Northampton General Hospital NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Northampton General Hospital NHS Trust is an 800-bedded acute trust with one main hospital, Northampton General Hospital (NGH). There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

We carried out this inspection as part of our routine focused inspection programme. We completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

We determined the extent of this focused inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The hospital was previously inspected under our comprehensive methodology in January 2014, when the overall rating was requires improvement.

We found the trust has taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people and outpatients and diagnostic imaging) as good overall. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating for the hospital was good. All five key questions were rated as good (safe, effective, caring, responsive and well-led). We have included some of the findings of the February 2017 inspection in this report to reflect our judgements about the trust overall.

We found that:

- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive, and inclusive.
- Leaders had a shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.
- The trust had a model of clinical leadership that was understood by staff we spoke with and showed excellent engagement with the consultant, medical and nursing bodies.
- The focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.
- The trust was very proactive in engaging with staff. Almost all staff were very positive about the leadership of the board and senior managers. The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this.
- Overall, almost all staff expressed high levels of satisfaction and were proud to work for the trust. Staff reported feeling respected, valued, supported and appreciated.
- The leadership teams were cohesive and inclusive and were focused on delivering safe, high quality care and treatment for all patients. Staff believed in the leadership of the hospital and were proud of the organisation and its culture.
- Staff were friendly, professional, compassionate, and helpful to patients in all interactions that we observed. All patients told us that the staff had been caring towards them and all spoke positively about the staff in all areas inspected.
- Patients and their relatives were supported during their stay within critical care services and staff provided opportunities to discuss care and treatment. This was delivered in a way that promoted dignity and confidentiality at all times.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety in all areas inspected.
- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. The design, maintenance, and use of facilities, premises, and equipment generally met all patients' needs. The environment of the entire estate (despite some parts being over 275 years old) was extremely well maintained.
- Medicines were generally stored and handled in line with the hospital's medicines management policy.

Summary of findings

- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse. Staff spoken to in all areas were aware of the processes to identify and respond to patient risk and there were systems in place to monitor and manage risks to patient safety.
- Medical and nurse staffing levels met patients' needs at the time of the inspection.
- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Pain of individual patients was assessed and managed appropriately.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- The emergency department had a recovery plan to improve performance to meet the national standard for patients being seen by a doctor within four hours following arrival, which had been agreed with local commissioners and other stakeholders. Performance had declined and was below the national average.
- There was clear evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) audit and performed better or as expected in six out of eight indicators.
- The critical care outreach team provided 24 hour cover seven days a week and assisted with the monitoring and treatment planning of deteriorating patients throughout the hospital, ensuring risks were responded to appropriately.
- The children and young people's service performed well in in a number of national audits including the National Neonatal Audit (2015) and the Epilepsy 12 audit (2014). Gosset ward was working towards achieving Bliss accreditation.
- The maternity and gynaecology service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs. Effective multidisciplinary working was clearly evident throughout the departments and services.
- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Patient's consent was obtained in line with trust policy and statutory requirements.
- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- The hospital staff worked with a variety of stakeholders and commissioners to plan delivery of care and treatment. There was a focus in providing integrated pathways of care, particularly for patients with multiple or complex needs.
- Access to services was generally effective and timely. Care and treatment was only cancelled or delayed when absolutely necessary.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- The hospital consistently met the referral to treatment standards over time.
- Waiting times for diagnostic procedures were lower than England average
- Due to ongoing bed capacity issues in the hospital, the hospital had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients. The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system.

Summary of findings

- The trust's strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access.
- Full and effective fit and proper person checks were in place.
- Generally effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the services.
- Service risk registers generally reflected the risks within the service and there was evidence of ownership, mitigations having being implemented and ongoing monitoring.
- Performance in national audits and benchmarking with regional and national peers was consistently used to drive improvements in services.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and service improvement methodology and achieved improved outcomes for patients.
- Innovative approaches were used to gather feedback from patient services and the public, including people in different equality groups. Rigorous and constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.

However, we also found:

- The critical care unit did not comply with the Department of Health's Health Building Note 04-02 critical care unit's standards; however, this had been risk assessed and was under review. Refurbishment plans were in place to address this.
- Mandatory training compliance did not always meet the trust target in some areas. Some staff in some areas were not up to date on annual safeguarding training. Overall, the trust compliance was meeting its target of 85%.
- There were not always effective systems in place regarding the storage and handling of medicines in some areas we inspected. The trust took immediate action to address this once we raised it with them.
- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- The maternity service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.
- Hospital wide bed capacity affected the ability of the critical care service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patients' dignity at all times.

We saw several areas of outstanding practice including:

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.

Summary of findings

- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The trust had a duty of candour sticker that would be placed into the patient's notes when the duty of candour had been applied. This included, for example, staff name, date, name of person/patient receiving information, account of incident, details of incident and if an apology was offered.
- Two members of the critical care team had been nominated for the 'Best Possible Care' Awards. Patients and those close to them, as well as work colleagues, voted for staff members who had gone above and beyond to exceed expectations and had made a real difference to patient care.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training (PROMPT).
- Gosset ward was working towards achieving Bliss accreditation. This means the ward had undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies which has helped to build the evidence for Bliss accreditation.
- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and feed these back to ultrasound community in England.

However, there were also areas of poor practice where the trust needs to make improvements. The trust should:

- Review pharmacy provision to meet the needs of the critical care service and be in line with national guidance.

Summary of findings

- Continue to review and monitor over eight hour delayed discharges in critical care and report incidents and mixed sex breaches using the electronic reporting system.
- Monitor staff mandatory training to ensure compliance with the trust's target including annual refresher training for safeguarding adults at level two and safeguarding children level two and three.
- Continue to monitor caesarean rates and perinatal mortality rates in the maternity and gynaecology service.
- Review multidisciplinary support to critical care services to ensure national best practice is following, in relation to therapy support.
- To monitor allergy testing ampules ensuring use within their recommended expiry dates.
- The trust should consider improving the facilities for parents to stay overnight on paediatric wards.
- Continue to monitor and review the impact of patients admitted to paediatric wards with mental health issues.
- Continue to monitor and review the effect on children's services due to the limited availability of psychologist support, particularly for children with long term conditions.
- Continue to monitor controlled drugs are effectively stored in outpatient areas.
- Continue to monitor fire exits are accessible at all times.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust (NGH) is an 800-bedded acute trust. There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

It has an income of approximately £250 million and a workforce of around 4,1875 staff. It provides general acute services to a population of 380,000 and a hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire. The trust is also a cancer centre, delivering cancer services to a wider population of 880,000 in the whole of Northamptonshire, and parts of Buckinghamshire.

The hospital has dedicated beds at the Cliftonville Care Home, Spencer Care Home, and Angela Grace Care Home for patients who no longer require acute inpatient care. NGH are responsible for the medical care of patients transferred to one of the care homes with all nursing care and management being the responsibility of the home.

For 2016/17, the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

We determined the extent of the inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The trust was previously inspected in January 2014, when the overall rating was requires improvement. We rated the end of life services as inadequate.

We spoke with a range of staff, including black and minority ethnic staff, nurses, junior doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professions, porters, and the estates team. We also spoke with staff individually as requested.

The inspection team inspected the following four core services at Northampton General Hospital.

- critical care.
- children and young people.
- maternity and gynaecology.
- outpatient and diagnostic imaging services.

We did not inspect urgent and emergency care, medical care (including older people), surgical care or end of life care as we had inspected these core services in February 2017. However, we have included some of the findings in this report to reflect our judgements about the trust overall.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission (CQC). The Inspection Manager was Phil Terry and the trust's relationship inspector was Justine Eardley.

The team included seven CQC inspectors, one CQC pharmacist inspector and a variety of specialists including consultants, senior nurses, and trust wide governance experts.

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?

Summary of findings

We carried out this inspection as part of our routine focused inspection programme completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

Before visiting, we reviewed a range of information we held about Northampton General Hospital and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We talked with patients and staff from all areas and departments. Some patients and staff shared their experience by email or telephone.

We held drop in sessions with a range of staff. These included nurses, doctors, consultants, health care assistants, allied health professionals, administrative and clerical staff, porters and the estates team, and black and minority ethnic staff. We also spoke with staff individually as requested.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Northampton General Hospital.

What people who use the trust's services say

In the 2016 CQC inpatient survey, the trust performed about the same as other trusts for all categories, with the exception of patients views of doctors (8.01 out of a maximum of 10) and also discharges processes (6.54 out of a maximum of 10), where the trust performed worse than other trusts.

This survey looked at the experiences of 77,850 people who received care at an NHS hospital in July 2016. Between August 2016 and January 2017, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 487 patients at Northampton General Hospital NHS Trust.

Facts and data about this trust

The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

For 2016/17, the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

The trust has beds spread across various core services including:

- 739 General and acute beds.
- 60 Maternity beds.
- 18 Critical Care beds.

Activity

Bed occupancy on the days of inspection was 104%. Bed occupancy has been in line with the England average between Quarter 3 2015/16 and Quarter 4 2016/17.

Between February 2016 and January 2017 the trust had:

- 116,773 A&E attendances.
- 91,271 Inpatient admissions.
- 560,061 Outpatient appointments.
- 4,539 births.
- 1,401 deaths.

Population served

The trust provides hospital care for a population of 380,000. The local population from April 2015 to March 2016 was predominantly white (86%), with 3% Asian, 2.5% black and 1.2% mixed.

Northamptonshire is a centrally situated county incorporating a mix of urban and rural areas. The population density is in the lowest 25% of upper tier authority areas within England. In spite of this, the county has seen one of the most significant levels of growth during the past 30 years, well in excess of national and regional growth trends. Whilst the population has grown across all broad age groups, this has been particularly high in those aged 65 and above. This is expected to continue in projections to 2021, with particular emphasis on the group aged 70 years and above. In spite of this

Summary of findings

growth at the top end of the age profile, the proportion of those aged 65 and above within Northamptonshire remains comparatively low against the national profile, with the child population (0-15 years) comparatively high.

Deprivation

Socio-economic deprivation is considered to represent an important health determinant. This is supported by the notable difference, which has been recorded between life expectancy in the most deprived and the most affluent areas of England. The extent of socio-economic deprivation in Northamptonshire is not as considerable as other parts of England, but specific pockets can be identified, particularly in the Corby and Northampton areas. Deprivation has a tendency to be concentrated in urban areas of the county. Health deprivation however has a higher occurrence at the most significant level in the county than overall deprivation. This is found within areas of Corby, Northampton, and to a lesser extent Kettering. The link between health deprivation and other forms of deprivation considered determinants is by no means explicit. Whilst 57% of those areas experiencing health deprivation amongst the top 30% in England also recorded similarly high levels of income deprivation, for environment deprivation, this was 22% and for barriers to services was just 8%.

Population age

The majority of local population in April 2015 to March 2016 was 18 to 74 year (67%) with a further 21% over 75 years. Data shows that the age of the local population is stable and similar to data collected in April 2014 to March 2015.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as good because:** We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for safe. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that: • Significant improvements had been made in establishing a safety culture across the hospital and this was reflected in all the core services we inspected and by all staff. • The trust had a systematic approach to the reporting and analysis of incidents. There were plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimise harm were reviewed. • There was a positive culture towards reporting incidents and learning from these to improve patient safety. • The trust met the requirements of the Duty of Candour regulation and there was evidence of good ownership by senior leaders within clinical teams. • Staff were confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and reflected local and national guidance. • Medical and nurse staffing across the trust was appropriate for the services delivered and in line with relevant guidance. • Appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients. • The medical oversight of the 'fit for discharge' patients in local care homes used by the trust was excellent. • The service provided critical care outreach 24 hours seven days a week with support for deteriorating patients throughout the hospital wards. • The trust simulation team was used by critical care services to reconstruct scenarios based on common errors that occurred in healthcare. Staff we interviewed spoke positively about the learning and told us it enhanced patient safety and experience. • Safety thermometer data from the last 12 months reported 100% of "harm free" care in the child health directorate.	Good

Summary of findings

- The outpatient service carried out harm reviews for patients waiting for 45 weeks and over. Staff held weekly referral to treatment (RTT) performance meetings where all aspects of the patient pathway were discussed, including the validation of all patients waiting over 18 weeks.
- The design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm.
- Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Standards of cleanliness and hygiene were well maintained in all wards and areas visited.
- Generally, appropriate systems for the handling and storage for medicines were in place.
- Suitable equipment was available to meet patient needs, and had been well maintained.
- Issues we had raised at the last inspection regarding reassessment of patients' venous thromboembolism (VTE) risk at 24 hours following admission had been addressed.

However:

- Mandatory training compliance did not always meet the trust target in some areas. Some staff in some areas were not up to date on annual safeguarding training. Overall, the trust compliance was meeting its target of 85%.
- There were not always effective systems in place regarding the storage and handling of medicines in some areas we inspected. The trust took immediate action to address this once we raised it with them.
- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- All staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. Staff were aware of the trust's policy and their requirement to apply Duty of Candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when Duty of candour processes were triggered.
- Our observation of records showed that when things went wrong patients, and their relatives, were offered a verbal and written apology and complied with Duty of Candour processes. This also included arranging local meetings and support for patients and relatives. Trust policies referred to Duty of Candour and detailed clearly how staff should manage incidents or complaints taking duty of candour into consideration.
- We reviewed ten serious incidents and medium incident reports, which showed clear evidence of Duty of Candour maintained by the trust. The reports showed that there were clear apologies and explanation to patients and their loved ones. The trust had also arranged for one incident investigation report to be reviewed by an external specialist for an independent review. The trust offered individuals to assist patients and their families to participate with investigation processes and offer explanations. We saw that copies of final investigation reports were shared with patients and their families.
- We saw Duty of Candour stickers available for staff to place in patients noted when incidents had occurred and Duty of Candour had been completed. The use of these was audited by the trust's governance team. Duty of candour was reported on quarterly to the trust's governance committee.

Safeguarding

- Overall, staff told us they felt confident reporting safeguarding concerns and were given support with this. Policies and procedures for safeguarding were in place and reflected local and national guidance.
- The trust had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. The trust had positive engagement with both the adult and children's local safeguarding children boards.
- Staff received training and had an effective understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. Staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Staff had access to the

trust's safeguarding team and they told us they were helpful and responsive. Staff were able to tell us how they would report concerns through the trust's procedures and they knew who they should contact.

- The safeguarding team took proactive steps to minimise potential abuse of children by reviewing all attendances by children to the emergency department within 24 hours.
- The safeguarding team actively reviewed all nationally published serious case reviews and took learning from these to reflect upon and change trust practices and policies. The safeguarding leads were actively involved in cross-county work regarding the recognition of domestic violence and appropriate support for patients affected.
- There was information relating to female genital mutilation and child sexual exploitation on the trust's intranet. All staff that we spoke with were aware that there were arrangements in place to safeguard women and children at risk and told us that the topic had been covered during safeguarding training.
- Some staff had undergone PREVENT training in line with the government's strategy to ensure that individuals are safeguarded from radicalisation. The training was planned as a mandatory topic in the service's 2017/18 training action plan.
- Staff told us that the hospital safeguarding team delivered bespoke training for staff in the emergency department and provided appropriate information on the dedicated intranet page regarding topics such as child sexual exploitation and female genital mutilation. Staff said the safeguarding team very visible in the department and were always available to give advice. There was a named safeguarding midwife who supported staff whenever required.
- At the time of our inspection, the specific child abduction policy was still in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as a concern. On our unannounced inspection, we saw laminated flow charts on paediatric wards detailing staff actions in the event of child abduction, which related to the child abduction policy, which was available on the trust intranet.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that 'All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing,

planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three'.

- Trust wide safeguarding training was offered either as mandatory, planned/cluster training or bespoke training which was offered across the month for staff. The trust safeguarding compliance rates for July 2017 were:
  - Safeguarding Adults Level 1 – 92%.
  - Safeguarding Adults Level 2 – 85%.
  - MCA – 85%.
  - Safeguarding Children Level 1 – 93%.
  - Safeguarding Children Level 2 – 85%.
  - Safeguarding Children Level 3 – 76%.
- In maternity and gynaecology service, at the time of our inspection, 84% of nursing and midwifery staff and 84% of medical staff had completed safeguarding children's level three training against a target of 85%. The service had an on-going action plan to deliver safeguarding level three training in line with guidance. As of July 2017, 62% of nursing and midwifery staff and 62% of medical staff had completed safeguarding adults' level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.
- In the children and young people's service, a review of staff training data in June 2017 identified 81% of nursing staff had completed children's level three safeguarding training. This was below the trust target of 85%. However, all staff told us they had attended safeguarding level three training. Staff also said there was a delay in uploading training activity onto the training database. Training data for doctors in June 2017 identified 94% of doctors had completed level three safeguarding training.
- The trust was in the process of reviewing the appropriate number of staff in the outpatient's service that had the required levels of children's safeguarding training in line with the 'Intercollegiate document on safeguarding children and young people' (March 2014). For example, staff within the integrated surgery department who were involved in the assessment and treatment of children were trained to level two only. Senior nursing staff were trained to level three. Nurses we spoke with who had direct contact with children said they had been told by safeguarding leads that they required to be trained to level two. Staff said they had access to a level three trained colleague for all clinics.
- In outpatients, senior managers told us that when staff had a concern about a child or a family in an outpatient clinic,

support was obtained from the person in charge. This may be the ward sister or their deputy who had undertaken the appropriate level of training according to the Intercollegiate Document. These safeguarding arrangements were supported by immediate access to a safeguarding professional, available during core working hours (8am to 6pm), who was able to respond to concerns and offer support and advice.

- Training statistics provided by the trust showed that 89% of nursing staff had completed level two safeguarding children and 86% safeguarding adults training level two. We saw 70% of nursing staff had up to date training in safeguarding children level three. The trust's internal target for this training was 85%. The information for doctors showed 68% had safeguarding adults level two training, 72% had safeguarding children's training level two and 64% had safeguarding children level three. We saw that further training dates were being arranged to address this shortfall.
- Senior managers said a discussion was held at the trust's Safeguarding Assurance Meeting in July 2017 to discuss the compliance of level three safeguarding training as it was felt that the trust was attempting to train more staff at this competency level than was required as per the Intercollegiate Document. The associate directors of nursing and the safeguarding team had been tasked to review the safeguarding roles and responsibilities across the trust in line with the Intercollegiate Document to confirm the correct number of staff requiring this training.

Incidents

- The trust reported incidents through an electronic database, which was easily accessible for staff and located on the trust intranet. The governance team managed incident reporting though the Strategic Executive Information System (STEIS).
- Departments had a monthly dashboard that was used to set the targets for safety performance and also used nurse sensitive indicators such as compliance with infection control protocols and care associated risk assessments. The dashboards also included the numbers of incidents and complaints, which were discussed at governance meetings and as 'hot topics' at daily nursing and medical safety huddles. Our observations and discussions with staff at all levels confirmed that they were aware of the 'hot topics' within their department.

Summary of findings

- The director of nursing, midwifery and patient services had introduced a ward accreditation system that RAG rated (which stands for the traffic light systems of red, amber, green) the quality of care provided in all in-patient wards with all wards progressing to achieve best possible care.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety. Staff at all levels understood their responsibility to report incidents both internally and externally. All staff had access to the hospital's electronic system for reporting incidents and staff that we spoke with described the process they followed.
- There were four never events reported from June 2015 to May 2016. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers. The never events included wrong site surgery, an incorrect tooth extraction, the insertion of incorrect lens and the retention of a foreign body. We reviewed the investigations and learning from these incidents and identified that the investigations were thorough and learning needs had been identified. Defined actions had been implemented including clinic notes being signed off in conjunction with patients' notes, an update, and roll out of theatre standards in line with national safety standards, and revision of all relevant standard operating procedures. The trust's medical director also hosted a shared learning event for all surgery staff in 2016.
- Between May 2016 and April 2017, the trust reported one incident which was classified as a never event. It was a surgical invasive procedure incident meeting serious incident criteria. We reviewed the investigation report and action plan regarding this latest never event and found that appropriate actions had been taken to learn lessons from this latest incident.
- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) which met the reporting criteria set by NHS England between May 2016 and April 2017. Of these, the most common type of incident reported as 'all other categories' with three incidents.
- There were 4,959 incidents reported to National Reporting and Learning System between March 2016 and February 2017, with 10 severe harm incidents, 36 moderate harm, 1,061 low harm and 3,849 no harm incidents reported. There were eight deaths reported by the trust over the period.
- Data showed that the trust was within the lowest 25% for reporting incidents, with an average reporting time of 83 days, compared to 26 days for all similar trusts from April 2016 to

September 2016. At the time of inspection, the trust reported that from August 2016 to January 2017 the time taken to upload an incident was 83 days, however this was not necessarily the time taken to report the incident. The governance team reported that they provide the divisional teams with information relating to delays in incident final approval and sign off at quarterly quality governance meetings.

- The trust had reviewed their serious incident policy to include the development of investigation panels and openly shared with local commissioners the initial assessments of incidents that were taken to the weekly internal 'Review of Harm Group' to determine whether a full serious incident investigation was required. This enabled a standardised approach to incidents occurring within the trust and the identification of any trends.
- Service leads regularly reviewed and updated the associated action plans. We saw that the incidents and learning was shared across the organisation, though the trust "Quality Street" governance magazine and at team meetings. Service leads openly discussed the incidents and the actions taken to prevent reoccurrence.
- The trust board reviewed the number of serious incidents and never events at each board meeting comparing current and historic data. This included the type of incident, overview of investigation and the identification of any learning for sharing. The governance team completed a serious incidents trend analysis for all serious incidents and never events from November 2015 to June 2016. This identified the common factors between incidents to enable learning. The report was shared with the divisional leads and trust board.
- Mortality and morbidity meetings were conducted monthly and there was an effective process in place to disseminate information to staff at all levels. Mortality and morbidity meetings were peer reviews of the care and treatment patients received with the objective to learn from them. Consultants identified those patients from the previous month to review and identify areas of learning. Minutes were circulated to ensure all staff had access to the cases discussed and junior doctors told us the learning was positive. Staff at all levels were invited to attend and relevant information was available on the trust's intranet, and hard copies were available in clinical areas for staff.
- The maternity and gynaecology service met the Royal College of Obstetrics and Gynaecology (RCOG) 'Improving Patient Safety' they held a monthly meeting to review perinatal and maternal mortality and morbidity. It was attended by the multidisciplinary team members. We saw the minutes and

lessons learnt were shared widely across the service. New clinical indicator maternity dashboards were developed and implemented. The information provided within the dashboards enabled the service to identify priority areas for improving the outcomes for women and their babies.

- The trust had implemented a learning from deaths policy, which had been ratified by the trust's board in July 2017 and was reviewing patients' deaths in accordance with the NHS National Quality board 'National Guidance on Learning from Deaths' guidance (March 2017). The trust had a system for reviewing deaths in accordance with this guidance, using the recommended structured judgement review tool, and was collating information in preparation for reporting data gathered in the first quarter to the trust board.
- Trust NHS Safety Thermometer data showed that, from December 2015 to December 2016, there had been a significant reduction in the number of acquired pressure ulcers. In December 2015 there were 17 reported in comparison to six in December 2016. This had followed a downward trend across the period.
- A 'Rapid Pressure Ulcer Prevention Turnaround Project' had been running on four wards since November 2016. The quality assurance and improvement matrons and the tissue viability team completed an SSKIN (SSKIN is a nationally recognised five step model for pressure ulcer prevention) compliance audit across inpatient wards to monitor compliance.
- Data from the Patient Safety Thermometer showed that the trust reported 111 new pressure ulcers, 22 falls with harm and 14 new urinary tract infections in patients with a catheter between April 2016 and April 2017.
- There were no cases of MRSA reported between May 2016 and April 2017 . NHS trusts have a target of preventing all MRSA infections, so the trust met this target within this period. Additionally, the trust reported 15 meticillin susceptible staphylococcus aureus (MSSA) infections and 21 Clostridium Difficile infections over the same period.
- The trust simulation team were used by critical care services to reconstruct scenarios based on common errors that occurred in healthcare. Staff we interviewed spoke positively about the learning and told us it enhanced patient safety and experience.
- Issues we had raised at the last inspection had been addressed. During our last inspection in February 2017, we found that medical and surgical wards were not compliant with the National Institute for Health and Care Excellence (NICE) standard regarding reassessment of patients' venous thromboembolism (VTE) risk at 24 hours following admission.

The VTE reassessments were not always recorded due to the hospital's transition from paper based records to the new electronic observation system. We raised this with the trust at the time and they took immediate action to address this issue.

- On this inspection, we looked at 21 VTE assessments and reassessments in four wards and found 95% had been completed and reviewed within 24 hours. This was a significant improvement on the findings of the last inspection. We brought the patient record missing the VTE assessment to the attention of the nurse in charge of the ward and senior management. The nurse took steps to immediately inform the doctors to address this. Senior management returned to the ward later the same day and the VTE assessment had been completed and the appropriate treatment prescribed.

Staffing

- Medical and nurse staffing across the trust was appropriate for the services delivered and in line with relevant guidance. Patients' needs were met effectively at the time of the inspection.
- For June 2017, the trust's substantive workforce capacity increased by 9.52 whole time equivalent (WTE) posts to 4,322.51 WTE. The trust's substantive workforce was at 89% of the budgeted workforce establishment of 4,871.31 WTE.
- The annual trust staff turnover decreased by 0.12% to 9.94% in June 2017, which was below the trust target of 10%. Turnover within nursing and midwifery decreased by 0.30% to 6.89%.
- Turnover in other areas was:
  - Medical Division: turnover increased by 0.02% to 8.14%.
  - Surgical Division: turnover decreased by 0.7% to 8.99%.
  - Women, Children & Oncology Division: turnover decreased by 0.56% to 8.61%.
  - Clinical Support Services Division: turnover increased by 0.33% to 12.83%.
  - Support Services: turnover increased by 2.76% to 12.45%.
- The vacancy percentage rates had increased for:
  - Administration and clerical staff.
  - Allied health professionals.
  - Estates and ancillary staff.
  - Healthcare scientists.
  - Nursing and midwifery staff.
- Healthcare scientists' staff group has seen the largest vacancy rate increase of 3.85% to 23.36%. Nursing & Midwifery staff group vacancy had slightly increased from 10.35% to 10.47%.
- The vacancy percentage rates had decreased for:
  - Additional professional scientific and technical staff.

  - Additional clinical services staff.
  - Medical and dental staff groups.
- Additional Professional Scientific and Technical staff group had seen the largest vacancy rate decrease of 2.85% to 15.31%.
- The 'Safe Nurse Staffing Report' to the trust's board showed that the overall fill rate for June 2017 was 95%.
- The trust's sickness levels from August 2016 to June 2017 were similar to the England average, and followed a similar trend. Sickness absence in April 2017 decreased from 3.70% to 3.29%, which was below trust target of 3.8%. Senior managers told us this was the lowest it has been for a number of years. Sickness absence for June 2017 increased slightly from 3.51% to 3.53%, which is below the trust target of 3.8%. All divisions were below the trust target except for Support Services at 4.11% and the Facilities Directorate showed the highest sickness rate of 5.75% (within that division).
- Nursing staffing was planned up to 12 weeks in advance and reviewed regularly including on a daily basis to allow senior staff the opportunity to allocate staff to different areas depending on skill mix.
- Nursing staffing levels in the hospital were discussed at regular intervals throughout the day at departmental and hospital-wide bed management, twice-daily safety huddles, and capacity meetings. There was an effective staffing escalation protocol in place and senior managers and clinical site supervisors monitored the hospital's staffing levels throughout the day and night.
- The planned daily consultant cover in the emergency department was below national recommendations of 16 hours per day as 14 hours cover was provided per weekday. Medical staffing for middle grade and junior doctors met the needs of patients at the time of the inspection. There was a designated consultant in charge on a daily basis.
- As of July 2017, across the whole trust the WTE medical agency staff usage was 9.02. Leaders of the medical service explained that they were aware of this and were actively recruiting and looking to create more attractive posts to reduce the vacancy rate. The risks related to medical staffing was entered on the risk register for medical services and actions related to recruitment and retention were documented.
- The proportion of consultant staff working at the hospital was about the same as the England average and the proportion of junior (foundation year one to two) staff was lower than the England average. Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidance to ensure patients received safe care and treatment.

- There were clear processes in place for the induction of temporary medical staff. This included a corporate and local induction for locums, which included statutory and mandatory training checks and local orientation.
- The workforce committee reviewed staffing levels across the organisation at regular intervals. The committee had oversight of all strategies relating to workforce and reviewed progress against plans at each meeting. In January 2017, there were 130 actual full time nurse vacancies against the predicted 128 across the organisation. To address the deficit in trained nurses, the trust had completed recruitment programmes across Europe, India, and the Philippines. We were told that from October 2016 to December 2016, 15 overseas nurses had accepted posts and were awaiting clearance. There were also 47 nurses awaiting Nursing and Midwifery Council decision letters to enable employment within the trust.
- The trust was also part of the 'Best of Both Worlds' innovation. Thiswas an innovative recruitmentcampaign launched by the trust at withthe other three leadinghealthcareproviders inNorthamptonshirein partnership with theUniversity of Northampton, to attract staff to relocate to live and work in Northamptonshire. The campaign aimed to put Northampton, Kettering and Northamptonshire firmly on the map as a top destination for all staff including new and experienced medical and nursing professionals to develop their careers.
- The trust were in the process of recruiting a retention of staff manager to assist overseas workers to orientate to the hospital and community. Orientation programmes include assistance with language and colloquialisms, orientation to shopping facilities, housing, and hobbies.
- The trust had also introduced an apprenticeship scheme designed to 'grow their own registered nurses' from health care assistants. Options were being considered as to how this would implemented across the divisions.
- Local community induction for overseas staff was completed in conjunction with a robust training programme, which enabled new staff to complete internal training and skills updates prior to commencing on the wards. All new staff completed a three-week supernumerary period under close supervision and mentorship. To ensure staff satisfaction with their new post, the trust completed a post commencement check with all staff to ensure they have been placed in their preferred location. This has assisted with the retention of overseas workers, with a fall in numbers of staff leaving from 12% to 0% in December 2016.
- Agency staffing was closely monitored by the trust, and in December 2016, the trust reported that total agency staff

expenditure for 2015/16 was £17.4 million. NHS Improvement required all trusts to cap agency expenditure. Northampton General Hospital has seen a three-month drop in expenditure from September 2016, however overall expenditure exceeds the cap by £2.5 million.

- Trust wide mandatory training compliance was 87% for June 2017. This was above the trust target of 85%.
- Appraisal compliance was 85% trust wide for June 2017. This was in line with the trust's target.
- The trust had a revalidation officer who ensured that all clinical staff requiring revalidation was completed. The trust had systems and procedures in place to support the process for all doctors who required revalidation. The aim of revalidation is to ensure that all doctors are up to date and remain 'fit to practice'.
- For critical care, the national core standards state that there should be at least one WTE band 8A specialist clinical pharmacist for each single level three bed and for every two level two beds. The pharmacy team were aware of the shortfall and a business case had been put forward which, if successful, would ensure standards were being met.
- The midwifery staffing ratios were monitored and were reported through the maternity dashboard on a monthly basis. At the time of our inspection, the ratio was 1:29.
- We saw that the planned and actual consultant rota provided 64 hours consultant presence per week on the delivery ward. No locum staff were being used at the time of inspection.
- A paediatric acuity tool calculated safe staffing ratios in line with the Royal College of Nursing safer staffing guidance in children's services. Staffing levels were continually reviewed to reflect the changing dependency needs of children and young people. Skill mix on the wards was 70/30. This meant 70% of the team were qualified nurses and 30% were health care support workers (HCAs).
- During the February 2017 inspection, we visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We reviewed 10 patients' records and saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors. Care home staff said there was positive relationship with the hospital doctors.

Medicines

Summary of findings

- Generally, appropriate systems for the handling and storage for medicines were in place. Medicines, including intravenous fluids and gases, were appropriately stored and access was restricted to authorised staff.
- There was a proactive, supportive and visible inpatient pharmacy service with effective multi-disciplinary working. The trust pharmacy team undertook leadership on medicines and medicine use within the trust. A seven-day service was available which included access to medicines and pharmacist advice if needed when the pharmacy was closed.
- Arrangements were in place to check patients' medicine requirements on admission. This was carried out by a team of pharmacists and Medicine Management Technicians by taking a detailed medicine history, undertaking medicine reconciliation on admission to hospital and checking for any contra-indications or unsafe prescribing. NICE guidance sets medicine reconciliation at 95% within 24 hours of admission; however, the trust rate was 63% (April 2016 to March 2017). Medicine Reconciliation was on the pharmacy risk register primarily due to pharmacy staffing levels; however, the risk had been reduced by the implementation of the seven-day pharmacy services.
- Controlled drugs (CDs) are a group of medicines which are subject to strict legislative controls due to their potential for abuse and harm.
- We found that CDs were generally stored appropriately. This included when patients brought in their own CDs. We checked CD records and found that administration and storage were documented correctly. Ward stocks of CDs were reconciled on a daily basis. We found some areas where trust policy for medicines' storage had always been followed: the trust took immediate action regarding this and this had been rectified by our unannounced inspection.
- At the February 2017 inspection, the trust did not have a system in place to de-nature CDs. This issue was raised at the time of the inspection and denaturing kits were provided immediately to address this issue. On this inspection, we found appropriate systems were in place regarding denaturing CDs. CDs were denatured at ward level before being disposed of into waste containers. This is in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 (DoH) or Healthcare Waste Regulations (DoH).

- Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent the potential of a medicine being given in error and causing harm to a patient.
- We found that fridge temperatures were generally being checked and recorded on a daily basis on most wards. There were some deviations from trust policy regarding checks on medication fridges but once we raised this with senior managers during the inspection, this was addressed immediately.
- The trust pharmacy department was open seven days per week with clinical pharmacists and technicians working weekdays at ward level. An out of hours' cupboard was available for staff to access medications in an emergency. On-call pharmacists also provided telephone advice out of hours.
- The trust had a current medicines' management policy, which was reviewed and updated with national guidance regularly.
- Medication errors were reviewed as part of the Medicines Safety Group to identify learning or trends. We saw that information gathered at this group was shared with the trust through the medicines' optimisation committee. A Medication Safety Thermometer audit was undertaken for allergy documentation, medicine reconciliation and omitted doses of medication. The results of these audits were discussed at the monthly 'Medication Safety Group' as well as directorate governance meetings and 'Clinical Quality Effectiveness Group'. The introduction of an Electronic Prescribing Medication Administration (EPMA) system had helped to reduce the number of recorded omitted doses. The Medication Safety Group action plan included reducing medication omissions as a high priority with a trust wide improvement project planned to start in September 2017. The Medication Safety Thermometer is a nationally developed audit tool. The audit tool was used at the trust to collect data relating to allergy documentation, medicines' reconciliations, and omitted doses of medicines (not documented and unavailable).
- The trust also used the NHS England Medicines Optimisation dashboard, which is viewed by external organisations to monitor and benchmark organisations in relation to medicines optimisation. The Medicines Optimisation dashboard supports NHS organisations by highlighting variations in local practice and provoking discussion on how they compare with other organisations. It is not a performance measurement tool and there are no targets. The trust used this information to drive improvements in patient safety.

Summary of findings

- Medicine incidents or trends in any medication issues were reviewed and discussed at the monthly 'Medication Safety Group' which then reported to the 'Medicine Optimisation Committee'. There were no reported medication related never events. When a medicine incident was reported there was full discussion with documented learning available. Learning from medicine incidents was shared and cascaded to staff in a consistent way.
- In the Medication Safety report (incorporating Medicines Optimisation data) for quarter one (April 2017 to June 2017), we saw that the proportion of patients with Medicine Allergy status documented on chart performance was 97%, in line with the trust target. The percentage of patients with an omitted medicine the day before (not documented) performance was 10%, slightly worse than the trust target of 7%.
- The trust were in the process of implementing an electronic prescribing system (EPMA). At the time of inspection, the system had been implemented in inpatient areas only, with plans to extend the provision of EPMA to the emergency department and assessment wards.
- The trust had an antimicrobial resistance and stewardship programme.
- Daily checks were in place to ensure emergency medicines were available and safe to be used. This ensured that the Guidance from the Resuscitation Council (November 2016) was followed.
- In response to the national inpatient survey results stating that patients do not routinely receive explanations of their medication and side effects before leaving hospital the trust have implemented a poster to prompt patients about medication side effects. The posters included information about medication information leaflets, and speaking to nursing staff and the pharmacist for further information.
- We saw action was taken to reduce medication errors in critical care. A standardised risk assessment was used and a library of medicines had been uploaded directly onto the medicine infusion pumps that provided an extra safety check.
- There was an effective system in place to share learning and updates in the maternity and gynaecology service. This included 'Stork Talk', where managers would update staff as well as review knowledge skills and keep up to date. For example, a recent update on the safe destruction of controlled drugs was discussed.
- However, in children's outpatients, we found 30 allergy-testing ampules were out of date, the oldest going back to 2015. The trust took immediate action to address this once we had raised

it as a concern. Pharmacy staff had planned to include the checking of allergy testing ampules in their organisational reviews. A review had been undertaken to check expiry dates of all medicines stored in outpatient areas.
- The trust had completed a safe and secure storage of medicines review in January 2017 to March 2017. The overall compliance for the trust was 85%, which was recognised by the trust as needing improvement. Plans were in place to address this.

Are services at this trust effective?

Good

We rated effective as good.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for effective. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- Evidence based care and treatment within the trust was effective and based on national guidance.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- The Hospital Standardised Mortality ratio (HSMR) was in line with the expected rate.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results and action plans were in place where outcomes were less positive than expected.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- Staff had the clinical skills, knowledge, and experience they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and knowledge.
- There was effective multidisciplinary working and we saw positive collaborative working to improve patient care and service provision in all areas visited.

- The service was working towards delivering sustainable seven-day services in line with its clinical strategy, with a focus on compliance with the key clinical standards.
- Staff generally understood the importance of consent and mental capacity and delivered care in accordance with legislation.

However:

- The National Hip Fracture Database audit showed the risk-adjusted 30-day mortality rate fell within the expected range nationally, but the audit's other outcomes were worse than the national average. Plans were in place to address this.
- The trust had a higher than expected risk of readmission for elective and non-elective admissions.
- The end of life service did not have the all the processes and information to manage current and future performance at the time of our February 2017 inspection. The trust had taken action to address this
- The maternity service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.

Evidence based care and treatment

- Evidence-based guidance was used to develop how care and treatment was delivered throughout the hospital. Almost all policies were up to date, reflected national guidance and staff said they were accessible via the trust's intranet.
- There was a clear programme of audits conducted in regards to compliance to organisational standards and protocols. There was a lead consultant and senior nurse responsible for managing each departments annual audit calendar.
- In accordance with National Institute for Health and Care Excellence (NICE) and other national bodies, such as the British Thoracic Society, Royal College of Physicians, and National Cardiovascular Outcomes Research, the trust was involved in data collection for numerous national audits. This included chronic obstructive pulmonary rehabilitation, rheumatoid and early inflammatory arthritis, cardiac rhythm management, cardiac arrest, heart failure, Parkinson's, falls and fragility fracture (including hip fractures), and renal replacement therapy. We saw evidence that audit findings and recommendations were shared within the clinical specialities

and changes to local practice were made, when indicated. Guidance from other professional associations, such as the Association for Perioperative Practice (AfPP) had been implemented.

- The trust had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow. In stroke services, for example, there were care pathways for patients who were thrombolysed (a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs) and patients who were not thrombolysed.
- The emergency department (ED) had developed a comprehensive falls' bundle that was based on a combination of National Institute of Health and Care Excellence (NICE CG56, 2007) and best practice guidelines for patients who have fallen from a standing height.
- The ED had developed electronic initial assessment tools (IATs) based on NICE guidelines and Royal College of Emergency Medicine (RCEM) clinical standards (RCEM, 2014). The IATs were mapped to each presenting symptom to the ED and contained guidance on tests that were required for specific symptoms and what conditions symptoms could be related to.
- The ED met most of the standards set out in the intercollegiate document 'Standards for children and young people in emergency care settings' (Royal College of Paediatric Child Health, 2012).
- Departments used the 'sepsis six' care bundle and active cancer sepsis care bundle pathways in line with RCEM guidelines and the UK Sepsis Trust (2014) for adults and children. These pathways are to aid those delivering care with the rapid recognition and treatment of severe sepsis. Care bundles are a group of best evidence based interventions to support improved outcomes.
- Pain scores had been recorded in all patient records that we reviewed and analgesia administered in a timely manner. Pain scores were recorded on initial assessment and the ED used a pain-scoring tool for adults that were based on the World Health Organisation's (WHO) 'pain ladder' on a scale from one to 10. Patients' nutrition and hydration needs were generally assessed and met in accordance with national guidance.
- Endoscopic procedures were carried out in line with national guidance and best practice. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) found that endoscopy services met the accreditation standards, which include

policies, practices, and procedures. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the Global Rating Scale (GRS) standards.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including Royal College of Surgeons (RCS) standards for emergency surgery.
- Medical device implants were recorded on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- The critical care service used a combination of national guidelines and policy to determine the care and treatment provided. These included guidance from the National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the Midlands Critical Care and Trauma Network.
- Following the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed a replacement called the dying person's care plan (DPCP). The DPCP was embedded on all wards across the trust.
- The hospital had received the UNICEF (United Nations Children's Fund) Baby Friendly Initiative accreditation for its maternity department. The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. The Baby Friendly award is given to hospitals that are deemed to have best practice standards in place to strengthen mother-baby relationships and to support mothers who chose to breastfeed.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths at a hospital is higher or lower than would be expected. The trust's HSMR for the 12-month period January 2016 to December 2016 was 'as expected', with a value of 97.4.
- The Summary Hospital-Level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within 30 days of discharge is higher or lower than would be expected. The trust's SHMI for the 12-month period January 2016 to December 2016 was 'as expected', with a value of 0.96.

Summary of findings

- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results.
- The trust was a mortality outlier for complications of surgical procedures or medical care and biliary tract disease. The trust had effective plans in place and progress regarding these actions was monitored by senior managers to ensure changes were embedded to improve outcomes for patients. We reviewed the actions the trust had taken to review and understand reasons why the outliers had been identified and saw that effective and detailed actions had been taken to address these concerns.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- The hospital performed better than the England average in the 2015 Bowel Cancer Audit. The hospital performed in line with the England average in the National Emergency Laparotomy Audit 2016 and the 2015 National Vascular Registry.
- The National Hip Fracture Database audit showed the risk-adjusted 30-day mortality rate fell within the expected range nationally, but the audit's other outcomes were worse than the national average.
- The trust reported consultant-specific data as part of the 'Everyone Counts' NHS England programme that is aimed at enabling members of the public to access information about outcomes after surgery. There were seven specialties that were included in the programme, such as vascular, colorectal, and urological surgery. The consultant outcomes reported were all within the expected range.
- Critical care services could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). A dedicated staff member was in post to support ICNARC data collection and reporting. The designated ICNARC data clerk collected performance and outcome measures for critical care patients and uploaded information into a national database. Data collected from the audit was analysed and actions taken to improve patient experience and outcomes.

Summary of findings

- ICNARC data for the period 1 April 2016 to 31 March 2017 showed that the critical care unit performed as expected and slightly better than similar organisations in eight out of the ten quality indicators. This included the number of unit-acquired blood infections, the number of non–clinical transfers to another unit, and out of hour's discharges to the wards.
- The trust had historically had a high caesarean section rate and was consistently higher than national average for some years. Actions had been put into place to ensure that women and babies received safe, appropriate, evidenced based care, which was not only based on national guidance but on their individual specific needs.
- The third Maternal, Newborn and Infant Clinical Outcome Review Programme' (MBRRACE) audit was published in June 2017. This looked at UK perinatal deaths for births from January to December 2015. The service was in the process of reviewing the audit outcomes and reviewing its action plan based on the previous audits. The stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was again up to 10% higher than the average for the comparator group.
- This third MBRRACE report reflected the service had a higher than average perinatal mortality over a period of time. The service had analysed the findings of this report and carried out detailed case reviews to understand these outcomes. We were provided with comprehensive actions plans that showed the range of actions the service was taking to improve outcomes for all patients. The service had incorporated the MBRRACE findings into its Maternity Safety Improvement Plan and Saving Babies Lives Action Plan. We saw the actions had been taken.
- A multi-disciplinary detailed local review was held in July 2017 to try to assess the deaths that were potentially avoidable and investigate local factors that might explain the rates being reported. Three areas of focus were identified:
  - Overall reporting system: what the service reported, the level of report, who the service reported to.
  - Relationship between neonatal and obstetrics teams with more MDT working and joint review of cases.
  - Intrapartum management with regards to recognition of the stages of labour and recognition of deviations from planned care and potential outcomes.
  - To review training needs analysis of staff in the service.
- Other actions taken included:
  - A review of reporting system had taken place and the clinical quality and safety midwife was the main point of contact

with MBRRACE to ensure robust, consistent and clear reporting. The service was awaiting the national tool for reporting this data which was due for general release to trusts later in the year.
  - A working group had been developed to improve communication and development of a service improvement plan between the maternity and neonatal services.
  - The service was to carry out a review of intrapartum monitoring in conjunction with the East Midlands Clinical Network.

- In the National Neonatal Audit 2015, 71% of babies born under 33 weeks at the trust were receiving mother's milk, either exclusively or as part of their feed at time of discharge from the unit compared to the national average of 58%.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The results were published in March 2016. The trust achieved four of the eight organisational key performance indicators (KPIs). The service had produced an action plan to address the shortfalls and issues raised by the NCDAH (2014 to 2015).

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working to deliver coordinated patient care.
- All relevant staff, teams and services were involved in assessing, planning and delivering care and treatment. Staff worked collaboratively to understand and meet the range and complexity of peoples' needs. For example, multidisciplinary meetings included physiotherapists and occupational therapists.
- There was daily communication between discharge co-ordinators, nurses and therapists, so that discharges were planned and delivered effectively.
- Staff could access the learning disability lead, critical care outreach team, pain management team, social workers, and safeguarding teams for advice and support.
- Staff worked with the critical care outreach team and hospital at night team to provide clinical support for deteriorating patients. There was an escalation policy for patients who required immediate review, for example, those with sepsis.
- Staff communicated with community health teams where necessary, for example, when discharging older patients with complex needs. Discharge letters were sent that included information from risk assessments, such as skin pressure

damage. In the community, we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services. The teams worked closely together, the community team told us they often provided cover for the hospital during peaks in activity.

- Care was delivered in a co-ordinated way when different teams or services were involved. The specialist palliative care team had established close links with other providers in the local area of end of life care, including the local hospice, primary care providers, and community nurses.
- In the Dickens therapy Unit (based at one of the three care homes that the hospital had provided beds for those patients assessed as 'fit for discharge'), we saw that the hospital's therapists were on site in the care home on Mondays to Fridays to provide a high level of therapy support for the hospital's patients. Staff at the two care homes we visited reported positive relationships with the hospital's staff to ensure those patients needs were being met.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff generally understood the guidance and legislation relevant to consent and informed decision-making. Patients were supported to make decisions as required by legislation and guidance, including the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- The trust's consent policy outlined staff responsibilities when obtaining consent. Staff showed us how they access the policy on the trust's electronic system. The policy was in date and reflected legislation and guidance.
- Staff we spoke with confirmed they had received MCA and DoLS training. Staff were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- The hospital used four nationally recognised consent forms. For example, there was a consent form for consenting adult patients, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures under a local anaesthetic. Staff we spoke with were aware of the consent forms and knew when each should be used.
- Trust wide staff compliance with mental capacity act training was 85%, which met the trust target.
- There was not always a clear record of discussions about DNAPCR with patients who had capacity. Mental capacity

assessments were not always clearly recorded to underpin decisions about DNACPR. We raised this as a concern during the February 2017 inspection, and the trust took urgent actions to clarify with all staff the procedure for recording patient's capacity status as well as carrying out further audits to ensure this was being complied with. Data from the trust showed that compliance has improved.

- The resuscitation team had developed an action plan from the most recent documentation audit results. The action plan identified commonly missed information and the specialty with most missed information. The resuscitation team fed back the audit information to each specialty and carried out targeted training sessions when necessary.
- Staff demonstrated how Gillick competence and Fraser guidelines related to the consent process in their practice. Gillick competency and Fraser guidelines refer to children (less than 16 years of age) and as to whether they are able to consent to their own medical treatment, without the need for parental permission or knowledge.
- Completion of certificates for terminations, in line with the Abortion Act (1967) and Abortion Regulations (1991), was carried out by two clinicians, which was in line with the legislation.

Are services at this trust caring?

Good

We rated caring as good.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people and outpatients and diagnostics) as good for caring. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- Staff were friendly, professional, compassionate, and helpful to patients in all interactions that we observed.
- Patients told us that the staff had been caring towards them and all spoke positively about the staff.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the wards and clinical areas were very busy.
- Staff communicated with patients and their loved ones in ways to help them understand their care and treatment.
- Staff were aware of the impact that a patient' care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.
- Feedback from patient surveys was generally very positive.

- We saw positive examples of staff understanding the personal and social needs of their patients and family in the children and young people's service.

Compassionate care

- Staff were friendly, professional, compassionate and helpful to patients at all times.
- Staff used humour when appropriate and respected patient's individual preferences, habits, culture, faith, and background.
- Patients told us that the staff had been caring towards them and all spoke positively about the staff.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the wards and clinical areas were very busy.
- During our inspection, we observed care being delivered by nursing, medical, therapy, and auxiliary staff interacted with patients in a positive caring manner. This included addressing patients by name, introducing themselves by name, actively listening, speaking politely and respectfully, and coming to the patient's level when they were in beds and chairs. We found all patients had nurse call bells within reach and these were answered in a timely manner by staff.
- Staff stressed to us that their primary concern was to ensure all patients received the best possible care. Staff confirmed that when they assessed patients' needs they took into account personal, cultural, social, and religious needs. Staff spoke about their patients with empathy, compassion, and courtesy. Many referred to discussions they had had with the patient and family members.
- We observed staff treating children with patience and compassion to put them at ease. Patients and those accompanying them were treated with respect.
- We saw outstanding examples of staff understanding the personal and social needs of their patients and family in the children and young people's service.
- We saw that Friends and Family Test results were regularly reviewed and shared with staff, and actions were taken to improve performance. The trust's Friends and Family Test performance (% recommended) was generally lower than the England average between April 2016 and March 2017. In latest period, March 2017, trust performance was 94 % compared to an England average of 96%. The trust reported that the percentage of patients who would recommend inpatient and day-case services had improved month-on-month from April to June 2017.

Summary of findings

- Between July 2016 and June 2017, the hospital's maternity Friends and Family Test (FTT) performance (% recommended) was better than the England average in all four areas of maternity. In the inpatient children's service FFT performance for the period February to April 2017, was just below the performance target of 94% and in the children's outpatient service was just above the performance target.
- The hospital participated in the National Cancer Patient Experience Survey 2015, which was published in July 2016. From April to June 2015, 703 eligible patients from the trust received the survey, and 483 questionnaires were returned completed. This represented a response rate of 69%, which was better than the national response rate of 66%. The trust scored in line with the national average for 40 of the 46 indicators relevant to hospital care, treatment, and staff. The trust scored better than the national average for two indicators, which were staff assisted patients to get financial help and free prescriptions. However, the trust scored worse than the national average for four indicators, which included patients felt they were always treated with dignity and respect by staff, and were told who to contact if they were worried following discharge. On a scale of zero (very poor) to 10 (very good), patients gave an average satisfaction score of 8.5, which was slightly lower than the national average of 8.7. The service had developed a detailed action plan in response to the results. We saw evidence that the majority of actions had been completed.
- The surgery service gathered feedback through a local patient experience survey. We saw actions to improve areas that received low scores.
- We saw from the National Care of the Dying Audit 2016 that the trust performed the same as the England average on the clinical indicator that patients were given an opportunity to have concerns listened to.
- The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to privacy, dignity, wellbeing and facilities, and the same as the England average for food. The patient-led assessment of the care environment audit (PLACE) for 2016 showed the trust scored better than the England average for how the environment supported the delivery of care for privacy, dignity, and wellbeing. The trust scored an average of 90%, while the England average was 84%.
- The trust August 2016 inpatient survey showed that there had been an improvement in patients reporting positively about treatment with respect and dignity (8.8 to 9.0), although this was in line with national average.

Summary of findings

Understanding and involvement of patients and those close to them

- Patients told us that they had felt involved in their care and treatment. We saw that patients were kept informed about the treatment plans at all times.
- Patients generally knew which doctor was looking after them and what diagnostic tests were being carried out.
- Staff spoke about the importance of keeping patients informed of waiting times and plans for care and treatment. Staff communicated with patients and their loved ones in ways to help them understand their care and treatment. This included adjusting the pace of their speech and recognising when patients may need extra support to communicate such as translation services.
- Staff in the ED had arranged for volunteers to attend the department and provide support and information for patients who may have social needs.
- Relatives were kept informed of plans for patients' admission or discharge as appropriate.
- We were provided with feedback about the end of life service from July to September 2016. We saw there had been 337 adult deaths at the hospital. Of these, 299 had been managed by the bereavement service. We saw the almost all families were satisfied with the level of care their loved ones had received. There were two negative concerns in relation to issues that had occurred on the wards.
- New staff nurses could be identified by a daisy badge which was worn for one year post commencement in post. This enabled patients to identify less experienced nurses.

Emotional support

- Staff told us that they would take the time to support patients and their loved ones if they were faced with distressing news. Staff were aware of the impact that a patient's care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.
- Staff were fully aware of how to make referrals to adult and children's mental health services when required. Staff working with children and young people were aware of the support that parents needed when children attended the ED.
- Staff referred patients and their loved ones to bereavement counselling services and support networks for carers and dependents.

- Staff had awareness of patients with complex needs and when to provide them with additional support to minimise the potential of them becoming anxious or distressed. Staff signposted patients and relatives to appropriate external organisations and charities when required.
- Staff advised patients how they could access an independent advocacy service to assist with communications with the trust.
- Therapy staff conducted access visits at home to ensure stroke patients and their families had appropriate support in place to enable them to manage their health, care, and wellbeing, and maximise their independence. Clinical nurse specialists, such as stoma care nurses, provided emotional support and advice to patients and those close to them. Patients received specialist support when coming to terms with adaptions in their everyday lives and were encouraged to manage their own health.
- Staff supported patients and their relatives to use the chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives as needed. Multi-faith options were available.
- Staff referred relatives to the patient advice and liaison service (PALS), bereavement service and chaplaincy services as required. The bereavement service was available Monday to Friday and was located within the hospital. Staff spoke highly of this patient support service.
- Staff in the chaplaincy team worked closely with the bereavement midwife based in the hospital maternity department. They arranged and delivered a regular remembrance service for those whose babies and children had miscarried or died. This was provided approximately every two months, and was supported by a national stillbirth and neonatal death charity. We saw a wide range of people attended this.
- The team also provided an annual remembrance service at a local church, for families and friends of adults who had died in the hospital.
- We saw that an organ donation link nurse directly promoted and supported staff and relatives with the organ donation programme.
- Children were cared for at the end of their lives in a dedicated room as part of the pathway. Bereavement support was provided on the paediatric wards, Gosset ward and in the community. The Snowdrop Suite (on the maternity unit) was dedicated to supporting bereaved parents and their relatives.

Are services at this trust responsive?
We rated responsive as good because:

Good

Summary of findings

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for responsive. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good. We found that:

- The trust worked proactively with a variety of stakeholders and commissioners to plan delivery of care and treatment. There was a focus in providing integrated pathways of care, particularly for patients with multiple or complex needs.
- Due to ongoing bed capacity issues in the hospital, the service had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients.
- The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- Whilst some night moves for patients were made due to the bed capacity issues, appropriate risk assessments were carried out.
- The trust had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.
- Excellent initiatives were in place to improve care for those living with a dementia.
- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- From November 2015 to October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average and no patients waited more than 12 hours from the decision to admit until being admitted. In June 2017, performance against this four hour measure was 88%, in line with the England average of 89%.

- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day and not rebooked within 28 days of surgery was 2%, below the England average of 8%.
- Patients had timely access to initial assessment, with 97% of patients referred to the palliative care team seen within 24 hours, between February 2016 and January 2017.
- The trust managed complaints swiftly, openly and constructively as part of a co-ordinated patient feedback system. The trust considered its handling of complaints to be fundamentally important in building its relationship with the public.

However:

- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.
- The end of life care service did not collect information on the percentage of patients who died in their preferred location or about the numbers of patients who were rapidly discharged, but had access to this information from an external source. Plans were in place for the service to address this.

Service planning and delivery to meet the needs of local people

- We saw that the needs of the local population were used to inform how services were delivered. For example, we saw that key demographics such as age and lifestyle factors were included in plans to expand urgent care facilities as a part of the overall strategy to reduce admissions via the emergency department (ED).
- The ED had undergone a re-design and expansion programme, which started in 2014 and was based on the increasing levels of activity and attendances to the ED. The increase in capacity meant that the ED was able to form a dedicated area within majors for frail elderly patients. This area was called the geriatric emergency medicine service (GEMS) and consisted of five rooms within close proximity to a toilet that was accessible and adapted for patients with physical disabilities.
- A consultant in ED had started developing the geriatric emergency medicine service (GEMS) in 2014 to make the ED

'frail friendly' and to improve staffs' skills in geriatric emergency medicine. The GEMS was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door. The emergency department had recently appointed a GP to work within the ED and develop their urgent care provision.

- Due to ongoing bed capacity issues in the hospital, the service had implemented a safety driven bed escalation process to address patient flow concerns in the hospital. Working with local commissioners, the hospital had purchased 77 beds in three nearby care homes for older people. Medical care and clinical oversight was provided by the hospital and personal and nursing care by the care home staff. All patients transferred to these beds were assessed as being medically 'fit for discharge' and most were awaiting either social care packages of care or a return to their own homes. This arrangement had created extra bed capacity for the hospital and was designed to focus inpatient 'acute' beds on those unwell patients being admitted to the hospital.
- The hospital's senior staff had focused on enhanced working relationships with the local council to improve processes for effective discharge processes that involved social care funding, availability of domiciliary care support for people living in their own homes and housing issues for homeless patients.
- The hospital had taken part in a 12 week trial with the local community NHS trust to assess and discharge patients with cognitive impairments using an evidence-based delirium pathway. Senior managers said this had proven successful in helping facilitate appropriate and safe discharges for some patients with complex needs who had been in hospital for a long time and was being looked at as part of the countywide plans to facilitate discharges.
- The trust's chief operating office held weekly meetings with peer colleagues across Northamptonshire to discuss health and social care pressures and actions that could be taken to improve care and treatment across the county. We were told by commissioners and stakeholders that this collaborative working had improved how the trust looked at the capacity and demands of care needs and were looking forward at promoting care within the community and reduce the number of patients attending the emergency department.

- The trust was planning to join some speciality services with other local acute trusts to improve the quality of service provided and senior managers were proactive in the development of cross county pathways of care designed to improve timely access and outcomes for patients.
- Children's outpatient appointments were held in dedicated paediatric facilities. Age appropriate play areas were in place for children and young people and were well supplied with toys and games. There was access to a play specialist if required. Clinics were held by acute and community paediatricians in general paediatrics and in some sub-specialties, for example, diabetes, cystic fibrosis, epilepsy, endocrinology and functions such as the shoe clinic. Visiting specialists from tertiary centres held local clinics in the outpatient department. Children's pre-operative assessments were held in the children's outpatient department.
- The service improvement team worked collaboratively with the complaints team to identify where internal processes could be improved. This resulted in a workshop with the complaints team and divisional representatives in November 2016. The workshop identified several key areas for improvement which included poor access to medical notes, directorates being given too long to respond, insufficient administration staff to coordinate processes, the need for additional complaints training and the need for improvement in local resolution. Actions identified included a room being dedicated to medical notes associated with complaints to enable access, a reduction in internal timescale, the sharing of good practice the production of a complaints workbook to assist with staff development and understanding and the relaunch of the 4C's (Comments, Concerns, Complaints and Compliments).

Meeting people's individual needs

- There was a Christian chapel on site. It was a quiet space where people of all faiths and none could pray or reflect. However, there was little attempt to make the area inclusive to those of other faiths.
- The maternity department had two bereavement midwives who provided support to women and those close to them. We saw there was a specialist room called the snowdrop nursery that had been refurbished by a bereavement charity. The snowdrop nursery had a courtyard for women to use and was sensitively designed, with a dedicated entrance and exit for families. Staff supported women to collect mementos such as photographs, footprints and handprints and provided information about making a memory box for parents.

- The hospital had a Macmillan cancer support information centre to ensure that people affected by cancer had access to comprehensive and appropriate information and support. The centre was open from 9am to 5pm, Monday to Friday. The service offered a drop-in service for information and support, as well as health, financial and life management advice. The team at the centre could refer to other healthcare professionals, provided details of local and national support services and organisations, details about complementary therapies and outreach sessions in the community.
- The information centre offered a team of experts and trained volunteers to answer questions, provide information regarding local support groups and help with the financial problems cancer can create. Patients and those close to them were able to access booklets, leaflets and other sources of information, free of charge.
- The hospital had leaflets available for relatives, for example, leaflets explaining procedures to be undertaken after the death of a patient. Leaflets for carers about end of life care at the hospital and information about decisions about cardiopulmonary resuscitation were also available. Staff told us leaflets could be provided in other languages, large print, and braille and in an audio format on request. Staff also told us they had access to translator services. The patient advice and liaison service (PALS) could book professional interpreters for patients.

Dementia

- The trust had worked collaboratively with the local NHS mental health trust to provide a dementia and mental health service within the hospital. The team had developed several projects to improve patient experience including introduction of finger foods, flexible visiting for carers, reclining chairs for each ward to enable relatives to stay overnight, activity boxes, dementia and buddy volunteers trained in dementia awareness.
- The trust had reported an improvement in the patient led assessment of environment for dementia care in with 82.3% from February 2017 to June 2017, in comparison to a national average of 75%.
- In the surgery service, theatre staff arranged for carers to accompany the patient to theatre where they had specific needs, such as a learning or sensory disability. Staff told us of one occasion were a patient with a learning disability required more than one procedure by different consultants and these were both done at the same time, to prevent the patient returning to the hospital.

- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- The 'butterfly' scheme was used to discreetly identify patients living with a dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- The surgical department took part in 'John's Campaign' for patients living with dementia. John's Campaign promotes hospitals to allow carers of patients living with dementia to stay with them in hospital, particularly during meal times as eating and drinking can be difficult for some of these patients when in hospital. Staff provided carers with food so that they could eat with their relative and felt that it had a positive effect on the patients' wellbeing.
- The discharge lounge had been specifically designed to cater for patients with a cognitive impairment.

Access and flow

- The trust admitted 91,271 patients from February 2016 to January 2017. There were 560,061 attendances to outpatients and 116,773 attendances to the emergency department. This was an increase in attendances across all areas in comparison to data collected for April 2015 to March 2016.
- We saw a strong operational team, who were forward thinking and actively sought answers for issues that may arise relating to capacity. There were clear criteria and processes for the opening of additional beds, with each decision risk assessed by the appropriate clinical lead. During our inspection, the trust was under considerable pressure due to increased activity. We saw that the team responded well to the additional demands, remained calm and methodically prioritised actions.
- The hospital held a safety huddle meeting two times a day. A representative from each ward and department attended these meetings. We observed a safety huddle during our inspection. Staff highlighted any staffing issues, capacity issues, potential discharges and patients who were not in the appropriate speciality ward. At these meetings, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated and all staff worked towards this positively.
- Patient flow and bed capacity meetings were held up to five times a day with senior staff focusing on safe and effective patient flow throughout the hospital. There was a clear focus

on safe, supported, appropriate discharge and all staff worked positively to improve patient flow. The hospital had a well-defined process for identifying patients for discharge for the next day.

- Bed occupancy was reported to be at 104% on one day of our February 2017 inspection and frequently over the past year, the hospital had had bed occupancy rates over 95%. At peak demand times, this represented an average of 9% of the bed base at the hospital.
- The hospital had a well-defined policy and process for the management of medically outlying patients and senior staff monitored the number of outliers throughout each day to ensure there was appropriate clinical oversight and appropriate nurse staffing levels.
- There were areas and departments in the trust that would be used for inpatients when there were significant bed pressures. These were called escalation areas or beds. These were areas that were not usually used for inpatients. The trust had a policy to guide staff regarding this and risk assessments were carried out. There were also clear guidelines regarding the types of patient that would be acceptable for the escalation areas. During our inspection, there were escalation beds open across the trust, including the Heart Centre, Beckett, Holcott, Brampton, Willow and Collingtree wards.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The hospital failed to meet this target from January 2016 to December 2016 and was below the England average for eight out of the 12 months. Overall, for that period the ED achieved 87% against an England average of 90%. The ED had a recovery plan to improve performance to this target, which had been agreed with local commissioners and other stakeholders. Senior staff told us that there were a number of contributing factors to the failure to meet the target, which included an increase in attendances and other trust wide issues. In June 2017, performance against this four hour measure was 88%, in line with the England average of 89%.
- Performance against the four-hour performance standard was a part of the urgent care overall improvement plan and was discussed at board level. It was recognised that performance against this target was affected by other factors in the trust and the wider care network, such as delayed transfers of care and patients that were waiting in inpatient areas whilst they waited for appropriate care to be arranged in the community.

Summary of findings

- From May 2016 to April 2017, the trust's referral to treatment time (RTT) for non-admitted pathways for patients treated within 18 weeks was 95% and this was better than the England average of 90%. For July 2017, performance was 92%, in line with the England average. The trust has been consistently above the England average and, where the England average had seen a gradual decline in performance, the trust had seen a gradual improvement in performance. A total 22,468 patients were waiting for an appointment with half that number of patients waiting less than seven weeks.
- In terms of cancer waiting times standards for quarter one 2017/18 (April 2017 to June 2017), the trust performed:
  - Two week wait for first appointment was 89%, below the England average of 93%.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 98% which was better than the England average of 97%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 70%, below the England average of 80%. This was comparable with the previous quarter.
- The services' dashboards for June 2017 showed improved performance in all of these standards:
  - The two week wait for first appointment performance standard was 93%, in line with national standard.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 97%, above the standard of 96%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 91%, above the national standard of 85%.
- The hospital's proportion of cancelled operations as a percentage of elective admissions for the period January 2017 to March 2017 was 2% greater than the England average of 1.1%.
- From January 2017 to March 2017, 1.7% of patients whose operation had been cancelled on the day were not rebooked to be treated within 28 days. This was lower than the England average for the same period at 8%.
- In April 2017, only 0.5% of patients were waiting over six weeks for a diagnostic test and this was better than the national average of 1.8%. As of June 2017, the service's dashboard showed 100% of patients were seen within six week.
- For June 2017, the proportion of clinics where the patient did not attend was 7% and this was same as the England average

of 7%. The service had plans to develop appointment scheduling to include an appointment reminding system, which contacts patients in advance by the patients preferred method.

- From March 2015 to February 2016, patients at the trust had a higher than expected risk of readmission to hospital for non-elective and elective admissions. The elective speciality clinical oncology was notably higher than the expected. Whereas, the elective specialty of general medicine was lower than expected. The hospital explained that they were working to reduce readmissions through a variety of programmes.
- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.
- Patients had timely access to initial assessment in the end of life care service, with 97% of patients referred to the palliative care team seen within 24 hours, between February 2016 and January 2017. The end of life care service did not collect information on the percentage of patients who died in their preferred location or about the numbers of patients who were rapidly discharged, but had access to this information from an external source. Plans were in place for the service to address this.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly. Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- The trust complaints' department and the PALS were managed separately by two managers who worked collaboratively to ensure patient and carer satisfaction. We saw that patients and carers were encouraged to share their comments or concerns and when necessary these were escalated and investigated by appropriate staff.
- The patient and carer experience and engagement group completed quarterly reviews of all complaints and concerns raised with the trust. The February 2017 report on showed that

the trust had received 405 complaints from April to December 2016, which was fewer than April 2015 to December 2015 when the trust had received 439 complaints. The report outlined trends and themes such as complaints regarding care, communication, discharge planning and delays in treatment. The report also identified complaints against the main location and division. There was no trend in the location of complaint, with inpatient services receiving the most complaints (25) in April to June 2016, trauma and orthopaedic service receiving the most complaints (24) in July to September 2016 and urgent care receiving the most complaints (24) in October to December 2016.

- In February 2017, there were 11 trust complaints with the Parliamentary and Health Service Ombudsman (PHSO). The role of the PHSO is to investigate and act upon complaints where individuals feel that they were treated unfairly or dissatisfied with the outcome of local complaints process. Of the 11 complaints, the trust were awaiting a decision from the PHSO whether nine complaints were to be investigated, one had been partially upheld with a local action plan being devised and one was closed as not upheld.
- There was a robust system in place for the investigation and writing of complaint responses. Complaints were investigated by the most appropriate clinical lead, and the information was shared with the complaints officer who compiled the trust response. The proposed response letter was reviewed by a member of the patient advice and liaison team whose responsibility was to ensure ease of reading as a non-clinical expert. Each complaint required sign off by the chief executive officer and at least one director. For example, the chief executive officer and the director of nursing, midwifery and patient services would sign off a complaint about nursing care.
- We saw that 93% of complaints were responded to within the timescale agreed by the complaints manager and patient/ relative.
- Action plans for learning from complaints were logged on a trust wide database. Staff responsible for actions were required to provide evidence of completion. Actions were rated as red (timescale exceeded), amber (on target) and green (complete) and tracked by the complaints team.
- The complaints' team devised quarterly division reports that outlined the number and type of complaint, details of themes and actions and details of any learning. The divisional leads were responsible for the sharing of the information and the ownership of the meetings.

Summary of findings

- The complaints' team had experimented in ways of capturing feedback from patients and their families about the complaints process. A trial was carried out by sending surveys to complainants through the clinical audit team, several weeks after the complaint closure and with response letters. The team had found that responses to the questionnaire had varied. The team were planning to revert back to sending surveys though the clinical audit team.
- Complaints that had safeguarding concerns were investigated in conjunction with the safeguarding team.
- Notice boards on the wards included 'You said' 'We did', in response to patient comments. For example on some wards, such as Willow and Hawthorn wards, patients had complained about the noise level at night. As a result, a sleep well pack was given to patients who had difficulty sleeping at night, which included earplugs and an eye mask.

Are services at this trust well-led?

Good

We rated well-led as good.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people, and outpatients and diagnostics) as good for well led. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating was good at hospital level. Urgent and emergency care was rated as outstanding for well led at that inspection.

We rated well led as good at trust level reflecting the clear vision and leadership provided at this level. We found the trust had taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety. We found that:

- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive, and inclusive. Leaders had a shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.
- The trust had a model of clinical leadership that was understood by staff we spoke with and showed, on the whole, excellent engagement with the consultant, medical and nursing bodies.
- The focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.

Summary of findings

- There was a trust vision and this was underpinned by objectives and plans that staff understood and were able to describe. The trust had a well-developed and established set of values that were recognised by almost all staff and were fully embedded in the way that all services were delivered.
- The trust's strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- A systematic approach was taken to working with other organisations to improve care outcomes, to tackle health inequalities and obtain positive outcomes for all patients in the local community.
- There were comprehensive systems in place to report and learn from risk with effective systems for identifying, capturing and managing issues and risks at team, directorate and organisation level in all services.
- Potential risks to patient safety and the quality of care and treatment for all patients due to increased pressures on bed capacity had been recognised and effective systems were embedded to maximise patient safety.
- Performance in national audits and benchmarking with regional and national peers was generally used to drive improvements in services.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and service improvement methodology and achieved improved outcomes for patients.
- The standard of the divisional risk registers was consistent and we were assured that there was effective divisional ownership and scrutiny. Action plans following serious incidents were completed and monitored effectively.
- The trust was proactive in engaging with staff. Almost all staff were very positive about the leadership of the board and senior managers. The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.
- Since the CQC visit in 2014, the trust had seen a consistent and positive improvement in its overall NHS Staff Survey results, which had resulted in significant improvements in staff engagement and overall satisfaction at work.

- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access.
- Innovative approaches were used to gather feedback from patient services and the public, including people in different equality groups. Constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.
- Full and effective fit and proper person checks were in place.
- There was an understanding of the Duty of Candour amongst almost all staff, and the trust had a being open policy. The role of the Freedom to Speak Up Guardian was well embedded in the trust.
- Fire safety processes were effective.

However:

- We saw that the trust was in the process of redeveloping the corporate risk register. We saw that the current format was not categorised or prioritised according to subject or severity. This meant that several risks relating to the same or similar issues appeared in different places in the risk register, such as staffing; therefore it was difficult to see the overall risk.
- Whilst we identified some potential risks to patient safety during the inspection, prompt actions were taken by the trust leadership team immediately to address those areas and risks that needing improving.

Leadership of the trust

- The trust had an established executive board with all members having worked within the trust in their current positions for at least 18 months. The executive team worked collaboratively to manage the trust and provide safe, high quality care for all patients. All leaders spoke highly of their peers and of all staff in the trust.
- The trust's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive and inclusive. Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the trust's culture.

Summary of findings

- The chief executive officer (CEO) particularly was seen by staff as highly visible and approachable by all staff. Visibility amongst the rest of the board was reported as very positive. The CEO was widely regarded by external stakeholders as being a strong leader who took swift, appropriate actions to manage service pressures without compromising the safety and quality of patient care and treatment as well as actively driving forward the trust's improvement agenda.
- The trust operated a clinically led model of leadership, which aimed to create more local decision-making and ensure greater collaboration between medical, clinical and managerial staff. Clinically led models of leadership have been shown to produce better results and improve the quality and safety of care provision. The level of constructive challenge between clinicians on the executive team was evident. The level of challenge from non-clinicians and non-executive directors was not fully captured on the trust papers presented to board, but there was evidence in the trust's various sub-group meeting minutes of challenge.
- We reviewed the quality governance committee meetings, for October, November and December 2016. Minutes from these meetings showed varied level of challenge to the executive directors, with 13 queries and two challenges in October 2016, five queries and one challenge in November 2016 and three queries and one challenge in December 2016. The director of corporate development, governance and assurance told us that the executive board had been working with the non-executive directors to identify areas for learning. The board had recently appointed two new non- executive directors.
- The medical, nursing and governance directors had clearly defined roles and responsibilities. The medical director was the lead for patient safety, quality and clinical effectiveness, with responsibilities that included the leadership of the medical staff, the resuscitation services, safety academy and quality improvement programmes. The director of nursing, midwifery and patient services was the lead for patient experiences, with responsibilities for complaints, practice development, safer nursing staffing and primary care and clinical commissioning group liaison. The director of corporate development, governance and assurance was responsible for medico-legal services, health and safety, compliance and information governance. Their role was also to support the medical and nursing directors in the improvement in quality of care.

Summary of findings

- Our discussions with leaders and senior managers confirmed that they understood the challenges to providing safe patient care. They were taking actions to address these challenges such as developing services to meet the needs of different patient groups.
- Senior managers and staff at all levels and grades told us that their main aim was to keep patients safe and provide the best care and treatment possible. This focus on safe patient care, despite the significant operational pressures during the days of the inspection, was clearly evident in all areas and from all staff we spoke with.
- The staff survey in July 2016 reported that 34% of staff reported positively about communication between senior management and staff, which was a 5% improvement from previous staff surveys.
- Nursing staff spoke positively about the director of nursing, midwifery and patient services, stating that their enthusiasm had promoted a renewed energy for development. Ward sisters and junior sisters managed the wards on a day-to-day basis and were supported in their duties by matrons. All ward sisters spoken with told us that clinical leads and matrons were accessible, supportive and visible. We observed matrons attending wards to support staff, discuss activity and share any issues that had arisen.
- We saw that leaders of services encouraged supportive relationships among staff through developing 'buddy' programmes for new starters and encouraging shared learning amongst staff groups.
- The trust had embarked on a leadership training programme and some senior nursing and medical staff were taking part in the programme. This meant there were comprehensive and leadership development strategies in place to ensure the delivery and development of a positive culture within the department.
- Leaders had taken action to drive improvements since the last inspection. At the February 2017 inspection, not all patients' records were stored appropriately but the trust took immediate action to address this concern by providing lockable note trollies for all clinical areas. We found all records stored appropriately on this inspection in all areas visited. We also found that significant improvements had been made in the completion and 24 hour review of patient's venous thromboembolism risk assessments.

Vision and strategy

Summary of findings

- The trust had a vision, which was widely acknowledge by the whole staff team. The trust vision was 'To provide the best possible care for all our patients' and the values were to '…put patient safety above else…aspire to excellence…reflect, learn and improve…respect and support each other'. Staff told us that the trust's values were important to ensure that the patient was at the centre of everything they did.
- Services had well defined strategic plans that set out defined realistic objectives for the future development and sustainability of the departments and was in line with the trust's overall strategy. There was a coherent strategy for engaging with key partners. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable and with full consideration of effective use of resources.
- We saw the trust operational plan for 2016/17, which had identified areas within the divisions as priorities. This included delivering excellence in the care of the elective patient, focusing on dedicated orthopaedic and ophthalmology services to increase quality, reduce clinical variation, and provide centres of excellence in the county.
- Plans had been developed through staff engagement exercises and consultation meetings. All staff we spoke with were aware of the strategy and their role in achieving it; this included having the opportunity to feedback and contribute to plans.
- The director of facilities and estates and the estates team had a complete oversight of the premises and facilities at the hospital and had a comprehensive estates' strategy 2015 to 2020 in place. The environment of the entire estate (despite some parts being over 275 years old) was extremely well maintained. There were also detailed plans for a rolling programme of ward maintenance and refurbishments for the next two years.
- Staff told us about the immediate plans to develop the urgent care facilities through external partnership working and the long-term plans for developing staff and existing services. Staff spoke positively about the recent appointment of a GP in the emergency department and the potential impact that would have in terms of opportunities for shared learning and governance arrangements.
- Specialist palliative care and ward staff told us end of life care was a high priority for the trust. The hospital had a three-year strategy for end of life care for adults for 2017 to 2019 to achieve its priorities and deliver good quality care. The strategy set out the trust's commitment to support the provision of safe,

responsive, effective, compassionate, and well-led care for patients recognised to be in the last year of life. This included those whose recovery was uncertain and those who were in the last days and hours of life.

- Each strategy objective had defined work streams with designated leads and individual action plans. For example, a key area was refining the streaming process to ensure that patients were being seen by the most appropriate service including referrals to external services. This was in line with NHS England Sustainability and Transformation Programmes and the Keogh report 'Transforming urgent and emergency services in England' published in November 2013.
- A systematic approach was taken to working with other organisations to improve care outcomes, to tackle health inequalities and obtain positive outcomes for all patients in the local community. Commissioners and stakeholders spoke positively about the way senior managers of the trust engaged with partners about the wide health and social care economy challenges in the county and were proactive in designing new pathways of care to improve access and outcomes for all patients.
- Progress against the strategy was monitored and discussed at divisional meetings with updates disseminated via departmental meetings and the trust's intranet.
- Senior staff attended trust wide multi-disciplinary meetings that fed through to executive level and the trust's board.
- The director of nursing, midwifery and patient services had implemented a ward accreditation scheme, whereby wards were monitored on a number of objectives, such as audit results, number of complaints, number of infections, response time for investigations and safeguarding referrals. The objectives and the wards ability to maintain targets generated a ward rating. Nursing staff told us that the accreditation scheme had encouraged the teams to develop ways in maintaining quality care and meeting target, this promoted a "healthy competition" between wards, with ward sisters aiming to be the first outstanding ward in the trust.
- Under the trust's health and well-being strategy, a programme was under design on building resilience and senior staff saw this as a key way to support staff in dealing with challenging situations. The trust's organisational development team had implemented the 'Rainbow Risk' process based on the trust values to facilitate staff diagnosing their preferred style of working and to establish mechanisms for interactions that draw the full potential out of relationships at work in a meaningful

and insightful way. The 'Rainbow Risk' process was short, simple, creative, and universally accessible, and senior staff said it had lasting positive effects on relationships and communication at work.

- The trust delivered and supported leadership and management development programmes including:
- The Francis Crick senior leadership programme (phase two). This was an 18-month development programme focused initially on the leaders in the clinically led structure. This programme covered managing quality and quality improvement, leading people, managing change, strategic effectiveness and financial effectiveness.
- The consultant development programme continued and aimed to engage and enthuse staff around topics of importance including quality improvement.
- Plans were in place to make the Royal College of Nursing leadership programme be available.
- The trust's organisational development team were in the process of developing a new management and leadership development for middle managers for bands 5 to 7 and equivalent roles across the trust The programme was due to available in 2018 and was intended to include transformational core modules with transactional/job specific options for managers to select. The programme was also to include a service improvement project that aims to further embed the trust values.

Governance, risk management and quality measurement

- Governance and performance arrangements were proactively reviewed and adapted to take into account national best practice. There was a governance system in place and monthly meetings were held and these were well attended by staff at all levels.
- There was an effective understanding of performance that integrated the needs of other areas in the trust and the needs of the community whilst focusing on patient safety and quality improvements within the department. The trust had devised a quality improvement strategy, which had been formally approved to be launched in February 2017.
- Monthly directorate governance meetings were held, which fed into monthly divisional governance meetings, who in turn reported to the trust governance group. We reviewed directorate and divisional governance minutes, which showed incidents, risks, audits, safety and quality improvements, clinical effectiveness, and patient experience were discussed and areas for improvement identified.

- Any potential serious incidents within a service were escalated to the trust governance team and reviewed at the weekly review of harm group meeting. If an incident was declared as a serious incident an appropriate senior member of staff would be appointed to lead the investigation and conduct a root cause analysis.
- The governance team had changed the root cause analysis investigation process for incidents by forming a cohort of specially trained individuals who would lead an investigation panel to conduct a root cause analysis. The team also included experts both internally and externally to establish the root cause and make recommendations from the learning identified. Previously investigations were completed by a designated senior nurse and clinician allocated by the governance team. The trust had recognised that the resource this provided made conducting a robust root cause analysis challenging.
- Services had a robust audit programme in place to ensure they were continuously improving their patient care. This programme was informed by national guidance, patterns of incidents and patient outcomes. Findings from audits were shared with staff through a variety of means, such as team meetings, safety huddles, and communication folders.
- Each ward maintained a nursing quality and performance dashboard, designed in line with recommendations set out in the 'High Quality Care Metrics for Nursing' report (2012). Patient data was audited monthly against quality care indicators, which included falls/safety assessment, pressure prevention assessment, and patient observation and escalations. A traffic light system was used to flag performance against agreed compliance thresholds. The data was reviewed monthly at the nursing and midwifery board and any red and amber areas were discussed and reviewed by the senior nursing team. Areas of variable or poor performance were discussed at trust board and divisional meetings and actions were taken to improve.
- Quality matrons assisted with the development of wards and clinical areas. Their responsibilities were to identify a baseline of each clinical area and then assist the team to develop systems and processes to improve standards. In conjunction with this, the director of nursing midwifery and patient services had introduced a ward accreditation scheme. This included the review of aspects of care and performance to identify where there were pressures and areas for improvement. Each ward was rated as red, amber, or green according to performance against trust targets and standards. For example, a green rating

would require audits to be completed in a timely manner, show achievement of targets, staff would need to be compliant with mandatory training, and there could be no outstanding actions for investigations and complaints.

- Each specialty within surgery held its own clinical governance meetings. We reviewed minutes of these which included incidents, complaints, audits, policy updates and training. These meetings that were well attended by members of the multidisciplinary team and minutes were available for those that could not attend. The department managers held team meetings within specific wards and theatres to cascade information. Most departments had daily staff huddles at handover to share information such as recent incidents, complaints, new policies and any relevant updates.
- Local risk registers generally reflected the risks within services and there was evidence of ownership, mitigations having being implemented and ongoing monitoring. Significant issues that threatened the delivery of safe and effective care were identified, and risks management including assessment, mitigating action and review was demonstrated.
- We saw that the trust was in the process of redeveloping the corporate risk register. We saw that the current format was not categorised or prioritised according to subject or severity. This meant that several risks relating to the same or similar issues appeared in different places in the risk register, such as staffing; therefore it was difficult to see the overall risk. There were also inconsistencies in the scoring of risks before and after mitigation. The trust governance lead was fully aware of the limitations of the risk register in its current format and told us that the risk register had been developed since our last inspection and required further user training and organisation. There had recently been changes to the governance team to enable one individual to be responsible for the production of an enhanced register.
- We saw that the quality governance committee meeting minutes in November and December 2016 did not evidence a review of the risk register and board assurance framework as per terms of reference, which documented that they should be reviewed at this committee monthly. However the chief executive advised that these were reviewed once a quarter and a wider range of the minutes reflected this.
- According to the trust's well-led framework gap analysis carried out in January 2017, to meet the requirements of NHS Improvements well-led framework, the revised Board Assurance Framework received internal audit opinion of substantial assurance in 2016 and had been revised to include indications

as to the level and type of assurance on which the trust board was relying. The trust's risk management strategy and implementation plan had been approved and the trust's clinical audit strategy and plan was place. The clinical audit function was now aligned within the governance division to provide improved support. The trust's clinical audit and effectiveness group had been strengthened with greater clinical representation and leadership.

- We saw that the trust had an effective structure for reporting and escalation, with specialists groups reporting into speciality committees and to the trust board. For example, the waste management group reported into the estates' governance group, the health and safety committee and then the quality governance committee and trust board. We saw evidence from meetings, which confirmed that information was shared up to, and down from trust board. The trust has a comprehensive audit calendar, which identified a risk of the month.
- The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to continually improve how care is delivered and to achieve transparency and overall improvements in healthcare. In 2016/17, the trust fully achieved six out of eight CQUINs to drive improvements in services. These included the CQUINS for end of life pathways, dementia discharge summaries, delayed transfer of care, acquired kidney disease and for staff health and wellbeing. The trust fully achieved the CQUIN for sepsis screening and antibiotic administration in the emergency department in 2016/17, but only partially achieved it for antibiotics given in inpatient wards. Another CQUIN, for reduction in antibiotic use per 1,000 patient admissions, was partially achieved.
- The trust had a number of nationally accredited services, including full accreditation for the endoscopy service under theJoint Advisory Groupon gastrointestinalendoscopy (JAG). JAG was established in 1994 under the auspices of the Academy of Medical Royal Colleges. The trust was also licensed by the Human Tissue Authority and the Medicines and Healthcare Products Regulatory Agency and compliant with the United Kingdom Accreditation Service(UKAS) Clinical Pathology Accreditation scheme. UKAS is the sole national accreditation body recognised by the government to assess the competence of organisations that provide certification, testing, inspection and calibration services. It evaluates these conformity assessment bodies and then accredits them where they are found to meet the internationally specified standard.
- There was a well-developed quality improvement programme at the hospital, which trained staff in quality improvement and

service improvement methodology. The trust's 'Making Quality Count' development programme enabled teams to come together and work on a quality improvement project using a 'learning through doing' approach. This approach had delivered a number of improvements in practice and clinical care. Staff said these projects had improved services for both patients and staff significantly. Recent quality improvement work had been submitted to the International Forum on Safety and Quality in Health Care where 25 posters had been accepted for presentation. One of these projects was also shortlisted for a national award.

- In 2017, the Improving Quality Efficiency (IQE) team supported one of the nursing sisters to win the trust's 'Achieving Best Care Award for Innovation' by redesigning the patient flow into and through the pre-operative assessment unit. Further to this they were supporting pre-operation by streaming the fit and healthy at outpatient's clinic so as they did not need a preoperative consultation. The IQE team also worked with the maternity service to improve patient outcomes in the diabetic clinic from a waiting time of over three hours to be seen in a multidisciplinary clinic. By redesigning the flow of the clinic, staff were able to reduce patient waiting times by 52 minutes. The trust's 'Making Quality Count' development programme enabled teams to come together and work on a quality improvement project using a 'learning through doing' approach. These projects had improved services to patients and staff significantly.
- We reviewed fire safety risk processes in a number of clinical areas and found that all fire safety equipment and processes were effective and in date. Risk assessments were thorough and were reviewed frequently. In accordance with trust procedures, regular checks of fire safety equipment and environmental checks were carried and documented. The trust had also carried out of review of all high rise buildings on site to ensure no risks due to building 'cladding' were present. Governance processes surrounding fire safety were well established and effective.

Culture within the trust

- Overall, almost all staff expressed high levels of satisfaction and were proud to work for the trust. Staff reported feeling respected, valued, supported and appreciated. Staff were proud of the organisation as a place to work and spoke highly

of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.

- All staff we met were welcoming, friendly, and helpful. It was evident that staff cared about the services they provided and were proud to work at the trust. All staff we spoke with were committed to providing the best possible care for patients. Staff felt there was a positive working culture and all teams and wards reported good team working. Staff referred to the 'Team NGH' spirit and culture. This mutual respect and support for each other was clearly evident in all areas.
- Nursing staff told us they felt respected and valued and reported very positive relationships with consultants. Staff agreed there was a culture of openness and honesty throughout the service. Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision.
- The culture of the trust was centred around 'patient safety first' and staff felt that they were not under pressure to achieve targets at the detriment of patient care. Staff told us that when the emergency department (ED) was experiencing high levels of demand it was seen as a hospital wide issue and staff from other specialities worked within ED to keep the doors open for patients. We saw this clear focus on patient safety by all staff at all times during the inspection, even when the ED was under considerable pressure due to the increased number of attendances. The level of staff support, respect, and commitment to each other was clearly evident in all areas.
- The trust had a well-developed staff health and wellbeing strategy and a variety of healthy lifestyle initiatives were available for all staff to access. Staff spoke highly of these initiatives which underpinned the trust's commitment to promoting a healthy workplace.
- Since the CQC visit in 2014, the trust had seen a consistent and positive improvement in its overall NHS Staff Survey results, which has resulted in a significant decrease in the number of key findings that were in the bottom 20% of all acute trusts.
  - In 2012, 24 out of 28 of the staff survey outcomes were in the bottom 20% nationally for acute trusts.
  - In 2014, 18 out of 28 of the staff survey outcomes were in the bottom 20% nationally for acute trusts.
  - In 2016, only two out of 32 of the staff survey outcomes were in the bottom 20% nationally for acute trusts, 26 were in line with the national average, and four were in the top 20% nationally.

- Likewise, the overall staff engagement score had improved over the same time period, rising to 3.83 in 2016 and the trust's senior managers attributed this improvement to:
  - The employee engagement strategy.
  - The trust's values.
  - Developing and engaging staff around quality improvement.
  - Implementing a clinically led structure and leadership development.
  - Stability within the executive team.
  - Clear focus on staff engagement and motivation.
- The trust's score of 3.83 was average when compared with trusts of a similar type. This was an improvement from the previous year.
- The trust introduced listening and learning events, for all staff. The format of which varies between informal events, workshops and question time events. These were reported as being well attended. The director of nursing, midwifery and patient services told us that these events had been used to formulate and share the nursing strategy, which was launched in December 2016. It was reported that over 1,000 nurses had contributed to the development of the strategy.
- "Dare to share" events had been introduced in 2016. These were open events, which staff could attend to hear about incidents that had occurred across the organisation. The initial meeting was so successful, that a large venue was required for the following meetings. Staff who attended the events were asked to comment on what they were taking back to the wards following the meetings.
- Staff attending the CQC drop in sessions were largely positive about the trust, their colleagues and their achievement. We heard representatives from all areas detailing changes to their service and plans for future developments. This included the estates department's plans to increase green spaces within the hospital site in line with the mental health initiatives for 2017.
- Staff were proud to be associated with the trust and spoke positively of their colleagues.
- Senior managers said the reduction in staff sickness absence was linked to good management, morale and motivation despite the considerable pressures that staff were under.
- A new appraisal system was being introduced and workshops were held to support it. The value 'Aspire to Excellence' was to be included within appraisals to encourage staff to identify one improvement within their area, which they could instigate. There was training on the methodology and this was designed to help build all staff's quality improvement appetite. Staffs' objectives were agreed to meet the trust's priorities.

- The Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS concluded that there was a serious issue in the NHS that required urgent attention if staff are to play their full part in maintaining safe and effective services for patients. A number of recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all organisations to appoint a Freedom to Speak Up Guardian and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns. The trust had followed all these recommendations and staff could access the Freedom to Speak Up Guardian in confidence. We saw that quaterly reports were prepared highlighting the main themses arising from contact with the Freedom to sepak Up Guardian. We saw actions had been taken including improvements made regarding non-invasive ventilation therapy and a review of maternity midwifery staffing, including a follow up assurance audit by the trust's internal auditors.

Equalities and Diversity – including Workforce Race Equality Standard

- In July 2014, the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workforce. There were two measures in place the equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.
- A practice and professional development forum had been organised to ensure staff from all backgrounds received an assessment of training and development needs and were given opportunities to meet those needs. The percentage of staff receiving equality and diversity training was in line with national averages.
- There was effective support for a diverse community by providing extensive interpreter and translation service, including for sign language. Information had been provided in easy read and picture-based formats for patients with learning disabilities.
- In the 2016 staff survey, the trust performed in line with the England average for the percentage of staff from black, minority and ethnic (BME) backgrounds experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, at 26% compared to 26%. The percentage of BME staff

experiencing harassment, bullying or abuse from staff in last 12 months was 23% compared to 27% nationally. It was better than the England average for the percentage of BME staff believing that the organisation provided equal opportunities for career progression or promotion at 72% compared to 76%: this was much less than for white staff at 88%. It performed better than the national average of 14% of BME staff who in the 12 last months had personally experienced discrimination at work from manager/team leader or other colleagues at 12%. However, this was significantly higher than for white staff at 6%.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a regulation that intends to make sure senior directors are of good character and have the right qualifications and experience
- There were comprehensive mechanisms in place for the fit and proper person test for newly appointed executives and board members with a clearly defined policy in place to govern this process.
- We reviewed eight director's files to assess compliance against fit and proper person legislation and all the required checks had been carried out. The trust also carried out audits of staff files to ensure appropriate documentation was in place. An effective policy was in place regarding all required checks and documentation and linked to the trust's recruitment policy.

Public engagement

- Innovative approaches were used to gather feedback from patients' services and the public, including people in different equality groups. Rigorous and constructive challenge from patients, the public, stakeholders, and regulators was welcomed and seen as a vital way of holding services to account.
- One of the trust's aims was to work with patient groups and friends and family test (FFT) data to understand the needs of patients and improve the customer service aspect of care. Ways of engaging with the local community and all patients were highlighted in the trust's 'Patient Experience and Engagement Strategy 2015 to 2018'.
- Staff within all services recognised the importance of gathering the views of patients and actively sought feedback. We saw FFT questionnaires, and patient comment cards available in all areas we visited. Since 2015, a number of further methods were developed to obtain patient feedback, including:

  - An online survey with over 50 languages was available. The online survey link was displayed throughout organisation in the two most popular languages after English, in Northampton.
  - Children and young people's online survey included within any text messages to parents as an additional opportunity for the child or young person to give their feedback. This includes three different survey options depending on the age of the child.
  - An electronic tablet device was set up within radiology.
  - An online survey set up for community maternity enabling the midwives to have the survey on their work mobile telephones.
  - Easy read postcards made available.
- The hospital had developed a suite of postcards bespoke to the trust and the different services which collected FFT responses (inpatients, maternity, outpatients/day case, and paediatrics). Postcards also contained important demographic questions enabling the organisation to identify recommendation rates in line with protected characteristics and demographic groups.
- Each month a spreadsheet was created by the information team, which detailed every service's response rates and recommendation rates. All responses were rated in relation to the most recent national averages at the time when the spreadsheet was produced. The spreadsheet was circulated trustwide. The trust used the patient experience headlines tool, developed by NHS Improvement to understand how its services were performing against the national and local area averages. The information team also triangulated negative feedback from FFT responses to data from the complaints' team in order to better understand areas to improve. We saw this was detailed in reports to the divisions
- Wards displayed 'infograms', which contained information on how each ward was performing in relation to FFT results. The infograms were produced monthly and included the FFT response rate, the percentage of patients who would and would not recommend the service, patient comments, and learning from feedback received. For example, 93% of patients recommended the hospital for April 2017 with 5,272 patients responding. This information as then broken down per divisions, per clinical area. Patient comments included, "The staff on Dryden ward manage to combine a friendly outlook along with a very professional approach. Although extremely

busy, nothing is too much trouble. As well as providing outstanding care, the team is able to maintain a high level of cleanliness throughout the ward". This was in in December 2016.

- The trust had developed 'real-time' and 'right-time' surveys, based on questions used in the National Inpatient Survey and areas that matter most to patients when they are in hospital. Four inpatient wards piloted the real-time survey from August 2016 and a further three wards from October 2016. The survey report was made available to ward managers on the same day the results were collected, which would enable staff to make immediate changes for the benefit of patients. Updates regarding the survey were included within the quarterly reports to patient and carer experience and engagement group (PCEEG). The survey resulted in some positive examples of how the feedback had been used to make immediate changes. For example:
  - Following patient feedback, lamps had been installed in all of the side rooms within Talbot Butler Ward as patients stating that it was difficult to read.
  - Creaton Ward had a number of comments relating to patients not sleeping well on the ward. Staff held two team meetings where they have discussed this and increased the use of the trust's sleep well packs.
- The 'right-time' survey was introduced in October 2016. Questionnaires were sent to 600 adults who had attended as an inpatient around one to two weeks following their discharge. We saw evidence that the results of the survey were discussed at the PCEEG in February 2017.
- From September to December 2016, the information team selected and contacted 100 recent inpatients to invite them to a listening event. Following the invite 13 patients agreed to attend the "always event" and nine attended on the day. The day was attended by 12 staff members and the trust's patient representative who acted as facilitators for workshops. The workshop aims were to identify "what patients always want". Some common themes were identified during discussions, which included waiting times, appointments not running to schedule and waiting times for pharmacy. The group agreed on four "always events" which were most important to them. These consisted of:
  - Teach back will always be used to ensure you understand information given at discharge.
  - You will always be treated with kindness, respect and dignity.
  - You will always be listened to.

  - Staff will always do everything they can to control your pain.
- In January 2017, a patient engagement event was held entitled 'Quality Conversation - A Winter Warmer'. An invitation was sent out to over 1,700 members of the hospital inviting them to attend the evening. The evening had presentations by senior staff and executive team members and these were followed by the opportunity to talk with the presenters and a number of other members of the senior team. Information stands were created especially for the event by different services including falls, volunteers' services, infection prevention, dementia care, and a number of others. Stands were also held by external services to the organisation including Healthwatch and local charities. Hot Soup and rolls were provided for attendees alongside tea and coffee. The event was also attended by the local radio station. Thirty people attended the event and feedback from the event was positive. Patients, carers and families were all given the opportunity to write down any Improvements which the trust should focus on and also any areas in which the trust does particularly well.
- The trust had also engaged with Young Healthwatch to arrange an 'enter and view' visit in October 2017. Young Healthwatch is for children and young people from the age of eleven to twenty four and has the same function as Healthwatch generally in terms of shaping and developing health and social care services and the 'enter and view' powers.
- The trust's 2016 "Quality Street" magazine included sections on learning from patient feedback. The trust analysed information shared through patients' feedback from complaints, friends and family test, patient advice and liaison service (PALS) and online reviews to identify the trends.
- The trust had established good links with numerous volunteer organisations, charities, and national support groups, such as Macmillan, Age UK, Northamptonshire Cancer Partnership, and Pets as Therapy team.
- Each month positive feedback received into the organisation was collated into a spreadsheet, divided into divisions. This included feedback received from:
  - Friends and Family Test.
  - Online review sites.
  - Social Media outlets.
  - Chief executive's office.
  - Directly into wards/services.
  - PALS office.
  - Complaints office.
- This was circulated throughout the trust and staff said this was really positive. Due to the compliment collation project success,

it was awarded a 2016 Patient Experience Network National Award (PENNA) in March 2017 at a national ceremony. As winners, the head of patient experience and engagement was given the opportunity to present the work undertaken around Compliments to the attendees of the Conference.

Staff engagement

- Staff told us they felt actively engaged and involved in the planning and delivering services. The directorate leads gave us examples of where staff had worked collaboratively to improve the service. For example, more day case procedures were carried out over the winter period, when bed pressures were increased, to reduce the number of admissions to the wards. Further examples included the 'infograms', which were created by staff on the band six development programme.
- Staff told us of innovative ways that the trust were using to facilitate staff raising ideas and solutions. Protected time was given to the project called 'pathway to excellence'.
- The trust had taken prove staff morale via the 'compliments collation'. Positive feedback was collated on a monthly basis and shared within the divisions. In December 2016, the medicine division received over 1,400 positive comments from FFT, online reviews, thank you cards and formal letters. This initiative had been shortlisted for a patient experience national award due to the positive effect it had on staff morale. The awards were to be announced in March 2017.
- Staff described monthly ward meetings taking place. Minutes were available to staff who were unable to attend. Staff also received daily updates regarding on any issues affecting the ward and/or trust at safety huddle meetings.
- The trust staff survey showed some improvements from 2015 to 2016. However, rates for Black and Minority Ethnic (BME) staff were slightly worse than rates for white staff. For example, 26% BME staff reported experiencing harassment, bullying, or abuse from patient's relatives or the public in the last 12 months in comparison to 29% white staff. This was an improvement from 30% in 2015.
- From the 2016 survey results, out of the 32 key findings, the trust performed better than other trusts in four questions (in the top 20%), about the same as other trusts in 26 questions and worse than other trusts in two questions (in the worse 20%).
- The four questions for which the trust performed better than other trusts were:

1. Percentage of staff appraised in the last 12 months (91% compared to the England average of 87%)
2. Quality of non-mandatory training, learning or development (4.11 compared to the England average of 4.05).
3. Staff motivation at work (3.99 compared to the England average of 3.94).
4. Effective team working (3.81 compared to the England average of 3.75).

- The questions for which the trust performed worse than other trusts were:

1. Percentage of staff satisfied with the opportunities for flexible working patterns (46% compared to the England average of 51%).
2. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (39% compared to the England average of 45%).

Innovation, improvement and sustainability

- The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear, proactive approach to seeking out and embedding new ways of working and new models of care.
- We saw that the discharge lounge provided four side rooms for patients who were unable to sit out for transfer and two separate waiting areas. One was for general patients whilst the other provided a quiet area for patients with dementia. The quiet area was manned at all times to ensure patient safety. Patients could be transferred to the department after their morning medication to prepare for discharge. Staff were able to assist with washing and dressing, provided meals, and coordinated the discharge.
- Mandatory training had been reviewed to include a face-to-face review of knowledge. This process involved staff attending a session where there knowledge and understanding of mandatory topics was assessed through questioning. Staff who did not pass the session were required to complete the full training programmes, whereby staff who successfully passed the assessment did not have to repeat the training and were reassessed the following year.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food

boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.

- The trust was also actively fundraising in order to transform a room in the elderly medicine centre into a therapy suite. This suite would include pop-up reminiscence rooms that can turn any care space into a therapeutic and calming environment.
- Improvements to quality and innovation were recognised and rewarded through the annual staff 'best possible care' awards. Within the awards scheme there were categories for patient experience, patient safety, clinical team of the year and innovation in practice. Dryden ward had been nominated for the 2016 patient safety award and the innovation in practice award.
- In 2016, the trust became the first British trust to sign up for pre-intent programme for the 'Pathway to Excellence' accreditation with an internally recognised nursing credentialing centre. Two submissions were accepted for poster presentation at the 2017 international pathway conference in the United States of America. The trust was also linking in with two other English NHS trusts to work collaboratively.
- The trust was also a member of East Midlands Patient Safety Collaborative, part of the national programme in the NHS to drive improvements in patient safety. The vision for the National Patient Safety Collaborative' programme is to create a comprehensive, effective, and sustainable collaborative improvement system that will support the development of a culture of continual learning and improvement in patient safety across England over the next five years as a minimum.
- The trust was selected as one of eleven national pilot sites for creating nursing associates. In December 2015, the government announced a plan to create a new nursing support role. This new role is for these nursing associates to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce with clear entry and career progression points.
- The geriatric emergency medicine service (GEMS) had been introduced in 2014 and had been developed to meet the needs of patients with complex needs and also provided a learning platform for staff.

Summary of findings

- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine.
- The trust had published an article inside a national journal on the commissioning for quality and innovation (CQUIN) in end of life care provision. The need for communication skills training for staff had been clearly demonstrated through the end of life care CQUIN. The service had put in a successful bid to Health Education East Midlands (HEEM) for funding for training, and the county lead nurses for EOLC education were developing a collaboration that included social care, to take the training agenda forward.
- There had been a number of innovative approaches to the underpinning and embedding the use of the amber care bundle, for example, an amber care bundle patient information booklet. The amber care bundle supports shared decision making during times of clinical change andprovides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. The service had implemented case-note stickers to support ward staff in preventing inappropriate patient bed moves for dying patient.
- The hospital had taken part in a 12-week trial with the local community NHS trust to assess and discharge patients with cognitive impairments using an evidence-based delirium pathway. Senior managers said this had proven successful in helped facilitate appropriate and safe discharges for some patients with complex needs who had been in hospital for a long time and was being looked at as part of the countywide plans to facilitate discharges.

Overview of ratings

Our ratings for Northampton General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	☆ Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Northampton General Hospital NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated an excellent stroke service.
- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor visited both homes on three other days of the week. We saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated, and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The trust had a duty of candour sticker that would be placed into the patient's notes when the duty of candour had been applied. This included, for example, staff name, date, name of person/patient receiving information, account of incident, details of incident and if an apology was offered.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training or PROMPT).
- Gosset ward was working towards achieving Bliss accreditation. This means the ward had undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies, which had helped to build the evidence for Bliss accreditation.

Outstanding practice and areas for improvement

- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and feed these back to ultrasound community in England.