Northumbria Healthcare NHS Foundation Trust

RTF

Community health inpatient services

Quality Report

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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)
RTFDH	Berwick Infirmary	Inpatient services	TD15 1LT
RTFDJ	Alnwick Infirmary	Inpatient services	NE66 2NS
RTFDX	Blyth Community Hospital	Inpatient services	NE24 1DX
RTFDM	The Whalton Unit	Inpatient services	NE61 2BT
RTFEF	Rothbury Community Hospital	Inpatient services	NE65 7RW

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community inpatient services as good because:

The service prioritised patient protection from avoidable harm and abuse. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. We saw evidence of an open and transparent culture in relation to incident reporting. Opportunities were available to learn from investigations and the service was aware of areas in which it needed to improve, such as falls. The department was clean and there was an active infection control and prevention audits, which showed high scoring outcomes. Risks to people who used services were assessed, monitored and managed on a day-to-day basis. Escalation and deterioration plans were in place for patients when staff had concerns regarding a patients condition and wellbeing. All wards had good staffing levels and frontline staff told us their managers supported them if they needed to increase their staffing numbers when patient dependency increased.

The trust's contribution to local and national audit was in line with the national average, and evidence of changes made by specialities in response to their outcomes was available and had been actioned. Accurate and up-to-date information was shared with staff and used to improve care and treatment and people's outcomes. People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. People had good assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to maintain and further develop their professional skills and experience. We saw strong and respectful multidisciplinary team working during our inspection and feedback from all disciplines emphasised this. They worked closely with the local authority when planning discharge of complex patients and when raising safeguarding alerts.

We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Feedback from numerous patients across all five of the community locations was exceptional. We heard that staff went the extra mile to be supportive, to assist patients over and above routine tasks and ensure that patients were fully included in all decision making regarding their health and wellbeing. Relatives said they felt involved in their care and had the opportunity to speak with the doctor looking after their family member. Staff spoke with passion about their work and were proud of what they did. Complaints and concerns were taken seriously and responded to in a timely way. Improvements were made to the quality of care as a result of complaints and concerns.

There was a clear vision and strategy for the service, which was well developed and well understood throughout the department. The behaviours and actions of staff working in the division mirrored the trust values of 'patient's first, safe and high quality care, and responsibility and accountability' of which we saw multiple examples of during our inspection. There was evidence of ownership of services and patient centred care was clearly a priority. Risks and potential risks discussions were ongoing and there was a governance structure for formal escalation where appropriate. Many of the wards were piloting a scheme called 'Board to Ward', which encouraged staff to develop safety and quality priorities specific to them and lead on improvements. It provided an opportunity to focus on the issues that matter at ward level, with staff having ownership in deciding what priorities should be, and how to meet these goals.

Summary of findings

Background to the service

Northumbria Health NHS Foundation Trust provides community inpatient services to a population across Northumberland. Inpatient facilities are located at Berwick Infirmary, Alnwick Infirmary, Rothbury Community Hospital, Blyth Community Hospital and The Whalton Unit in Morpeth. All wards are nurse led with daily and weekly support from GPs and consultants.

Berwick Infirmary is a small community hospital located within the town centre of Berwick upon Tweed. Service provision at this hospital includes: inpatient services for elderly medicine, stroke and orthopaedic rehabilitation and palliative care. Berwick Ward 1 is a 24-bedded ward with an average length of stay of 22 days.

Alnwick Infirmary has a 30-bedded community inpatient ward with an average length of stay of 41 days. Ward 1 provides specialist rehabilitation and support for inpatients. This multidisciplinary ward cares for patients who may be recovering from an illness, operation, or following a period in another hospital. Physiotherapists and occupational therapists work with the nursing team to provide the support patients need to help them with their recovery and gain confidence.

Blyth Community Hospital provides care and treatment locally delivering specialist care for the elderly. It has two elderly care rehabilitation wards. Ward 2 has 26 beds and Ward 3 has 27 beds. The average length of stay at Blyth was 29 days. Both wards in the hospital provide specialist rehabilitation, discharge planning and support for patients admitted to hospital for a range of acute medical conditions.

There are 30 beds in the Whalton Unit, which is in the grounds of the former Morpeth Cottage Hospital. This ward focuses on elderly rehabilitation and palliative care.Occupational therapists and physiotherapists are based within the unit. The average length of stay on this unit is 29 days.

The smallest inpatient ward is in Rothbury Community Hospital (formerly Coquetdale Cottage Hospital). It has 12 beds with an average stay of 6 days. There is one ward, which provides a range of care covering specialties such as physiotherapy, occupational therapy and palliative care. The ward also provides private respite care.

We spoke with 19 patients and relatives and 20 members of staff. We observed care and treatment and looked at care records for 31 people.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, Consultant Physician.

Team Leader: Amanda Stanford, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and Expert by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

Summary of findings

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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 9 to 13 November 2015.

What people who use the provider say

People who used the service said:

- They felt safe and cared for.
- Staff were respectful of their privacy and dignity.
- Family members felt involved in the care of their relative.
- Patients stated they were treated with kindness and compassion throughout their hospital stay.
- Staff were open and honest.
- Patients felt staff took the time to explain procedures and ensured they understood.
- Communication was very good with full involvement of patients and families in decision-making.
- Patients told us that the units were very clean and fresh bedding was provided daily.
- Family member stated the care was exemplary.
- Patients and family members would recommend the hospital to friends and family.

Northumbria Healthcare 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

Summary

We rated safe as good because:

The service prioritised patient protection from avoidable harm and abuse. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. We saw evidence of open and transparent culture in relation to incident reporting. Staff were able to learn from the feedback received from senior managers and were comfortable reporting their concerns or any near misses. Opportunities were available to learn from investigations and the service was aware of areas in which it needed to improve, such as falls. The Duty of Candour process and practice was embedded across all community inpatient locations.

There were established work streams, projects, and pilots in place to improve harm free care. The department was clean and there were infection control and prevention audits, which showed high scoring outcomes. We found that medicine management and recording of information was to a high standard and well maintained. Training levels exceeded trust targets as a whole and staff competence was apparent during inspection. All safeguarding training took place as part of the trusts mandatory training programme and nursing staff demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes to be followed. Support and guidance was provided as necessary by the trust's professional lead for safeguarding adults.

Risks to people who use services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or challenging behaviour. Risk assessments were person-centred, proportionate and reviewed regularly. The service consistently and appropriately applied national early warning scores (NEWS) which is an assessment to identify when care needs to be escalated. Escalation and deterioration plans were in place for patients when staff had concerns regarding a patients condition and wellbeing. All wards were adequately staffed and frontline staff told us their managers supported them if they needed to increase

Good

Are services safe?

their staffing numbers when patient dependency increased. Risks to safety from service developments, anticipated changes in demand and disruption were assessed and managed effectively.

Safety performance

- There were no cases to date during 2014/15 of Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile in community inpatient services.
- There had been no never events between August 2014 and August 2015. Never Events are serious incidents that are wholly preventable.
- The safety thermometer data showed a reduction in the occurrence of falls with harm. Staff felt that the change was due to the implementation of the falls strategy and an increased focus on delirium.

Incident reporting, learning and improvement

- There were 13 serious incidents reported across all five locations between August 2014 and August 2015. Nine of these incidents related to falls with harm, three related to ungradable pressure sores and one was an identified breach of confidentiality. Reports, reviews and investigations were in place for all incidents. There was completion of a root cause analysis for all category three and category four pressures ulcers.
- Data showed that from August 2014 to July 2015 there were 137 reported pressure ulcers grade 2 and above across all five locations, 88 reported falls without harm and 33 catheter and new urinary tract infections across all community inpatient locations.
- Pressure ulcer pathways were in place for the monitoring, treatment and reporting of pressure damage with links to heel damage and skin integrity pathways. At the time of inspection, Berwick Hospital had been pressure ulcer free for 200 days.
- High incidences of slips, trips and falls were identified across the main sites. As a result, there was implementation of an inpatient falls strategy for elderly care in June 2014. Awareness raising and training commenced and staffing increased for those individuals requiring one to one nursing care. The safety thermometer data showed a reduction in the occurrence of falls with harm. Staff felt that the change was due to the falls strategy and an increased focus on delirium.
- We saw the implementation of white communication boards, which identified individuals who were at a high risk of falls with a falling star icon. Patients most at risk were placed in beds close to the nurse's station. Line of sight monitoring was less easily achieved in The Whalton Unit due to the layout of the ward and the single rooms.
- We observed structured morning safety huddles (meetings) which reviewed things done well, problems overnight, potential safety issues for the day shift from night staff, any trust wide issues and key challenges and targets for the week ahead. This was part of the joint handover between medical and nursing teams and included all members of staff required to run the ward effectively.

Duty of Candour

- Staff members were familiar with the process for duty of candour. Senior management advised the trust used the electronic reporting system to record and monitor notifiable safety incidents which invoked the duty of candour regulations. The Trust has updated its 'Being Open policy' to include the CQC duty of candour regulations; it also made reference to the recently issued NMC/GMC professional duty of candour guidance. This policy was available to all staff.
- Staff understood what was meant by openness and transparency and had completed training as part of their induction process. .
- We saw two examples of duty of candour in practice and saw documentation of an apology, root cause analysis, action plans and lessons learned. These documents were detailed and thorough.

Safeguarding

- The trust Safeguarding Board was the key mechanism through which safeguarding governance, assurance and service development was monitored.
- All safeguarding training took place as part of the trusts mandatory training programme. We found that across the Berwick and Alnwick locations, 100% of staff had completed safeguarding adults level 1 and 2 and as well as safeguarding children and young people level 2. Blyth recorded training levels for safeguarding adults at 88% and safeguarding children at 80% against targets of 85%.

Good

Are services safe?

- When we spoke with nursing staff, they demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes to be followed.
- Matrons checked the level of staff competence when random safeguarding checks were completed. These checks included looking at records and talking to staff.
- Ward managers in each location kept a purple file easily accessible for all staff, which contained reminder notes and standard operational procedures (SOPs). Data within the purple file was up to date and regularly reviewed by the ward manager and matron.
- The trust employed a professional lead for safeguarding adults, a disability liaison nurse and a professional lead for mental capacity, deprivation of liberty and Mental Health Act.

Medicines

- The medicines management risk assessment report highlighted that community inpatient services were 100% compliant with medicines for emergency use, vaccines, disposal of medicines, controlled drugs, injectable medicines, patient group directions, supply and ordering, policies, and standardised operational procedures.
- The percentage of patients with medicines reconciliation within 24 hours of admission averaged at 85% from July 2014 to June 2015 for community inpatients. This is below the stretch target (not minimum standard) of 95%. For May and June 2015, the service was above target at 95.5% and 99% consecutively.
- Antibiotic audits were ongoing throughout the year.
- Patients who had a dose of a critical medicine omitted within a 24 hour period was an average of 1.4% from July 2014 and June 2015. The trust stretch target was 1.8%, showing results were better than target.
- Patients, who had an omitted dose within a 24 hour period, excluding patient refusal and valid clinical reasons, averaged 15% from July 2014 and June 2015.The trust target was 10% showing results were worse than target.
- Fridge temperatures were regularly checked and at the correct temperature, clean and suitable. Storage of fridge items compliance rate was 98%.
- Stock medication ordering was weekly with nonstock items ordered and delivered on the same day.
- The medicines room was locked at all times but there was no signage on the door advising of oxygen storage at Berwick Infirmary. Staff at Berwick Infirmary followed guidance for locking and securing the medication trolley to the wall.
- We found some out of date drugs and dressings stored at Berwick, Alnwick, Rothbury, and Blyth. These were disposed of appropriately.
- Controlled drugs management was good across all community inpatient locations; all were in date and recorded appropriately when administered. We found excessive controlled drug stock at one location; this was due to waiting for the central pharmacy to collect the items as there was no routine collection process. The pharmacist visited each location weekly and stock was reviewed three monthly.

Environment and equipment

- The staff informed us that they had appropriate facilities and equipment to care for patients on their wards. There was no storage of bariatric equipment on site but ward managers advised they could obtain the necessary equipment promptly.
- Checks were made of the resuscitation equipment in all community locations. Each location was fully equipped; regular checks were made and up to date. Checks of oxygen took place and cylinders were in date.
- The resuscitation trolley was behind a locked door on Ward 2 at Blyth Community hospital. A concern was raised with staff during inspection regarding quick and efficient access to the trolley. This was addressed during the inspection.
- We observed that all hoists, electrocardiogram (ECG) and electronic blood pressure machines had evidence of in-date safety testor servicing.
- There was no designated storage area for equipment at Berwick Infirmary. Side rooms were used but not signposted.
- The 15 steps visit took place randomly as an unannounced audit. This is a programme to view the ward and care environment from the patients perspective within 15 steps of walking on ward. There were high levels of compliance with these audits.
- The trust was rolling out the Well Organised Ward (WOW) initiative, which seeks to standardise ward supplies using the '6S' approach – sort, set, shine, standardise, sustain, and safety.

Good

Are services safe?

Quality of records

- We checked 31 sets of records in total across five community inpatient locations. We found that the general standard of record keeping was good. Care plans were in place and individualised, there were risk assessments pertaining to individual need, risk and action plans.
- There was a monthly documentation audit. NEWS audits took place on a monthly basis to ensure correct completion and to determine trends. Results from audits were of a high standard and where improvement was identified, action plans were created and implemented to improve the standard.

Cleanliness, infection control and hygiene

- Infection control information was visible in all ward and patient areas.
- Wards and patient areas were visibly clean. We observed staff wash their hands, use hand gel between patients and comply with 'bare below the elbows' policies.
- Infection control audits across Berwick, Alnwick, and Blyth Ward 2 and Ward 3, The Whalton Unit and Coquetdale Ward showed 100% compliance for the cleanliness of commodes, 100% compliance for hand hygiene and 100% compliance in the cannula audits for the months of April to July 2015 inclusive.
- We saw the use of personal protective equipment (PPE) when dealing with patients on most occasions. However, there were two occasions during our inspection when PPE was not in use during delivery of care.
- We saw 'I am clean stickers' in use but these were not observed on any equipment other than the blood sugar monitoring machines.
- During the inspection, we saw that the sluice was clean and waste disposal was in use as required by relevant guidelines and protocols.
- The management of sharps was satisfactory and appropriate.

Mandatory training

- Training compliance rates were of a high standard and continually above the national average and the trust's own target of 85%. We found that nursing staff at all five community inpatient locations had completed 100% of the trust mandatory training. This training included risk management, health and safety, infection prevention and control, moving and handling, safeguarding level one and two, information governance and basic life support. Allied health professionals across the five locations showed similar training results but had lower completion percentages for training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The training available to staff was a mixture of eLearning, face to face and external training. Staff felt that eLearning had been more beneficial and accessible for those employees living and working in rural locations.

Assessing and responding to patient risk

- Internal transfer standardised operational procedures and ambulance service bypass and inclusion protocols were in place for assessing and dealing with deteriorating patients.
- Records held completed malnutrition universal screening tools (MUST), Braden (tool used to assess risk of patient developing a pressure ulcer) and falls assessments. Initial NEWS scores (assessment of respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate, and level of consciousness) and pain assessments were well documented.

Staffing levels and caseload

- No formal staffing acuity tool was in use at the point of inspection. We were told that staffing rotas were planned based on one nurse to eight patients (1:8) on day shift with one nurse to ten patients (1:10) on late and night shift. However, this was an informal process until the safer staffing tool is formally implemented.
- All wards were nurse-led with daily and weekly support from GP's and consultants. The community hospital vacancy rates were 7% at Berwick, 12% at Alnwick, 9% on Blyth Ward 2 and 11.0% on Ward 3, 7% at Rothbury and 4% at the Whalton Unit.
- We found existing staff backfilled vacancies, sickness and staff holidays. Agency staff were not required at Berwick or Alnwick community hospitals. Blyth Ward 2 covered 896 hours and Ward 3 covered 703 hours with agency staff over a six month period from May to October 2015. The Whalton unit covered 51 hours in

Good

Are services safe?

June 2015 and 13 hours in October 2015 with agency staff. Agency staff had been inducted into the service and whenever possible the same staff were used to promote continuity of care.

- Out of hours medical cover was provided by a not for profit social enterprise team of doctors. They were available from 20:00 to midnight at the weekend and 18:30 to midnight on weekdays. ENPs contact NSECH for medical support after midnight.
- The trust sickness target was 3.5%. Except for Alnwick Infirmary, sickness levels across the community inpatient service for nursing were consistently above the trust target. Rates were 11% for nursing and 5% for health care assistants (HCA) across the five community inpatient locations for 2014 - 2015. We found staffing levels to be appropriate and nursing staff said the teams worked well covering shifts for one another. They said there were occasions, depending on the complexity of patients that additional staff were rostered but acknowledged there could be times of high pressure.
- There were no concerns raised regarding allied health professional coverage. One physiotherapist was on site every morning, Monday to Friday. An additional physiotherapist was available three mornings each week and a technical instructor was available all day Tuesday to Friday at Berwick Infirmary. Alnwick, Blyth, and Rothbury hospitals had similar arrangements. The allied health professional at the Whalton Unit was available on a full time basis.

Managing anticipated risks

- All buildings appeared to be in a good state of repair internally. However, the buildings were old and not fully suitable for providing care to elderly patients. There was a plan to replace Berwick Infirmary with a new building. Business continuity plans were in place and senior staff explained these during an interview. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions required by departments and staff to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.
- In recent years, each community hospital encountered a major incident which required implementation of their major incident plans. Each situation was managed successfully. These included arsenic contamination, power outage with fallen trees and lockdown while police dealt with an armed suspect.

Good

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 effective as good because:

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. People had good assessments of their needs, which included consideration of clinical, mental and physical needs as well as nutrition and hydration needs. We found that all staff were actively engaged in activities to monitor and improve quality outcomes. The trust's contribution to local and national audit was in line with the national average, and evidence of changes made by specialities in response to their outcomes was available and had been actioned. Accurate and up-to-date information was shared with staff and used to improve care, treatment and people's outcomes.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was in place to meet these learning needs. Staff were supported to maintain and further develop their professional skills and experience. There was evidence of easily accessible guidelines on the trust intranet for staff to access and use to refresh their practice skills. Staff worked collaboratively to understand and meet the range and complexity of people's needs. We saw strong and respectful multidisciplinary team working during our inspection and feedback from all disciplines emphasised this.

Evidence based care and treatment

- Staff said they were able to access all policies and procedures on the intranet. There were also printed copies available for the more commonly used policies and procedures. These were stored in the ward manager's office.
- Departmental policies, procedures and guidelines originate from nationally recognised best practice guidance such as the National Institute for Health and Care Excellence (NICE). All staff followed NICE guidance concerning falls prevention, fractured neck of femur, pressure area care and venous thromboembolism (VTE).
- The trust had many standardised assessment tools, action plans and referral forms for identifying need, risk, potential risk and safeguarding concerns. We found the completion of documents appropriate and consistent across all five locations.
- Local audits include indicators of hyperglycaemia in adult in patients with diabetes, audit regarding the appropriate use of Deprivation of Liberty Safeguards, audit of the correct use of Braden score and skin bundles in elderly care as well as diagnosing delirium and identifying risk factors on admission.

Pain relief

- Initial pain score assessments took place with patients. However, pain assessment reviews following the prescribing of analgesia were not always recorded. Nonetheless, most patients stated their pain was under control.
- We saw evidence of the involvement of the physiotherapy team with respect to exercises to encourage movement and mobility to reduce pain related to stiffness.

Nutrition and hydration

- Staff were aware of the nutrition and feeding needs of all patients. Magnetic stickers on boards discreetly identified those requiring thickened fluids, soft food, diabetic meals or assistance to consume their food. We observed fluids safely in reach of patients and there were fluids available throughout the day and night as required. We saw fluid balance charts in place but it was not always clear what the fluid target was for each patient.
- The trust met the required standards of the 10 key characteristics of good nutritional care as set by the Nutrition Alliance; they applied the malnutrition universal screening tool (MUST) and met the standards required by the Government Buying Standards for food and catering services. Speech and language therapy advice was available on request. Speech and language therapists had a base at Blyth and they were able to assess patients during meal times.

Good

Are services effective?

- A nutritional volunteer supported patients at Berwick Infirmary 21 hours each week to help with nutrition and hydration of patients who require assistance.
- Patient feedback regarding the quality of food was very high. There were no negative comments and we saw staff the extra mile to be supportive . A patient at the Whalton Unit wanted a specific meal so the chef went to the shop to purchase the ingredients. Adherence to culture and preference was apparent on wards across the five community inpatient locations. Special diets were available as required.
- Patients with MUST scores had a red file at the end of their bed so that staff could identify those patients requiring extra support with nutrition. We reviewed 31 records and MUST assessments were completed appropriately.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored information showed that the intended outcomes for people were being achieved. All local and national audit outcomes were discussed at the monthly integrated governance and performance meetings. Performance was analysed and action plans generated with feedback sharedappropriately. The outcomes for people in this service compared wellto other similar services.
- All local and national audit outcomes were discussed at the monthly integrated governance and performance meetings. Performance was analysed and action plans generated with feedback shared appropriately.
- The quarterly excellence in safety report from the trust board showed performance, themes, trends and benchmarking and sharing of learning to the governance committees and business unit.
- There was participation in relevant local and national audit. Examples included Inpatient falls resulting in hip fractures, Diabetes (Adult), National Diabetes Inpatient Audit, National Audit of Intermediate Care, Palliative Care End of life document audit and delirium audits. Staff were involved in activities to monitor and improve people's outcomes.
- There was a clear approach to monitoring, auditing and benchmarking the quality of these services and the outcomes for people receiving care and treatment. The quality and outcome information showed people's needs were being met. Quality and outcome information was used to inform improvements in the service.

Competent staff

- Appraisal rates were consistent across the community hospitals. All staff on Ward 1 at Alnwick community hospital had received their appraisal (100%). This included nursing staff, chaplaincy, allied professionals and ancillary staff. Berwick Infirmary was similar in that all allied professionals, ancillary staff, domestic services, portering services and chaplaincy appraisal rates were 100%. 92% of nursing staff on Ward 1 had received their appraisal. The rate of appraisals at Blyth Community Hospital was 100% for allied professionals and ancillary staff. 77% of nursing staff on Ward 2 and 54% of nursing staff on Ward 3 had received their appraisals. 100% of staff at the Whalton Unit, Morpeth and Rothbury had received an appraisal. Induction attendance was 100% and mandatory for all staff including agency staff.
- Staff advised that formal clinical supervision was not provided. Informal supervision was available on a day to day basis and as required. A clinical supervision trial had commenced at Alnwick Infirmary. Senior managers were visible on the wards and there was provision for support and guidance on a day-to-day basis.
- We saw evidence of support provided to staff through advanced training and additional speciality training to enhance their skills and performance.
- Staff advised that peer support was very good and frequent. Staff told us that team members worked well together and had done so for many years. Staff felt able to approach colleagues for advice and support across all inpatient locations.
- For those newly qualified, the trust offered a preceptorship programme to help with the transition from university to nursing in a busy hospital environment.
- The trust offered practical support to help nurses meet the requirements of revalidation through a wide variety of education, training and practice development as well as opportunities to undertake various degrees and postgraduate qualifications and leadership development.
- We found that community inpatients had links established with specialist nursing professionals such as multiple sclerosis, tissue viability, diabetes, Parkinson's

disease, stoma care and speech and language therapy. A range of standardised, documented pathways and agreed care plans were in place across all five of the community inpatient locations. Staff were aware of these pathways and we saw evidence of best practice.

Multidisciplinary working and coordination of care pathways

- We attended multidisciplinary handover discussions. The Whalton Unit handover was doctor led and attended by nursing staff, an occupational therapist, a physiotherapist and a social worker. All staff contributed and had a good knowledge of the patients. They discussed discharge and forward planning.
- We found that ward staff worked closely with the local authority when planning discharge of complex patients and when raising a safeguarding alert. The Admission Avoidance Resource Team (AART) was a service for adults living at home in North Tyneside. Once a patient returned home, the team could provide urgent response for rehabilitation and support if patients become unwell or were in need of additional help to enable them to stay at home safely.
- The dietician visited community inpatient locations once each week but was available by telephone to provide guidance and advice when necessary.

Referral, transfer, discharge and transition

- The trust managed adult social care services on behalf of Northumberland County Council. This ensured ease of transition between hospital, community health and social care services and promoted continuity of care. This gave people greater choice and control over their care to help them to live independently at home and to avoid hospital admission where appropriate.
- We saw good integrated working, which reduced delayed transfers and enhanced patient transition back to their own home.
- The average bed occupancy across the trust was 80% for quarter (Q) 1 in 2014/15 against the England average of 86%, Q2 was 79% (Eng. Avg. 86%), Q3 was 79 (Eng. Avg. 87%), Q4 was 83% (Eng. Avg. 88%) and Q1 2015/16 was 77% against the England average of 86%.
- The number of discharges from community inpatients through Short Term Support Services between April 2015 and June 2015 inclusive was 100 patients. Of the 100 patients, 67 were managed by care led services and 33 were managed by therapy led services.
- The readmission rate trust wide was 10%, and the trajectory target figure was 8% for April 2015.

Availability of information

- We observed that patient records were stored securely and no patient identifiable information was visible to people attending the ward.
- Records were available for nursing staff and there were no concerns in obtaining relevant information about patients.
- We found that sharing of confidential information between teams and the local authority was in line with the trust policy and procedures. Consent from patients was required prior to sharing information with external organisations.
- There were leaflets and information on all wards visited. Information explaining conditions, support such as chaplaincy, risks, hygiene and ward statistics were clearly on display. Translation of information would occur when necessary due to all information being in English.

Consent

- The trust had a consent policy in place, which followed the Department of Health model consent policy. The policy included the process for consent, documentation, responsibilities for the consent process, and consent training. The policy also included consent for children, advanced decisions, Lasting Power of Attorneys guidance, Mental Capacity Guidance and checklist. Details about accessing Independent Mental Capacity Advocates (IMCAs) were available. The policy also outlined guidance on provisions for patients whose first language is not English including the use of an interpreters list and language line.
- Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) was included on corporate induction of all clinical staff and is included in mandatory patient safety training.
- We found during our inspection that capacity assessment documentation was appropriate on the inpatient wards.
- The Deprivation of Liberty Safeguarding Policy version 4 was in place across all five of the community locations. The policy was updated in line with the 2015 Supreme Court ruling on Deprivation of Liberty.

Good

Are services caring?

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

Summary

We rated caring as good because:

Feedback from numerous patients across all five of the community locations was positive. We heard that staff responded compassionately to their needs and were skilled in dealing with vulnerable individuals with complex physical and mental health needs. Relatives said they felt involved and had the opportunity to speak with medical and nursing staff when required.

We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary. Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.

Patients told us they felt empowered because both nursing staff and consultants kept them informed, included them in decision-making and listened to their wishes. They also told us staff checked that patients and relatives had understood the information given to them and were always available for questions. We observed staff discuss care options, treatments and provide choice to patients. Patients were listened to and emotionally supported. Communication obstacles were overcome confidently and compassionately when working with people living with dementia and learning disabilities.

Compassionate care

Patient feedback was positive across all community inpatient locations. 4,934 patients responded to the Friends and Family Test survey. 97% of patients would be extremely likely or likely to recommend the service to friends and family. 95% of patients staying overnight said their care was excellent, very good or good. Patients scored the trust 9 out of 10 for kind and compassionate care.

Berwick Infirmary

We spoke to four patients, one carer and two relatives at Berwick Infirmary. All patients felt safe on the ward, felt cared for and stated that the atmosphere was warm and friendly. It was felt that due to the ward layout, staff were able to check on their wellbeing frequently.All individuals spoken to said staff were respectful of their privacy and dignity and that there was full inclusion with decision-making. Family members felt involved in the care of their relative and had no complaints. One patient said they had been treated with kindness and compassion throughout their hospital stay and stated that “everything is great, they couldn’t do anything better”. There was one issue raised regarding noise levels from other patients at night. Staff were addressing the issue by providing the patient with a single room.

Alnwick Infirmary

We spoke to three patients at Alnwick Infirmary. All patients spoke highly of the care they had received and felt staff were open and honest. Patients felt staff took the time to explain procedures and ensured they understood. One patient highlighted that staff were very particular when attending to patient hygiene. All patients said the ward was clean and prompt action was taken when problems arose. A patient informed us that the call bell response was within approximately two to five minutes. All patients spoken to said staff were kind, caring and respectful towards patients at all times.

Blyth Community Hospital

We spoke to four patients and three relatives at Blyth Community Hospital. Patients felt that communication was very good with full involvement of patients and families in decision-making. Patients stated they felt safe, that the ward was clean and that staff were open and honest. One patient stated that nursing staff were very good at monitoring pain and checking that analgesia had worked. Additional pain relief was available when required. We were told staff were kind, friendly and willing to do anything for the patients. Another patient said they had received lots of information about their condition and about the support they would require once home.

The Whalton Unit, Morpeth

We spoke with two patients at the Whalton Unit. Patients stated that all staff were respectful of their wishes, privacy and dignity. They discussed good quality care and support

Good

Are services caring?

and advised they had felt safe throughout their stay. Patients told us that the unit was very clean, there was fresh bedding daily and staff were very quick at answering the call bells. One patient explained they had received a high level of involvement from the occupational therapists and physiotherapists.

Rothbury Community Hospital

We spoke with a patient and family member at Rothbury community Hospital. They both stated that the staff were friendly, caring and compassionate. The patient felt safe and the family member stated the care was exemplary. Both would recommend the hospital to friends and family. Other patients were not in a position to speak with us due to the nature of their illness.

Understanding and involvement of patients and those close to them

- Patients advised us that nursing staff made a great deal of effort to explain tasks and processes. Patients highlighted that staff checked they understood information and were always available for questions. One patient spoke at length about being involved in their discharge planning and with care arrangements for their return home.
- The trusts interpreter service were under review. Informal arrangements were in place with Interpreting translation Line (ITL), Becoming Visible and the Big Word. Translation services were available 24 hours each day, along with face to face interpreting, audio to text transcription, voice over, braille, British sign language interpretation, lip speaking, and large print and deafblind interpreting.
- Information was available for patients on the wards regarding their care, procedures, hygiene and conditions.

Emotional support

- Some patients we spoke with felt that emotional support was occasionally lacking during busy periods. Staff advised that they sit with patients and discuss their concerns but recognised that during busy periods the emotional support could be difficult to provide.
- Each ward had individual visiting times. The community inpatient wards were flexible when a patient was very ill or when a relative had to travel to visit. Blyth community hospital has open visiting and staff felt this was beneficial to both visitors and patients.
- Carers assessments were discussed with patients and relatives. Access to an online carers assessment was available through the trust website linking to social services. Carer assessment discussions took place during the weekly MDT board round meeting highlighting concerns of physical and emotional difficulties for some carers.

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 responsive as good because:

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. The needs of different people were taken into account when planning and delivering services and reasonable adjustments were made to remove barriers when people found it hard to use or access services. For example, money from the trust's Bright Charity was given to Blyth Community Hospital to help normalise the care environment for patients living with dementia.

Care and treatment was coordinated with other services and other providers and there was evidence of competent multidisciplinary working between all professionals. Team discussions focussed on discharge and forward planning. They worked closely with the local authority when planning discharge of complex patients and when raising safeguarding alerts.

We found there was openness and transparency in how complaints were dealt with. We noted several suggestion boxes and posters encouraging feedback from the public around the units. The people we spoke to said they felt very confident about raising concerns or making a suggestion. Complaints and concerns were taken seriously and responded to in a timely way and improvements were made to the quality of care as a result.

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.
- Patient assessments for those with complex needs and long term conditions took place on a multidisciplinary basis with social services, an occupational therapist and physiotherapist, with input from medical and nursing staff. Specialist liaison nurses were involved when required and appropriate handovers were in place for district nursing and care agency staff prior to discharge.
- The trust 'Keep calm and ask' campaign encouraged patients and their families to ask any questions they may have. This was rolled out across the trust to improve the patient experience.
- Patients discussed rehabilitation undertaken in the kitchens to regain the skills they may have lost following illness such as stroke. Breakfast clubs had been in place at Blyth but times were changed to create a lunch group at the patients request.
- There were no delayed transfers of care.

Equality and diversity

- Community inpatient teams across all five locations demonstrated personalised patient care in line with patient preferences, individual and cultural needs, and in line with the person centred care approach.
- Each ward had individual visiting times. The community inpatient wards were flexible when a patient was very ill or when a relative had to travel to visit.
- The Trust's chaplaincy team provided comfort and support to people in hospitals across the trust. The trust's chaplaincy service covers all hospitals in Northumberland and North Tyneside. The chaplains, supported by trained volunteers, visited patients on hospital wards and in quiet spaces away from clinical areas. The chaplaincy team had strong links with the leaders of local churches and faith communities and churches provided volunteers to help patients attend services in the chapel.
- The trust had literature available for Buddhist, Christian, Hindu, Muslim and Sikh religions. There was access to Muslim prayer mats.
- Ward managers were clear about zero tolerance for discrimination.

Meeting the needs of people in vulnerable services

- Money from the trusts Bright Charity was given to Blyth Community Hospital to upgrade the day room and side rooms on ward 3. Dimmer switches, redecoration and work in the garden made the rooms less clinical and made a difference for dementia patients and helped normalise the care environment.

Good

Are services responsive to people's needs?

- Metallic boards in patient bed areas identified special requirements such as falls risk, dietary needs, target oxygen saturations, nil by mouth, mobility needs, short term memory difficulties and food/fluid texture requirements.
- The wards displayed information about their dementia champion, details about delirium and supporting information for dementia care. There was a comprehensive dementia awareness folder for staff held at the nurses station which emphasised a needs led approach to challenging behaviour.
- Pictures of food and meals were available for patients who had memory or speech difficulties enabling patients to have as much choice and input as possible.
- Falls improvement workshops took place with all staff in 2012 prior to the implementation of the falling stars metallic board, which identifies those at a high risk of falls.
- Most patient assessments were multidisciplinary assessments with a social worker, physiotherapist and occupational therapist. This linked with community handover and a fuller integrated, comprehensive assessment of patient need prior to discharge.
- The care plans we viewed demonstrated that people's individual needs were taken into account before care started.
- Patients living with dementia had a "This is me" care plan in place. This is a tool for people with dementia to use so that staff became aware of their needs, preferences, likes, dislikes and interests. It also enables health and social care professionals to see the person as an individual and deliver person centred care that is tailored specifically to the person's needs. Dementia care champion roles support staff to achieve best practice for dementia care.
- There was a good awareness amongst staff of the delirium that patients experience because of their treatment in this environment.

Access to the right care at the right time

- Community hospital locations were rural and widespread. We found that each hospital is easy to access when you live locally but delays can occur when requiring services at the main site due to the one hour travel. There were good rail and bus links.
- We saw links with the main site using telemedicine to be highly beneficial cutting journey times and patient cost while receiving consultancy from a senior medical professional.
- Patient escalation plans were in place for each patient in case of deterioration. The detail on escalation plans were of a high level, which meant treatment could continue without the patient having to transfer back to one of the main hospital sites. Overnight plans were in place as part of the nursing pathway.
- Access to advice and support from other departments was available by telephone as and when required. Staff advised that obtaining support was straightforward and easily achieved.
- Average length of stay for patients at Berwick Infirmary was 22 days, Alnwick 41 days, Blyth was 29 days. The Whalton Unit average length of stay was 29 days and the shortest average length of stay was at the Coquetdale Unit with 6 days.
- Community hospital admissions were from the main sites such as Wansbeck General, NSECH, and North Tyneside and on occasion from Newcastle hospital. Each patient underwent a re-assessment and update of need. We found that nurse to nurse referrals took place to enable admission of palliative care patients. Additional support and training enabled staff to work with nasal gastric tubes and with patients experiencing delirium.
- Ambulatory care pathways were in place across the trust. Medical care was available to patients in hospital on the same day they presented to prevent the patient from needing admission to a ward. This includes assessment for blood clots in the legs or lungs, skin infections, palpitations and low blood count as an example.
- There were no mixed sex accommodation breaches between November 2014 and November 2015 across all five of the community inpatient locations.

Learning from complaints and concerns

- We found that seven complaints were received in total across the five community inpatient locations over a 12 months period from August 2014 to July 2015. Three complaints were about Alnwick Ward 1; three were about Blyth Community Hospital Ward 2 and one complaint about The Whalton Unit, Morpeth.
- Staff were aware of the process and procedure for escalating complaints to ward managers. Grievances

Good

Are services responsive to people's needs?

were addressed at ward level initially and information relating to the Patient Advice Liaison Service (PALS) was available and shared with patients as necessary. Information leaflets were visible across all wards.

- Formal complaint investigations were held by the operational service manager who was also involved in monitoring the number and percentage of complaints closed within the timescales agreed with the complainant.
- Discussions regarding complaint issues took place at the Complaints, Claims and Concerns Monitoring Group (CCCMG) held quarterly and chaired by a non-executive director. The CCCMG is a formal subcommittee of the safety and quality committee. The complaints dashboard report on performance was available to the safety and quality committee on a monthly basis. There was triangulation of information between social media and patient experience data before reporting to CCCMG.
- The quarterly excellence in safety report from the trust board shows performance, themes, trends and benchmarking prior to sharing of learning to the governance committees for the business unit.
- We found that the ward staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.

Good

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 well-led as good because:

There was a clear vision and strategy for the service, which was well developed and well understood throughout the department. The behaviours and actions of staff working in the division mirrored the trust values of 'patients' first, safe and high quality care, and responsibility and accountability' of which we saw multiple examples of during our inspection. There was evidence of ownership of services and patient centred care was clearly a priority. The board appeared well connected to the ward and leadership was good at all levels. There was a governance structure for formal escalation of risk where appropriate. Many of the wards were piloting a scheme called 'Board to Ward', which encouraged staff to develop safety and quality priorities specific to them and lead on improvements.

There was a strong focus on continuous learning and improvement throughout community inpatient wards. Safe innovation was supported and staff were encouraged to regularly take time out to review performance and make improvements. The business unit welcomed views and input from staff and the local community. This created a sense of engagement and empowerment and enabled patients and staff to improve the quality of care provided.

Service vision and strategy

- The community services business unit strategy states that the trust aims to ensure that quality underpins decisions, safe health and care services to patients and service users, to maintain long term financial strength, attract, retain, support and train staff, and to develop an internationally recognised brand and build strong local and national relationships.
- The business unit contributes to the annual planning process and the development of the annual plan through engagement with clinical and specialty based teams and key stakeholders. The annual plan focuses on the key objectives that each business unit will aim to deliver. Each of these links to the trust's strategic plan and vision. Cross cutting business unit objectives and some business unit specific objectives form part of the annual plan for the Trust. Some of the objectives are to ensure compliance with the Care Act, to promote delivery of the highest standards of end of life care, develop integrated and comprehensive information systems to support whole system integration and to respond to the findings of the 2015 staff survey.
- The business unit identifies a number of safety and quality priorities that will form part of the Annual plan for the trust which was included in the annual planning process. The business units embraces the trust values that 'every person's contribution counts'.

Governance, risk management and quality measurement

- Governance arrangements were in place to enable the effective identification of risks, monitoring of such risks and the progress of action plans. Regular detailed reporting enabled senior managers and representatives of the trust's board to be aware of performance and improvements, which positively affected service delivery. The views of the public and stakeholders were actively sourced on a regular basis.
- Clinical governance minutes over the 12-month period showed a record of discussions around serious incidents and action planning, complaints, patient experience, audits, risk register discussion, financial management and the dementia strategy.
- The business unit reviewed the risks on the risk register, and discussed these issues at monthly clinical governance meetings.

Leadership of this service

- We found a clear management structure in place. Staff were aware of senior managers, their roles within the organisation and how to contact them as necessary.
- The trust approach to quality included encouraging leadership at all levels. The clinical and management leaders monitored performance and improvements; quality panels oversaw a new team accreditation scheme, which created an incentive for front line staff to improve service quality.
- Many of the wards had begun piloting a scheme called 'Board to Ward', which encouraged staff to develop

safety and quality priorities specific to them and lead on improvements. It provided an opportunity for staff to focus on the issues that mattered at ward level, and encouraged ownership of the chosen priorities. By providing a single focal point, the board aimed to improve regular engagement and communication on the ward and highlight: The vision, values and priorities of the trust as a whole, the local priorities of the ward, the ward's performance on locally agreed objectives and key areas for improvement.

- Through 'Board to Ward', all staff were empowered in conversations about safety and quality of care, given an opportunity to participate, gain a better understanding of the trust's overall quality and safety priorities and, ultimately, be involved in continuous improvement.
- Management support and line management was available as and when required. Senior managers were regularly present on wards and staff said they were approachable.
- Ward managers spoke highly of senior management, and advised they were supportive, proactive and took time to listen to the views and concerns of the team.

Culture within this service

- The relationship between the staff and the senior team was strong. Staff members at all levels reported that there was an open door policy, that they could report concerns regarding the service and would feel comfortable speaking directly to senior management. Several staff members were able to give examples of when they had done this and how well received their comments were. This empowered the staff further to speak up when they felt care could be improved.
- At ward level, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Community inpatient staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. Staff said high quality compassionate patient care was a priority.
- Morale appeared good across all five of the community inpatient locations. Staff were positive in their attitude and were 'can do' about their practice and the challenges they faced.

Public engagement

- It was felt by staff that patient engagement improved patient health and wellbeing and had a positive impact on their recovery. The trust had volunteers who assisted at mealtimes to ensure patients received the support they needed as part of a drive to improve the nutrition of patients. Volunteers helped with simple activities such as having a chat about old times, playing cards or reading a book aloud to increase the social interaction of patients, many of whom were elderly.
- The trust engaged with patients and carers through user forums. These included forums for carers of people living with dementia and for people living with long-term conditions.

Staff engagement

- The community inpatients staff survey shows 83% of staff felt satisfied with the quality of work and patient care they delivered. 91% felt their role made a difference to patients. 123 respondents contributed to the staff survey.
- Staff were encouraged to use the 'We're Listening' mechanism (on the staff forum) to give the trust feedback and ideas to improve quality of care. The trust held quality and safety days where they looked at how staff can use tools to measure deliverable improvements.
- Training sessions offer frontline teams a variety of training and accreditations – linked to developing improvement skills to apply in a real life work context.
- Staff at Rothbury community hospital stated that it "was a wonderful place to work" and that they "felt supported and valued".

Innovation, improvement and sustainability

- Quality improvement projects in place over the last 12 months included reviewing: the single point of access arrangements; implementation of joint health and social care admission avoidance; roll out of positive risk taking; locally based complex care arrangements; case management reviews for over 75 year old patients; mental capacity assessments; the learning disability pathway and projects around the Care Act 2014.