wards had 16 beds open apart from Alton ward who still had 17 beds. Staff told us this was a strategic decision which had been made by the senior management team
- One ANP told us they had recently been working closely with the community oxygen therapists to try and progress a patient to the point where care could be delivered at home. This had been a very successful experience for the patient predominantly, but the ANP spoke of how this had been a shining example of the great level of MDT working. They continued to tell us they regularly work closely with specialist nurses as they themselves are not specialists in everything so rely on their specialist knowledge when planning a programme of care for patients.
- The day treatment centre (DTC) planned their surgery lists to accommodate the needs of the local population. The senior management team told us if there was an increased need for a specific surgical speciality, they would accommodate this by additional lists to meet the demand.
- Managers in the wards told us there was an increase in the number of patients living with dementia. To meet the needs of these patients, improvements to the environments and additional activities and equipment had been delivered to wards. In Hudson Ward, there was an activities co-ordinator who planned and provided activities for patients.
- Therapy staff would provide care and treatment for patients during the weekdays. If a patient needed to continue their therapy treatment at the weekends, they would plan a programme to be supervised by ward staff.

Are services responsive to people's needs?

Equality and diversity

- Policies were in place to ensure that the equality and diversity of staff was respected. On Hudson ward, a member of staff told us that the Willow suite could be used for staff prayers.
- Equality and diversity training was part of the mandatory training programme and completed as a face-to-face training session or e-learning session. We asked the trust to provide data on the number of staff that had completed their equality and diversity training but this was not provided.
- Staff could access translation services 24 hours a day if necessary and staff knew how to do so.
- Although staff were knowledgeable about their access to translation services, there appeared to be less knowledge about access to British sign language (BSL) interpreters. One ward manager told us they had never had a patient who required that service but was happy they would be given adequate amounts of time to arrange this.
- The trust had taken action to provide literature for patients and posters in languages other than English. We saw patient leaflets in other languages and welcome signs in Bolsover hospital that contained a variety of other languages.

Meeting the needs of people in vulnerable circumstances

- The trust were very focused on improving care for patients living with dementia. Many of the ward staff told us many of their patients were living with dementia, which was why there had been a focus to get the care right for these patients. During our inspection, we visited three wards where steps had been taken to improve the environment so it was more suitable for patients living with dementia. This included using colour coding for the bays where patients were allocated to assist with orientation and also coloured toilet seats.
- All of the wards in the trust had access to orange-rimmed plates, orange tumblers and adapted cutlery for patients who required these. During our inspection, we saw evidence of these items being used.
- The most recent result from the Patient-Led Assessments of the Care Environment (PLACE) from 2015 relating to dementia was 79.74% which was above the national average of 74.51%. The assessment for how facilities meet this requirement is new to the PLACE

assessment and looks at how the environment is designed to meet the requirements of a patient living with dementia. Staff told us there had been a lot of improvements made since this last assessment and are hoping for a better result in the next assessment.

- All of the inpatient wards in the trust had fully implemented the principles behind John's Campaign. John's Campaign is a campaign for family and carers of patients living with dementia to stay with them whilst they are in hospital. Staff who we spoke with told us how they welcomed the family and carers of patients living with dementia at all times and tried where possible to accommodate them if they wished to stay with them. On Baron ward, staff told us how they would make sure the family or carers staying with a patient were offered a meal as well and were encouraged to sit with them in the dining room. During the inspection, we saw evidence of this being put into place.
- All of the wards had at least one dementia champion. Dementia champions received an enhanced training package to increase their own knowledge and provide a source of knowledge for their colleagues. The trust had a dementia nurse specialist who provided staff with information and advice on patients living with dementia.
- Throughout the inpatient wards, there had been an increase in the amount of equipment that was available for patients living with dementia. During our inspection we saw evidence of jigsaws, dominoes, fidget boxes and twiddlemuffs being used by patients. Twiddlemuffs are double-sided knitted muffs with various soft items attached both inside and out. People living with dementia often have restless hands and like to have something to keep their hands occupied. We also saw one ward had purchased a robotic seal (Paro-seal) as part of increasing their dementia friendly ward. The paro-seal is aimed at reducing the anxiety in patients living with dementia.
- Hudson ward at Bolsover Hospital had an activities co-ordinator who provided a programme of activities for all patients on the wards with a focus on keeping patients living with dementia active. Due to the success of the activities co-ordinator at this hospital, other ward managers were hoping to recruit an activities co-ordinator for their wards.
- In ward areas where an activities co-ordinator wasn't available, therapy staff had introduced activities including singing, gardening and reminiscence sessions.

Are services responsive to people's needs?

We also saw evidence of staff sitting down with patients any playing games of dominoes and cards. To support the reminiscence sessions they ran, therapy staff produced a Sparkle magazine which contained information about the past which patients living with dementia would identify with.

- Therapy staff told us where they had to complete a kitchen assessment with a patient living with dementia, they would try to complete this at their own home where they would be more orientated to the surroundings and would have a more beneficial experience.
- Staff told us they always looked at ways in which they could individualise a patient's care. An example of this was on Fenton ward and involved a patient that had cerebral palsy. So that they could orientate themselves in preparation for being discharged, the therapy staff reorganised the room so it was more like their room at home. This made sure staff could accurately assess they would be safe at home, but also helped to prepare for discharge quicker.
- If the wards received a referral for a patient with learning difficulties, staff told us they had access to a learning disabilities nurse specialist who would be able to provide advice for staff on how to individualise care for them. On one ward, staff had access to a range of visual aids for patients with learning disabilities if this was appropriate for them. One ward manager told us when they had a patient with learning disabilities in the past; they encouraged their carer to stay with them as they would be a good source of information about the patient. They also said most of the patients had 'this is me' documents which contained personal details including their likes and dislikes.
- Patients who would soon be discharging from hospital had a planned 24-48 hour admission into the assisted virtual house. This allowed patients the ability to 'practise' living alone and being independent in their needs, but still have the security of staff nearby if they were struggling. This enabled staff involved in the patients care to make any final adaptations to the patients discharge plans if required.
- Some wards we visited had their own therapy room attached to the ward. The therapy room on Hopewell Ward, Ilkeston Hospital allowed not only one to one therapy sessions to be conducted, but was large enough to accommodate group activities if required. Staff told

us although it was unusual in a healthcare environment to have carpeted floors, this was intentional so that patients who were on a rehabilitation programme could adapt to mobilising on carpet.

- On all of the wards we visited, we observed staff picture boards at the entrance to the ward. On these boards as well as their picture, it also had their names and job titles. There was also a poster near the boards which explained the different uniforms that staff wore and roles of staff.
- The environment on each ward was bright with patients being encouraged to use the dining room for meal times. At some of the hospitals that we visited, there were garden/outdoor spaces which patients were encouraged to use. The senior managers at Hopewell Ward told us that they had received funding from the league of friends to improve the outdoor area for patients and encouraged them to use this area with their visitors as much as possible, weather permitting.
- The layout of the wards in the inpatients services varied from hospital to hospital. Some hospitals had bays for up to three patients and other bays for up to six patients. Some bays had their own bathrooms in, whereas larger bays would have the nearest toilet and bathroom allocated.
- There was a provision on most ward areas where staff could speak to patients and their relatives in private, especially if they were breaking bad news. A staff member was particularly proud to have their area called the willow suite where patients and their relatives could go and receive additional emotional and spiritual support.
- In some of the hospitals, there were rooms available for patients who were on an end of life pathway. This included a large en-suite room with an additional sitting room for relatives to stay in on Hopewell Ward, Ilkeston Hospital. Staff told us that these rooms were regularly used.

Access to the right care at the right time

- Data provided by the trust showed between February 2015 and January 2016 238 patients experienced a delay in their discharge. The largest percentage of these (34%) was due to a delay in care packages being provided for patients returning to their homes, 24% was due to patient or family choice, 16% were awaiting allocation

Are services responsive to people's needs?

of a residential home placement and 14% of patients were awaiting allocation of a nursing home placement. The remaining 12% had no recorded reason for delayed discharge.

- The managers of the day treatment centre (DTC) told us they operated a flexible working week which was dependent on the requirement of the patients and what the visiting consultants could provide. If there was a high demand for a surgical speciality, the DTC could be flexible to provide weekend surgery. They were able to tell us about the times when they had done this to meet the demands of certain specialities.
- Data provided by the trust showed there had been 23 operations cancelled between April 2015 and March 2016, with two of these cancellations being considered as urgent patients. All patients were re-booked for their procedures in a 28 day period. The two patients who were considered as urgent patients had their procedures re-booked in three days of their original date.
- Data provided by the trust reported the overall average referral to assessment time was 5.5 weeks and the overall average assessment to onset of treatment time was 6.4 weeks.
- Across the whole of the community inpatient services, there were no recorded single sex breaches in the previous 12 months.
- During normal hours, the GPs or the advanced nurse practitioners (ANPs) on the ward would review the new patients and complete the admitting process. Out of hours, the wards were required to contact the local out of hour's service. All of the wards had a direct phone number which they could contact them on to request a visit by them.
- During our inspection, we saw a varied length of stay (LOS) for patients between 14 days up to 57 days. The target LOS for the trust was 20 days and this was monitored through the quality always programme and results displayed in the wards. There were clearly documented reasons for the patient with an extended LOS. Staff that we spoke with were not always aware of what the trusts target LOS was.
- Physiotherapy staff told us when patients were discharged back into the community, there was good physiotherapy provision so that therapy can continue.

- Hospitals had a strict admission criteria which they adhered to although one ward manager told us they would consider patients outside of this criteria depending on the acuity of the ward at that time and with more senior advice.
- Physiotherapy and OT services were available weekdays only and not at weekends. If patients required exercises to be completed at the weekends, this would be with the supervision of ward staff. Senior staff told us that all nursing staff were able to monitor rehabilitation of patients.
- The bed occupancy rate for 2015/16 was 74.6% which was lower than the rate of 86.4% for 2014/15. Clay Cross ward reached the highest occupancy rate of 95.5% during 2015/16.

Learning from complaints and concerns

- The community inpatients service received 16 formal complaints from February 2015 to February 2016. Of these complaints, five were completely upheld which meant the trust accepted the issues raised in the complaint and five were partially upheld which meant that the trust had accepted some of the issues raised. This demonstrated that the trust were open and transparent about complaints and apologised. Common themes to the complaints were around the care that patients had received and poor communication.
- Staff told us that they were aware of the complaints process and that they would all try to resolve any complaints or concerns locally. If they could not resolve it themselves, they would escalate to their managers first before signposting them to the Patient Experience Team.
- Ward managers would investigate any formal complaints involving their departments and give them feedback on specific issues during ward meetings. If there were general lessons which could be learnt from other complaints not directly involving their ward or department, these were also shared at ward meetings. This meant there was evidence that lessons were learnt from investigations into complaints.
- We saw evidence of patient experience posters and leaflets advising patients and their relatives or carers on how they could provide feedback to the ward or service

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as a whole if they had any concerns or complaints. Near to the posters were comments slips which patients and the public could use to raise their issues and a box in which they could post them in.

- Information about the complaints process was contained in the information pack that all patients

received on admission. Despite this, patients who we spoke with told us they were not aware of the complaints procedure, but would be happy to speak to the manager of the ward or matron if they had any concerns or complaints.

Are services well-led?

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

We rated the leadership of the community inpatient services as good.

We found:

- Staff were fully aware and understood the DCHS way which was based around the core vision and values of the trust.
- There were effective governance arrangements in place to monitor quality, performance and patient safety. There was clear evidence that information from all meetings was shared so all staff were aware.
- Local leaders were visible and staff told us they felt supported and valued and their managers were approachable. There was an open culture with local management and staff felt they would be able to raise any concerns with them.
- There was positive feedback from all staff about the chief executive and they appreciated the way in which she tried to communicate with staff to keep them up-to-date with trust information.
- There was a trust level risk register which was regularly reviewed by the quality directorate. There was a clear process for staff to escalate local level risks if mitigating actions did not remove the risk.

However we also found:

- The service is only able to participate in a minimal number of national audits and therefore it was not possible to benchmark its performance.
- There was mixed feedback from staff about the visibility and support given by the remainder of the executive board.

Service vision and strategy

- The trust had a vision which was to become the best provider of local healthcare and a great place to work and had values to support this. From this, a 'DCHS Way' had been devised which encompassed the vision and values.
- All staff we spoke with were aware of the 'DCHS Way' which had quality at the heart of this and could tell us what this meant to them. We also saw posters displayed around the ward areas which displayed the 'DCHS Way'.

- Some wards had a local ward vision which all local staff members to that ward had been involved in devising. An example we saw was the vision on Hudson ward. They had used the acronym 'Hudson' to come up with their MDT vision which revolved around all staff members committing to providing high quality care 24 hours a day, reflecting the DCHS way.
- The trust had a 'Big 9' which were subdivided into three target groups. Three relating to quality, three relating to people and three relating to business. The quality targets for 2015/16 were improving information sharing for all clinicians, increasing the number of referrals to smoking cessation and identifying the services which patients with a learning disability accessed and improving the services so that they were more equitable. All core services including community inpatients services were involved in achieving the trusts 'Big 9'. The 'Big 9' were reported monthly through the Chief Executive's report to the board.
- There appeared to be some confusion as to the reasons behind the decision taken by the senior management to reduce the number of beds in the wards. Staff told us that this had been a strategic decision but there had been no communication about this. This meant there may not be a clear link for staff between organisational and local strategy.

Governance, risk management and quality measurement

- Governance arrangements to monitor quality, performance and safety were in place and provided assurance to the trust board. There were governance meetings at all levels which were held on a regular basis to discuss key issues such as incidents and complaints, risks, best practice guidance, audits and lessons learnt. These meetings were minuted and there was a clear demonstration of information being shared with all staff members from these meetings.
- The service did not have its own risk register. Instead, service related risks were part of the trust risk register. Senior managers told us this meant they were fully aware of all the risks present in the trust and what actions were being taken to mitigate the risks. If a ward

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has a risk, they escalated this via the matron to be added to the trust risk register. This was then discussed at relevant governance meetings before a decision made.

- Matrons held monthly meetings to discuss significant governance issues including incidents, complaints, risks raised by the wards or risks that may affect the wards and lessons learnt. These meetings were formalised and records of discussions made. The minutes of these meetings were shared with ward managers for discussions at their ward meetings. We saw the minutes of ward meetings which reflected this flow information being discussed.
- The managers of the day treatment centre (DTC) told us all of the surgeons who performed operations at Ilkeston did so under a contract between DCHS and the acute trusts. The medical director monitored this contract and there was a regular service level agreement meeting to discuss any issues in relation to the contract including any fitness to practice issues with the surgeons.
- There was clear evidence in the governance minutes that auditing was important to the service, with many local audits being conducted. However there was minimal participation in national benchmarking audits. This meant that the service found it difficult to make comparisons in regards to the quality of care provided compared with other providers.
- It was not always possible for the service to participate in national audits of quality because of limited patient numbers. However, some audits could have been completed and were not such as the national audit of intermediate care which they had previously completed in 2014. The trust were scoping the feasibility of participating in the National Diabetic foot Care Audit through the use of their Clinical Effectiveness and Audit Team.

Leadership of this service

- The chief executive was well established in her role and was well known amongst the staff. All staff we spoke with told us they regularly read the Friday emails which she sent out with important updates.
- The staff were less aware of the remainder of the executive board members and their roles and

responsibilities. Staff did however tell us the executives would occasionally visit the wards to conduct unannounced insight visits but this was the only engagement with them they had.

- Staff were aware there were opportunities for them to meet the executives regularly if they wished in the form of drop in sessions. Unfortunately due to the logistics and where these drop in sessions were held, staff found it difficult to attend them.
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- Good leadership was important to the trust and they would always try to support individuals to do a good job. Performance issues at leadership and management levels were appropriately addressed. An example of this was where the ward manager from a different ward was asked to take over to improve the leadership and culture in a ward that had experienced difficulties. Since the new ward manager took over, all staff reported there had been a significant improvement and they now felt very well supported.
- Staff described ward leaders and matrons as approachable, supportive and very visible, which also included access and support by managers out of hours via an on-call system. One member of staff who had experienced difficulties told us their managers had been very supportive and made them feel valued. Another member of staff said once they had asked for help, the senior staff could not have been more supportive of them.
- Staff who we spoke with told us it was very common for their ward manager and at times the matron to help them out in the wards if they were experiencing periods of increased activity or if the acuity of patients had increased.
- The trust had performed better than average in 24 of the key findings on the NHS staff survey. This included staff reporting the trust as a positive place to work, staff being motivated at work and the support they received from their managers.
- The trust was supportive of staff to develop their leadership and management skills. Some of the staff we spoke with had been encouraged to complete leadership courses and attend leadership conferences as a way of developing their own leadership and management styles.

Culture within this service

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- Staff generally reported a positive culture in the whole of the community inpatient services. Staff were supportive of each other, there was generally a team ethos and staff enjoyed their role. During our inspection, we saw very positive examples of the whole team working together.
- There appeared to be a high level of morale across the service with staff saying that they enjoyed working for the trust as there was an open and patient centred culture. One member of staff told us they travelled a considerable distance to work where they did because they enjoyed working for the trust so much.
- In the most recent Pulse staff engagement survey report, 70% of the staff would recommend the trust as a place to work for. This supported the positive comments made by staff about working for the trust. The Pulse staff survey is an independent survey which the trust participates in quarterly.
- All staff we spoke with told us that there was an open and honest culture. Staff were encouraged to report incidents and there was a no blame culture when incidents were reported.
- On the wards, staff told us that there was an open door culture with their managers which they felt comfortable to raise any concerns with them in person.
- Staff told us about the caring culture within the trust. An example of this was the Willow suite on Hudson ward which was also encouraged to be used by staff who wanted to meet their spiritual requirements and if they themselves had experienced an upsetting incident. They could use this area to reflect on their incident and receive emotional support by their peers should they require it.

Public engagement

- During our inspection, we saw examples of 'you said, we did' in some of the ward environments which demonstrated how staff acted on the feedback which patients had given them. Data provided by the trust also included examples of where the 'you said, we did' system was used especially in relation to the provision of food.
- Staff on one ward told us there were regular focus groups which both staff and patients or the public could attend. This enabled patients and the wider public to

put forward their points of view and offer feedback of any personal experience of care received which could help to shape services provided by the trust. We saw minutes from these meetings to support this.

Staff engagement

- The results of the Pulse independent staff survey showed high satisfaction with the trust, with 70% of staff recommending it as a place to work and 89-91% of staff recommending it to their family and friends as a place to receive care and treatment.
- Following the results of the NHS staff survey 2015, the trust completed an action plan of how they would address the key findings where they scored below the national including equality and diversity management in the trust.
- The trust provided details about three forums which are run for staff to drop into and discuss relevant issues to them. These three forums are DCHS staff forum, leadership forum and the frontline care council (FCC). All of these forums were opportunities for staff to put forward their issues and concerns and could be an important way to communicate between board and ward staff. During our inspection, staff only mentioned the DCHS staff forum which they could access.
- The trust had a staff health, wellbeing and safety group which met bi-monthly and reviewed all aspects of staff wellbeing and looked at ways the trust could improve staff' wellbeing. The trust forwarded minutes that had been produced from the meetings.
- Staff told us they kept up-to-date with key information through the regular monthly ward meetings, email communication from their managers and also the trust intranet. Another member of staff also told us they were able to access their emails from their own computers which they found very useful as they did not always manage to access their emails whilst they were on shift.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through their 'Extra Mile' awards. Nominations were received either from staff working at the trust or, from the public. We were told about staff and teams being nominated for these awards.

Innovation, improvement and sustainability

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- Alton ward at Clay Cross hospital were awarded a silver dignity award in July 2015 for the improvements that had been made to the provision and dignity and respect for patients.
- Managers from the day treatment centre (DTC) had recently started to undertake a piece of work looking at the sustainability of the services that they provided as part of the Provider Planned Care Transformation Group. This work will look at providing the trust with recommendations about the future services which should be provided.
- Recently, a piece of work was concluded on the sustainability of the endoscopy department at the hospital. Due to the age of equipment and the costs that would be required for re-commissioning the service, the trust decided that it was unable to sustain this service in the future and have stopped providing endoscopy services.
- On Fenton ward, the ward manager had identified there was a gap when it came to activities being provided for the patients. To get round this, they were investigating the possibility of accessing a local day centre where patients could go for short periods of time, or from where staff could visit the ward to conduct activities there.
- Therapy staff on Butterley ward told us that they had been provided with a pool car for them to use when they completed patient home visits. They told us this had improved the service that they could provide to the patients.