Bradford Teaching Hospitals NHS Foundation Trust

RAE

Community health inpatient services

Quality Report

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Date of inspection visit: 21 - 24 October 2014
Date of publication: 27/04/2015

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)
RAE3A	Westwood Park Community Hospital	Westwood Park Community Hospital inpatient services	BD6 3NL
RAE4H	Eccleshill Community Hospital	Eccleshill Community Hospital inpatient services	BD10 0JE

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community inpatient services as 'requires improvement' for safety. We found that there were systems in place to report incidents. Incidents were reported using an electronic Datix system (Datix is a patient safety incidents healthcare software). At Eccleshill Community Hospital, we found that there was poor incident reporting. Staff told us this was due to the length of time it took them to report incidents. Staff told us they were aware of how to use the system to report incidents. We found that there were policies and procedures in place for safeguarding. We found that there were differences between the two community hospitals in the number of staff who had received training.

At both community hospitals there were potential delays in the receipt of medications, due to the arrangements with the pharmacy. It was not clear what governance arrangements were in place to monitor and manage the safe delivery of medications to the hospitals by a security guard. Throughout our inspection, we saw both community hospitals were visibly clean and tidy. However, we had some concerns about cross infection in relation to where commodes were being cleaned and stored. We saw that both community hospitals displayed information on planned, and actual, staffing numbers. The service did not use an acuity or dependency tool to determine staffing levels and staff told us that, at times, it was difficult to maintain staffing levels.

We rated community inpatient services as 'requiring improvement' for being effective. We found that there were policies and procedures in place and these were available for staff. Staff told us that information was not collected by the trust on the criteria of patients admitted onto the community wards. At the time of the inspection, staff told us they did not have access to 'length of stay' information, nor was the trust able to provide this to us. Annual appraisal levels varied between the two hospitals.

Overall, we rated community inpatient services as being 'good' for caring. We spoke with patients and relatives, who said they were treated with care and compassion. Patients' emotional wellbeing, including whether or not they showed symptoms of anxiety and depression, were assessed on admission to each ward area. Appropriate referrals for specialist support were made, where required.

We rated community inpatients services as 'good' for being responsive. There were interpreting services available to meet people's needs. We found the community hospitals had arrangements in place to meet the religious and cultural needs of patients. Local priests, religious leaders and the hospital chaplaincy team visited the community on a regular basis. We found that there were differences in the level of medical cover at both community hospitals, which meant that, at Eccleshill Community Hospital, the service was not always able to be as responsive to people's needs as the staff could be at Westwood Park Community Hospital. We found that patients and relatives had access to complaints information. There had been one informal complaint at Westbourne Green Community Hospital and action plans to improve services had been developed as a result of this. There was no 'named nurse' system in place for patients

We rated community inpatients as 'requiring improvement' for being well-led. We found that most staff were unclear about the vision and strategy for the trust and for intermediate care services.

Staff told us that quality and patient experience was a priority and strong teamwork resulted in a better patient experience. In general, staff reported an open and learning-focused culture on the wards. We found that there were differences in the way both community hospitals were managed. How learning was shared between both services was unclear. We found that there was good, positive local leadership. There had been a recent restructure, so there was a new matron and manager in post for the community hospitals.

Summary of findings

Background to the service

The trust had four community hospitals. They were Westwood Park Community Hospital, Eccleshill Community Hospital, Ward F3 (at St Luke's hospital) and Westbourne Green Community Hospital. At the time of our inspection, we were told that the beds in Shipley Community Hospital and Westbourne Green Community Hospital were closed and Westbourne Green was due to reopen in December 2015.

The community hospitals were part of the elderly and intermediate care service in the division of medicine at the Bradford Teaching Hospital NHS Foundation trust.

The community hospitals provided a less 'acute' environment, although medical care was provided by the trust's consultants for elderly care. These wards were for patients of any age, but usually older people, either following an acute hospital stay, or who were trying to avoid an acute hospital stay, by focusing on rehabilitation and restoring functional abilities.

During our inspection, we talked with 16 medical staff, nursing staff and allied healthcare professionals, and examined 20 medical/nursing records. We spoke with 18 patients and relatives.

Our inspection team

Our inspection team was led by:

Chair: Michael Marrinan, Executive Medical Director, Kings College Hospital, London

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team of 46 included CQC inspectors and a variety of specialists including medical, paediatric and surgical consultants, junior doctors, senior managers, nurses, midwives, a palliative care nurse specialist, a health visitor, allied health professionals, children's nurses and experts by experience who had experience of using services.

Why we carried out this inspection

We carried out this comprehensive inspection because the Care Quality Commission (CQC) had placed Bradford Teaching Hospitals NHS Trust in risk band 4 in the CQC intelligent monitoring system.

How we carried out this inspection

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

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

The inspection team inspected the following one core services at Eccles Hill Community Hospital and Westwood Park Community Hospital:

- Inpatient services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning

Summary of findings

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Bradford on the 20 October 2014, where 21 people shared their views and experiences of the Bradford Teaching Hospitals NHS Foundation Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups to hear people's views and experiences.

We spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out the announced inspection visit between 21 and 24 October 2014.

What people who use the provider say

• The NHS Friends and Family Test response rate was consistent with the England average. The percentage of patients who would recommend the services was consistent with, or higher than, the national average in September 2014.

• The trust performed around the same as other trusts in relevant questions in the inpatient survey for 2013 with the exception of one question. This was regarding whether patients felt they received enough emotional support during their stay.

• The cancer patient experience survey results for 2012/2013 for inpatient stay showed the trust was in the top 20% for three indicators and consistent with other trusts in 33 indicators. They scored in the bottom 20% of trusts in eight indicators. This included provision of information and being provided with enough care.

Good practice

Our inspection team highlighted the following areas of good practice:

Animal-assisted therapy (AAT) is a type of therapy that involves animals as a form of treatment. The goal of AAT is to improve a patient's social, emotional, or cognitive functioning. During our inspection, we were told that a therapy dog visited the ward on a weekly basis. We observed patients enjoying the visit from the dog.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Action the provider MUST

- Ensure that staffing levels on the community wards reflected the trust's own planned levels and an acuity or dependency tool was used to determine staffing levels.
- Ensure that that there was effective medical cover at the community hospitals so patients were assessed, reviewed and their needs responded to in a timely manner.
- Ensure that medical and nursing staff at the community hospitals are up to date with mandatory training.

Summary of findings

Action the provider SHOULD take to improve

- Explore why staff at Eccleshill Community Hospital are not using the incident reporting system.
- Review the governance arrangements to monitor and manage the safe delivery of medications to the community hospitals by a security guard.
- Review the criteria and protocols for admission to the community hospital beds to ensure effective use of the service.
- Ensure that the medication fridge at Eccleshill Community Hospital is repaired promptly
- Review the suitability of the sluice room at Eccleshill Community Hospital.

Bradford Teaching Hospitals NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

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

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community inpatient services as 'requiring improvement' for safety. We found there were systems in place to report incidents. Incidents were reported using an electronic Datix system. At Eccleshill Community Hospital, we found that there was poor incident reporting. Staff told us this was due to the length of time it took them to report incidents. Staff told us they were aware of how to use the system to report incidents.

We found that there were policies and procedures in place for safeguarding. There were differences between the two community hospitals in the number of staff who had received training. Staff at Eccleshill Community Hospital were not up to date with their training, which may have affected their ability to identify safeguarding issues.

We found that, at both community hospitals, there were potential delays in the receipt of medications from the pharmacy service. It was not clear what governance arrangements were in place to monitor and manage the safe delivery of medications to the hospitals by a security guard.

We saw that, throughout our inspection, both community hospitals were visibly clean and tidy. However, we had some concerns about where commodes were cleaned and stored.

We saw that both community hospitals displayed information on planned and actual staffing numbers. The service did not use an acuity or dependency tool to determine staffing levels. Staff told us that, at times, it was difficult to maintain staffing levels.

We found that there were differences in the level of medical cover between the community hospitals, which meant that, particularly at Eccleshill Community Hospital, patients did not always have a timely medical review of their needs and did not have timely access to medical advice, if required.

Requires improvement

Are services safe?

Incident reporting, learning and improvement

We found that there were systems in place to report incidents. Incidents were reported using an electronic Datix system. Staff told us they were aware of how to use the system to report incidents.

We saw information in the April 2014 Trust Board meeting, that indicated that there had been an increase of over 10% in the number of reported incidents covering the same period as the previous year, across the trust. However, information from the national reporting and learning system found that in the period 1 October 2013 to 31 March 2014, the trust was in the lowest 25% of reporters nationally despite increasing their reporting rate.

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety Thermometer information was recorded monthly. However, results from this were not always displayed.

Eccleshill Community Hospital

We saw that, between 1 July 2014 and 9 October 2014, there had been 35 incidents reported. We reviewed the incidents and noted that 22 were related to falls. However, ten of these had not been categorised as such. For example, we saw that one fall had been categorised as “bed”, but related to a patient falling out of bed onto the floor.

We found that, from discussions with staff, there was poor incident reporting. Staff told us this was due to the time it took them to complete the incident forms. Staff reported they had not received training on the Datix incident reporting system and they did not routinely receive feedback from incidents they did report. However, staff were able to tell us about local learning from one patient fall incident. The investigation into the incident found that a buzzer was not working. Lessons had been learned and actions taken to prevent a recurrence. The ward had implemented a system for checking all buzzers at the beginning of each shift with a named person identified to take responsibility for checking and escalating failures in the system.

We saw that safety information was displayed on the ward’s noticeboard, which included information on falls and pressure ulcers.

Westwood Park Community Hospital

We saw that between 1 July 2014 and 9 October 2014, there had been 54 incidents reported. Of these, 30 of the incidents were reported as falls, slips or trips and six were related to pressure ulcers. Staff told us they routinely completed incidents if a patient had a fall on the ward and would update the falls risk care plan.

Staff told us they generally only received formal feedback from the trust on key themes and action plans that had been developed. However, they also told us that feedback from the incidents they had raised was inconsistent. Incidents were a standing item on ward meeting agendas and were discussed at handovers between staff.

We saw that safety information was displayed on the ward’s noticeboard. We saw the last fall on the ward had happened on the 21 October 2014 and the last incident of a pressure ulcer occurred on the 20 October 2014. We noted that an incident form had not been completed for the fall on the 21 October; we brought this to the attention of the ward manager. During our inspection, one patient fell on the ward and staff reacted promptly. We saw that within a very short space of time an incident form had been completed on Datix.

Safeguarding

Eccleshill Community Hospital

The ward manager told us that staff training for safeguarding was not up to date. There were safeguarding procedures and protocols in place and staff were aware of these. Staff had an understanding of how to protect patients from abuse. Staff were able to describe signs of abuse and the appropriate actions and systems for reporting allegations of abuse.

Westwood Park Community Hospital

The ward manager told us that staff were up to date with the required safeguarding training. There were safeguarding procedures and protocols and staff were aware of these. Staff had an understanding of how to protect patients from abuse. Staff were able to describe signs of abuse and the appropriate actions and systems for reporting allegations of abuse.

Medicines management

Eccleshill Community Hospital

We found that pharmacy services were provided by an external provider. Staff told us they had to be proactive as discharge medications could take three days to arrive on

the ward. We were told medications were delivered routinely, once a day, but occasionally a security guard would deliver medications to the ward. It was not clear what governance arrangements were in place regarding this, or what training was in place for the security staff.

The ward manager told us that, for patients who were on an end of life pathway, anticipatory medications would be prescribed before they were transferred onto the ward. Anticipatory prescribing is designed to enable prompt symptom relief, at whatever time the patient develops the symptoms, by ensuring there is a supply of the required medications. Staff could call the GP or emergency doctor for advice about medication when there was no medical cover on the ward.

Westwood Park Community Hospital

We found that a scanner system had been introduced for medicine management, which was supplied by an external provider. Currently drug charts had to be faxed to the pharmacy, which had led to delays in drug delivery in some cases, due to the poor legibility of the fax paper. If the pharmacy received the chart in the morning, the medications would arrive on the official run as planned at 2pm. If medication was required after that time, an "unofficial run" was made by a security guard at 6pm. It was not clear what governance arrangements or training were in place for the security staff guards. The ward manager told us the security guard did not transport controlled drugs.

For medications to be ordered and delivered, the same day medication charts had to be faxed to the pharmacy in the morning. However, the consultant did not routinely visit the ward until the afternoon, which meant any new medications that were prescribed would not be ordered and received until the next day.

During the week, pharmacy cover was provided by the external provider and on weekends the pharmacy at the Bradford Royal Infirmary was used.

Safety of equipment

Eccleshill Community Hospital

During the inspection, we found that the temperature of the fridge for storing medication was not monitored correctly. Records indicated this had happened for over two months. The ward had escalated the issue with the maintenance department. A new part had been ordered and received, but had not been fitted. The ward did not have a timescale for the repair to be completed. We raised this with the trust at the time of the inspection and they arranged for the fridge to be reviewed and repaired, or replaced.

We found that the ward had suitable resuscitation equipment available. Routine checks of the equipment had been completed daily.

Westwood Park Community Hospital

We saw that, in the patient lounge, portable call bells were used so that patients were able to call for assistance if they needed to. Within the hospital, there was a therapy kitchen with rehabilitation resources. There was also physiotherapy gym equipment, which included parallel bars and other equipment to aid mobility. The service ensured that appropriate equipment was available for patients to use.

We found the ward had suitable resuscitation equipment available. We found that routine checks of the equipment had been completed daily.

Records and management

Eccleshill Community Hospital

At Eccleshill Community Hospital, we found that nursing records of patient care were completed by day and night staff. Day staff completed notes within the multidisciplinary team notes. However, night staff completed a separate set of notes, which meant that, if staff needed to refer to the notes, they were not in chronological order. In their record keeping guidance for nursing and midwifery staff (2009) the Nursing and Midwifery Council (NMC) stated that nurses, "Should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment." The care plans we reviewed did not document all care given. This meant the staff were not working within current NMC guidance.

The ward manager told us that, following a root cause analysis (RCA) investigation of an incident, part of the learning had been in initiating an improvement in the documentation.

Westwood Park Community Hospital

There were two sets of care records for each patient. One set of the records were kept by the patient's bedside. We

found that there was no confidential information in these bedside records. The other set of records were used by all the clinical staff and were stored in a locked trolley to protect patient confidentiality.

Within nursing records, we saw that staff completed the 'wellbeing' section in the care plan. This was completed twice a day, once by day staff and once by overnight staff. We saw that in all the records we reviewed that they had been completed appropriately.

Cleanliness, infection control and hygiene

Eccleshill Community Hospital

We saw that the ward was visibly clean and tidy. Staff told us that the sluice room was so small they had to clean commodes in the cleaner's room. This might have posed an infection control risk, if contaminated commodes were being cleaned where cleaning products and equipment were being stored, including clean cloths and mops.

We saw wheelchairs and commodes had been labelled with "I am clean" labels. We saw there were cleaning schedules above beds to document that the bed space had been cleaned when patients were discharged. We reviewed eight schedules and found four had not been completed.

Westwood Park Community Hospital

We saw the ward was visibly clean and tidy. We observed nursing and medical staff undertaking good hand hygiene practices throughout our inspection. As part of our inspection, we checked three commodes and found they had been checked and cleaned, as per the trust policy. Clean commodes were stored in the sluice room. Staff told us the infection control and prevention team had 'insisted' that this was where they should be stored. However, this might have been an infection control risk if contaminated fluids were being disposed of in the sluice and the commodes were splashed by these fluids.

We saw that equipment that had been cleaned had green 'I am clean' labels on them. We saw this on a variety of equipment, including commodes and the hoist. We observed cleaning staff cleaning patient rooms, including under beds.

Mandatory training

We noted that 76% of nursing staff and 80% of medical staff had received training in assessing mental capacity against a target of 75%. However, only 25% of allied healthcare professionals had received this training. Across the division of medicine, there was a target of 75% for staff to receive training in adult basic life support. The figures for completing this training were 60% for medical staff, 85.62% for nursing staff and 75% for Allied Healthcare professionals.

Eccleshill Community Hospital

Staff told us that they received mandatory training through a full day's 'sweeper' study day, which incorporated all the required training and e-learning. Staff told us some training was by e-learning and this was difficult to keep up to date, due to work commitments. The ward manager told us that in-house training had been set up for infection control, which included housekeepers and cleaners.

Westwood Park Community Hospital

Staff told us that they had received mandatory training through a full day's 'sweeper' study day, which incorporated the required training and e-learning. Staff told us there had been problems with accessing the trust's intranet site for e-learning and access had only been given this year. As a consequence of this and staffing issues/ shortages, the majority of staff were not up to date with their e-learning. The ward manager told us they received monthly statistics for training figures for their team.

Assessing and responding to patient risk

Eccleshill Community Hospital

We found that daily observations were recorded for all patients on the ward. Where appropriate, the ward used the national early warning score (NEWS) tool for patients whose conditions were deteriorating. However, it was unclear if medical attention would be able to be sought within the timescales on the NEWS chart.

Westwood Park Community Hospital

We found that appropriate risk assessments were completed for patients with the community hospital. For example, we saw completed risk assessments for developing pressure ulcers, medication, footwear and nutrition.

We saw that the falls risk assessments were completed for patients and, where appropriate, movement alarms and sensors were used to support staff in caring for patients. Staff gave us an example of a patient who was currently at

high risk of falling. They had discussed this with the patient and their family and had agreed an appropriate management plan to meet the specific needs of the patient.

Staffing levels and caseload

Eccleshill Community Hospital

Staff told us that it was difficult for the rehabilitation support workers to undertake therapy work, due to sickness and vacancies of other staff groups on the ward. The ward manager told us that the therapy assistants were assimilated into the healthcare assistant numbers on the ward. Recruitment of new staff was ongoing, with interviews for qualified staff due to be held the following week.

The planned and actual staffing levels were displayed on a noticeboard in the corridor of the ward. On the day of the inspection, the actual number of staff was the same as the planned levels. Nursing staff usually worked two long days and two shorter shifts per week.

The ward manager worked from Monday to Friday. We were told that staffing was difficult and they regularly had to "plug the gaps" in the rotas. The ward had been closed previously, due to the shortage of staff. The ward manager told us the ward did not use a staffing acuity tool to look at staffing numbers. Staff told us they felt that, at times, there were not enough staff to meet patients' needs.

We were told that some staff had been transferred to the community hospital ward following the closure of Westbourne Green Community Hospital. The ward manager told us this had been an unsettling time for staff, with some staff having to work on the acute wards in the main hospital.

If patients required extra support, or one-to-one nursing, this was escalated to the matron/bed manager so extra staff could be used to provide support to the ward. Agency staff were used. For any who were new to the ward, a local induction sheet was used to ensure they were aware of the ward environment and key trust policies and procedures.

There were two consultants that covered the community ward. Each consultant would visit the ward every week and would provide cover for each other. However, this meant patients would only see their own consultant once a week.

We were told that medical cover had been reduced on the ward since October 2014. GP cover from the local surgery had stopped in October 2014 and cover was now provided by a GP specialist in the trust. The GP specialist was present for two sessions a week, which currently overlapped with the consultant on a Monday. The medical cover on the ward was Monday, Wednesday and Thursdays. There was no medical cover on the other two week days, or at the weekend.

Westwood Park Community Hospital

The hospital used the NICE endorsed Safer Nursing Care Tool (SNCT) to determine optimal nurse staffing levels across all adult inpatient areas. This was undertaken six monthly across all adult inpatient areas with required reports presented at the public Board of Directors meetings. The reports were then posted on the Trust's web page. The dates the 2014 reviews were undertaken were May 2014 (presented at July 2014 Board meeting) and the Trust informed us that the next scheduled review was in November 2014.

However the Trust acknowledged that both the NICE Guideline – 'Safe staffing for nursing in adult inpatient wards in acute hospitals' - and the SNCT were recognised to not be applicable to rehabilitation / intermediate care adult wards such as the Community Hospitals. However in the absence of nationally recognised applicable tools at this stage the outcomes were balanced with a higher degree of professional judgement & nursing quality indicators.

We saw the planned and actual staffing levels were displayed on a noticeboard in the corridor of the ward and that the actual levels matched the planned staff numbers on the day of inspection.

We saw information on the division of medicine risk register, which stated that there was a risk that appropriate and safe staffing levels may not be achieved at Westwood Park Community Hospital, due to a depletion of registered nurse (RN) availability (4.5 vacancies and two RNs on long-term sick leave). This had been recorded as posing a risk to patient safety and quality of care. The risk register stated that the mitigation actions should provide sufficient numbers of RNs to achieve two RNs on each shift. In addition, staff told us they had escalated the need for an extra Allied Healthcare assistant on a late shift. Some staff had been transferred to the community hospital ward

Requires improvement

Are services safe?

following the closure of Westbourne Green Community Hospital. One staff member told us that this "didn't make a big impact, as they just covered the staff absences and vacancies".

The ward manager told us it was a struggle to manage staff shortages, but they felt they had a good team of staff who provided good care to patients. Agency staff were used to cover staff shortages on the ward. In addition, staff from the acute hospital wards within the division of medicine sent staff to cover shortages if they could.

The ward manager worked from Monday to Friday. Band 6 sisters/charge nurses worked throughout the seven day period, but did not usually work night shifts. Ward managers were supposed to work three clinical and two managerial shifts each week. However, due to the staff shortages the ward manager was spending 100% of their time working clinically. A staff member who was new to the community hospital ward was the second most qualified member of staff on duty. The Trust informed us that the Board of Directors had committed in principle to enabling all Ward Manager's to have a defined time allocation for supervisory time. However at the time of the insepction this has not been implemented. The trust had recognised that to enable such a system to operate successfully and consistently key areas needed to be addressed such as appropriate staff shift patterns, staff rostering & having the appropriate nursing workforce levels. Significant work has been undertaken in all of these areas this year including further investment in the nursing workforce numbers.

There were limited therapeutic recreational activities available for patients. Existing staff delivered activities for patients two to three times a week, as staffing allowed. Staff told us that the suggestion of an activity coordinator had been raised with the matron.

We found that the ward had on site medical presence on all weekdays except Wednesday and that medical advice was available at all times with a facility for early review if required..

Managing anticipated risks

Eccleshill Community Hospital

Staff told us that patients were assessed on admission and those with greater needs were nursed closest to the nurse's station, so they could be more easily observed. Staff also said that all patients had risk assessments, including falls, in place. If a patient had a fall, and if injuries were apparent, the patient would be transferred back to Bradford Royal Infirmary. However, this meant that patients with no obvious injuries might not be reviewed by a doctor for a number of days, due to the medical cover arrangements on the ward.

Westwood Park Community Hospital

We saw that staff completed intentional rounding every two hours, for each patient. Intentional rounding involves health professionals carrying out regular checks with individual patients at set times to identify and meet patients care needs. For example: hydration, positioning of pillows and placing a call bell within reach.

Requires improvement

Are services effective?

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

Summary

We rated the community inpatient services as 'requiring improvement' when it came to being effective. Appropriate policies and procedures were in place and these were available for staff.

Staff told us information was not collected by the trust on the criteria of patients admitted onto the community wards. At the time of inspection, staff told us they did not have access to length of stay information, nor was the trust able to provide this to us. There were no named nurse systems in place for patients on the wards.

Staff we spoke with at Eccleshill community hospital did not fully understand the processes for assessing someone under the Mental Capacity Act.

Annual appraisals and training levels varied between the two hospitals.

We found that, for both community hospitals, there were no named nurse systems in place for patients.

Evidence-based care and treatment

The trust monitored and identified whether they followed appropriate National Institute for Health and Care Excellence (NICE) guidance relevant to the services they provided. We found that policies based on NICE and the Royal Colleges' guidelines were available to staff and accessible on the trust intranet site.

Eccleshill Community Hospital

The ward manager told us that audits were undertaken on the ward. For example, there was a mattress audit. The ward manager also told us they inputted data into the system, but often did not receive information or action plans following this.

An audit had been undertaken on the ward about the number of patients sent from the ward to accident and emergency (A&E) via 999 calls. Of the eight patients reviewed, four had returned to the community ward and four had been readmitted to the medical ward at Bradford Royal Infirmary.

Westwood Park Community Hospital

There was a planned audit schedule, which included snapshot audits and point prevalence audits. The ward manager told us one day per month was dedicated to auditing, for example, recently audits had included basic care audits and a risk assessment audit. They also told us that this enabled them to review any key issues in relation to patient care.

We saw there was nutrition and hydration guidance for staff to follow, which was based on the latest NICE guidance.

Animal-assisted therapy (AAT) is a type of therapy that involves animals as a form of treatment. The goal of AAT is to improve a patient's social, emotional, or cognitive functioning. During our inspection, we were told that a therapy dog visited the ward on a weekly basis. We observed patients enjoying the visit from the dog.

Nutrition and hydration

Eccleshill Community Hospital

During our inspection, we observed a mealtime. We found patients were encouraged to have their meals in the dining room to aid independence. The ward had their own kitchen and staff cooked the meals on site. The cook would discuss with the patients or their families any dietary needs. The cook was able to provide snacks and cakes outside of meal times.

Westwood Park Community Hospital

We saw menu options were displayed on the wall for patients to see. We observed the chef on the unit speak to patients to ask what food they would like that day. We were told this happened each day, so patients could have individual choice. During our inspection, we observed staff offer to support patients by bringing them drinks. Patients who were able to make their own drinks were able to get drinks at any time they wanted one. Staff told us that, if a patient had a specific dietary requirement, such as eating only gluten-free food, they would liaise with the catering provider to ensure the patient received this.

Requires improvement

Are services effective?

We saw that appropriate nutritional assessments were completed. A dietician visited the community ward one morning per week and developed nutritional plans for staff to follow for individual patients.

Approach to monitoring quality and people's outcomes

Eccleshill Community Hospital

Staff told us that information was not collected by the trust on the criteria of patients admitted onto the community ward. At the time of inspection, staff told us they did not have access to length of stay information, nor was the trust able to provide this to us. This limited the ability of staff to monitor the effectiveness of the care provided on the ward.

We saw that there was a safe campaign within the trust. Each month there was a key theme. The ward were currently implementing the 'Think Glucose' campaign. Staff told us they had access to specialist nurses for diabetes and they visited the ward as needed.

Westwood Park Community Hospital

When patients required specific interventions that staff on the ward were unable to undertake, they would access support from the relevant practitioner. For example, if a patient had a leg ulcer and needed four layer bandages, the district nursing team would visit the ward to undertake this.

The ward staff were implementing the 'Think Glucose' campaign at the time of our inspection. Within the acute hospital sites, we saw posters with this message displayed. These posters were not displayed within the community hospital.

Competent staff

We saw information from the division of medicine, which showed that just over 94% of staff had received an annual appraisal by August 2014.

Eccleshill Community Hospital

The ward manager told us that some staff were behind with training and appraisals. Access to e-learning had been limited, as staff had had difficulties in accessing the training system to complete this. Staff told us there was additional in-service training, which was undertaken with the three community teams. All staff had received dementia training.

We were told that clinical supervision was not a mandatory requirement from the trust, but the ward manager encouraged informal supervision and discussion of issues at ward meetings. Staff told us they were not aware of whether or not the trust had a clinical supervision policy.

Westwood Park Community Hospital

The ward manager told us that staff appraisals were completed and that the main objectives for each person were set by the trust. There was opportunity for staff to choose personal objectives. For example, there was an objective in relation to commode cleaning. Staff had training to ensure commodes were cleaned to the required standard, which should lead to a reduction in the number of Clostridium difficile (C. difficile) infections across the trust. There were also some national objectives in relation to completing documentation.

We were told that clinical supervision was not a mandatory requirement from the trust, but the ward manager encouraged staff to access supervision where possible. Staff told us there were clinical supervision mentors within the trust. The ward manager told us that they encouraged staff in the community hospital to keep a reflective diary. A reflective diary is a record of a person's learning experiences. It allows for reflection on their observations and responses to situations, which can then be used to explore and analyse ways of thinking.

Multidisciplinary team working and coordination of care pathways

Eccleshill Community Hospital

Staff told us that daily board rounds were undertaken. Consultants from the acute hospital visited on Mondays and Thursdays and GPs were asked to cover and review patients at other times. There were no named nurse systems in place for patients on the ward.

There were some patients requiring end of life care on the ward. For these patients, staff would liaise and work with the local hospice to provide a holistic plan of care.

Westwood Park Community Hospital

Staff at the community hospital told us how they participated in multidisciplinary meetings to discuss and plan care to meet the needs of individual patients. Therapy staff visited the ward each day. The physiotherapist stayed for half a day and the occupational therapy staff were there all day, from Monday to Friday.

Requires improvement

Are services effective?

There were no named nurse systems in place for patients on the ward

The staff used an audiotaped handover system to help ensure handovers were succinct and targeted. We observed a handover between staff. Staff also had a printed handover sheet to use and update throughout the day. Medical staff, on the days they visited, undertook board rounds, as well as participating in multidisciplinary team meetings. We observed staff during the board rounds updating the electronic handover sheet, as they discussed patients.

Referral, transfer, discharge and transition

Eccleshill Community Hospital

Staff told us that, when patients were admitted to the ward, they usually had a discharge date for 10 to 14 days later. The majority of patients usually had complex social discharge needs. Sometimes, there were delays in accessing social care support, which could then delay discharges. Staff were concerned about the lack of timely discharge letters sent to GPs, which may have affected a patient's continuity of care. A central hub based at Bradford Royal Infirmary had been developed to help improve patient flow and to sort out care packages.

Occasionally, patients were admitted to the ward from home via a referral from the GP. If this happened, the GP would provide the medical cover for the patient. For surgical patients who were admitted to the ward from another hospital, the patients were reviewed by the elderly care physician at Bradford Royal Infirmary prior to transfer.

Westwood Park Community Hospital

Staff within the community hospital gave examples of two patients who had fallen. One patient had been transferred back to the Bradford Royal Infirmary site to be reviewed by medical staff and came back to the ward after this. Another patient who had fallen was reviewed by paramedic staff who felt the patient did not need transferring back to the Bradford Royal Infirmary.

During the board round, we observed staff discussing patients' care and treatment. We saw that one patient had been admitted the previous day with an estimated date of discharge for three weeks' time. We observed staff discussing this with the patient. Staff told us that any equipment patients required for discharge home could be ordered.

Availability of information

Eccleshill Community Hospital

Information was available for patients. For example, we saw information about the Mental Capacity Act 2005 and dementia. Information was available in an easy-to-read format.

Menus were available in picture format for patients who had difficulty reading. There were also volunteers assisting with meal times, who would support patients to make choices and understand the information presented.

Westwood Park Community Hospital

There was a patient leaflet for patients and their families, once they had been admitted onto the ward. Staff told us they could provide the information in different languages, if required. There was easy-to-read information available.

The ward could produce information locally using a pictogram program. Leaflets were available in different languages from the trust headquarters.

Consent

Eccleshill Community Hospital

The ward manager told us that staff training on mental capacity was not up to date. There was specific training available for the Deprivation of Liberty Safeguards and this was due to be discussed at the ward manager's meeting in November 2014. Staff did not fully understand the processes for assessing someone under the Mental Capacity Act; they told us that any mental capacity assessment/best interest meeting would be initiated by a social worker. For patients with fluctuating mental capacity, staff told us that, occasionally, medical staff would assess their mental capacity. Staff told us there had not been a Deprivation of Liberty Safeguards application made for the two years prior to the inspection.

Westwood Park Community Hospital

The manager told us that staff were up to date with the required mental capacity and Deprivation of Liberty Safeguards training. Staff were able to give us an example of how they had recently had a patient with fluctuating mental capacity, due to an acute episode of delirium. In this instance, staff worked closely with the patient's family to find out about the patient's individual needs were, until the delirium subsided. There had been no recent situations where a Deprivation of Liberty Safeguards application had

Requires improvement

Are services effective?

been required. If required, and if it was in response to an individual's needs, staff would use the hub at the Bradford Royal Infirmary site for best interest meetings, Deprivation of Liberty Safeguards or mental capacity meetings or requests.

The ward was part of a pilot looking at screening for delirium or dementia and depression using a scoring system. The ward manager gave an example of how they would explain care and treatment to patients who did not have capacity to make decisions. For example, when a patient did not have the capacity to make decisions, but needed an air mattress to relieve their pressure areas. The patient had not wanted an air mattress, but staff were able to communicate the reasons why this was needed in a way that the patient understood.

Good

Are services caring?

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

Summary

Overall, we rated community inpatient serves as being 'good' when it came to being caring. As part of our inspection, we observed care on the community wards and the attitude and manner of staff speaking with patients and relatives.

The patients and relatives commented positively about the care and support they had received on the wards.

We found that staff spoke to people with care and compassion. Patients' emotional wellbeing, including anxiety and depression, were assessed on admission to each ward area, and appropriate referrals for specialist support were made, where required.

Dignity, respect and compassionate care

Eccleshill Community Hospital

Staff spoke to people with care and compassion. We received five comment cards largely from patients and/or their relatives, who accessed the services. The majority of comments were very positive and people felt they had been treated with kindness, dignity and respect.

At lunchtime, we noted that all patients were wearing plastic aprons. We had not seen staff asking patients if they wanted to wear aprons. Staff were not promoting individual choice, respecting patient's views or responding to individual need.

The side rooms on the ward all had en suite bathrooms. However, there were no doors; only a curtain, which did not span the full length of the doorway to the floor. Therefore, the patient's privacy and dignity may not always have been maintained.

Westwood Park Community Hospital

Staff spoke to people with care and compassion. We saw that they supported patient choice. For example, patients were encouraged to mobilise and sit where they chose, whether it be in the lounge area, or in their own rooms.

Patient understanding and involvement

Eccleshill Community Hospital

Patients told us that they felt involved in their care and knew what was happening from day to day. They told us that staff listened to them and explained their care.

Westwood Park Community Hospital

Staff told us that there were patient information leaflets available for use with patients to support them with their understanding of different conditions or treatments. One patient told us that they were aware of the plans for their discharge and had been involved in discussions about this.

Emotional support

Eccleshill Community Hospital

Patients' emotional wellbeing, including anxiety and depression, were assessed on admission and appropriate referrals for specialist support were made, where required.

Westwood Park Community Hospital

Patients' emotional wellbeing, including anxiety and depression, were assessed on admission and appropriate referrals for specialist support were made, where required. One patient told us that staff were "lovely and caring". Another patient was very complimentary about staff, the food and the ward environment. One relative told us, "The care and communication with staff was excellent."

Promotion of self-care

Eccleshill Community Hospital

Staff on the ward told us how they encouraged and supported patients to be as independent as possible.

Westwood Park Community Hospital

Staff on the ward told us how they encouraged and supported patients to be as independent as possible.

Good

Are services responsive to people's needs?

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

Summary

We rated community inpatients as 'good' for being responsive. We found that there were interpreting services available to meet different people's needs. We found that the community hospitals had arrangements in place to meet the religious and cultural needs of patients. Local priests, religious leaders and the hospital chaplaincy team visited the community on a regular basis.

We found that patients and relatives had access to complaints information. There had been one informal complaint at Westwood Park Community Hospital, and action plans to improve services had been developed as a result of this.

Planning and delivering services which meet people's needs

Eccleshill Community Hospital

Staff told us of recent changes made to better meet patient's needs. For example, the admission criteria had changed for the community ward because of the implementation of the 'virtual' ward service, which facilitated people to stay in their own home. Patients admitted to the wards were therefore more heavily dependent and the hospital was also caring for some palliative care patients. The service was also admitting younger patients.

There were no dedicated activities for patients to participate in to encourage their personal wellbeing and rehabilitation. There was a reminiscence box on the ward manager's office, but staff told us this was rarely used.

We found that translation services were available. Staff had access to a 24-hour language line to support people whose first language was not English.

We saw that there were separate male and female bathrooms on the community ward.

Westwood Park Community Hospital

The ward manager told us that the admission criteria to the community hospital ward had become "quite loose". Admission was agreed following a review and examination by a physician for elderly care from Bradford Royal Infirmary.

There was an interpretation service available. Staff gave us an example of how they worked with the patient and their family to meet their needs. The family of a patient, who was Ukrainian, had requested that they be given Ukrainian food. However, on discussion with the patient, staff found the patient wanted to have English food, not Ukrainian food. Staff discussed this with the patient's family to let them know about the patient's choice. This was a positive example of how staff tailored care to meet individual needs.

Staff told us that the interpretation service could be responsive, but it could be difficult to get access to interpreters for some Eastern European languages. Staff also told us that leaflets were available in different languages and that: "You just needed to know who to contact," to get them.

Equality and diversity

Eccleshill Community Hospital

We found that the hospital had arrangements in place to meet the religious and cultural needs of patients. Local priests, religious leaders and the hospital chaplaincy team visited on a regular basis.

Westwood Park Community Hospital

We found the hospital had arrangements in place to meet the religious and cultural needs of patients. Local priests, religious leaders and the hospital chaplaincy team visited on a regular basis. There was a dedicated room, which patients could use if they wanted to pray in a quiet and peaceful environment.

Access to the right care at the right time

Eccleshill Community Hospital

We were told by staff that, if a patient was admitted onto the community ward on a Tuesday, they would not be reviewed by the medical team until the following Thursday. We reviewed nine patient records to see how quickly they had been seen by a doctor. Of the nine patients, we saw that two had been seen the next day. Three had been seen

within one to two days and the remaining four were reviewed three to five days after admission. Some patients did not have a timely medical review of their needs and did not have timely access to medical advice, if required.

If staff required medical input out of hours, they contacted Ward 3 at the Bradford Royal Infirmary for advice, and then the patient transferred to A&E on the advice of the care of the elderly team who would undertake an early review in A&E. Staff also contacted the 111 service for advice or the 999 ambulance service. If the 999 service was contacted, and patients were transferred to Bradford Royal Infirmary A&E department, the patient would then wait with the other patients for assessment. Staff told us that, in recent months, five patients had been transferred to the Bradford Royal Infirmary via the 999 ambulance service.

Westwood Park Community Hospital

Staff told us they could contact the consultant or registrar when they needed them and they would return to the ward to review the patient. If staff required medical input out of hours, they contacted Ward 3 at the Bradford Royal Infirmary for advice, and then the patient transferred to A&E on the advice of the care of the elderly team who would undertake an early review in A&E. Staff also contacted the 111 service or the 999 ambulance service for advice. If the 999 service was contacted, and patients were transferred to Bradford Royal Infirmary A&E department, the patient would then wait with the other patients for assessment.. Staff we spoke with felt that this was adequate medical cover.

Complaints handling (for this service) and learning from feedback

Eccleshill Community Hospital

The ward manager told us there had been no recent complaints about the ward. We saw that complaints information and leaflets were displayed and available for patients and relatives.

Westwood Park Community Hospital

There had been one informal complaint recorded in the six months prior to our inspection. The complainant had raised concerns about depleted staffing levels on a late shift. As a result, the ward manager told us an action plan and escalation guidance was developed. This was also reviewed as part of the action plan from the complaint.

Requires improvement

Are services well-led?

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

Summary

We rated community inpatients as 'requiring improvement' for being well-led. We found that most staff were unclear about the vision and strategy for the trust, or for their own intermediate care services.

Staff told us that quality and patient experience was a priority and strong teamwork resulted in a better patient experience. In general, staff reported that there was an open and learning culture on the wards. We found that there were differences in the way both community hospitals were managed and how learning was shared between both services was unclear.

We found that there was good, positive local leadership. There had been a recent restructure of the management for community hospitals; there was a new matron and manager in position.

Service vision and strategy

Eccleshill Community Hospital

Most staff were unclear about the vision and strategy for the trust. Staff were also unable to describe what the vision was for their own intermediate care services. The ward manager told us that, at ward meetings, they discussed the local vision of the service, but some staff were not interested in the 'politics' of the service.

Westwood Park Community Hospital

Most staff were unclear about the vision and strategy for the trust. Staff were also unable to describe what the vision was for their own intermediate care services.

Governance, risk management and quality measurement

Eccleshill Community Hospital

The ward manager on the community ward told us that they could not access the risk register, so any risks had to be forwarded to the manager who would review the risks and then, if appropriate, would put it on the risk register. We were told that the main issues for the ward were staffing shortages and issues with the estate. For example, the sluice room was small, so commodes had to be cleaned in the cleaner's room. This was now on the risk register and had been escalated to the chief operating officer. Staff indicated that there were delays in actioning requests, partly as the building was owned by a different NHS trust.

Learning from incidents was shared at team meetings and staff were able to attend clinical governance meetings, which were held each month. For example, staff told us of an incident where a patient had fallen and the call buzzer was found not to be working. Staff now check that the call buzzers work three times each day. Staff told us they attended these meetings in their own time and did not have facilitated time to do this during their working day.

We saw a report from the local Healthwatch following an 'enter and view' visit in June 2014. Enter and view visits are carried out by Healthwatch to see how a service is being run and make recommendations on any areas for improvement. We saw that there were four recommendations made, however, at the time of our inspection in October 2014, it was unclear if the service had resolved any of these concerns.

Westwood Park Community Hospital

Incidents were a standing agenda item at team meetings. As part of learning from incidents, staff went through the global lessons learned document. The ward manager told us that they ran reports from the Datix incident reporting system to look at themes and trends in relation to incidents on the ward. This review included actions taken and any key topics and themes that needed sharing with staff.

The ward manager also told us that they attended monthly clinical governance meetings and feedback was given to staff from these on a monthly basis.

A monthly proforma was completed, which included any issues. For example, security prescribing and staff shortages. Issues were escalated to the clinical site manager. For example, if there were concerns regarding staffing shortages there was an escalation procedure. The ward manager told us this worked much better now they were part of the acute trust.

Requires improvement

Are services well-led?

The ward manager told us the ward had their own risk register, which included staffing levels, broken piped oxygen and one bath/ shower. We were told that the piped oxygen should be fixed within a month of the inspection. In the meantime,. the service had bottled oxygen available, which was used. Checks were undertaken by staff to monitor the oxygen bottles so they were changed appropriately. Staff could access the risk registers through the trust intranet.

Leadership of this service

Information from the annual NHS Staff Survey 2013, indicted that 27% of staff felt that there was good communication between senior managers and staff. The trust-wide score was 25%, while the national average for acute trusts was 34%.

Eccleshill Community Hospital

There had been a recent restructure that included a new matron and manager for the community hospital. The matron had been off sick since September 2014. Staff told us that the chief nurse had visited the service. The chief executive had also visited the hospital and met with staff.

Ward meetings usually took place on a monthly basis. However, due to pressure on the service, they had been conducted every six weeks. The last meeting had not gone ahead, but the ward manager had written some notes of what would have been discussed and shared these with staff.

Staff told us there had been a "listening event" with the chief executive two weeks prior to the inspection and, as a result, they felt more involved in how the trust was changing.

Westwood Park Community Hospital

We found that there was good, positive local leadership at the community hospital. The ward manager told us that when they had managerial days they would use these to provide a supportive/coaching role to staff.

Staff told us that, in the past, they had felt "out on a limb" from the rest of the trust, but since a staff reorganisation this was much better and they received more information. Staff told us that the chief nurse had visited the service. The chief executive had also visited the hospital, but did not visit the ward.

Culture within this service

Eccleshill Community Hospital

Staff told us that quality and patient experience were a priority and strong teamwork resulted in a better patient experience. In general, staff reported an open and learning culture on the wards. They felt able to raise issues with managers, if required.

Following the temporary closure of the Westbourne Green Community Hospital site, staff were going through a period of uncertainty regarding how and where services would continue to be provided. Staff had been moved from the closed unit to cover staff shortages in the community and acute hospital wards. Staff were unclear as to when Westbourne Green Hospital would reopen, or which staff would work at the hospital when it did.

Westwood Park Community Hospital

Staff told us that the quality of the patients' experience was a priority and strong teamwork resulted in a better patient experience. In general, staff reported an open and learning culture on the wards. They felt able to raise issues with managers, if required.

Following the temporary closure of the Westbourne Green Community Hospital site, staff were going through a period of uncertainty regarding how and where services would continue to be provided. Staff had been moved from the closed unit to cover staff shortages in the community and acute hospital wards. Staff were unclear when Westbourne Green Community Hospital would reopen, or which staff would work at the hospital when it did.

Public engagement

We saw that the trust had developed a patient and public experience strategy for 2015 to 2018. From the annual NHS Staff Survey 2013 for the division of medicine, 85% of staff felt satisfied with the quality of work and patient care they were able to deliver. This compared to a trust score of 83% and a national average of acute trusts of 79%. However, we also noted that 46% of staff had witnessed potentially harmful errors, near misses or incidents compared to a trust score of 38% and a national average of acute trusts of 33%.

Eccleshill Community Hospital

Requires improvement

Are services well-led?

Staff told us that they worked a mixture of normal shifts and long days. The ward manager told us that there was a target from the trust that 70% of staff should work long days. However, it was not clear if staff had been involved in the discussions and decisions about shift patterns.

Westwood Park Community Hospital

Staff told us that they worked a mixture of normal shifts and long days. The ward manager told us there was a target from the trust that 80% of staff should work long days. However, it was not clear if staff had been involved in the discussions and decisions about shift patterns. Some staff expressed concerns about long days, as patient dependency was high and, as a result, the work was physically demanding.

We saw a 'You said, we did' poster displayed on the wall, which highlighted that patients had raised issues about call bells and television remote controls not working. We saw actions were recorded and these issues were now resolved.

Innovation, improvement and sustainability

Eccleshill Community Hospital

Staff completed a taped handover at the end of every shift. This was supplemented with a paper handover sheet for reference. This helped to ensure that the handovers were completed in a timely manner and staff could finish on time. Also, staff were still available to provide care while the next shift were listening to the tape.

Westwood Park Community Hospital

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust had not always protected service users from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure there are suitable arrangements in place for staff to receive appropriate training, supervision and appraisal including the completion of mandatory training, particularly the relevant level of safeguarding training so that they are working to the up to date requirements and good practice.