Northampton General Hospital NHS Trust

Quality Report

Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD
Tel: 01604 634700
Website: www.northamptongeneral.nhs.uk

Date of publication: 27/03/2014
Date of inspection visit: 16, 17 and 29 January 2014

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	Requires improvement
Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Requires improvement
Are acute services at this trust caring?	Good
Are acute services at this trust responsive?	Requires improvement
Are acute services at this trust well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Northampton General Hospital NHS Trust (NGH) is an acute trust with 800 bedded acute hospitals. At the time of our inspection of the acute services proved by the trust, it had an income of about £250 million and a workforce of 4,300 staff. It provided general acute services to a population of 380,000 and hyper acute stroke, vascular and renal services to people living throughout Northamptonshire, a population of 691,952. Between 2001 and 2012, there was a 9% growth in the population of Northampton, with significant increases in the 0 to 4 year and 60 to 64 year age groups (30% and 45% respectively). The trust's main hospital site is Northampton General Hospital (NGH). It also provides services, inpatient beds at three community hospitals in Northamptonshire: Danetre Hospital in Daventry, Corby Community Hospital and Hazelwood Ward in Isebrook.

Before visiting, we looked at a wide range of information we held about the trust and asked other organisations to share what they knew about it. We carried out an announced visit on 16 and 17 January 2014, and during that visit we held group meetings with different staff members from all areas of the hospital. We looked at the personal care and treatment records of patients, observed how staff were caring for people and talked with patients, carers, family members and staff. We reviewed information that we asked the trust to provide. We also held a public listening event where patients and members of the public shared their views and experiences of the trust and we continued to receive and review information from various sources during and after our inspection. We carried out a further unannounced inspection at night between the hours of 8pm and 1am on 29 January 2014.

During our inspection, NGH appeared to be very clean throughout. In a national survey the trust was noted to have been performing well in relation to infection prevention and control.

The trust had a recent history of poor staffing levels on some wards. During our inspection, we saw that action had begun taken to address staffing issues. Staff told us that improvements in staffing levels were already having a positive impact on services. The trust was also experiencing a shortfall in consultant cover in the Accident and Emergency service and the labour ward, and had begun taking action to address this. It had also responded to recent concerns around staffing and care on two medical wards and had taken action, including increasing the staffing establishment to address those concerns.

Many of the executive post holders are either new to post or in interim positions. This had an impact on the trust's leadership as staff reported that senior leaders, with the exception of the chief executive, were rarely visible on wards and were unaware of the positions and responsibilities of most executive post holders. There have been significant changes at the executive level of the trust for some time, and the chief executive was aware of the need for stability among this group in order to address the leadership concerns across the trust.

Areas of poor governance, specifically in relation to the management and maintenance of equipment, and to the dispensing of medications to patients on discharge, were identified during our inspection. Both areas were taken up with the trust and the trust has actively responded at the time of our inspection.

Our inspection revealed that end of life care was an area where the trust required more focus and commitment to improve.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

Requires improvement

We found that services at Northampton General Hospital NHS Trust were safe although some improvements were needed. We found that staffing levels were usually appropriate. However, the trust's nationally measured Summary Hospital-level Mortality Index (SHMI), which measures deaths occurring following treatment at the hospital were within the expected range.

We found that medical staffing in Accident and Emergency (A&E), on the labour ward and for the out-of-hours endoscopy rota was sometimes lower than expected. However we did not see evidence of unsafe care in those departments.

We found a lack of appropriate testing and maintenance of equipment across the trust during our inspection. However, the trust had started to address this, and this work was continuing.

NGH were performing well in relation to infection prevention and control and also in relation to never events.

There was a significant issue with bed capacity within the trust as there were delays in discharging patients appropriately. We found that patients' medications to take out (TTOs) were not always dispensed by the pharmacy in a timely manner, which meant some patients could not leave with them. TTOs were being transported to patients' homes in a taxi, later in the day or during the evening following discharge, but there was very limited governance supporting this process. When we brought this practice to the attention of the chief executive during our inspection, this activity was immediately stopped and the trust immediately undertook a review of its practice around discharge medication.

Are services effective?

Requires improvement

We found the services at Northampton General Hospital NHS Trust were effective but some improvements were needed.

We found that national and best practice guidelines to care for and treat patients were in use across the trust and the trust participated in all the clinical audits for which it was eligible. The trust had recently made a significant investment in staffing.

There was an effective system in place to discuss a patient's care and treatment, and this included consultants, doctors and nurses and integrated multidisciplinary ward rounds.

We found that bed flow in the trust was not effective and resulted in patients not being cared for on appropriate wards, experiencing multiple moves within the trust, extending their length of stay in hospital and then delaying their discharge home.

Summary of findings

The emergency care pathway was not efficiently managed. The trust had data that demonstrated it has been struggling with an ineffective emergency care pathway for many years. It had requested external reviews and collaborative forums to try and address this issue. During our inspection, we witnessed a very busy A&E department that was the bottleneck of the hospital. The trust did not have effective direct admissions wards. All patients, including those referred by GPs, were cared for in A&E. The area was not able to support the numbers of patients present, and therefore, the recommended waiting times for A&E patients were not being achieved for their first assessment, which is one hour.

We found that members of the dedicated specialist palliative care team could not confirm the number of patients or identify any of the actual patients who required end of life care. Therefore, we were not confident about the team's ability to effectively support the ward staff and manage those patients' needs.

Are services caring?

Good

We found the services in Northampton General Hospital NHS Trust to be caring.

We observed caring, compassionate staff in each of the service areas we visited. Patients and their relatives spoke very highly of the caring nature of the staff. Patient dignity was respected and upheld.

We found that the delays in the A&E department meant staff there often looked after patients for a considerable length of time. During our visit, we witnessed one patient in A&E for 11 hours. Patients were found beds and given food and drink by A&E staff, and the patients we spoke with felt their needs had been met.

We listened to staff and recognised an overwhelming sense of dedication and commitment from many employees of the trust. However, this was not the case in all departments, and a common phrase during our inspection was that staff attitudes varied 'depending on the middle managers'.

The trust had no risks or elevated risks identified in this domain. We looked at the Friends and Family Test results and found that the overall performance for the trust was in line with the England score with A&E being higher than the England score. On the NHS Choices website the trust has an overall rating of 3.5 out of 5 stars with the main positives identifies as excellent care, professional staff and being treated with dignity and respect. The trust performed in line with other trusts in the national inpatient survey.

Are services responsive to people's needs?

Requires improvement

We found that the services at Northampton General Hospital were effective but improvements were needed.

Care and treatment was planned to meet the individual needs of patients. Two medical wards had been adapted to care for patients with cognitive

Summary of findings

impairment. Additionally, pressure-relieving mattresses had been added to some wards and the trust had made an investment to ensure that this equipment was more widely available across all departments based on assessments of patients' needs.

The Early Warning Score (EWS) system for monitoring deterioration in patients was seen to be in use across the trust and there was evidence of appropriate escalation by nursing staff.

Staff told us that the translation services within the trust worked well and there was still an opportunity to request a face-to-face interpreter, which staff valued.

An external review of the eye /ophthalmology clinic had been commissioned and a number of actions recommended as a result. We saw evidence that lessons had been learned from this review and that the recommended actions had been taken; patients and staff said had led to improvements at the clinic.

People's religious preferences were recognised. The hospital employed two Christian chaplains who were able to obtain the services of ministers from different faith groups if patients wished to see them. The chapel within the hospital held Christian and Muslim services on a weekly basis and was open to patients, relatives and staff of all faiths.

Treatment for children in A&E was not responsive to their needs. Northampton General Hospital could not guarantee that a qualified registered sick children's nurse (RSCN) would be on duty at all times. The A&E service did not have the staffing capacity or space to ensure that patients could be assessed and treated in a timely manner.

Are services well-led?

Requires improvement

We found that the services at Northampton General Hospital were not well-led. Robust leadership was not consistent at all levels across the trust. Governance was poor and this had an impact at every level of the organisation. We saw examples of good local leadership in some areas, but this was not consistent. Members of the executive team within the trust were not widely visible and did not demonstrate authority in a number of areas. The exception was the chief executive, previously the medical director, who was referred to very positively on numerous occasions.

The trust had identified issues relating to governance but had not effectively led the management of them. It had recognised the challenges within the emergency care pathway. However, there did not appear to be a co-ordinated process to address this which meant that the risk to patient safety and welfare had not been managed. During our inspection we revealed a number of risks which had not been identified through the trust's quality monitoring systems. These related to the supply of medication after patients were discharged,

Summary of findings

maintenance of equipment, inappropriate completion of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR) form, the specialist palliative care team's lack of knowledge of patients in that group and the regular occurrence of multiple patient moves within the trust.

Staff who managed complaints were experienced and led a robust process of complaints management. However, there was no mechanism to ensure that recommended learning and actions resulting from complaints were achieved within an appropriate time frame. During our inspection, we observed that some actions relating to complaints had been outstanding for over three months.

There were significant delays in serious incident reporting and the resulting action plans were slow to be completed. At the time of our inspection, the trust had recently begun to use a simulation suite to re-create incidents in order to learn how to deal with them, so this was expected to improve. We saw examples of learning from incidents at a local level; for example, A&E staff identified a high-risk patient and flagged them on the department's IT system. However, learning from serious incidents was lacking across the trust which meant that improvements to the quality and safety of service provision was not embedded in the serious incident investigation process.

Throughout the hospital there was varied and, overall, poor compliance with both mandatory training (which had remained on the trust's risk register for three years with evidence of limited improvement) and completion of annual completion of personal development plans (PDPs). This meant that patients may have been at risk from staff who were not up to date with their training and / or had not had any performance concerns addressed.

Summary of findings

What people who use the trust's services say

The Friends and Family tests had been introduced to give patients the opportunity to offer feedback on the quality of care they had received. The Northampton General Hospital Trust (NGH) scored 8% lower than the average for England for the inpatient component of the test, while its A&E score was 18% higher than the national average.

Analysis of data from the Adult Inpatient Survey, CQC, 2012, showed that, in general, the trust had performed about the same as other acute trusts. However, it had performed worse than other trusts on two factors: those related to patients being subjected to noise from a) staff, and b) other patients.

During the summer of 2013, CQC sent out a maternity survey questionnaire to all women who had given birth in January or February 2013 at one of the NHS trusts in England. Responses were received from 171 women who had used the services at NGH. The survey asked people to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust in England was given a score out of 10 for each question (the higher the score the better). NGH had performed about the same as most other trusts that took part in the survey: it scored 8.9 out of 10 for questions relating to labour and birth, 8.5 out of 10 for staff and 7.8 out 10 for care in hospital after birth.

Between June and October 2011, CQC sent a questionnaire to patients who had recently attended an outpatient appointment at one of the NHS trusts in England. Responses were received from 468 patients who had attended NGH. Again, based on their responses, each NHS trust was given a score out of 10 for each question. In most cases, NGH was found to be similar to other trusts. However, it scored better than other trusts on the questions about 'Finding out test results' were it scored 8.9 out of 10 and 'Explanation of test results' with a score of 8 out of 10.

The Department of Health's national Cancer Patient Experience Survey, 2012, showed that NGH had improved across 64% of standards in comparison to its results for 2010.

There are in total 62 reviews of Northampton General Hospital on the NHS Choices website for the period January 2013 to December 2013; there are 24 positive comments rated five stars. Themes include: excellent A&E care, professionalism, waiting times, respect and dignity, and cleanliness. There are four negative comments rated one star. These relate to communication, lack of care and treatment, waiting times and unprofessional staff.

The Patient Led Assessment of Care Environment (PLACE) audit for 2013 gave NGH a rating of 99.4% for cleanliness.

We held a listening event in Northampton Guild Hall on the evening of 15 January. This event was very well attended by over 70 members of the public. It was extremely beneficial and informed our inspection, and the experiences of some of the people we spoke with are reflected within this report.

Areas for improvement

Action the trust MUST take to improve

- The do not attempt cardio pulmonary resuscitation (DNACPR), paperwork was misleading and being incorrectly completed and used.
- Equipment was not being adequately tested or maintained.
- Ensure adequate supply and use of capnography machines in theatres.
- Medication is being dispensed to patients after they have left hospital, it is being delivered by a taxi and no risk assessment of the medication, the delay and the impact and risk of this action is taking place.
- Address the lack of pharmacists allocated to the off NGH site ward to review and advise on mediation arrangements.
- Children are being treated in an adult A&E department, there are very limited dedicated A&E facilities or specialist staff to care for children.

Summary of findings

- Patients are being regularly moved around the hospital and there is no system in place to monitor this and the impact it is having on patients and their treatment, their length of stay and their experience.
- The door leading into the maternity unit labour ward could be left open and posed a risk of unauthorised access to this high risk area.
- The appraisal and mandatory training rates across the trust does not ensure that staff are being adequately supported and developed in their roles.

Action the trust SHOULD take to improve

- The management of serious incidents in the trust is not robust; the process of reporting is delayed, training in report writing is absent, monitoring of action plans is not consistent and timely. Organisational learning is limited if not absent. However there was evidence of learning in the area in which the incidents occurred
- Access to equipment is an issue within the trust.
- Actions following a complaint are realised and logged. However there are considerable delays in initiating actions; some actions from complaints remain outstanding over three months after the actions have been agreed and the complaint has been responded to.
- Records were not available when required and were not always accurately completed with information regarding patients specific needs.
- We found food supplements and nutritional drinks were not monitored to ensure consumption within expiry dates.
- We found evidence that Body Mass Index (BMI) calculations were being guessed.
- Care record templates and audits were based on acute hospital setting and not necessarily appropriate for a community hospital service.
- Staff reported that learning from incidents and feedback when they reported incidents was not always given.
- There are no formal arrangements in place to provide multi-faith spiritual support, even in areas where end of life care is given.

Good practice

Our inspection team highlighted the following areas of good practice:

- The A&E department having been commended for its contribution to the trauma audit and research network.
- The maternity unit having one of the highest home birth rates nationally.
- The hospital having excellent training facilities on site where simulation exercises take place.
- The achievement of the Gold Standard for palliative care at Danetre Hospital.

Overall rating:

Requires improvement

Northampton General Hospital NHS Trust

Detailed findings

Hospitals we looked at:
Northampton General Hospital, Corby Community Hospital – Inpatient Ward, Danetre Hospital – Inpatient Ward, Isebrook Hospital – Hazelwood Ward.

Our inspection team

Our inspection team was led by:

Chair: Mr Edward Palfrey, Medical Director Frimley Park Hospital NHS Foundation Trust (2000-2014), Consultant Urologist

Head of Hospital Inspection: Siobhan Jordan, Care Quality Commission (CQC)

The team of 35 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, dietician, patients and public representatives, experts by experience and senior NHS managers.

Julie Walton, Head of Hospital Inspection led the team that visited the three off-site services with an experienced clinician.

Background to Northampton General Hospital NHS Trust

Northampton General Hospital NHS Trust (NGH) was an acute trust with 800 bedded acute hospitals. It had an income of about £250 million and a workforce of 4,300 staff. It provided general acute services to a population of 380,000, and hyper acute stroke, vascular and renal services to people living throughout Northamptonshire, covering a population of 691,952.

The population in Northampton grew by over 9% between 2001 and 2012, with particularly big increases for the 0 to 4 year and 60 to 64 year age groups (30% and 45% respectively).

The trust's main hospital site was based at Northampton General Hospital, which was close to Northampton town centre.

Detailed findings

It had an inpatient ward within the Danetre Community Hospital with 29 beds that provided rehabilitation after discharge from the general hospital. The community hospital also provided palliative care services and dedicated stroke care.

Within the Isebrook Hospital, NGH had a 34-bedded rehabilitation ward called Hazelwood Ward for elderly patients. This service assisted patients who were recovering from a stroke and medical conditions that had impacted on their independence.

There was a further 22-bedded rehabilitation ward within Corby Community hospital also caring for patients that had a stroke and required rehabilitation after an illness.

All sites were visited as part of this inspection. Before and during our inspection we heard from patients, relatives, senior managers and all types, grades and categorise of staff about the issues that were having an impact on the services provided by this trust.

We found Northampton General Hospital trust to be very clean throughout our inspection and the trust was noted to have been performing well in relation to infection prevention and control.

The trust had had a recent history of poor staffing levels on wards. We were pleased to note on our inspections that much work has taken place and continues. The trust had actively recruited from Portugal and Ireland. Most nurses on the wards and other staff commented on the positive impact this was having.

With regard to Accident and Emergency (A&E) services, and reflecting the national picture, the trust was experiencing a shortfall in consultant cover and had started to address this. The maternity unit had very good staffing levels for midwives, but consultant cover for the labour ward required improvement.

Within the executive posts, it was evident that there were recruitment challenges that had had an impact on the trust's leadership. Many of the executive post holders are either new to post or in interim positions. There have been significant changes at this level of the organisation for some years, and the impact of these is discussed within this report. The chief executive was aware of many of the challenges and expressed commitment throughout the inspection but will require support to address these issues.

We identified within the inspection areas of poor governance specifically in relation to the management and maintenance of equipment as well as the dispensing of mediations to patients on discharge. Both areas were taken up with the trust and the trust has actively responded.

We found on our inspection that end of life care was an area where the trust required more focus and commitment to improve.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because it represented the variation in hospital care according to our new intelligent monitoring tool. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Northampton was considered to be a high-risk service.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Detailed findings

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the Clinical Commissioning Group (CCG), Area Team (AT), Trust Development Agency (TDA), Health Education England (HEE) and Healthwatch. We carried out announced visits on 16 and 17 January 2014. During the visit we held group meetings with different staff members with a range of staff in the hospital: nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of trust including the wards, theatre, outpatients and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records. We held a listening event on 15 January 2014 when patients and members of the public shared their views and experiences of the Northampton General Hospital location. An unannounced visit was carried out on 29 January 2014.

Requires improvement

Are services safe?

Summary of findings

We noted that nurse staffing levels were improving and were good across the trust as a whole, work in this area continues. The midwife to mother ratio of 29:1 was also good. However, there were some gaps in medical staffing such as in Accident and Emergency (A&E), labour ward cover and adequate staff to facilitate an out-of-hours endoscopy rota.

We noted examples of poor governance across a number of areas within the trust, which had affected safety. A specific concern was the lack of appropriate testing and maintenance of equipment across the trust as a whole. Work had already started to address this, and it was accelerated immediately and was continuing.

There was a significant capacity issue within the trust and a key objective was clearly to discharge patients appropriately. We found that patients' tablets to take out (TTOs) were not being dispensed in a timely manner so that patients could leave with them. Practice had been to send the TTOs to the patient's home in a taxi, later in the day or early evening. There was very limited governance supporting this process. Once brought to the chief executive's attention, this activity stopped immediately. We also noted the absence of pharmaceutical support to the trust's inpatient facilities that were not on the main hospital site.

Due to the lack of robust governance processes at all levels in the trust, we could not be confident that safe care would be delivered at all times.

The Summary Hospital-level Mortality Index (SHMI) reports on mortality at trust level across the NHS using a standard and transparent methodology. The SHMI gives an indication of whether the number of deaths at the trust is as expected, higher than expected or lower than expected when compared to the national baseline (England). The trust SHMI was higher than expected compared to the national baseline from January 2012 to March 2013. However the trust has provided evidence for April to June 2013 showing that they were within expected range.

This trust had a very positive history of having no never events (classified as such because they are so serious that they should never happen). There had been none since 1 December 2012. The trust is also within the expected range in relation to infection prevention and control.

The trust had started to take action to strengthen governance before our inspection. The CEO acted on the specific issues we raised while on site in a very responsive manner and we noted widespread support for the chief executive, who is known to the workforce as she had previously been the medical director.

Our findings

Safety and performance

A serious incident (SI) folder had recently been introduced in A&E and staff spoken with were familiar with a recent SI and the required actions and learning for the department. The SI had been thoroughly investigated and there was clear evidence of departmental learning. However, it was not clear how this had been shared across the organisation.

There was a practice brought to our attention prior to the inspection, which detailed patients in A&E being "greyed out" on the A&E IT system. This suggested that they had left the department and the clock would stop measuring their length of time in the department. However these patients had not actually left the department and were waiting further investigations, we confirmed this on our inspection.

Information from the NHS Safety Thermometer tool was used across the trust and we noted this in most areas. On our inspection, staff on the medical wards reported that the trust had purchased 200 new air mattresses. Ward staff told us these had a positive impact on pressure area care. Patient safety boards displayed in the various wards and operating suites we visited showed the figures for the previous month on specific areas. Pressure sore data and improvements was noted on the NHS safety thermometer tool.

We observed good use of the paper-based system of surgical safety checklists in place in the operating theatres we visited. This included the use of the World Health Organization (WHO) surgical safety checklist. The critical care service had a good system in place for the registrar on call and consultant to discuss each patient and handover

when shifts changed. We were informed that the outreach team provided a service 24 hours a day, seven days a week and that there was one person from the outreach team who worked during the night. However, we were told by staff that, if there was staff absence or low staffing on ITU, the staff member providing the outreach service would support ITU and the outreach service would not be covered.

Infection rates (August 2012 to July 2013) were within acceptable ranges for methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) and Clostridium difficile (C. difficile), for trusts of a similar size.

Within the maternity department we noted the cleaning standards for obstetrics and gynaecology were 100% compliance for the past four months and just over 99% for 2013.

The staff who we spoke with in the outpatients clinics told us that there was a problem with the availability of patient records and that this had got worse over the previous few months. We were told by senior clinicians that on one day of our visit there were 29 sets of patient records missing from the required 97 relating to patients being seen that day.

Learning and improvement

On most wards and areas we visited, staff told us they reported incidents using the computerised system called Datix. Learning from incidents was shared by ward managers within their ward but staff told us learning from incidents in other areas of the trust was not routinely shared across all divisions. In children's services staff spoken with, which included nursing and medical staff, were aware of the trust's incident reporting system and used the online Datix system to report incidents and they received timely feedback from either the ward sister or the risk manager. Staff were confident of the correct procedures to follow when incidents occurred and that they knew how to access the incident report form. We reviewed a serious incident investigation report about a patient who had fallen on Allebone Ward and broken their hip in August 2013. The report indicated that the family of the patient were immediately informed of the incident as the patient required surgery. Actions to ensure all or indeed most staff were trained to reduce and prevent falls was not yet actively undertaken on this ward as we would have expected.

At our last inspection, we had identified that storage and recording of medicines were not compliant with the Health and Social Care Act's regulation for management of medicines. On this latest inspection, a pharmacist who was part of the inspection team reviewed the storage facilities on a number of medical wards and found that they were now compliant with the regulations under the Health and Social Care Act 2008 around storage and recording of medicines. We noted that during medication rounds staff who were administering medicines were not distracted or disturbed from their work and wore tunics to signal to others that they were focusing on this duty.

Wards recognised by the trust as areas which cared for a number of patients with dementia had been refurbished to provide a more suitable environment taking into account the specific needs of these patients.

Systems, processes and practices

Equipment

We found that pre-planned maintenance of equipment was not undertaken and in surgery we found air cylinders that were out of date. We were assured that these would be replaced immediately. We asked the trust about the scheduling of equipment testing and were issued with a report which stated that 47 pieces of equipment out of 308 had no label to identify when they were last tested. This report was sent to us on 25 January 2014 following our visit. When we undertook our unannounced visit on 29 January 2014 we saw that the equipment in theatres had been safety checked.

There were no emergency call alarms in the anaesthetic rooms or operating theatres in the main theatre suite, which does not comply with the NHS Estates Health Building Note 26 (HBN 26).

Care planning

We reviewed 12 patient records across four wards in surgery and noted that appropriate risk assessments had been completed accurately, such as venous thromboembolism (VTE) risk assessments, pressure ulcer risk assessments, and nutrition and fluid assessments.

Children's pathways were in place for treatment, integrated care and transition. Comprehensive medical and nursing records were well documented and there was good information about the children's care and treatment.

Requires improvement

Are services safe?

We looked at 29 sets of records for patients with particular reference to the recording of information relating to patients at the end of their life or at risk of deterioration in their health. We looked at the records relating to the Early Warning Score (EWS) system that the trust used which identifies when a patient is at risk of deteriorating health. This then should trigger the nurse who has completed the patient's observations to obtain medical intervention and a treatment escalation plan to be put in place. We also looked at the records relating to DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) decisions. Out of the 29 sets of records that we reviewed only 12 were fully completed. This is under the trust's own audit of DNACPR records across the trust which was recorded as being at 53% completion in November 2013 and 54% completion in December 2013.

Staffing

Staffing vacancies were noted across the trust. In particular there was a shortage of consultant cover in A&E, HDU and in Maternity where national guidance or recommendations could not be adhered to. For instance in Maternity the number of consultant hours required by the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth recommendations state that the trust is curently 38 hours short of consultant cover in the delivery suite. Similarly the College of Emergency medicine recommend that the trusts requires a further seven consultants to ensure safe care. Staff at all levels told us that it was difficult to get a doctor during evenings and weekends. In some areas staff stated that the impact of the shortages meant that there was a lack of overall direction and governance for the team.

Monitoring safety and responding to risk

Risk assessments were completed and identified the needs of patients. We saw that risk assessments started in A&E were continued throughout the patient's journey.

We visited nine acute medical wards. We did not see people having to wait for attention from staff; there were sufficient staff on the wards to meet the needs of patients at all times. There were no clear monitoring systems in place around food and meal replacements given to patients on the wards.

Anticipation and planning

Although a tool was in use to forecast the number of patients expected to be admitted each day, we found no evidence of actions being taken to make sure the number of beds required would be available. We did not see any additional intermediate care capacity (beds in the community setting) to support the predicated number of patients coming into the hospital.

A nationally recognised tool which determined safe staffing levels for nursing staff was in use in the hospital. The Director of Nursing told us that she undertook this activity twice a year and reported to the trust board. The nursing skill mix acuity tool for A&E was not in use at the time of inspection. Nor was it met in the community hospitals, therefore there was no effective anticipation and planning.

There was no consistency around the organisation of patients' notes. We looked at patients' notes and assessments on all the wards we visited.

Requires improvement

Are services effective?

(for example, treatment is effective)

Summary of findings

The trust had data which demonstrated that it has been struggling with an ineffective emergency care pathway since 2011. It had requested external reviews and collaborative forums to try to address this.

On our inspection, we witnessed a very busy A&E department that was the bottleneck of the hospital.

The trust's direct admissions units were not effective as they had patients in them and were not able to accept patients directly from the referring GPs. All patients, even those not true A&E attendees but referred by GPs, were cared for in this area. The area was not large enough to support the numbers of patients it was receiving by this route and therefore A&E patients were not being seen within the first assessment time frame of one hour, because there was no capacity to assess them.

The poor bed flow in the hospital was described by most, if not all, specialties and staff. Staff described in detail that patients could not be admitted directly onto the most appropriate ward and often spent some of their hospital stay in alternative wards. To rectify this situation, patients often had frequent moves to get to the right ward. The trust did not appear to appreciate the impact that the current model of care was having on both the flow of patients and their experiences. Many patients shared with us details of multiple moves. One man who was dying had been moved five times. Delays in being discharged from the HDU were also well recognised as an on-going issue. Nursing patients in recovery areas when no appropriate beds were available was well known, and was witnessed on our inspection.

Surgery had had to be cancelled because of medical patients occupying beds on surgical wards. One patient we spoke to had her procedure cancelled on three occasions and her length of stay, which should have been one night, was actually going to be 10 nights when we spoke with her. This lady was 85 and had a mental health condition. Her extended stay in hospital had caused this to deteriorate, although she was seen and supported by the mental health team.

Patients and their families described on comments cards, at our listening event and when we spoke with them on the wards, the impact that being moved within the hospital had on them, and the delays that this caused

Our findings

Using evidence-based guidance

We saw good evidence that care was evidence based. Examples of this included clinical pathways in use in A&E, although we were told that there was also a significant number of proforma that were not yet in place. The Intensive Care National Audit and Research Centre (ICNARC) report published data from all the NHS trusts taking part in the audit (95% of eligible units). Following the ICNARC report published in July 2013, the trust had completed an analysis of the data and suggested recommendations. The data demonstrated that the mortality rates for elective and emergency surgical admissions were above the average compared with other units. We noted that a joint surgical and anaesthetic mortality and morbidity meeting had been held in October 2013 to review the findings from an independent review of the patients' records. Three actions were agreed as a result of the review, which included a review of the surgical escalation policy and improvements in record keeping, especially by junior doctors. We asked to see a copy of the surgical escalation policy and noted that the policy in use was dated December 2012. Therefore this action had not yet been completed; we did not see evidence in relation to the improved record keeping action. The importance of having joint meetings was also acknowledged at the meeting, and it was agreed to continue these to ensure there was learning across specialties.

The children's inpatient service demonstrated that it was using national and best practice guidelines to care and treat children. National audits demonstrated the trust was similar to other trusts, for example, in managing pain in children

Following recent guidance from the Department of Health, the trust had stopped consistently using the Liverpool Care Pathway (LCP) in its previous form. However, from our discussions with staff and our inspection of patient records, it was clear that there was confusion and a lack of clarity

Requires improvement

Are services effective?

(for example, treatment is effective)

about what had replaced this guidance. When we asked staff on the wards and in the specialist palliative care team how many patients were receiving end of life care, the majority of staff were not able to provide us with this information.

There was little evidence of clinical audit in outpatients that the trust was monitoring the effectiveness of clinical practice against standards across outpatient services other than in the ophthalmology clinic.

Performance, monitoring and improvement of outcomes

The trust participated in all the clinical audits for which it was eligible. The service was using national and best practice guidelines to care for and treat patients. The Sentinel Stroke National Audit Programme (SSNAP) was a programme of work that aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards. The data for the trust showed that between OctoberApril and DecemberJune 2013, only 52% of patients were taken to the stroke unit within four hours of admission. The target was 90%. The SSNAP audit identified that 36.5on average from October to December 2013 48.7% of patients were scanned within an hour with an average waiting time of 82 minutes.

We found evidence on wards of matrons' audits in areas such as C. difficile, wound care, cannula insertion and catheters.

Surgical specialty groups met monthly to monitor mortality rates and the actions taken to address any issues that arose. Written notes of meetings confirmed this. We were also made aware that joint mortality and morbidity reviews started in October 2013 between the surgical specialties and the intensive therapy unit (ITU) to ensure there was cohesive learning. Mortality rates relating to fractured neck of femur in 2012/13 were higher than expected. As a result of this, a review of the clinical processes was undertaken and a decrease in the mortality rate had been seen in 2013. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's overall HSMR was within the expected range, which was consistent with the previous year.

In March 2013 the maternity department had an external review undertaken by the Royal College Of Gynaecologists & Obstetricians. It concluded that the trust's maternity services complied with most of the standards. The caesarean section (CS) rate had improved in December 2013 to 23%. There is a new vaginal birth after caesarean (VBAC) process in place with a lead midwife to help reduce the number of elective caesarean sections.

We looked at four patient records with regard to the care plan relating to end of life needs. We found that the completion of the records was not consistent and that there were gaps in all four of the records that we looked at.

Staff, equipment and facilities

We spoke with junior doctors during both the day and night inspections. Some felt that on-call duties were 'brutally busy' although others felt that shifts were generally steady with occasional peaks. The opinion varied depending on the area they worked in and some doctors told us they came in and worked on their days off. Training data demonstrated that there were various levels of compliance across the trust. However, overall, the trust was not adequately compliant with both mandatory training and personal development plans (PDPs) and annual appraisal of staff. The trust had made changes to these processes. However it did not have an action in place to address this. Children's services annual appraisals are in place to support professional development and the appraisal rate was 67%. We noted that consultant appraisal rate was at 100% and we were advised this was due to the recently implemented and mandatory revalidation processes.

Multidisciplinary working and support

Staff in the A&E department told us that they would care for all patients who present to the department whether they are an expected admission or not. The hospital did have direct admissions units for both medicine and surgery, but patients could not go to these units as they were full. This activity was supportive of specialist colleagues; however it had a direct impact on capacity and assessing patients who presented as an emergency to the A&E department.

We observed integrated handovers, which included 'huddles' at the patient's bedside on the surgical wards. For those patients who were admitted to the trust for elective surgery, we saw documented evidence of pre-operative information and theatre handovers to ensure that patient care and treatment were consistent. Children received an effective service from a multidisciplinary approach to supporting children. Community Services demonstrated

Requires improvement

Are services effective?

(for example, treatment is effective)

effective multidisciplinary working both internally and externally. Patients benefitted from discharge which was effectively managed between the hospital and community teams.

Good

Are services caring?

Summary of findings

We found the services in Northampton General Hospital NHS Trust to be caring.

We observed caring, compassionate staff in each of the service areas we visited. Patients and their relatives spoke very highly of the caring nature of the staff. Patient dignity was respected and upheld.

We found that the delays in the A&E department meant staff there often looked after patients for a considerable length of time. During our visit, we witnessed one patient in A&E for 11 hours. Patients were found beds and given food and drink by A&E staff, and the patients we spoke with felt their needs had been met.

We listened to staff and recognised an overwhelming sense of dedication and commitment from many employees of the trust. However, this was not the case in all departments, and a common phrase during our inspection was that staff attitudes varied 'depending on the middle managers'.

The trust had no risks or elevated risks identified in this domain. We looked at the Friends and Family Test results and found that the overall performance for the trust was in line with the England score with A&E being higher than the England score. On the NHS Choices website the trust has an overall rating of 3.5 out of 5 stars with the main positives identifies as excellent care, professional staff and being treated with dignity and respect. The trust performed in line with other trusts in the national inpatient survey.

Our findings

Compassion, dignity and empathy

Patients were treated with compassion and dignity. Throughout our inspection we saw staff directing patients in corridors and ensuring they knew where they were going. We saw staff talking to patients with kindness in all departments. We observed care on the surgical wards that was delivered with dignity and respect.

The A&E department has a very comfortable well equipped relatives' room with refreshment facilities. We observed staff speaking to patients with kindness. There were mixed views of the care being provided in EAU, as we heard both positive and negative comments from patients.

We observed staff interactions on the wards and around the hospital. In corridors, we noted that staff were friendly and helpful to people visiting the hospital, and took time to ensure that visitors and outpatients were able to find their way.

During our inspection visit on the surgical wards, we observed care that was delivered with dignity and respect. One patient we spoke with told us that they had been treated with dignity and respect by the nursing staff. While in the intensive care unit (ITU) we saw that patient-centred care was provided in a compassionate manner and that the patients' privacy and dignity were respected at all times.

We observed staff introducing themselves to children and the parents in a respectful way and we also observed positive interactions between nursing staff and the children and their parents while inspecting the children's ward. However, parents sleeping on the wards told us they were sleeping in chairs. We heard mixed views about the overnight accommodation, as beds for parents were not consistently available.

One patient told us that the consultant that they had seen had been, "excellent in every way".

Involvement in care

Patient and public involvement were sought from the trust through various meetings and patient forums We were informed that the Trauma & Orthopaedic (T&O) team held very successful meetings that included the public and they were involved in the development of the orthopaedic services.

We spoke to a number of relatives who said they were well informed. At the listening event a lady told us how the staff kept her well informed. We met her again on Knightley ward, where she was encouraged and supported to visit three times a day to assist her mother to eat and also to settle her at night. She made it very clear this was because she wanted to do this, and it was no reflection on the care on the ward which she described as "marvellous".

We also heard from a family who accompanied their relative in the ambulance to the nursing home they were

Good

Are services caring?

going to be admitted to. Within the children's area we noted good facilities for parents who had babies in the neonatal unit. Despite the environment not supporting a comfortable overnight stay, parents did express feeling welcome on the ward.

Trust and communication

All of the staff we spoke with, including mortuary staff and porters, spoke very respectfully about patients at the end of their life.

Emotional support

Most of the women we spoke to in the Maternity Unit told us they were happy with the care.

The trust's chaplains told us about the annual service held for parents whose children have died.

We found emotional support was provided, not only in the areas where you would expect it such as critical care and end of life care, but also that staff in all areas were prepared to 'go the extra mile' to ensure that patients and their relatives were supported throughout their admission and discharge to the hospital.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the services at Northampton General Hospital were responsive but improvements were needed.

Care and treatment was planned to meet the individual needs of patients. Two medical wards had been adapted to care for patients with cognitive impairment. Additionally, pressure-relieving mattresses had been added to some wards and the trust had made an investment to ensure that this equipment was more widely available across all departments based on assessments of patients' needs.

The Early Warning Score (EWS) system for monitoring deterioration in patients was seen to be in use across the trust and there was evidence of appropriate escalation by nursing staff.

Staff told us that the translation services within the trust worked well and there was still an opportunity to request a face-to-face interpreter, which staff valued.

An external review of the eye/ophthalmology clinic had been commissioned and a number of actions recommended as a result. We saw evidence that lessons had been learned from this review and that the recommended actions had been taken. Patients and staff said had led to improvements at the clinic.

People's religious preferences were recognised. The hospital employed two Christian chaplains who were able to obtain the services of ministers from different faith groups if patients wished to see them. The chapel within the hospital held weekly Christian and Muslim services and was open to patients, relatives and staff of all faiths.

Treatment for children in A&E was not responsive to their needs. Northampton General Hospital could not guarantee that a qualified registered sick children's nurse (RSCN) would be on duty at all times, as detailed in The Allitt Inquiry (DOH 1991). The A&E service did not have the staffing capacity or space to ensure that patients could be assessed and treated in a timely manner.

Beds in the ICU and HDU were not always accessible because the hospital could not always accommodate accepting patients from these areas, 43% of discharges from ITU/HDU had been delayed in the previous month.

There had been issues within the eye/ophthalmology clinic. An external review was commissioned and a number of actions recommended as a result. There was evidence of learning from this review and the implementation of the actions had been realised by both patients and staff.

We met with members of the specialist palliative care team. However, they could not confirm the number of patients, or indeed identify the actual patients, who were at this stage in their life. We would therefore challenge the trust's ability to meet the patients' needs if this information was not clearly accessible so as to identify and support such a defined group.

The capacity issues and the changes in leadership had had an impact, and continued to have an impact, on the trust's ability to respond. Sometimes patients were accepting of this because they had no other experiences for comparison.

Our findings

Meeting people's needs

We looked at the A&E attendance around the time of our inspection and it varied between 342 on 20 January 2014, of whom 244 (71.3%) were seen within the four-hour target to 163 on 25 December 2013, of whom 161 (98.8%) were seen within four hours.

There was no direct correlation between high numbers entering A&E and poor performance, 274 patients were seen on 12 January 2014, of whom 266 were seen within four hours (97.1%). In contrast, 224 patients were seen in A&E on 31 December 2013, of whom 167 (74.6%) were seen within four hours. The following day, 256 patients were seen in A&E yet the target was reached. The trust struggled to meet the needs of patients in A&E within the national target of four hours.

The hospital was failing to meet the target of 95% of patients in A&E being seen within four hours. The hospital

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

saw a varying numbers of patients and there was no set pattern to the number of patients attending. However we found that there was no direct correlation between high numbers entering A&E and poor performance,

There was no separate Children's A&E. Children who arrived at A&E were booked in at reception with adults and then either referred to the triage nurse or through to minors for assessment and treatment. Children had to wait with adults and were not prioritised. The number of children attending the department was 15,392 (19%) out of the 81,218 attendances from April to December 2013. The trust did not consider this a sufficient number to justify a dedicated children's service. This is recognised as a high number of children's attendances.

We received information before the inspection that patients were often transferred between wards late at night. There were no records of actual times of transfer available on the wards. Discussions with portering staff responsible for moving patients confirmed that on average they moved five patients a night who were often elderly. It is recognised widely that moving elderly, unwell and patients or patients with dementia can cause distress to them. If patients are disorientated by a move it can increase their risk of falling. Also patients and their families told us that frequent moves impacted on the planned care and often in their opinion extended the time they had to stay in hospital.

We were informed that, because of the unavailability of beds, there were often delayed discharges of patients in ITU and HDU who were medically fit to be discharged to a ward. Trust data from November 2013 demonstrated that delays occurred on a frequent basis. In November 2013, there were a total of 10 delayed discharges from ITU and 32 delayed discharges from HDU.

On the maternity unit we noted a door was open and although a curtain was in place, there was an issue with privacy and dignity for a lady when she was most vulnerable.

In outpatients, We spoke with patients about whether their appointments took place at the allotted time. Their views were mixed but the majority said that they did not wait excessively. Their views were split equally between patients who said that they were informed about any delay to their appointment time and those who said that they were not kept informed.

The staff told us that they felt that the introduction of a bereavement office where relatives could go to obtain information in the event of their relative's death had been an improvement for relatives.

Access to services

The trust was meeting the national 18-week maximum waiting time for patients to have planned surgery and for patients to receive an operation within 28 days following cancellation. However, the trust was performing worse than expected for those patients who were on an incomplete pathway for longer than 26 weeks, specifically for elective surgery in T&O, general surgery, urology and oral surgery.

In outpatients, patients' views were mixed with an almost equal split between those who said that they had never had any problems with the booking system and had not had appointments cancelled and those who said that they were not happy with the booking system, and/or that their appointment had been cancelled.

Every patient that we spoke with about the parking situation said that it was difficult to find a parking space.

Vulnerable patients and capacity

Nursing staff on the various surgical wards explained that medical staff completed a dementia screening assessment for patients over the age of 75, and that this process was audited. The trust figures demonstrated that, although improvements had been made on a monthly basis for the initial assessment, the trust was not on track to meet its own target of 90% for referral for specialist diagnosis, as it achieved 75% in December 2013. In December, 71% of the nurses and healthcare assistants working in adult inpatient wards had received dementia training, this is over the trust's ambition to have 50% trained, which was a CQUIN target. Also every member of staff, clinical and non-clinical, received a letter attached to their payslips outlining the fundamentals of dementia care.

The trusts had a recent investigation due to safeguarding adult concerns on two wards. The trust was working with the local health authority, the Trust Development Authority and the CCG on actions required as a result of the investigation. We noted on our inspection that the performance in safeguarding both children and adults was not at an acceptable level and not meeting the trust's own internal standards. We were also made aware of a recent incident in A&E where a child presented following significant abuse. The trust was awaiting findings of the

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Serious Case Review (SCR). However, again, compliance with safeguarding children's training was not at an acceptable level at 52%, which is considerably lower than expected. Also children were not guaranteed to be seen by appropriate skilled Registered Sick Children's Nurses (RSCNs).

Leaving hospital

We were told by patients that discharge was often delayed as a result of medication being unavailable. We also identified that in response to this the trust had been dispensing medications to patients hours after discharge and using a taxi to deliver it to their home address.

On the inpatient ward at Corby Community Hospital the social worker was based on the ward and this assisted the effective discharge of patients. Community services worked well with social services to facilitate appropriate discharges

Learning from experiences, concerns and complaints

We saw little evidence that the trust learnt form complaints in the A&E department. The A&E department had received 37 complaints between April and mid-December 2013. However the trust board paper stated that there were 34 actions as a result of complaints in A&E that remained outstanding in actions being both identified and delivered.

As part of the discharge process, patients were given the Friends and Family test to complete. On the medical wards we visited, we saw both positive and negative comments summarised so that staff could read them, and learning objectives were discussed at ward meetings and displayed for staff as a reminder.

We noted an experienced complaints team with a clear structure and robust process of complaints management. However it lacked robustness in ensuring timely actions took place. The responsibility to complete the action plan and provide evidence that that actions were complete remained within divisions. We did not see a mechanism in place to ensure recommended learning and actions were delivered in an appropriate time frame. We noted Medicine being of particular concern, in quarter 1 (April to June 2013) they had 53 outstanding actions, where learning had been identified and no evidence had been provided to confirm action had been taken. The Director of Nursing stated she was responsible for complaints and complaints relating to nursing was brought to her attention. This suggested that overall complaints ownership may be lost in the trust, as who was looking at all of the complaints as the director of Nursing was the executive lead. The non-executive board member who we spoke to informed us that complaints were discussed at the board six monthly. We felt this was not frequent enough. Complaints are a good measure of the overall experience of patients and families of a hospital, and most trusts review monthly.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

We saw examples of good local leadership in some areas, but this was not consistent. Members of the executive team within the trust were not widely visible and did not demonstrate strong leadership in a number of areas. The chief executive was referred to very positively on numerous occasions giving the impression to the inspection team she was the only person visibly leading the trust.

The trust recognised the challenges within the emergency care pathway. However, there did not appear to be a co-ordinated process to address this.

Trust-wide governance was poor and this had an impact at every level of the organisation. We had specific concerns about the way in which TTOs were being supplied to patients after discharge. We were uneasy about the access to and maintenance of equipment to support good patient care. We identified significant issues with the DNA CPR forms and the specialist palliative care team within the trust. We had specific concerns as the trust lacked an internal palliative care consultant. The DNACPR form issues were corrected rapidly.

We recognised a significant concern raised by both patients and staff about patient moves. However, the trust had no way of recording the number of patient moves, which in turn meant the issue was not being tracked, monitored or addressed. It was evident that this was a trust-wide issue affecting all services.

Within the complaints team, there was evidence that the staff members were experienced and led a robust process of complaints management. The accountability to ensure the timely delivery of actions following a complaint remained with the divisions. Trust-wide, there was no mechanism to ensure that recommended learning and actions were delivered within an appropriate time frame. We noted from board papers and observed actions were outstanding for over 3 months in some areas.

We saw examples of learning at a local level, such as A&E staff identifying a high-risk patient and flagging them on the department's IT system. This had resulted from a serious incident that had previously occurred within the department. However, learning from serious incidents was found to exist in isolation. We found significant delay in reporting SIs, subsequent action plans were slow and often isolated, and we found no evidence of organisational learning from incidents across the trust as a whole. Although the trust had started to use its excellent simulation suite to re-create incidents and how to deal with them.

Junior doctors stated that they felt well consulted at the trust. We held a meeting attended by 70 consultants and they shared how they recognised the problems. It appeared that there was an enthusiasm to improve the culture with the appropriate leadership. Two initiatives particularly demonstrated this, the Safety Academy and quality efficiency and support team (QuEST), which is a vehicle for trusts to aspire to a level of excellence in quality and safety which is beyond all current expectations. Both were in the early stages, however we noted significant examples of the commitment to change.

Throughout the hospital there was varied and, overall poor, compliance with both mandatory training and annual completion of personal development plans (PDPs).

Lack of governance across a number of areas meant that patients could not be guaranteed to have safe care all the time. Inadequate processes and training for staff could also compromise their ability to care for patients.

Our findings

Vision, strategy and risks

The trust had experienced significant changes to key positions on the board over the last few years. It had considered a possible merger with Kettering General Hospital (KGH) and only received confirmation in the last six months that this was no longer the plan. Within the executive team it was evident that recruitment challenges had had an impact on the trust's leadership. Many of the executive post holders are either new to post or in interim positions. Also posts had been advertised and not recruited to, therefore the trust continues to work on strengthening its executive team.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The trust has had had a recent history of poor staffing levels on wards. We were pleased to note on our inspections that much work has taken place. However in the November Board papers it is noted that the total vacancies for the trust was at 128.77 whole time equivalent (WTE) in October 2013. The Director of Nursing has changed her portfolio to allow her to focus her attentions on safe staffing levels on the wards. The trust had actively recruited from Portugal and Ireland. Most nurses on the wards and other staff commented on the positive impact this was having.

The trust was at the outset of its Foundation Trust application. The chief executive was aware of many of the challenges and expressed commitment throughout the inspection but will require support to address these issues.

Quality, performance and problems

The trust had recently implemented a new system to monitor quality, the QuEST initiative.

Quality of care being delivered on the wards was displayed on new boards throughout the hospital they displayed data from the NHS safety thermometer .The trust also had a Quality Exception Score card which had 145 indicators on it, which it reported to the trust board. We noted 44 of the 145 indicators were amber or red in the November board papers.

We noted poor performance in the trust's response to reporting serious incidents (SIs). This was also recognised at the board and of the nine SIs reported within one month, none of them were reported within the national time frame of two working days. Two of the SIs were reported within seven days, however seven SIs were not reported within eight days of the incident occurring. We did see evidence from learning from SIs. However, we noted delay in actions being implemented and an absence of organisational learning across the whole trust.

We were told by the majority of the staff we spoke with that they were familiar with and used the Datix incident reporting system. However, we were also told that staff often did not have time to complete incident forms and the lack of feedback had also been a disincentive to report. Staff also shared with the team that there had been a significant backlog in managing the Datix system and the trust were working through this. An analysis of the number of patient safety incidents reported to the national reporting learning system (NRLS) against the number of incidents expected to occur at a trust of this size can indicate any potential under reporting.

A number of audits, both national and local, had been carried out to demonstrate to the trust the level at which it was performing and complying with national standards. We noted a variation in performance across these audits.

Leadership and culture

Throughout our inspection we were given numerous examples referring to the chief executive and her visibility and commitment to the organisation. We also heard many references to and examples of where a safety culture was being created, such as a safety academy and the recent introduction of QuEST. The new simulation suite was something the trust was very proud of and provided a purpose built area to re-enact incidents and learn in a simulated environment. The culture of the organisation was changing. However, staff had mixed views on the level of change required. Staff commented on positive changes in cultural however they also referred to issues within "middle management" and described a trust that didn't always listen to front line staff. At the admin and other group meeting we heard of examples where staff had been told to get on with it and felt they had not been listened to. Staff in the community settings also described a lack of appreciation in the difference in the care they delivered to that at the main acute hospital.

The risk register for children's services identified the lack of capacity in the paediatric assessment unit (PAU) and the intended action to move the unit to a larger area. However there was nothing on the risk register to highlight the issue of the A&E and not meeting the needs of children in line with national policy and the NSF for children (2003).

Some nursing staff told us that they were confident in raising concerns to their direct line manager or to a medical staff member if it concerned a patient. Nursing staff told us that the matron for anaesthetics and critical care and ITU consultants were very approachable and supportive. Senior nurses in A&E felt that concerns around flow and the impact on safety in the emergency department was not being addressed in a systemic way by the rest of the trust, despite having external reviews.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Patient experiences and staff involvement and engagement

In the most recent national outpatients' survey (2011) the trust scored 'about the same' as other trusts. However, they did score 'better than expected' with regard to patients being told how to find out their test results and having the results explained to them.

In the CQC national inpatient survey the trust performed "about the same "as other trusts' in all 10 areas of questioning. And in NHS choices has an overall score of 3.5 out of 5. The main positives are excellent care, professional staff and being treated with dignity and respect.

The results of the 2012 NHS staff survey are organised into 28 key findings. In 24 of the 28, NGH were placed in the bottom 20% of trusts nationally. Staff at NGH in 2012 are less likely to recommend the trust as a place to work or receive treatment, and report lower levels of fairness and effectiveness of incident reporting procedures or good communication with senior managers.

The 2013 survey had 91 questions that could be compared with 2012. Twenty eight questions had deteriorated between 2012 and 2013;12 questions achieved the same percentage score in 2012 and 2013 and 51 questions achieved a slightly better percentage score in 2013 than in 2012.

We did interview the director of human resources who was aware of the actions that were required, but we recognised that they had not been implemented in time to have had a significant impact on the 2013 results.

Staff also expressed an absence of staff recognition initiatives and the staff awards process had to be described to them in a group meeting we held. This suggest not all staff are as engaged as we would expect in such initiatives.

Learning, improvement, innovation and sustainability

We identified across the whole trust a lack of focus on the importance of mandatory training and appraisals. The exception was for Medical staff where due to the revalidation process they were 100% compliant with appraisals in the areas we inquired. Poor mandatory training attendance rates and poor appraisal rates were identified risks for general surgery, trauma and orthopaedics (T&O) and theatres, potentially jeopardising both staff and patient safety. In Maternity only 50% of staff had received appraisals and in gynaecology only 64.71%. However 100% of the consultant staff had appraisals as part of their revalidation and three of the consultants were trained appraisers. In two medical wards, Allebone and Brampton, no staff had a personal development plan (PDP) and no medical ward had above 60% of staff with a PDP in place.

The Midwifery team were short-listed for the Royal College of Midwives awards for their work on reducing caesarean sections through their new vaginal birth after caesarean (VBAC) process. This unit was also able to share with us excellent performance nationally in the numbers of mothers having home births.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010: Requirements relating to workers. People who use services were not protected from the risks of receiving care or treatment that is inappropriate or unsafe because risk assessments were not consistently carried out to ensure care was delivered to meet service users' individual needs and there was inadequate monitoring of food supplements and the calculation of body mass index. Regulation 9 (1) (a) (b) (i) & (ii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Requirements related to the management of medicines. People who use services at Danetre Hospital, Corby Community Hospital and Hazelwood Ward (Isebrook Hospital) were at risk of receiving inappropriate treatment because there was no dedicated pharmacist review and oversight of the management of medicines.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises. How the regulation was not being met: People who use the service were not protected against the risks associated with appropriate measures in relation to the security of the premises as the door to the delivery room was left open for a period of three minutes during our inspection. Regulation 15 (1) (b).

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. How the regulation was not being met: People who use the service were not protected against the risks associated with unsafe or unsuitable equipment because of inadequate maintenance. Regulation 16 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. How the regulation was not being met: People who use the service were not protected against the risks associated with a lack of proper information and documents (including the DNACPR) being accurately recorded about their care and treatment. Regulation 20 (1) (a). Outpatient records could not be located when patients attended appointments in the Outpatients department. Regulation 20 (2) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers. How the regulation was not being met: Staff were not supported to deliver care and treatment safely to people using the service as they did not receive appropriate training, supervision and appraisal. Regulation 23 (1) (a).