Bridgewater CHCT - Newton Community Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Newton Community Hospital is a newly built facility offering both inpatient and outpatient services. It was built to replace an older nursing home and community facility and was previously managed by St Helens Primary Care Trust.

The inpatient unit was supported by a multidisciplinary group of staff employed through various organisations including the local authority, 5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community Healthcare NHS Trust and local GPs. The inpatient unit had 30 beds and primarily provided intermediate care either as a step-up facility to reduce the need for an admission to an acute hospital or as a step-down facility following discharge from hospital.

The outpatient facility supported the local community and surrounding areas with consultant or nurse led clinics. The facility was managed by an outpatient's manager and supported by nurses, reception and, administration staff and medical secretaries. Clinics included cardiac teams, dermatology, ear, nose and throat and a newly formed skin cancer clinic.

Care was generally safe. Evidence showed that staff reported information through the national safety thermometer tool and internal quality monitoring. Incidents were recorded on the trust's Ulysses system and the ward manager completed risk assessment and risk management plans. We identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks which could impact on the trust overall assurance of the unit. We judged this to be a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. However staff had implemented a range of developments at the hospital over the last year that had helped to improve the safety of care, for example the development of tissue viability assessments.

Staff delivered care using evidence-based guidance through standard operating procedures. Discharge planning was effective and the multidisciplinary team (MDT) worked with staff in the community to help prevent hospital admission, and to support patients after they are discharged.

Patients commented on the caring and compassionate approach of staff and that patients were involved in decisions about their care. Discharge planning started when patients were admitted, and families were fully involved. The team had daily multidisciplinary meetings to ensure the planned care remained appropriate.

While it wasn't clear what the long term vision for Newton Hospital was, at ward level the multidisciplinary teams were committed to meeting the needs of the people who used the inpatient unit. Comprehensive assessments were completed by each member of the team and progress was discussed within the daily multidisciplinary team meetings. However, the lack of clarity regarding the long-term purpose of the hospital was having a detrimental effect upon the staff who worked there.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Care was generally safe. Evidence showed that staff reported information through the national safety thermometer tool and internal quality monitoring. Incidents were recorded on the trust's Ulysses system and the ward manager completed risk assessment and risk management plans. We identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks which could impact on the trusts overall assurance of the unit. However staff had implemented a range of improvements at the hospital over the last year that had helped to improve the safety of care, for example the development of tissue viability assessments.

Are services effective?

Care was effectively delivered through the use of evidence-based guidance and standard operating procedures. The unit provided effective intermediate care as either a step down or step up facility and provided two weeks of outreach support for any patient being discharged from the unit. Discharge was planned on the day of admission and care was planned to achieve that goal, with 70% of patients returning to their own homes. There were usually enough staff, though there were unfilled vacancies. These were being filled by agency staff who were employed on a block booking, but this often resulted in too many staff on some shifts.

The greatest challenge for the unit and its staff was the long term vision and how it could best be used to service the local population. At present it was being used as an intermediate care facility, and the trust was discussing with local commissioners about developing a vision and purpose for the future.

Are services caring?

Patients said that they felt involved with their care and that staff treated them with respect. We saw staff interacting with patients in a respectful manner. Curtains were closed around beds where necessary to protect patient privacy. We saw staff supporting and encouraging patients to be as independent as they could and patients told us they were grateful of this encouragement. Patient feedback collected through surveys and involvement in ward audits confirmed their satisfaction with the service.

Are services responsive to people's needs?

The multidisciplinary team was committed to meeting the needs of the people, who used the inpatient unit, and admission and discharge data showed a steady pattern; an average length of stay of three to four weeks and 70% of patients were discharged to their own homes.

Patients told us the service was what they needed at the time of admission. This was the case for both patients coming from home or from an acute hospital. Patients who had received the outpatient service following discharge all said it had helped to give them extra confidence to remain independent. We saw that the ward delivered care and treatment specific to patients' assessed needs.

Comprehensive assessments were completed by each member of the multidisciplinary team and progress was discussed at daily multidisciplinary team meetings. Daily discussion at the multidisciplinary team meetings helped ensure any issues or delays with discharge were dealt and communicated in a timely manner within the team and with the patient and their family.

Are services well-led?

A new ward manager had recently been appointed and was providing good leadership and direction to the unit.

Summary of findings

An independent review of Newton Hospital had been commissioned by the trust in 2013 due to concerns about the quality of care and contractual purpose of the unit. An action plan had been developed and associated risks identified. However a number of actions had not been completed including some that had been identified as high risk. These included agreeing the governance arrangements for the management of the medical staff, which had a target completion date of August 2013 according to the action plan.

Summary of findings

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

Community inpatient services

Staff were dedicated to providing a high quality service to the patients on the ward at Newton Community Hospital. This was reflected in the comments made by patients and their relatives. Services were tailored to meet the needs of patients requiring intermediate care. The service also included post discharge outreach support of up to two weeks to reduce the risk of further readmission.

Care was generally safe. Evidence showed that staff reported information through the national safety thermometer tool and internal quality monitoring. Incidents were recorded on the trust's Ulysses system and the ward manager completed risk assessment and risk management plans. We identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks which could impact on the trusts overall assurance of the unit, for example data reporting errors in the quality report. However staff had implemented a range of developments at the hospital over the last year that had helped to improve the safety of care, for example the development of tissue viability assessments.

Patient risks were assessed and plans developed to reduce those risks. There was a daily multidisciplinary review of patient risks and progress to make sure that the planned care remained relevant and patients were making suitable progress.

Care was effective and around 70% of patients were discharged back to their own home. Staff had developed evidence based guidance and standard operating procedures that all members of the multidisciplinary team used. However some of the generic trust guidelines would benefit from being improved to ensure they met the needs of an inpatient unit rather than community service.

Patients and their relatives commented favourably on the care they or their relative received. We saw staff being respectful towards patients, and ensuing that patients were treated with dignity. Patients were involved in decisions about their care, were part of the regular multidisciplinary team meetings, and consideration of the families needs was also apparent.

There had been a number of changes at the hospital over the past year, following an independent review that the trust had commissioned due to concerns about safety and quality at the hospital. The unit had appointed a new manager who was providing good leadership and direction for the staff; and who had developed local working guidance and policy to ensure staff received the appropriate training and support, for example pressure area care management and medicines management. However, clarity about the long term vision of the unit was required as staff do not currently feel included with developing and defining the service.

Summary of findings

What people who use the community health services say

We spoke with a number of patients and their relatives on the inpatient unit, and also with some patients who had recently been discharged. All were positive in their comments about the quality of care that they had received, and their involvement in planning their care.

Patient experience was discussed frequently within the outpatient department as part of the daily huddle. Part of the productive community services model included recording and reviewing patient experience. Information was gathered and discussed at the daily huddle and reported on the notice board. Information received from 37 'Talk to Us' feedback forms collected between October and December 2013 all contained positive comments. Comments included the cleanliness of the unit and helpfulness of the staff.

Areas for improvement

Action the community health service MUST take to improve

- Develop effective reporting mechanisms to ensure that the board are fully sighted on activity and performance at the hospital.
- Develop effective systems to identify, assess and manage risks.

Action the community health service SHOULD take to improve

- In conjunction with commissioners agree a clear vision for Newton Hospital including appropriate commissioning arrangements.
- Complete actions identified during the independent review of Newton Community Hospital in 2013 and review the effectiveness of those changes.
- Develop and approve specific guidance and protocols that are focussed on inpatient services.
- Commission and provide training that meets the needs of staff working within an inpatient facility.
- Make sure staff are aware of the process for recording DNA CPR and test that this is recorded appropriately.
- Review staff levels at Newton Hospital in light of the current commitment and ensure that permanent staff are recruited including those employed by other organisations.
- Ensure that all staff have received appropriate training to identify, review and report incidents accurately including root cause analysis.

Bridgewater CHCT - Newton Community Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; a school nurse, health visitor, dentist, GP, consultant geriatrician, community midwife, nurse, occupational therapist, senior managers, and 'Experts by Experience'. Experts by Experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Bridgewater CHCT - Newton Community Hospital

Newton Community Hospital is a newly built facility offering both inpatient and outpatient services. The hospital was built to replace an older nursing home and community facility and was previously managed by St Helens Primary Care Trust.

The inpatient unit was supported by a multidisciplinary group of staff employed through various organisations including the local authority, 5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community Healthcare NHS Trust and local GPs. The inpatient unit had 30 beds and primarily provided intermediate care either as a step up facility to reduce the need for an admission to an acute hospital or as a step down facility following discharge from hospital.

The outpatient facility supports the local community and surrounding areas with consultant or nurse led clinics and minor surgery.

Why we carried out this inspection

Bridgewater Community Healthcare NHS Trust was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. We used the information we held and gathered about the provider to decide which services to look at during the inspection and the specific questions to ask.

Detailed findings

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 always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Community inpatients services for adults
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Bridgewater Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 3 and 6 February 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 26 locations including two community inpatient facilities at Padgate House and Newton Community Hospital. The remaining locations included six dental practices, and two walk-in centres, St Helens' Walk-in Centre and Leigh Walk-in Centre. We carried out unannounced visits on 5 and 6 February 2014 to Newton Community Hospital, Padgate House and the Wheel Chair Centre.

Community inpatient services

Information about the service

The inpatient unit was situated on the ground floor of Newton Community Hospital. The hospitals main reception provides access to the inpatient facility. The unit had same sex bays and single rooms along a single corridor. Bays held up to eight patients and were divided by the nurse's station and staff room. The unit had its own day room, dining room, therapy room and hairdressers. Single and smaller rooms had en suite facilities.

The ward manager was employed by the trust, and patient needs were met by a mixture of nursing staff recruited by the trust, and therapy staff were employed by 5 Boroughs Partnership NHS Foundation Trust. Social workers were employed by the local authority and GPs were employed under a separate contract with the local clinical commissioning group. The staff identified here are described as the multidisciplinary team (MDT).

We saw monthly admission and discharge statistics which showed the unit was predominantly working at 95% occupancy. During our inspection, we spoke with approximately 20 patients and relatives. We spoke with the ward manager and senior staff about the unit and spoke with a number of the nursing staff and staff contracted to support the unit. We reviewed patient information, we observed how care was delivered and reviewed, we looked at management and personnel information and we also reviewed information received from the trust and other stakeholders.

Summary of findings

Staff were dedicated to providing a high quality service to the patients on the ward at Newton Community Hospital. This was reflected in the comments made by patients and their relatives. Services were tailored to meet the needs of patients requiring intermediate care. The service also included post discharge outreach support of up to two weeks to reduce the risk of further readmission.

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Community inpatient services

There had been a number of changes at the hospital over the past year, following an independent review that the trust had commissioned due to concerns about safety and quality at the hospital. The unit had appointed a new manager who was providing good leadership and direction for the staff; and who had developed local working guidance and policy to ensure staff received the appropriate training and support, for example pressure area care management and medicines management. However, clarity about the long term vision of the unit was required as staff do not currently feel included with developing and defining the service.

Are community inpatient services safe?

Safety in the past

There had been concerns regarding the safety of care in the past at the hospital, which had led the trust to commission an independent review in early 2013. Concerns included medication errors, and patients developing pressure ulcers.

There was a system to record incidents (Ulysses), which staff used, and the ward manager completed risk assessment and risk management plans. Staff had taken steps to reduce the reoccurrence of incidents, including the development of comprehensive patient assessments.

Staff had not reported any safeguarding concerns in the last 12 months but were confident of the process to follow should they need to. The social workers who worked on site had supported staff and shared resources around the process.

The trust reported 83 serious untoward incidents between November 2012 and November 2013 of which 55 occurred in patients' homes. The most common type of serious incident reported was pressure ulcers (grades 3 and 4), which accounted for 70 of the 83 incidents. CQC received 186 notifications via the national reporting and learning system (NRLS) between November 2012 and November 2013. The majority of these (90%) occurred in the community.

From data received from the trust prior to the inspection, we were not able to identify any never events or serious untoward incidents (SUI) attributable to inpatient services within the last 12 months. When we inspected the inpatient facility however we identified two SUI's that were attributable to Newton Hospital, a medication error and a patient fall that had resulted in injury. One had been recorded on the Ulysses system in August 2013 as an SUI but had not had a root cause analysis investigation carried out. One had been entered on the system in May 2013 as an incident but closed in June 2013 after which a root cause analysis had taken place commissioned by NHS Liverpool and only recorded as an SUI after being placed on the risk register in December 2013.

Learning and improvement

Not all staff had received training in order to understand or carry out a root cause analysis investigation. Evidence that

we reviewed demonstrated that learning did not always take place following an incident, and there were discrepancies in information that had been recorded and reported on.

We asked the clinical manager if any incidents had led to a RCA investigation. We were shown one completed RCA incident report for the inpatient unit. The incident that led to the RCA investigation had not been reported as an SUI. Staff we spoke with on the unit had not received training in reporting incidents or investigating incidents within an RCA framework; this included the ward manager who was testing their understanding of the process by undertaking an RCA on a recent complaint received on the ward.

The incident that had been investigated using an RCA framework had been recorded on Ulysses on the 5th May 2013 as an incident, and involved the administration of the wrong dose of a controlled drug over a number of days. The incident was closed on Ulysses on the 25th June 2013. An RCA investigation report was commissioned by NHS Merseyside and completed on the 24th October 2013, though it was not clear from the evidence provided to us how this decision had been reached. Lessons learnt were shared with the trust at the time of the report in October 2013. The incident had then been added to the trusts risk register in December 2013 as an SUI and last reviewed on 17 December 2013. One of the actions from the RCA was that staff should print their name following their signature in the controlled drugs book. We checked to see if this had happened and found the change in procedure had not been implemented. We discussed this with the ward manager who informed us they had only recently been provided with the outcome of RCA and were to discuss the lessons learnt at the next ward meeting.

Incidents recorded on the Ulysses system included immediate action taken and final outcome. None of the entries supplied to us on the days of inspection included complete action taken, so we were unable to determine if any of the lessons had been learnt from incidents. Of the records we received of incidents recorded on Ulysses we noted inconsistencies in the incidents recorded to the system and reported within the monthly quality report. For example we were provided with the details of incidents from December 2013 recorded on the Ulysses system of which there were 6, including 2 health hazard incidents, one of which was a moving and handling incident. We were provided with the quality reports from October, November and December 2013. When we compared the incidents noted above with the December 2013 quality report there were 11 incidents recorded but this did not include the health hazard incidents.

Systems, processes and practices

Systems had been developed to identify and assess the need for improvements to the patient environment, patient experience and patient care. This included the development of an end of bed file index so staff could access information quicker.

When the ward manager commenced in post in July 2013 they developed a quality ward round audit. The audit was developed by members from the MDT. We discussed the audit with the ward manager and were told it was developed to enable the MDT to gain a snapshot of how safe and effective care was on the ward. Improvements made following the quality ward round audit included the introduction of a clutter free environment, improvements to the decor and the provision of fruit offered to patients throughout the day.

Staff had developed a productive community ward notice board. The notice board contained details of risk areas both within the ward and of patient care. Staff had daily huddles around the board to discuss the information, and raise any concerns they had. Staff had further opportunities to raise concerns within the daily MDT meetings and monthly ward meetings. Staff also told us that the ward manager had an open door policy and were encouraged to raised any concerns with the ward manager.

The ward had an infection control lead nurse. We saw audits for hand hygiene and notices above each sink for good hand washing procedures. We saw staff following recently introduced procedures of 'you use it, you clean it' where by every item of equipment had an 'I'm clean' sticker dated and initialled. The sticker was removed when someone used a piece of equipment and reapplied once the equipment had been cleaned. The unit had visible procedures for the management, storage and disposal of clinical waste. Procedures of this type helped reduce the risk of infection and cross contamination.

We asked ward staff how people were identified who were not to be resuscitated. A do not attempt cardio pulmonary resuscitation (DNA CPR) record would be placed on someone's file when a decision had been made. We were told by staff information was recorded on the electronic

care system as a yellow star and recorded within patient notes. We were shown the yellow star on the electronic system but it was difficult to find the information within the paper record. It was unclear if the information the ward held on DNA CPR was appropriate and in a format available to other professionals when required.

The ward manager had developed a quality report within the last three months. The report was used to inform the productive community ward notice board and improve efficiency of the ward. We were told by the clinical manager that at the time of the inspection the trust board had not received a monthly or quarterly report from the inpatient unit.

Monitoring safety and responding to risk

The ward manager collated information on ward performance and introduced measures to address concerns. This had included the introduction of intentional rounding to improve patient observation and reduce the risk of incidents occurring for example patient falls. The contact was recorded within the patient's records.

The ward manager had recently developed competencies for the different grades of nurse. The competencies had as part of the process, peer review and patient feedback incorporated into them. The ward manager was waiting for the competencies to be approved by the trust before using them.

We were given an up to date copy of the action plan that had been developed following the independent review of the hospital in 2013. The action plan had been included on the trusts risk register which stated that progress should be reviewed fortnightly by a member of the board. It was difficult to ascertain when the plan had been reviewed as action taken was not dated. Original target dates remained in place and had not been revised. As a consequence many of the actions remained incomplete some months past their target date. We were unable to determine from the completed actions when they had been completed and if they had been effective in reducing risk.

The MDT met monthly to discuss safety and risk. An action plan had been developed by the ward manager to respond to areas identified. Training needs had been assessed locally and as part of the trusts training needs analysis. Training had been developed by both the trust and the MDT and attended as required. We were told by some nursing staff they had not attended some of the locally delivered training which they thought would have been beneficial, due to a lack of time. Staff told us that time was available for them to attend mandatory training, but not the locally developed training which they would have to complete in their own time.

A patient representative was included within the MDT bi monthly quality ward audit. We saw a patient information pack had been developed in response to patient requests. We also saw a 'Getting To Know Us' notice board included pictures of the different colours of staff uniforms and described the different roles of the uniform band. This had been requested from patient feedback.

Anticipation and planning

The independent review that the trust had commissioned was completed in March 2013, and an action plan developed and endorsed by the Quality and Safety Committee in June 2013, who noted that the action plan needed to be both robust and met as a matter of urgency. We reviewed the action plan, and noted that many of the actions had at the time of the inspection not been completed within the agreed timescales. There were 31 actions in total, and at the time of our inspection 14 of those had not been completed, 8 of which had a target date for completion of August 2013 or earlier.

We could not see any evidence to ascertain if the completed actions had been tested to evaluate their effectiveness. For example one of the completed actions was the provision of dementia training. Whilst some training had been provided not all staff had attended training, and some staff we spoke with told us that they lacked enough knowledge to deal with issues as they arose on the ward, for example a patient with dementia who was constantly trying to egress the ward.

Staff told us they felt isolated from the rest of the trust; they had developed their own risk assessments and risk management framework. The action plan developed as part of the independent review had been adopted by the ward manager and steps had been taken by the MDT to meet expectations within some of the actions. This had included the development of standard operating procedures and local policy; however at the time of inspection only two of the policies had been approved by the trust for use operationally.

Ward staff were frustrated at the lack of agreed direction for the unit. Clarity of the commissioning intention and

Community inpatient services

direction for the hospital was pivotal to many of the recommendations made within the independent review. The action plan RAG rated this red with a target date of August 2013. The trust had been unable to gain commissioning intent for the inpatient facility at the time of our inspection.

Are community inpatient services effective?
(for example, treatment is effective)

Evidence-based guidance
The ward manager and senior nursing staff had developed standard operating procedures (SOP) using NICE (National Institute for Health and Care Excellence) guidance. There had been 16 SOPs developed since the summer of 2013, though at the time of the inspection none of them had been approved by the trust. Staff we spoke with were clear of their roles within the inpatient unit but were frustrated the unit's purpose was not clear.

The unit had developed and completed a number of clinical audits including tissue viability, falls and vitamin deficiency. Assessments were undertaken at admission and discharge and evaluation completed on the clinical effectiveness of health initiatives and support provided during inpatient treatments.

Monitoring and improvement of outcomes
There were various processes in place to monitor the outcomes for patients and develop care as appropriate. The quality ward round enabled the ward manager to determine how effective the ward was at meeting the needs of the patients; quality assurance was collated on the productive community ward notice board and discussed during the daily staff huddles; calendars had been developed to monitor falls and pressure care to enable the team to determine if there were any specific days where issues were more prevalent. Patient satisfaction was recorded on feedback forms and a weekly independent volunteer helped patients less able to complete a form.

We saw records from the therapy team that considered health assessments from GPs and nurses on the ward, including timescales and plans for treatment or discharge which were linked to the frequency and intensity of therapy offered. Daily MDT meetings ensured practice was shared and patient care was discussed and reviewed as required. Admission procedures included comprehensive assessment of key areas of health needs including tissue viability and nutrition screening, assessment of personal care needs included infection and continence and risk assessments for falls and venous thromboembolism. Services, equipment and community packages of care were all in place for the patient when they returned home.

However, staff we spoke with told us that because there was a lack of clarity regarding the hospital, external agencies were unsure as to the purpose of the facility; some considered the hospital as a semi acute unit while others considered the unit as an intermediate care facility, and this led to some inappropriate referrals for admission, for example patients with continuing healthcare needs whose care would have been better provided in residential settings.

Sufficient capacity
The inpatient unit has increased in size over the previous three years. This had been as a response to winter pressures which resulted in a requirement for more inpatient beds. The increased capacity in bed numbers had not reduced and the facility now used the additional beds on an ongoing basis. However additional permanent staff were only slowly being recruited to the unit. The unit had two qualified nursing vacancies since the summer of 2013. The therapy team had the same number of staff since the unit had 18 beds. The ward manager told us the ward would like more unqualified nursing staff to support the morning shift, as the unqualified nursing staff help the therapy team to deliver some of the rehabilitation exercises.

One of the risks identified on the risk register was inconsistent care due to staff vacancies, and the use of agency staff. Actions had been developed to mitigate this which included the use of a single agency and the development of a specific induction pack for the agency staff. Staff were now blocked booked which had improved consistency, but the block bookings had been made for periods of up to 3 months at a time. This had led to other difficulties in terms of inconsistent staff numbers; some shifts had too many staff and others too few, which in turn was creating a difficulty for the ward manager in determining dependency levels of patients, to assist with the development of a ward establishment profile for the future.

Community inpatient services

Multidisciplinary working and support

The MDT had developed ways of working that allowed the unit to be managed through a shared decision making process. The daily MDT meeting had gone some way to developing this way of working as members from each team were present at the meeting when each patients care was discussed. A dedicated and formal process for shared decision making was soon to be formalised with the support of 5 Boroughs Partnership NHS Foundation Trust.

Each member of the MDT had their own set of policies and procedures from which they were working. The policies and procedures were different dependant on which organisation staff were employed by. Within the unit members of the MDT had agreed a shared way of working based on each member's professional and clinical background. A standard set of SOP's were working well at ward level but still required approval from the trust.

The MDT meetings served to address issues as they arose. Delays in discharge were discussed and problems addressed. All members of the team remained clear as to when discharge was expected and any additional support required from any specific team was actioned. This may have included an assessment for equipment, continuing health care or access to additional support networks. The team worked together to ensure the patient was only discharged when their needs for discharge were met.

Two weeks of outreach support were provided for any patient discharged from the unit. The outreach service worked to ensure patients had everything they needed and were supported through some of the initial anxieties of being back home. Coordinating patient discharge through the MDT and the use of the outreach team had seen a reduction in readmissions to the inpatient unit at Newton Hospital and attendance at A&E in the local acute hospitals.

The ward gave every new patient an introductory pack, which included the feedback form 'talk to us'. A volunteer came in weekly to support patients with completing the form. Information collated from the feedback and patient views expressed during day to day activities was discussed and actions for improvement agreed and implemented. There was about a three month turnaround when the unit received the information from the 'talk to us' forms from the trust. The ward utilised the patient representative to feedback information at the bimonthly quality ward audit.

Are community inpatient services caring?

Compassion, dignity and empathy

Patients we spoke with all said they felt they were involved with their care. We saw within patient records they had been asked key questions and plans had been developed where possible in a person centred way. The unit worked with a clinical connection point (CCP) team who worked with GPs in the community to help assess patients in their own homes. Patients told us they were provided with information and the support they needed to stay at home. We were also told that when patients fell, they may need extra help to build their confidence. Patients we spoke with confirmed when they came in after a fall they could stay until they were confident to go home again.

We looked around the ward and the facilities. We noted the communal bathrooms had some toiletries in them. We discussed with the manager the concerns around toiletries in communal areas and they were immediately removed. The ward had a friends group who helped raise funds for the patient and ward facilities. The nurse told us they would approach the group to seek agreement to fund individual toiletries and toiletry bags for those patients without.

Involvement in care

Patient records we reviewed demonstrated that consent had been gained before treatment or support was given. When we spoke with patients they confirmed this was the case. We saw that files at the end of patient beds contained care plans and risk assessments. All patient care was reviewed daily within the MDT meeting and we observed the various teams updating records within those meetings. The MDT meetings resulted in a joint plan of care for each patient. The plan was agreed or amended in discussion with the patient.

We spoke to some patients that had used the hospital previously and were now living at home. We were told the service continued to be good in the community with support offered until staff were sure people could cope on their own. We were told by three family members they had been invited to attend a meeting with their family member before they were discharged from hospital to ensure everything was in place and that they could cope independently.

Community inpatient services

Trust and respect

We asked patients and visiting relatives if they felt they were treated with respect and everyone confirmed that they were. One relative, shared some anxieties with us regarding their relative, and after we raised this, medical staff immediately took the time to offer reassurance. We spoke to the relative later who was happy that they had been able to discuss their concerns with staff and were more reassured.

Everyone we spoke with said staff treated them well. We observed staff interacting with patients in a respectful manner. Curtains were closed around beds as required to protect patient privacy. We saw staff supporting and encouraging patients to be as independent as they could and were told by patients they were grateful of the encouragement.

Emotional support

We spoke with some relatives of patients and were told they had been involved with the support their family member had received. One told us they felt their needs had also been assessed when the unit decided on the support their family member needed when they got home. We spoke to some people who were anxious about going home; and were present at an MDT meeting where this was discussed and the person's discharge date was delayed pending some further conversations with a community matron to help allay the patient's anxiety.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

At ward level the MDT were committed to meeting the needs of the people who used the ward. The different staff groups had changed their working days to meet the needs of the ward including the doctors who now worked an evening shift to help support admissions.

The admission and discharge figures for the inpatient unit showed a steady admission and discharge pattern. An average length of stay at three to four weeks and around 70% patients were discharge back to their home.

Ward level quality reports had identified a number of patients coming into the unit with pressure sores. The ward had developed a system where all pressure sores were photographed upon admission. The pressure area would be reviewed daily and discussed within the MDT. We observed an MDT meeting and discussed the care of the pressure areas with one of the patients on the unit. The patient told us that staff had taken good care of the pressure sore and it was now much improved.

Access to services

From evidence supplied to us demonstrated the hospital was providing an intermediate care service. Provision was predominantly step down provision from hospital but up to 40% was provided via the clinical connection point after initial support at home had identified the need for more intensive support.

People we spoke with told us the service was what they needed at the time of admission. This was the case for both patients coming from home and patients coming from an acute hospital. People we spoke with who had received the outpatient service following discharge all said it had helped to give them that extra confidence boost to remain independent.

Vulnerable patients and capacity

Staff received training at induction on safeguarding and mental capacity but many staff said they wanted more focused training to cover aspects of inpatient care. The trust had secured level 2 safeguarding training delivered by the local authority mid-2013. We noted from ward meeting minutes in June 2013 that all staff on the ward were encouraged to attend; we also noted the MDT had delivered some training at ward level on mental capacity assessments. However we spoke with some nursing staff who said they had not been able to attend the MDT due to a lack of time.

The inpatient ward completed a dementia assessment with every new patient. The assessment gave staff the information they needed to refer the patient onto specific support services. We were told by some of the staff that access to some of the mental health clinics including the memory clinic had proved more difficult in recent months. The quality report confirmed this; prior to September 2013 all patients with a specific threshold score on the dementia test had been referred onto other specialist services. In more recent months this had not been the case.

Patients on the ward who lacked capacity were supported appropriately through best interest assessments and decisions. There were enough senior staff trained to

undertake best interest assessments, but as noted previously front line staff had identified a need for further especially training designed specifically for circumstances found in a community hospital.

We spoke with various members of the MDT and were confident staff knew how to respond to allegations or signs of abuse. Staff we spoke with were all aware of the phone number and procedure for escalating concerns. There had not been any safeguarding alerts raised by the ward in the last 12 months.

Leaving Hospital

Discharge was discussed with patients on admission; this gave patients and staff ideas about expectations and anxieties. Comprehensive assessments were completed by each member of the MDT and progress was discussed within the daily MDT meetings and communicated in a timely manner with the patient and their family.

Each team had dedicated referral routes for continuation of specific support as required. This included the outreach team supplied by the trust, extended therapy or rehabilitation supplied by 5 Boroughs Partnership NHS Foundation Trust and adult social care support provided by the local authority or privately dependant on patient circumstances. Access to equipment was arranged during inpatient provision and the outpatient team could ensure everything was set up and understood by the patient upon discharge. This type of organisation at discharge helped ensure a smooth transition from inpatient unit to independent living.

Learning from experiences, concerns and complaints

There was a patient questionnaire titled talk to us which included information about how the patient found their experience of using services. The ward had also developed their own questionnaire more specific to inpatient treatment. The results of the questionnaire were recorded in the monthly quality report and on the productive community ward notice board.

A copy of the patient charter was available within the ward and included details of how to complain if patients were not happy with aspects of their care.

The ward also sought patient feedback within ward rounds and daily discussions. A recent consultation on visiting times resulted in further flexibility when relatives and family could visit. Friends of Newton Hospital had also been involved with supporting and influencing the development of the unit.

Are community inpatient services well-led?

Vision, strategy and risks

There is a lack of clear vision for Newton Hospital. There had been a range of concerns identified at Newton Hospital in the recent past including risk management, pressure sore management and medicines management. The trust had in discussion with the clinical commissioning group commissioned an independent review of the hospital to establish what action it needed to take to improve the quality of the service.

The independent review started in January 2013 and led to a comprehensive set of recommendations. Key to implementing the recommendations had been securing commissioning intentions for the hospital. At the time of the inspection this had not been achieved, and continued to cause concern for the staff who do not feel fully integrated into the trust. An action plan was developed following the review, and this features on the corporate risk register. When reviewing the action plan it was clear that some actions remained unmet or were now outside of their timescales to be met; staff were not clear when this would be completed. The ward manager had been given a copy of the action plan but had not been given the content of the review and the recommendations made within it. The trust had undertaken a range of activity to develop services at the hospital including training and support from the tissue viability nurse specialists.

The risk register was complex; there were nine open risks, which either had no review date or review dates that were overdue. It was unclear how risks have been mitigated as no residual risks ratings had been added to any of the risks. The completion of the risk register was inconsistent. Owners of risks were unclear; some risks identified the ward manager as the owner when the risk itself had not been reviewed some 12 months before the ward manager was in post.

The ward manager had a file of risk assessments. Risk assessments had been completed on a generic risk assessment tool. Risks, impact, controls, gaps in control,

assurance, gaps in assurance and mitigating actions had all been identified. None of the specific Newton Community Hospital environmental risks had been included on the risk register.

Quality, performance and problems

We identified errors and inconsistencies in data that could lead to skewed assurance at the board regarding the unit. In the December 2013 Newton Community Hospital In-patient Unit Report produced for the Quality and Safety Committee dated 14/01/2014, for example, the text of the report stated that 100% of patients who reached the dementia assessment threshold were referred for further assessment, but the data showed that in October 2013, of the 32 patients assessed as reaching the threshold, only 12 were referred on for further investigation.

The same report showed approximately three or four patients with pressure ulcers each month. No ward patients with pressure ulcers were included in the NHS safety thermometer, which is a snapshot of patient care carried out by surveying all inpatients on one day each month. The quality report also stated that there were no ward-acquired venous thromboembolisms (VTEs), but between September 2013 and December 2013 the trust reported six 'new' VTEs to the safety thermometer, meaning that treatment started after the patients were admitted to the ward. The safety thermometer only looks at a sample of patients each month and uses a different methodology to the trust's own quality report: we discussed these apparent inconsistencies with the clinical lead and they were put down to data errors.

The quality report was noted to have been written by 3 members of staff, however when discussing this with one of the authors they indicated that they had not seen the report. We asked how the report fed into the board and were told it would come though the clinical lead in the future. It was unclear from our discussions with staff as to who was accountable for the production and quality assurance of the report.

Leadership and culture

We spoke with a range of professionals within the inpatient and outpatient facility at the hospital. Every staff member we spoke with had a deep sense of pride and commitment to their role and the care of the patients using the service. Staff stated that they felt that the hospital was semi-detached from the rest of the trust because the infrastructure needed to manage an MDT inpatient facility was not clearly evidenced within the community trust. Policies and procedures were generic and whilst fit for purpose in some circumstances required an appendix specific to an inpatient environment. The development of standard operating procedures (SOP) and care pathways had to be followed on a day to day basis, yet these SOP and pathways were yet to be approved by the trust.

The trust identified in 2012 that they were unsure of the function and performance of the Newton Community Hospital. The hospital had historic governance issues and had predominantly been a stand-alone service. The independent review identified the need for clear clinical governance as a matter of urgency. The report also identified that service level agreements needed to be developed between clinical staff from different management organisations. However staff identified to us that there was a lack of clear clinical leadership running through to the trust board; the continuing use of separate policies for the different professional groups and the development of service level agreements 10 months after completion of the review had not been identified as a risk on the corporate risk register.

The commissioning intentions and direction of the unit remain an issue. The lack of corporate direction impacts on the provision and morale at the inpatient unit. Staff we spoke with in focus groups from the inpatient unit all described a lack of clarity as to the role of the hospital. Most thought the building was under-utilised and required branding from the trust to develop its identity.

Patient experiences and staff involvement and engagement

Patient views on their experience were sought at both trust and ward level. Information was used to inform changes to procedures and the patient group was used to consult with on standard operating procedures and care pathways.

The new ward manager had developed staff to lead on aspects of service delivery. Staff had volunteered to lead on aspects of service development including risk assessment and audit. The MDT ethos and culture had grown and staff supported each other in the delivery of the service. All staff within the MDT were encouraged to develop ways of working. Staff from all teams were engaged with the progress of the unit.

Community inpatient services

All staff we spoke with knew who their manager was and who they could turn to for support. Staff we spoke with felt involved with the direction of the unit but only at a local level.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users at Newton Community Hospital. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users at Newton Community Hospital. Regulation 10(1)(b) and 10(2)(c)(i)