West Suffolk NHS Foundation Trust

Newmarket Hospital

Quality Report

56 Exning Road,
Newmarket
CB8 7JG
Tel:01284 713000
Website:www.wsh.nhs.uk

Date of inspection visit: 8 and 9 March 2016
Date of publication: 04/08/2016

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

Ratings

Overall rating for this hospital	Good
Medical care (including older people's care)	Good

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Good	Services in the Rosemary Ward at Newmarket Community Hospital were rated as good. Patients were cared for by competent and caring staff who had the training and experience to provide safe and effective service. Staffing levels were appropriate for the acuity of patients and use of agency staffing was minimal. Staff were well informed regarding the care and support that patients required and there was effective multi-disciplinary working. The service was responsive to people's needs and wishes, including those who were approaching the end of their lives. However, patients were having to wait longer to access the service due to shortages in community provision for people who were ready to be discharged. The service was well led and well managed. There was an open, learning culture with a readiness to learn from incidents and complaints. Regular audits ensured that performance was monitored and action taken to drive improvement, such as in the completion of patients' records. Risk were identified, including that some equipment was outdated.

Newmarket Hospital

Detailed findings

Services we looked at
Medical care (including older people's care)

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Newmarket Hospital	4
Our inspection team	4
How we carried out this inspection	4
Our ratings for this hospital	4

Background to Newmarket Hospital

The Rosemary Ward is a 16 bedded reablement unit to help patients recover after a period of ill health.

The ward is based at the Newmarket Community Hospital on Exning Road in Newmarket and provides a "stepping stone" service for patients that are medically fit to leave hospital but need further support to return home safely. The ward admits patients over the age of 18. The majority of admissions are via the West Suffolk hospital, but some patients are admitted from a neighbouring provider hospital and some are community admissions to avoid admission to acute services. Occasionally patients in need of palliative care are admitted. Patients are encouraged towards independence through occupational therapy and physiotherapy. The average length of stay is around 24 days.

This was an announced inspection undertaken as part of a comprehensive inspection of West Suffolk NHS Foundation Trust.

Our inspection team

This inspection was carried out by one Inspector, an Assistant Inspector and two Inspection Managers.

How we carried out this inspection

We undertook an announced inspection on the 8 and 9 March 2016 at the Rosemary Ward as part of a comprehensive inspection of West Suffolk NHS Foundation Trust between the 8 and 10 March 2016.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care (including older people's care)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Rosemary Ward is a 16 bedded reablement unit to help patients recover after a period of ill health. The ward mainly admits patients over the age of 18 that have been discharged from hospital and declared medically fit but who need some additional support prior to discharge home. Most admissions are from the West Suffolk hospital, but some patients are from a neighbouring provider hospital and there are some community admissions to avoid admission to acute services. Occasionally patients in need of palliative care are admitted. The average length of stay at the time of our inspection was 24 days.

The ward consisted of an eight bedded bay, six side rooms and two rooms for people with lower levels of dependency. A day room was used for activities, and sometimes for meals. A 'quiet room' offered a space for private conversations with visiting relatives.

The service was taken over from a private provider when this organisation's three-year contract to deliver community health services ended on 30 September 2015. The new contract was for 12 months, with an option to extend for another 12 months by mutual agreement with the local clinical commissioning group (CCG). There was close collaboration with Suffolk Community Healthcare which continued to provide support services, such as auditing and risk management, to the Rosemary Ward. There were twice-weekly pharmacy visits by staff from West Suffolk Hospital. A local GP practice, 'The Rookery', had the GP contract for the ward and doctors from the practice visited daily. A consultant specialising in the medical care of older people visited weekly. Out of hours ward staff would telephone 111, or 999 in an emergency.

During this inspection, ten staff and other health professionals involved in the service attended a focus group and gave us their views. In addition, we spoke with five staff in greater detail and with three patients. We listened to a handover session and observed care. We looked at four sets of medical records and reviewed other information requested by us and provided by the trust.

Medical care (including older people's care)

Summary of findings

Services in the Rosemary Ward at Newmarket Community Hospital were rated as good.

Patients were cared for by competent and caring staff who had the training and experience to provide safe and effective service. Staffing levels were appropriate for the acuity of patients and use of agency staffing was minimal. Staff were well informed regarding the care and support that patients required and there was effective multi-disciplinary working.

The service was responsive to people's needs and wishes, including those who were approaching the end of their lives. However, patients were having to wait longer to access the service due to shortages in community provision for people who were ready to be discharged.

The service was well led and well managed. There was an open, learning culture with a readiness to learn from incidents and complaints. Regular audits ensured that performance was monitored and action taken to drive improvement, such as in the completion of patients' records. Risk were identified, including that some equipment was outdated.

Are medical care services safe?

Good

The safety of services in the Rosemary Ward was rated as good because:

- Staff were clear about their responsibility to keep people safe and had received the training to help ensure safe practices.
- There was an effective system for reporting incidents and sharing any learning arising from these incidents.
- Patients' records were legible and well organised.
- Staffing levels were generally good, with limited need for agency staff to provide cover.

However:

- Some records were incomplete, for example follow up actions from incidents were not always consistently recorded and actions taken were not always recorded in patient care records.
- Some equipment, such as patient beds, was outdated. Insufficient or inappropriate equipment was noted as an amber risk on the ward's risk register..
- The ambient room temperature where medications were stored was not being recorded.

Incidents

- Staff understood how to report incidents. They felt that there was an open and honest approach and stated that , "We are very much encouraged to do incident forms for anything that is not to plan".
- Staff recorded all incidents on paper forms. These were then scanned and sent to the Suffolk Community Healthcare (SCH) risk team for collation, entry onto an electronic record system and production of reports.
- The incident forms were lengthy but staff felt that they were good in that they encouraged reflection about what could have been done to avoid the incidents. Our scrutiny of completed incident forms confirmed that questions on the form encouraged consideration of the causes of incidents, for example whether a patient who had suffered a fall at night had received sedation that evening and whether appropriate assistive technology was in place (and functioning correctly).
- The form required a chronology and record of checks made subsequent to any falls to ensure patient safety,

for example 15 minute checks for an hour followed by half-hourly checks. However, our scrutiny of the forms revealed that the record of follow up action was not completed for every incident.

- A root cause analysis examined any contributory factors, such as the level of staffing at the time, and sought to identify changes that could have prevented the incident.
- The matron or a Band 6 senior nurse reviewed and signed incident forms. Relevant notes were added, for instance on the incident form for a patient who had fallen there was a reminder that falls care plans must be completed for any patient assessed as being at risk of falls.
- The incidents were discussed and any learning was shared in staff meetings. A member of staff described how a nursing sister would take examples of incidents and make a presentation of the issues to encourage learning. This included the importance of record keeping to demonstrate that appropriate action had been taken.
- The SCH Risk Manager informed us that plans were in place for recording all incidents directly onto the electronic system over the next couple of months.
- There had been 46 incidents reported between 1 October 2015 and 31 November 2015, but these included outpatients clinics and minor accidents involving staff. One incident, a dislocated shoulder, was recorded as having 'moderate' harm, while all the other incidents had no, or low, impact on patients.

Safety thermometer

- The quality and safety dashboard data was displayed on the ward noticeboard. The dashboard data is a tool to provide staff with information to improve quality of patient care. Information includes data such as pressure ulcer occurrence and falls sustained by patients.
- Data for October 2015 to February 2016 showed that there had been no hospital acquired pressure ulcers. There had been one 'fall with harm' in January in this 16-bedded unit.

Safeguarding

- Staff told us that they had received training in safeguarding and were confident that they would spot potential signs that a person was being abused. They knew the process for raising concerns and details of safeguarding contacts were clearly displayed in the staff room.
- Suffolk Community Healthcare had continued to provide safeguarding support. Managers stated that the safeguarding lead in the community healthcare team worked closely with the West Suffolk Hospital safeguarding leads and met regularly with staff on the Rosemary Ward. They also provided safeguarding training. All staff received safeguarding training on recruitment and this was refreshed and monitored.
- Concerns were flagged and dealt with promptly and thoroughly. An example was where a family was keen to have their relative back home, but was resistant to having any care and support in looking after the person. Staff had assessed the patient as lacking capacity and a best interest decision had been taken to keep them in the ward. A case conference had been arranged, to which family members had been invited, so that the issues could be discussed and a decision reached.

Cleanliness, infection control and hygiene

- Precautions were taken to prevent the spread of infection. For example, when we visited the ward one patient was being barrier nursed as they were suffering from diarrhoea.
- "I am clean" stickers were visible on equipment to show that it had been cleaned and was ready for use.
- Disposable curtains were used around the beds.

Environment and equipment

- The 'crash trolley' of emergency resuscitation equipment had been checked daily and was fully stocked and ready for use.
- There was adequate space around each bed area to allow patient movement safely. A day room had been redecorated using funds raised by the local Rotary Club.
- Equipment, such as the emergency defibrillator and portable suction equipment, had electrical testing stickers indicating that PAT testing had taken place. However, there was no servicing sticker on the bath hoist.
- Some equipment, such as the beds, was outdated. The beds could not be adjusted to meet the range of patients' needs, this meant there was a risk to patient safety and an increased manual handling risk to staff. The ward's risk register noted 'insufficient or inappropriate equipment to facilitate meeting the needs of patients' as an amber risk.

- We found a number of hoists and hoist slings jumbled up together. Some of the slings were single use, while others were reusable. All appeared clean but it was unclear which slings were intended for use with which hoists. We brought this to the attention of the matron.

Medicines

- A checklist was used by the pharmacy technician from West Suffolk Hospital who visited twice a week to ensure stock rotation and that medicines were in date. Medicines inspected were all in date and correctly stored.
- The temperatures of refrigerators used to store medication that needed to be kept cool were monitored and recorded daily. We saw that the temperatures recorded had remained within acceptable limits.
- The room in which medications were stored was cool, but the temperature of this room was not routinely recorded to ensure optimum conditions were maintained.

Records

- Patients' records were held in a secure trolley at the nursing station.
- We reviewed four sets of patients' records. These clearly documented involvement from a range of healthcare and social care professionals.
- The notes were legible and well organised. Body maps were completed and allergies and other risks to the individual patient, such as fragile skin, were noted. Appropriate care plans were in place and there was evidence that these were regularly reviewed.

However, where actions to be taken had been identified in care plans there was not always documentation confirming that this had happened.

- Senior staff told us that the service was good at getting consent generally but not always so good at documenting it, for example the provision of personal care.
- There were regular monthly audits of documentation to monitor standards of completion. A drop in performance to only 86% was noted in December 2015, with failures in recording contact details and allergies and with consent for treatment not being obtained. By the January 2016 audit these shortcomings had been addressed and an 11% improvement had been achieved.

Assessing and responding to patient risk

- The risks to individual patients, for example of developing pressure sores, were assessed on admission. Appropriate action was taken to reduce the risks. If, for instance, a person was at risk of falls they would be admitted to the main ward, rather than put in a side room or one of the low dependency rooms, so that they could be kept under closer observation.
- There were hourly checks on patients, with a red flag system used to ensure particular attention was paid to vulnerable patients, for example those at risk of falls.
- Falls incidents were amalgamated in a monthly report, so that incidents could be discussed and action taken to reduce the risks. A Band 5 nurse was the 'falls champion'. This helped keep a focus on falls prevention.
- The service used assistive technology, such as 'crash mats'. However, the ward did not have the more modern beds that can be adjusted to patients' needs.
- Staff stated that if a patient became unwell, they would call the local GP practice or 111 out of hours. In an emergency they would ring 999.

Nursing staffing

- The ward was only 25 hours a week under its full establishment for nurses and was fully staffed with healthcare assistants. Recruitment was in progress to ensure continuity of care.
- At the time of our inspection, there were two registered nurses on duty throughout the day, plus a recently qualified registered nurse working as a supernumerary as this was their first day.
- Normal staffing levels were two registered nurses per shift, plus one health care assistant at night and two or three health care assistants during the day for 16 patients. Data provided by the service for November 2015 (the most recent data available) showed that the ward was fully staffed at night, with 99.5% of the planned nursing cover and 86.2% of the planned healthcare assistant cover.
- Bank staff were utilised to ensure this level was maintained. Staff told us that the change of contract gave access to the wider pool of bank staff at West Suffolk Hospital.
- There was very little use of agency staff, with the maximum usually being no more than two or three shifts in a week.

Medical care (including older people's care)

- There was a mix of older and more experienced staff and younger staff who brought a fresh approach. Several of the staff had been at the hospital for many years. Staff told us that team working was good and that new recruits were made welcome.
- Data from the patients surveys in January and February 2016 showed that all but one of the 24 patients who completed the surveys confirmed that someone came quickly when they needed assistance. However, one patient in February referred to shortage of nurses, "Which sometimes means waiting when the unexpected happens". Staff confirmed that there were occasional shortages due to sickness, which nurses found frustrating, as they could not provide the quality of care that they would like.

Medical staffing

- A consultant specialising in the medical care of older people visited the ward weekly.
- A local GP practice provided day-to-day cover, with doctors from the practice visiting each day and being on call until 6.30pm.
- The low acuity level of patients on the ward meant that this was suitable medical support. Staff told us that they were able to get additional medical support from the practice if required outside of the usual visits and ward rounds.

Major incident awareness and training

- Staff had fire safety training and there were weekly checks to ensure the alarm system was functioning correctly.
- The service had a business continuity plan in place and had been involved in tactical planning, for example a pandemic influenza exercise with West Suffolk hospital. The matron told us that a gas leak 12 months ago gave an opportunity to test the business continuity plan and this worked well. The back-up plan included an arrangement to place patients with local care homes if the ward needed to be evacuated.

Are medical care services effective?

Good

Effectiveness of services was rated as good because:

- Patients surveyed agreed almost unanimously that their care and treatment had a positive effect on their wellbeing and helped them to better manage their condition.
- Local audits were in place to ensure best practice.
- We observed competent and professional care. Staff had good access to training and personal development.
- Staff were well informed regarding the care and support that patients required and there was effective multi-disciplinary working.
- Patients' consent to treatment and care was sought and due regard was paid to the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- However, not all forms relating to patients' wishes regarding resuscitation in the event of heart failure were fully completed.

Evidence-based care and treatment

- Most admissions were from the West Suffolk Hospital, with some from a neighbouring provider hospital and some community admissions to avoid admission to the acute hospitals. Occasionally patients in need of palliative care who had expressed a desire to be cared for in the community hospital were admitted.
- Staff used an admissions checklist to try to avoid readmission to the acute hospitals. Incident reports were made for any readmissions. If the consultant noted deterioration, or if blood tests revealed complications, the patient would be returned to the acute hospital. There were 16 patients returned to West Suffolk Hospital between 16 October 2015 and 22 February 2016. The reasons for readmittance to the acute hospital were varied. Three of the four patients referred back due to chest pains/possible heart attacks subsequently returned to the Rosemary Ward within 24 hours. This indicates that staff erred on the side of safety and acted promptly if they had significant concerns about a patient.
- On admission all patients were asked if they had memory problems. If so, they were screened and if any signs of dementia were noted this would be highlighted to their GP for follow up in the community.
- There was evidence that local audits were undertaken to ensure best practice. These audits included documentation and medication handling. The service

had access to audit data for the community hospitals within Suffolk. This enabled performance to be benchmarked, for example against the 'safety thermometer' checks.

Nutrition and hydration

- Patients were regularly weighed and the Malnutrition Universal Screening Tool (MUST) was used to identify any patients at risk of malnutrition. Staff checked that patients were having adequate food and drinks. Audits checked that nutrition was monitored.
- Patients who required their fluid balance monitoring or were on fluid restriction had a fluid chart in place but the low level acuity of these patients meant that many did not require close fluid balance monitoring.
- Where patients required a specific diet such as diabetic or soft diet, this was able to be catered for. One member of staff we spoke with told us there were no issues in getting specific meals for patients.

Pain relief

- Pain relief was discussed in handover meetings and a pain chart was in place for any patient that required pain relief.
- One of the training courses offered to nursing staff was a 'Persistent Pain' study day (with five separate dates available).
- Staff told us that if a patient arrived without a drugs chart this would be recorded as an incident. They would immediately telephone the referring hospital ward and ask for the drug chart to be sent across immediately to ensure that patients did not have to go without pain control.

Patient outcomes

- In surveys of patients in January and February 2016 all but one of the 24 patients who completed the surveys agreed that the care and treatment that they had been given had a positive effect on their wellbeing and helped them to better manage their condition. In February 2016 one patient commented that they were extremely likely to recommend the ward to family and friends because, "When I came in I was so tired, low and worn out but now I feel I can go home and have the ability to look after myself and my family better".

Competent staff

- All 24 people who completed the two patient surveys conducted in January and February 2016 confirmed that they had confidence in the skills of the staff treating and caring for them.
- Mandatory training was still being provided through Suffolk Community Healthcare and staff could also access sessions at West Suffolk Hospital. Staff were able to book training via a database at times that suited them, and several dates were offered for face-to-face training. The ward co-ordinator monitored completion of training and reminded staff if their training needed refreshing. A lot of the training was via e-learning, with extra help being given to staff who had dyslexia. Staff told us that they felt that the training was good and equipped them to carry out their duties safely and effectively.
- Individual training was supplemented by regular team meetings and study days, for example on bereavement, to keep staff up to date.
- Staff could access further training, for example in certification of expected deaths and in syringe-driver use. One nurse told us that they felt valued and appreciated being given the chance to have, "some enrichment in my training".
- Staff were encouraged to develop and progress. For example one healthcare assistant was being supported in their ambition to become a registered nurse with weekly day-release to study at a local college and a mentor within the service.
- Personal development reviews were used as opportunities to talk with staff about mandatory training and other training opportunities, for example with registered nurses who want to do more courses to contribute to their degrees.
- At the time of inspection, appraisals were up to date for most staff or dates had been booked for these to be completed. An exception was that, with the change of line manager, the matron's appraisal had become overdue.

Multidisciplinary working

- Professionals from social care, physiotherapy and occupational therapy worked closely with the nursing and medical staff. We saw from patients' records that multidisciplinary meetings were attended by the consultant, nurses, social workers, therapy staff and the discharge planner.

- Staff told us that there were good relationships with GPs and other local services. A book identifying patients by number and their initials contained notes regarding the patients' needs and any other relevant information for the visiting GP practice doctors.

Access to information

- Staff were well informed regarding the care and support that patients required. Staff contacted the hospital wards from which patients were being transferred and used a checklist to ensure that all the information needed was obtained.
- Handover meetings contained clear summaries and instruction about how the individual patients needed to be cared for and supported.
- Healthcare professionals, such as therapists, kept whiteboard entries for each patient up to date.
- Staff told us that documentation was helpful and informative, for example part-time staff and staff returning from leave had access to the multi-disciplinary notes in one place and this provided them with a clear picture of the patients' evolving needs and care and treatment.
- All but one of the 24 patients who completed surveys in January and February 2016 agreed that when different members of staff saw them they knew about the patient's condition and treatment.
- On discharge from the ward, patient information was provided to the patient's GP within four hours of discharge to ensure continuity of care. This clinical letter was sent by fax to GPs to update them on the patients' progress and included details of any remaining issues and changes to medications.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent had been gained and documented for photographs to be taken of patients' wounds.
- Staff received training regarding consent and capacity. They were well supported in ensuring compliance with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). A flow chart helped guide decisions regarding any patient who appeared to lack capacity and the community services safeguarding lead telephoned weekly to check if there were any concerns and to discuss any potential DoLS applications.
- At the time of our inspection there was one DoLS in place for a patient who wanted to discharge themself but who lacked capacity and was at high risks of falls. The patient's family were in agreement and the service had identified supported living accommodation for the person to move to when a vacancy occurred. This showed that the service was acting in accordance with the law and seeking the most suitable outcome for the patient.
- However, not all forms relating to patients' wishes regarding resuscitation in the event of heart failure, were fully completed. Failure to record decisions that the staff "do not attempt cardiopulmonary resuscitation" (DNACPR) made the service open to the risk of being challenged if resuscitation was not attempted. Audits of completion of DNACPR forms had flagged that the ward was under-performing. The matron told us that some nurses were comfortable in asking patients about their wishes, but others were not. Training had been provided in how to approach these sensitive discussions, but staff who still felt uncomfortable were not pushed. This could mean that the patient did not get a DNACPR discussion, although generally it just resulted in them waiting a few more days before being asked. Data indicated that there had been an improvement in completion of DNACPR forms from 80% in November 2015 to 92% in January 2016.

Are medical care services caring?

Good

We rated caring as good on the Rosemary Ward because:

- Patients were treated with dignity and respect.
- Patients were included in decisions regarding their care, treatment and discharge planning.
- Emotional support was provided to patients and their families.

However:

- Some patients felt that they were not provided with sufficient information about where they could access to emotional support if they needed it.

Compassionate care

Medical care (including older people's care)

- Staff were observed assisting patients in a caring and considerate manner. They were respectful of patients' dignity and privacy, for example by drawing curtains.
- In February 2016 all 10 of the people who completed a patient survey said that they were likely, or very likely to recommend the ward to family and friends. In the January 2016 survey 12 of the 14 people completing the survey said the same, while two people did not express an opinion.
- Everyone who completed these two surveys agreed that staff made them feel that they really cared about them and their condition.
- Confidentiality was observed, for example by identifying patients by just their initials on the whiteboard used by the multi-disciplinary team.
- We spoke with three patients, all of whom were pleased with the care they received and we were told that staff were, "Very kind and caring".
- The service catered for patient's different needs, for example we saw that there were chairs and other equipment for bariatric patients.
- One person told us that when their dying relative was being cared for on the ward they were very pleased that the patient was allowed to have a beer.

Understanding and involvement of patients and those close to them

- A large majority of the patients who responded to surveys in January and February 2016 agreed that their treatment and care plan was explained in a way that they could understand and that they were involved as much as they wanted in making decisions about their care and treatment. They felt that clear information was provided about their illness. Most said that staff made them feel comfortable about asking important questions even at busy times. However, two of the three patients with whom we spoke said that they were not sure about the arrangements that were being made for them to return home.
- Staff told us that patients' care needs were discussed with them so that they could be involved in the decision of whether they were ready to go home or if it was better for them to stay a bit longer so that the service could help them, for example to achieve better mobility.
- Senior staff told us that they had observed that staff were good at asking patients their preferences. Our own observations confirmed this.
- We found staff considerate of the frustrations felt by some patients who wanted to go home but were not yet ready.

Emotional support

- There were chaplaincy visits twice a week and the chaplaincy team could be contacted at other times to provide emotional support to patients.
- A member of staff we spoke with told us that it was possible to have patients referred for counselling if it was required on discharge.
- There were a number of support groups for patients with specific health concerns. Staff signposted people to these groups if they required additional emotional support.

Are medical care services responsive?

Good

Responsiveness of services were rated as good because:

- While there were clear criteria regarding admissions, the service was prepared to accept complex discharges and people who were approaching the end of their lives.
- There was a proactive approach to learning from complaints.

However:

- Patients were having to wait longer to access the service, due to shortage of community provision for people who were ready to be discharged.

Service planning and delivery to meet the needs of local people

- The Rosemary Ward is a 16 bedded reablement service, supported by multiagencies, that helps patients recover after a period of ill health. The unit provides an intermediate facility between acute care and community services.
- An admissions checklist was used to reduce the likelihood of readmission to the acute hospitals, but as the service accepted complex discharges, readmission was sometimes necessary. Between mid-October 2015 and the end of February 2016 there were 11 patients readmitted to the West Suffolk Hospital, with a further

five patients being readmitted to the hospital but returning to the Rosemary Ward within 24 hours. Reasons for readmission ranged from chest pains to falls.
- People who were approaching the end of their lives were able to stay on the ward if this was their preference. Some patients discharged from the acute hospitals who needed palliative care and who were not going directly into a hospice but not well enough to go home were admitted. There were no end of life patients on the ward at the time of our inspection.

Access and flow

- Senior managers told us that the ward used to be able to accommodate admissions within three to four days. The length of time from referral to the ward was not formally collated, but increasing problems in getting people back out into their homes due to shortages in community placements meant that spaces were not as quickly available. Staff had also noticed that the service was receiving more patients with complex health issues, such as multiple strokes, advanced Parkinson's and heart failure.
- Generally, patients were transferred about teatime, although there had been one instance when a patient arrived about 10.30 pm and another when a misunderstanding resulted in a patient arriving on an ambulance before the patient occupying the bed was discharged. This was reported as an incident.
- Bed occupancy was approximately 93% with an average length of stay of 24 days. Relations with the discharge planning team at West Suffolk Hospital (WSH) were reported by staff as being good, and having improved with the transfer of the contract to the trust. The discharge planner from WSH rang every morning to go through referrals and review each patient and discuss any delays to their discharge.
- The progress of each patient and discharge plans were discussed at the multidisciplinary meeting, which were attended by the discharge planner.

Meeting people's individual needs

- The communal lounge had a range of chairs to accommodate the varying needs of patients. This included chairs with varying seat heights to encourage patient's mobility.
- The service used the 'This is me' form to help staff gain insight into the needs of dementia patients.
- Different dietary preferences and requirements were catered for, for example if a patient was vegetarian.
- Staff told us that they checked if people had any specific support needs, for example they ensured that hearing aids worn by patients were working effectively.
- A full range of equipment was available to care for patients including pressure relieving mattresses and bariatric equipment for those requiring it.
- Staff could access a translation service if required to effectively communicate with patients and their relatives and carers though this was not often required.
- Additional support was available from West Suffolk Hospital for patients requiring particular input, for example from dieticians and tissue viability.
- There were plans in place to restart the falls clinic at Newmarket Hospital which we were told would also be available to patients before discharge if it was required.
- Staff had good knowledge of each patient and discussed dates of discharge and what each patient would need in preparation for being discharged, for example organising the medicines that they needed to take home with them.
- Hot food was prepared on site and patients confirmed that meals were, "Nice and hot" and that there was a good choice of food.

Learning from complaints and concerns

- The service had a complaints policy in place. Information about how to make a complaint and how to contact the Patient Advice and Liaison Service was clearly displayed on a notice board in the ward. The matron told us that any complaints were brought to their attention and that they could get advice and support from the Patients' Experience lead.
- The matron described complaints as opportunities to improve. Complaints were reviewed at the next team meeting to identify learning. This learning had included not to get offended if the complainant asked to speak to a more senior member of staff.

Are medical care services well-led?

Good

Services were rated as good for well-led because:

- The trust had a clear vision, priorities and ambitions that were shared with staff.

Medical care (including older people's care)

- Good planning and collaboration with Suffolk Community Healthcare had ensured a smooth transition when the trust took over the contract for the service.
- There was good leadership within the ward and from senior management within the trust.
- Staff felt well supported, valued and involved.
- Risks were clearly identified and audits ensured that performance was monitored and action taken to drive improvement.

Vision and strategy for this service

- A clear vision, priorities and ambitions had been developed in consultation with staff, patients and the local community by the trust. On taking over the service these were shared with staff at Newmarket Community Hospital. Staff told us that they were, "Comfortable" with what the trust was seeking to achieve. However there was some anxiety regarding the future of the service due to the uncertainties of the short-term contract which meant that there was not a long term clinical strategy in place for the service.
- The transfer of community services (Suffolk Community Healthcare) to a partnership of West Suffolk Hospital NHS Foundation Trust and two other providers had been conducted whilst maintaining a continuity of governance arrangements and staff felt the services transfer had been well managed. The governance arrangements that had been conducted locally by SCH were in the process of being transferred to West Suffolk Hospital.

Governance, risk management and quality measurement

- Risks pertaining to Newmarket Community Hospital were still held on the Community Risk Register and the SCH risk manager attended the corporate risk committee meetings at West Suffolk Hospital. The risk register had captured potential risks arising from the transfer of contract, for example changes affecting the storage of controlled drugs as well as issues such as delayed transfer of care impacting on patient flow. This showed continuity in the identification and monitoring of risks.
- Incidents were reported to the SCH team and any trends picked up would be escalated through to the WSH Trust team. Any 'duty of candour' issues or serious incidents would be immediately passed on by telephone to the trust's governance team.
- Audit data was submitted to the SCH quality and governance team which was working closely with trust counterparts. The matron received peer support on action plans resulting from audit findings. Quality assurance visits included audits aligned with the CQC five key questions and used the CQC key lines of enquiry. The wide range of audits conducted included medication chart audits, documentation chart audits and hand hygiene audits. We saw that the regular monthly audits of documentation had detected a drop in performance to only 86% in December 2015, with failures recorded in recording contact details and allergies and consent for treatment not being obtained. By the January 2016 audit these shortcomings had been addressed and an 11% improvement had been achieved.
- Audit results were reviewed with staff at monthly team meetings. Any reasons for reduced performance were explored and improved performance was celebrated. Actions were planned and performance monitored. This led to outcomes such as the improvement in completion of DNACPR forms from 80% recorded in the November 2015 audit to 92% by the January 2016 audit.

Leadership of service

- Good leadership was being provided to the ward by the matron and two ward sisters. They were well supported by senior management within the trust. The trust's chief executive visited regularly, about once a month, to meet with staff and patients. The chief nurse had also visited several times.
- Staff described their managers at all levels as supportive and approachable, for example Band 6 staff were supportive if a member of staff was upset. Staff said that they could always approach the matron or another senior manager if they had any concerns. There were clear and practical instructions about whom to contact if there were issues and on-call managers were available to provide a quick response. Staff told us that they would not hesitate to contact senior trust managers if they needed to do so. A ward sister gave us the example of needing to arrange agency cover one weekend and gaining authorisation from the chief nurse. Staff at all

levels told us that they felt that more support was available since the trust took over the contract. As a community hospital it could feel isolated but, "There are more people to reach out to now".

Culture within the service

- Staff were positive about the way in which the transfer and development of the service was being handled. One nurse told us how, during handovers, there had been discussions with staff about the dynamics of role of the Newmarket staff within the health community. "They listened to us and they were interested in the way our ward ran and took feedback from us".
- A manager commented that they were, "Really proud of our team", and comments from staff indicated that this respect was mutual.
- Staff stated that there was an open and positive culture of wanting to promote the best for patients and for staff.

Public and Staff engagement

- We saw that the ward had a 'You Said…We Did' board which recorded patients comments and the service's response, for example aiming for more prompt responses to call bells. Patients had said that there was, "Not enough to do" and this had been addressed by a courtyard being tidied and made ready for use.
- Staff told us that they felt welcomed into the trust and that the transition had been well handled. They said that they were given a lot of information beforehand and this meant that the changeover had gone very smoothly.

Continuous improvement and sustainability

- The consultant had plans to resurrect a falls clinic that would alternate monthly with a Parkinson's clinic. The aim was to bridge the gap between community and hospital care as part of the strategy to reduce the need for admission to hospital.

Outstanding practice and areas for improvement

Outstanding practice

- Good planning and collaboration with Suffolk Community Healthcare had ensured a smooth transition when the trust took over the contract for the service.
- There was effective multidisciplinary working, communication and an open and positive culture of wanting to promote the best for patients and for staff.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure patient care records are fully completed to include detail of actions taken and care delivered.
- Whilst the paper format of incident reporting remains in place the trust should ensure that follow up actions from incidents are recorded.
- Ensure a robust process for completion of DNACPR records
- Review outdated equipment , specifically patient beds, and ensure appropriate maintenance and replacement plans are in place.