Care Quality Commission

Northampton General Hospital NHS Trust

Northampton General Hospital

Quality Report

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

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	**Requires improvement**
Medical care	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused inspection on 23 September 2014 to review the trust's progress in meeting the requirements of the warning notice that was issued on 28 March 2014 for regulation 10 (Quality monitoring of the services provided) against the regulated activity of 'Treatment of Disease, Disorder or Injury', specifically to sections 10(1)(a)(b), (2)(c)(i). We inspected the Accident and Emergency Service and the Medical Care service. As this was a focused inspection, we did not inspect every key line of enquiry under the five key questions.

Our key findings were as follows:

- The trust had taken significant actions to meet the concerns contained in the warning notice and that the warning notice was now to be removed.

Recommendations for improvement for the trust were:

- The trust should continue to embed effective training and staff appraisals systems in place to ensure trust targets are met
- The trust should continue to monitor the capacity and demand of the ED to ensure all patients are assessed within the 4 hour target time.
- The trust should continue to review all areas of patient risk and ensure all areas of risk highlighted on the corporate risk register are reviewed within the prescribed timescales.
- The trust should continue to monitor all out of hours patient moves and embed the risk assessment process to achieve its target for 100% completion of these risk assessments.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We did not inspect all areas in all domains. Areas we visited were visibly clean and the trust had effective procedures in place to minimise infection control risks. The trust had reconfigured the physical environment to ensure the department was secure and that significant improvements had been made to the children's ED. Building work was underway designed to provide more accommodation for the ED. Records were being completed in accordance with trust policies. The trust had appropriate safeguarding protocols in place and staff had had appropriate training. The department had appropriate levels of staff on the day of our inspection. The department had made significant improvements to ensure staff had had an annual appraisal and there were effective support systems in place for staff. Multi-disciplinary team working was effective within the department. Staff were kind, respectful and compassionate in their interactions with patients. Patients spoke highly about the caring attitude of staff. Patients said they were kept informed of the treatment options and that they wishes were respected. Patients' privacy and dignity was respected. Plans were in place to extend the hours of the Urgent Care Centre to ease the flow within the ED. The trust had implemented rapid assessment protocols for patients arriving by ambulance and the use of Emergency Nurse practitioners to "see and treat" patients that had been triaged to reduce waiting times. Whilst the trust had taken actions to meet the four hour target for the ED, pressure on available beds within the hospital, coupled with increased attendances meant that the ED was not achieving the 95% four hour target consistently. We saw that the Emergency Care Intensive Support Team (ECIST) had undertaken a follow up review and noted that significant changes had been made to the ED process and infrastructure. Including improvements such as the introduction of rapid assessment and "see and treat" was in place for minors patients. The trust had plans in place to address the other areas for improvement. The trust had plans in place to

reconfigure the ED to increase capacity designed to alleviate bed capacity concerns to reduce the number of four hour target breaches. An Urgent Care Programme Board had been established as part of the trust's partnership working and we saw that a project plan had been developed for the ED however not all actions had been clearly defined and reviewed regularly. The trust maintained a risk register that included the ED performance being adversely affected due to the demands on the service (for example by reduced access to beds, and increased GP referrals) and this was reviewed regularly.

Medical care — **Requires improvement** 

The number of permanent nursing staff was variable, with a reliance on bank and agency staff, but patients' needs were being met by the staff on duty when we visited. Staff were aware of the trust's incident reporting procedures. Wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance. Performance information, including patient safety risks, was on display in ward areas. Regular audits were being carried out on the main risk areas. Appropriate records were being maintained. There were procedures in place for the safe handling of medicines. Staff followed the trusts' procedures for effective infection control measures.

Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Performance and outcomes did not meet trust targets in some areas. Most staff said they were supported effectively, but there were limited opportunities for regular formal supervisions with managers. Staff appraisals' compliance had significantly improved since the last inspection. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes. Staff uptake of mandatory training was below the trust's target. Multi-disciplinary worked was effective staff told us.

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff

Summary of findings

interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. People we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Overall medical inpatient services at the hospital were caring.
There was an elevated demand on bed availability at times, and the trust had escalation plans in place. Services met the needs of patients. The hospital had taken significant action to monitor the number of patients moved out of hours. The practice of sending patients medication via taxis had now ceased and people received their medicines as part of the discharge process. There was a lack of activity for some other patients. We observed a multidisciplinary integrated approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacists.
Information was available for patients regarding how to make a complaint.
The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, with information boards for staff to highlight each ward's performance. The visibility and relationship with the management board was reported as effective. The trust had enhanced its governance and risk management and quality management systems and had taken significant steps to record and review all areas of risk. The trust had taken appropriate action to meet the requirements of the warning notice served after the last inspection and had plans in place to address the outstanding areas of risk. Board meeting minutes reflected the progress that had been undertaken.

Northampton General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care

Detailed findings

Contents

Background to Northampton General Hospital

Northampton General Hospital NHS Trust (NGH) is an 800-bedded acute trust. At the time of our inspection, it had an income of about £250 million and a workforce of 4,300 staff. It provides general acute services to a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 691,952. The Trust is also a cancer centre delivering cancer services to a wider population of 880,000, the whole of Northamptonshire, and parts of Buckinghamshire.

The trust's main hospital site was Northampton General Hospital. The hospital also had acute and rehabilitation services based at the Danetre Hospital in Daventry, Corby Community Hospital and Hazelwood ward at the Isebrook Hospital, however as of April 2014, these services were transferred to another NHS provider trust.

A comprehensive inspection as part of the wave two methodology for acute hospitals was carried out on the 16 and 17 January 2014.

Various concerns were raised throughout this inspection and the trust was issued with a warning notice and five compliance actions for the main site. The warning notice was issued in relation to regulation 10 (Quality monitoring of the services provided) against the regulated activity of 'Treatment of Disease, Disorder or Injury', specifically to sections 10(1)(a)(b), (2)(c)(i). The Trust had until 30 June 2014 to be compliant.

Our inspection team

The inspection team consisted of an inspection manager, three inspectors and a special advisor clinician.

How we carried out this inspection

This was a focused inspection specifically looking at the non-compliance identified within the warning notice around regulation 10(1)(a)(b), (2)(c)(i). The inspection was unannounced and commenced in the early morning. As this as a focused inspection looking at the specific areas contained in the warning notice, we did not inspect the Critical Care service across all the five key questions so the evidence gathered regarding this part of the inspection is therefore included in the Medical Care service report instead.

Detailed findings

We visited the Emergency Department, and a range of specialty-based medical wards including stroke care (Eleanor and Holcot Wards), Allebone, Benham, Creaton, Victoria, ICU, HDU and the patient discharge lounge.

As part of our inspection we spoke with 30 staff which included doctors, nurses, the clinical site supervisor, senior managers, Pharmacists, Pharmacy Technician, Matrons, Charge Nurses/Sisters, Ward Clerks, Porters, Healthcare Assistants. We also spoke with 25 patients and two relatives. We looked at the records of 10 patients.

We reviewed information we had received about the trust before the inspection, as well as further documents provided by the trust as part of the inspection.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

Urgent and emergency services

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

Information about the service

The Accident and Emergency department (A&E) provided a 24-hour service seven days a week, for a population of 380,000 people. The department has facilities for triage, minor and major injuries and a resuscitation area. There is also an Emergency Admissions Unit (EAU) which supports people being admitted to the hospital through A&E. The A&E department is led by a Consultant known as the clinical lead.

The minors department is adjacent to the main A&E department and is staffed by Emergency Nurse Practitioners (ENPs). It provides a service seven days a week from 9am to midnight. This department only sees children over the age of one year.

The hospital is a designated Hyper Acute stroke unit and provides this service across Northampton. NGH is a trauma unit and the nearest trauma centre is University Hospitals Coventry & Warwickshire in Coventry.

All non-elective admissions to the hospital go via the A&E department as well as patients referred by their General Practitioner (GP).

We spoke with 5 patients during our inspection and with 10 members of the trust's staff, including the matron, doctors, senior nurses, nurses, health care assistant and a member of the integrated discharge team.

Summary of findings

Safe:

We did not inspect all areas in this domain. Areas we visited were visibly clean and the trust had effective procedures in place to minimise infection control risks. The trust had reconfigured the physical environment to ensure the department was secure and that significant improvements had been made to the children's ED. Building work was underway designed to provide more accommodation for the ED. Records were being completed in accordance with trust policies. The trust had appropriate safeguarding protocols in place and staff had had appropriate training. The department had appropriate levels of staff on the day of our inspection.

Effective:

We did not inspect all areas in this domain. The department had made significant improvements to ensure staff had had an annual appraisal and there were effective support systems in place for staff. Multi-disciplinary team working was effective within the department.

Caring:

Staff were kind, respectful and compassionate in their interactions with patients. Patients spoke highly about the caring attitude of staff. Patients said they were kept informed of the treatment options and that they wishes were respected. Patients' privacy and dignity was respected.

Responsive:

Urgent and emergency services

Plans were in place to extend the hours of the Urgent Care Centre to ease the flow within the ED. The trust had implemented rapid assessment protocols for patients arriving by ambulance and the use of Emergency Nurse practitioners to "see and treat" patients that had been triaged to reduce waiting times. Whilst the trust had taken actions to meet the four hour target for the ED, pressure on available beds within the hospital, coupled with increased attendances meant that the ED was not achieving the 95% four hour target consistently.

Well led:

We saw that the Emergency Care Intensive Support Team (ECIST) had undertaken a follow up review and noted that significant changes had been made to the ED process and infrastructure. Including improvements such as the introduction of rapid assessment and "see and treat" was in place for minors patients. The trust had plans in place to address the other areas for improvement. The trust had plans in place to reconfigure the ED to increase capacity designed to alleviate bed capacity concerns to reduce the number of four hour target breaches. An Urgent Care Programme Board had been established as part of the trust's partnership working and we saw that a project plan had been developed for the ED however not all actions had been clearly defined and reviewed regularly. The trust maintained a risk register that included the ED performance being adversely affected due to the demands on the service (for example by reduced access to beds, and increased GP referrals) and this was reviewed regularly.

Are urgent and emergency services safe?

We did not inspect all areas in this domain. Areas we visited were visibly clean and the trust had effective procedures in place to minimise infection control risks. The trust had reconfigured the physical environment to ensure the department was secure and that significant improvements had been made to the children's ED. Building work was underway designed to provide more accommodation for the ED. Records were being completed in accordance with trust policies. The trust had appropriate safeguarding protocols in place and staff had had appropriate training. The department had appropriate levels of staff on the day of our inspection.

Incidents

- We did not gather evidence in this area.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean and had appropriate hand washing facilities available. Hand sanitising gel dispensers were available at the entrance to the department.
- We looked at two toilets and found them both visibly clean.
- Cleaning schedules were in place and the two we looked at had been competed in accordance with trust procedures.

Environment and equipment

- The Emergency Department (ED) was made up of a minors and majors department, an emergency observation area (EOA) and a resuscitation room. The minors department was now self-contained, with appropriate doors in place. There was a separate paediatric ED for children and adolescents. During the inspection the trust were undergoing building work, for the additional accommodation for ED and this was expected to be completed by mid-December. The entrance to the main ED now had secure doors in place.
- The EOA was staffed by one nurse and one healthcare assistant (HCA). There were four beds and capacity in the waiting room for four seated patients. We were told that the observation area was used for patients who were waiting for blood results or admission to a mental health hospital. The EOA did not have any toilet or

bathroom facilities and therefore patients had to use the facilities within the main ED. The trust had recognised this as an issue and the new build would include bathroom and toilet facilities.

- During the September 2014 inspection, we saw that the trust had made significant improvements to the children's ED. There was a new children's department placed centrally within ED, this was located next to the main nurses station. The children's area was fully enclosed with its own entrance which could be accessed via use of a swipe card.
- There were three rooms within the children's ED for consultation and treatment, with one additional room for adolescents. The additional room could be used by the paediatric area or adult area as it had a door on each side of the room, which had a dual entrance so that it could be accessed or locked form either side according to demand. The unit also had a dedicated waiting area with toys.

Medicines

- We did not gather evidence in this area.

Records

- We were shown that all relevant details of the patients' safety checks were recorded on the trust's electronic patient record system.
- We looked at five patients' records and found that their observations had been recorded accurately and in accordance with trust procedures.

Safeguarding

- We saw from the trust's records for August 2014 that the number of staff that had level1 training for safeguarding children and young people was 96%. 88% of staff had had safeguarding children and young people level 2 training and 61% of staff had had the level 3 training.. 75% of staff had had safeguarding vulnerable adults training.
- Staff we spoke with were aware of the trust's procedures for safeguarding vulnerable adults and children and confirmed that they had had training in this area. Staff were able to tell us about the signs of potential abuse and knew how to alert relevant senior staff in cases of potential abuse.

Mandatory training

- We looked at the trust's overview records for August 2014 and noted that 95% of ED staff had had the trust's induction training, 64% of staff had had health and safety training and 72% of staff had had relevant updates on manual handling training.
- We saw that the trust had prioritised staff training and plans were in place to ensure all staff had completed relevant mandatory training refresher courses.

Assessing and responding to patient risk

- We were told that the consultant and nurse in charge undertake safety rounds every two hours, the safety rounds consist of checking on all patients in the department. These checks were performed to ensure patients were monitored for changes in their condition and to ensure they had been correctly prioritised for assessment according to their clinical presentation.
- The hospital used the trust's National Early Warning Score (NEWS) tool to record patient's observations at regular intervals and calculate an overall score designed to alert nursing staff when a patient was showing signs of deterioration. Based on the scoring matrix, a review by a doctor would then be requested.

Nursing staffing

- ED had 11 nurses working on an early shift, 14 on a late and 11 on a night shift. This would include two shift leaders per shift. We were told that most of the shifts were fully staffed and following a recent recruitment drive there was less usage of agency nurses, particularly within the past month.
- During the previous inspection we identified concerns regarding Children's ED. We saw that children were not prioritised and their pathway followed the same route as an adult patient. There were not enough children's nurses to ensure that there was always a paediatric registered nurse on duty, or that as a minimum there was always a nurse on duty trained in paediatric life support.
- The children's ED was staffed by one nurse and one health care assistant. We were told that the majority of shifts were covered by a registered children's nurse, five appointments had been made since the previous CQC inspection, one nurse had not commenced their role, but we were told that they were due to commence in October 2014. We were provided with confirmation that seven dates in September 2014 did not have a paediatric nurse within the ED, however, those shifts

were covered by a nurse who had been trained in paediatric life support. We were provided with evidence that all shifts in October were expected to be covered by a paediatric nurse.
- We were told that as part of the business plan, additional children's nurses were required to increase the number of dedicated children's nurses to two per shift and the recruitment process for this had begun.

Medical staffing

- We were told that the trust had seven A&E consultants plus one locum. Consultant cover was provided between the hours of 8am and midnight Monday to Friday with cover provided for six hours at weekends. We were told that there was an on-call consultant rota outside of these hours. The Emergency College of Medicine recommends that there should be a minimum of 10 WTE (whole time equivalent) consultants with 16 hours per day consultant presence including at weekends. The trust informed us that they were actively recruiting for additional consultants but that this was a national problem.

Major incident awareness and training

- Staff told us that appropriate security personnel were employed and we noted that a security guard responded within one minute to a call for assistance from a senior nurse in the ED.
- We saw from the trust's overview training record for August 2014 that 59% of ED staff had had refresher fire safety training. Staff we spoke with were aware of fire procedures. Firefighting equipment was in place and was serviced regularly.

Are urgent and emergency services effective?
(for example, treatment is effective)

We did not inspect all areas in this domain. The department had made significant improvements to ensure staff had had an annual appraisal and there were effective support systems in place for staff. Multi-disciplinary team working was effective within the department.

Evidence-based care and treatment

- We did not gather evidence in this area.

Pain relief

- We did not gather evidence in this area.

Nutrition and hydration

- We were told that people who remained in the department for long periods were offered meals and drinks. The patients we spoke with had been provided with a sandwich and a drink.

Patient outcomes

- The trust was expected to achieve an unplanned re-attendance rate to the ED of less than 5%. The trust have consistently failed to meet this target throughout 2013/14 and 2014/15.

Competent staff

- Staff we spoke to said they received annual appraisals that including planning for their training and development needs. We saw from the trust's records for August 2014 that the number of staff that had had an appraisal was now 88%.
- Staff said they had good informal support from managers and that formal supervisions were carried out when required.

Multidisciplinary working

- The daily safety huddles were meetings which involved senior nurses from each department / directorate and other relevant staff members, for example, the bed manager and duty manager. Staff talked positively about the huddle and it was their perception that it had made a difference.
- Staff told us that there was effective communication and multi-disciplinary team working across the ED.

Seven-day services

- We did not gather evidence in this area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not gather evidence in this area.

Are urgent and emergency services caring?

Urgent and emergency services

Good

Staff were kind, respectful and compassionate in their interactions with patients. Patients spoke highly about the caring attitude of staff. Patients said they were kept informed of the treatment options and that they wishes were respected. Patients' privacy and dignity was respected.

Compassionate care

- We spoke to some of the patients who had been on the department for a long time, they were satisfied with the care that they had received and told us that staff had been very attentive and had made sure they had everything they needed. We were told that beds were ordered for patients if they had been in the department for more than three hours. One of the patients who had regularly attended ED said that the care on the department was always very good and that it was much better than the care provided at ward level.
- We observed one senior nurse supporting a patient in the main reception with great sensitivity and compassion.
- All interactions we observed between staff and patients was positive, respectful and compassionate. Patients' privacy and dignity was respected.
- Patients said the staff were kind and considerate and responded to their needs quickly.

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed of the treatment options and actions to be taken by the staff in the ED.

Emotional support

- Staff told us there was effective liaison with other healthcare professionals to obtain appropriate levels of support for patients when required.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Plans were in place to extend the hours of the Urgent Care Centre to ease the flow within the ED. The trust had implemented rapid assessment protocols for patients arriving by ambulance and the use of Emergency Nurse practitioners to "see and treat" patients that had been triaged to reduce waiting times. Whilst the trust had taken actions to meet the four hour target for the ED, pressure on available beds within the hospital, coupled with increased attendances meant that the ED was not achieving the 95% four hour target consistently.

Service planning and delivery to meet the needs of local people

- The department were supported by an urgent care unit which was provided by the local Clinical Commissioning Group (CCG), funded and sourced separately. The urgent care unit had a streaming nurse and GP and was operational between the hours of 11am and 7pm. We were told that the trust had submitted a proposal to extend the hours of the urgent care centre as the department saw a peak in attendances during the evening and it was anticipated that this would ease the flow within ED.
- We saw that there was a business plan in place to increase the capacity of the ED including six additional trolleys in majors and four beds within the resuscitation unit.

Meeting people's individual needs

- Other new measures put in place since the previous inspection, were, rapid assessment for patients arriving by ambulance and patients being 'seen and treated' by Emergency Nurse Practitioners (ENP).
- The rapid assessment process meant that all patients arriving by ambulance could expect to be assessed within 15 minutes of arrival by a nurse or healthcare assistant under supervision of a nurse. This process was introduced to improve flow and ensure patients were triaged promptly according to their clinical priority.
- This rapid assessment process was expected to be further refined as the exiting resuscitation unit will be converted to a rapid assessment unit to enable the consistent and rapid delivery of the Fast Initial Assessment for all majors and resuscitation patients.

- The See and Treat service run by the ENPs was introduced with an aim to reduce waiting times and improve patient flow by seeing patients when they arrive, assessing their needs and providing relevant treatment.

Access and flow

- During the previous inspection we identified that there was an issue with flow within ED. We were told that a review of the trust's capacity had taken place by an external contractor. As a result a 10am and 2pm huddle took place every day. The daily huddles were meetings which involved senior nurses from each department / directorate and other relevant staff members, for example, the bed manager and duty manager. This enabled key staff to have an overview of the current 'state' of the hospital, in particular patient flow within each area and any other issues of significance.
- We were told that this had improved how the hospital worked holistically and that everyone took responsibility for the bed status and number of patients attending ED rather than individual departments being entirely responsible.
- Although it was the perception of staff that the flow within the department had improved we did not find evidence to support this.
- We reviewed the scorecard for general medicine which was used to report on monthly performance for the directorate, including ED targets. In line with national standards, the trust were expected to achieve a 95% compliance of all patients being admitted, transferred or discharged within a four hour period.
- We requested data for 2013 and 2014, we were provided with comparative data for June, July and August for the years 2013 and 2014. We saw that there had not been any evidence of improvement in meeting the four hour target during this period. For June, July and August 2013 were not meeting the 4 hour target and that achievement was, 93%, 94% and 90% for each month respectively. We observed that for the same period in 2014, it was reported at 93%, 93% and 91%.
- Activity had in fact been higher cumulatively during June, July and August 2013 than in 2014, yet performance had been slightly worse. June 2014 was 4% higher but August had been 6% lower. However, it was only August that was lower in attendance figures.
- We saw that the September operational performance report prepared for the Finance Committee reported a failure to meet the four hour target. The report recognised causes, including, higher time to first assessment in ED overnight, poor speciality referral times, high volume of ambulances and attendances at specific times, beds not being available early enough during the day as well as staffing challenges. Although it was noted it had not considered the unplanned re-attendance rate.
- We saw that there had been a slight increase in 2014 of the percentage of patients being admitted compared to patients not being admitted for the same period in 2013. Between June and August 2013 and the same three month period in 2014 the increase ranged from an 11% to a 17% increase (for type 1 and type 2 patients seen in the ED). The trust had not undertaken an audit on the admission/ non-admission rates during periods of consultant presence compared to when there was no consultant (as a senior decision maker) present.
- We were told by the staff that we spoke with that the main reason for delays were due to a lack of available beds in the hospital. We reviewed the breach report for a five separate weeks during 2014/15, namely the last two weeks in September and the last week in each month for June, July and August.
- We found that on average over the five week period, the percentage of patients breaching was much higher due to waiting for a specialist review (medical and surgical combined - 26%) or waiting for a hospital bed (all types – 21%) followed fairly closely by ED cubicles being full (14%) and 'other' (15%). We noted that breaching the four hour target due to 'other' causes was significantly high for the last week in June and July at 19% and 37% respectively. Because the reason was recorded as 'other', this meant that an accurate analysis of the cause could not be established. We also noted that for August, 18 breaches were due to 'deviation from ED protocol'; again this provides limited information for an accurate analysis of the cause. These may distort the information and interpretation which can be gleaned from the breach analysis report.
- For the week ending 21 September 2014 and saw that 37% of patients within the ED had breached as they were awaiting a clinical decision from an ED consultant, 19% breached due to ED processes, 21% of patients were awaiting a review from a medical or surgical specialist and 19% breached due to waiting for a medical or surgical bed.

Urgent and emergency services

- The percentage of patients waiting for a bed or specialist review may have impacted on the patients waiting for a cubicle and also waiting for clinical assessment.
- We were told by the staff that we spoke with that the medical assessment units were always full to capacity and it was very difficult for patients to be admitted to the units.
- We saw that the ED was very busy on the day of our inspection and that a number of patients had breached the four hour target. Once person had been in the department in excess of 13 hours.
- Staff also told us that the ED regularly accepted patients who had been referred directly to the medical assessment units by their GP. This was because there were no available beds on the assessment units. We were provided with data which showed that on average this accounted for seven patients per day.

Learning from complaints and concerns

- We saw that information was on display regarding the trust's complaints procedure.
- Staff we spoke with knew how to support patients in they wished to express a concern.

Are urgent and emergency services well-led?

Requires improvement

We saw that the Emergency Care Intensive Support Team (ECIST) had undertaken a follow up review and noted that significant changes had been made to the ED process and infrastructure. Including improvements such as the introduction of rapid assessment and "see and treat" was in place for minors patients. The trust had plans in place to address the other areas for improvement. The trust had plans in place to reconfigure the ED to increase capacity designed to alleviate bed capacity concerns to reduce the number of four hour target breaches. An Urgent Care Programme Board had been established as part of the trust's partnership working and we saw that a project plan had been developed for the ED however not all actions had been clearly defined and reviewed regularly. The trust maintained a risk register that included the ED performance being adversely affected due to the demands on the service (for example by reduced access to beds, and increased GP referrals) and this was reviewed regularly.

Vision and strategy for this service

- We noted that Emergency Care Intensive Support Team (ECIST) had undertaken a follow up visit to review progress made since the previous visit and to see the impact of the improvement programme developed jointly between McKinsey and the trust to improve the patient experience and flow in the emergency care pathway.
- ECIST reported that significant changes had been made to the ED processes and infrastructure. The ECIST report had similar findings to this CQC September 2014 inspection and concluded that some improvements had been made, for example the introduction of rapid assessment and see and treat was in place for minors' patients. However, the ECIST report commented that opportunities for improvement remained. In summary these were to, identify how an early senior assessment model could be developed, improve the streaming to primary care, improve recruitment arrangements, particularly for middle grade doctors, review the triggers and response arrangements when ED is under pressure, increasing the streaming of patients to ambulatory care and that the main causes for breaches in ED were due to a lack of availability of inpatient beds and obtaining a speciality opinion. The trust had action plans in place to address these issues.
- We saw that there was a business plan in place to increase the capacity of the ED including six additional trolleys in majors and four beds within the resuscitation unit. The trust had identified that additional nursing staff were required and this formed part of the project plan. The trust also confirmed that there would be an increase of 7.6 WTE in junior doctors to ensure the new build was adequately staffed.

Governance, risk management and quality measurement

- In our previous inspection, we found that there was no evidence to demonstrate that the recommendations from external reviews of the ED service had been implemented or resulted in any changes to treatment or care. The trust told us that the recommendations for improvement to the ED, as detailed in the review by the

Emergency Care Intensive Support Service, had been subsumed into the Urgent Care Programme. The Urgent Care Report had been presented to Board regularly. The last update was provided in June 2014 with the programme delivering required changes to treatment and care. The trust had sought additional support for the urgent care programme this has increased the clarity of reporting and improved performance.

- An Urgent Care Programme Board had been established as part of the trust's partnership working. We saw that a project plan had been developed and for the ED this was separated into four work streams, the ED rebuild, recruitment, clinical education and the electronic admission system record development. We were told that this was supported by an action plan which was updated on an ongoing basis as each element of the overarching plan was achieved. We were provided with a copy of the actions agreed at the meeting held on Wednesday 10th September 2014. There were four actions listed, one for each ED work stream. Each action had a deadline and a named person responsible to address the issues identified following evaluations undertaken with two external partners.
- We were provided with a copy of a 'highlight' report for the Integrated Healthcare Governance Board, the report provided an overview of the work undertaken by a consultancy firm which considered the trusts' performance, implementation of feedback from external support companies and an overview of the 'One Version of Truth'. The report included a review of recommendations and details of the current position.
- The position of the recommendations as at 12 May 2014 were reported on, however, it was not clear who had ownership for the recommendations or what the expected timescales were for achievement and whether this had been met or surpassed. Updates lacked detail and there was also no information on the effectiveness of recommendations implemented. Each recommendation was rated as Red, Amber or Green (RAG) according to progress.
- For example, one recommendation stated, "Design and implement an admission policy that reviews the expected length of stay of the individuals and transfers them to an admission unit only if the expected length of stay is less than 48 hours, otherwise they are admitted directly to a base ward". The progress reported on as at 12 May 2014 stated, "Once flow improves through the hospital, the Trusts assessment units will be more able to work as effective assessment units". The plan did not report on the current status of achievement, whether the admission policy had been designed / implemented and whether it was working. Only that this would be effective once flow improved. This demonstrates that there was a lack of control, ownership and accountability for recommendations made. We were subsequently informed that the policy was in the process of being updated to incorporate any recommendations made by the Urgent Care Board.
- We looked at the trust's risk register dated 10 September 2014, and saw the ED performance being adversely affected due to the demands on the service (for example by reduced access to beds, and increased GP referrals) was included as a potential risk. The trust outlined a series of actions to mitigate this risk, including daily performance analysis with twice weekly analysis being undertaken with the Consultants, the Bed Management team and ED Senior Nurses in Performance, implementation of two hourly patient safety rounds, and review of all patient safety incidents. This risk was being reviewed on a monthly basis and the risk register updated accordingly.

Leadership of service

- Staff spoke highly of the ED leaders and said support was effective and ongoing.

Culture within the service

- Staff said there was a positive team working ethos within the ED and that everyone worked hard to ensure patients' needs were met.

Public and staff engagement

- We saw that the ED had wall mounted electronic devices by which patients and their relatives could leave feedback. We saw "You said, We did" posters on display showing what examples of feedback received and what actions had been taken to respond. For example, partitions had been placed to separate the different parts of the main reception desk to afford greater privacy to patients when booking in at reception.

Innovation, improvement and sustainability

- We did not gather evidence in this area.

Medical care (including older people's care)

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

Information about the service

We inspected medical care (including older people's care) at Northampton General Hospital where we visited nine acute medical inpatient wards. We inspected a range of specialty-based wards including stroke care (Eleanor and Holcot Wards), Allebone, Benham, Creaton, Victoria, ICU, HDU and the discharge lounge.

We spoke with 20 patients and two relatives and 20 staff. We also reviewed 10 sets of patients' notes.

We spoke with a wide range of staff in different roles and grades across the medical wards. We observed care and treatment and looked at care records. We also reviewed the information provided by the trust.

Summary of findings

Safe:

The number of permanent nursing staff was variable, with a reliance on bank and agency staff, but patients' needs were being met by the staff on duty when we visited. Staff were aware of the trust's incident reporting procedures. Wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance. Performance information, including patient safety risks, was on display in ward areas.

Regular audits were being carried out on the main risk areas. Appropriate records were being maintained. There were procedures in place for the safe handling of medicines. Staff followed the trusts' procedures for effective infection control measures.

Effective:

Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Performance and outcomes did not meet trust targets in some areas. Most staff said they were supported effectively, but there were limited opportunities for regular formal supervisions with managers. Staff appraisals' compliance had significantly improved since the last inspection. Pain relief, nutrition and hydration needs were assessed appropriately and

Medical care (including older people's care)

patients stated that they were not left in pain. There was some measurement of patient outcomes. Staff uptake of mandatory training was below the trust's target. Multi-disciplinary worked was effective staff told us.

Caring:

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. People we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Overall medical inpatient services at the hospital were caring.

Responsive:

There was an elevated demand on bed availability at times, and the trust had escalation plans in place. Services met the needs of patients. The hospital had taken significant action to monitor the number of patients moved out of hours. The practice of sending patients medication via taxis had now ceased and people received their medicines as part of the discharge process. There was a lack of activity for some other patients. We observed a multidisciplinary integrated approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacists. Information was available for patients regarding how to make a complaint.

Well led:

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, with information boards for staff to highlight each ward's performance. The visibility and relationship with the management board was reported as effective. The trust had enhanced its governance and risk management and quality management systems and had taken significant steps to record and review all areas of risk. The trust had taken appropriate action to meet the requirements of the warning notice served after the last inspection and had plans in place to address the outstanding areas of risk. Board meeting minutes reflect the progress that had been undertaken.

Are medical care services safe?

Requires improvement

The number of permanent nursing staff was variable, with a reliance on bank and agency staff, but patients' needs were being met by the staff on duty when we visited. Staff were aware of the trust's incident reporting procedures. Wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance. Performance information, including patient safety risks, was on display in ward areas.

Regular audits were being carried out on the main risk areas. Appropriate records were being maintained. There were procedures in place for the safe handling of medicines. Staff followed the trusts' procedures for effective infection control measures.

Incidents

- Staff were aware of the trust's policy for reporting and recording incidents and accidents. Senior staff said there was a high level of incident reporting. Junior staff were aware of how to use the hospital's computerised system to report concerns. Performance, patient safety data and learning from incidents was generally discussed at monthly ward meetings.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators
- Staff on the stroke ward/rehabilitation ward were aware of the main areas of risk for patient safety including risk of skin damage.
- We observed that patients at high risk of falls on Creaton wards had sensor mats in use to alert staff when the patient was attempting to move. Staff said the risk of falls was constantly being assessed and they received feedback from senior staff about the prevalence of falls on the ward. This showed that the ward had taken actions to reduce the risk of falls and that learning from incidents was shared within the staff team.
- Coronary Care Unit staff told us there had been no pressure ulcers at grade two or above for the past 82

days. Regular audits were competed for the skin damage risk assessments and a pressure ulcer care plan was in place to minimise risks of skin damage for patients.

- In the Board's meeting minutes on 25 September 2014, it was reported that six new serious incidents were reported and two of the six Serious Incidents reported in June 2014 were classified as causing severe harm or death; this represented a reporting rate of 0.24%, which was below the national average. Aggregated mortality resulting from the 5 high risk diagnosis groups (acute myocardial infarction, stroke, fractured neck of femur, pneumonia and heart failure) was reported to be better than the national average for 2013-4 at 75.
- No never events, a harmful event so serious it is deemed it should never happen, had been reported for the previous three months prior to the inspection.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care. Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (venous thromboembolism, VTE).
- Safety thermometer audits were done by each ward and looked at the instances of falls, newly acquired pressure areas, venous thromboembolism assessments and urine infections for patients with a catheter.
- Senior staff told us that summary information from the monthly Safety Thermometer audit was usually shared with staff regularly via team meetings.
- We saw that wards displayed key information about patient safety risks and local audits completed. For example, Benham ward had not had an avoidable pressure ulcer for 204 days and the completion of the patient observations (using the national early warning score or NEWS tool) was 100% for the month of August 2014.
- In the trust's Board meeting minutes for 25 September 2014, it was reported for In August 88.5% patients experienced 'harm free care' in the trust which was below the national average of 93%. This was due to the increase in "all harm" which includes those patients which had been in the trust for more than one month and were recorded again the second month. In particular there had been an increase in pressure ulcers. Catheter-related urinary tract infections, falls & harm from blood clots, remained at or below the national average.

Cleanliness, infection control and hygiene

- Wards and communal areas were visibly clean and odour free. Personal protective equipment (PPE) was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage, regarding hand washing for staff and visitors, was on display.
- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate that barrier nursing was in place.
- Generally, cleaning schedules had been completed as required. Housekeeping staff told us that there were sufficient supplies of cleaning materials available to use. Cleaning store rooms were generally clean and tidy and we noted that Control of Substances Hazardous to Health (COSHH) information sheets for cleaning materials were available for staff.
- Personal protective equipment was available for staff to use.
- Staff followed universal infection control procedures when we carried out observations in most instances. Nursing staff and doctors generally used hand sanitising gels at patients' bedsides before and after seeing patients.
- Recent audits of hand hygiene for Benham ward showed 100% compliance for August 2014.
- The trust Board meeting minutes for 25 September 2014 reported that there have been fourteen C. Difficile cases in the year which was above the monthly target but overall the trust was below the national annual target of 35. No methicillin resistant staphylococcus aureus (MRSA) cases had been reported for the past three months.

Environment and equipment

- The environment was generally clean and tidy, and the décor was mostly well maintained. Clinical areas were generally well maintained.
- There were systems to maintain and service equipment as required. Hoists had been serviced regularly. Portable electrical equipment had been tested regularly, to ensure it was safe for use.

- The discharge lounge was at the end of a corridor, which belonged to the adjoining ward, Victoria. In order to reach the lounge patients had to walk or be wheeled through the corridor, past Victoria ward's two single side rooms and four bays with four beds in each. Therefore, Victoria Ward was a thoroughfare for patients, hospital staff, for example, porters assisting patients, and relatives coming to collect patients. The bays were open, which meant the patients had no privacy and were subject to noise and movement from a busy access route.
- On Creaton ward, we noted that bed rails were used of a number of patients, but they did not have protective plastic bumpers in place. Staff we spoke to said bumpers were used if required and were aware of the trust procedure for obtaining them. Staff told us there was one set of bed rail bumpers available for this ward. We also found that at 6am, three patients who were at risk of falls and were using ultra low rise beds, did not all have crash mats on the floor next to the bed. Staff told us that the crash mats were removed at busy times. We informed senior nurses about this practice, as there was not clear guidance in the patients' care plans about the use of these crash mats. The trust took immediate action to address this issue and provided us with their detailed guidance for staff regarding the use of bed rail "bumpers", ultra-low beds and crash mats. The trust also responded immediately to revise the bed rails risk assessment to enable staff to evidence their clinical reasoning regarding their decisions to use bed rails, bed rail "bumpers", ultra-low beds and crash mats.

Medicines

- Pharmacy technicians told us that all patients had a review of their medicines within the first week and that there was increased time allowances for pharmacy staff to spend in ward areas.
- Generally, wards followed the trust's procedures for the storage, administration and recording of medicines so that patients were protected from the risks associated with inappropriate handling of medicines.

Records

- We looked at the documentation kept to record peoples' vital signs observations, fluid balance charts, food intake and repositioning charts. We found a consistent level of recording on the wards that we visited.
- Wards had lockable patient note trolleys but not all trolleys were able to be locked when not in use. We did not observe any confidential records left unattended however.

Safeguarding

- There were effective safeguarding policies and procedures, which were generally understood and implemented by staff, including agency and locum staff. We saw information posters, relevant contact details for the safeguarding adult's team and copies of the trust's policies about safeguarding in ward offices.
- We saw from the trust's records for August 2014 that the number of staff that had level1 training for safeguarding children and young people was at or above 95% for all 14 wards. 75% of staff had had safeguarding vulnerable adults training.
- Staff were aware of the signs of potential abuse and knew how to escalate concerns with regard to the trust's procedures.

Mandatory training

- Staff told us that they had had mandatory training events annually, which included infection control, moving and handling, and health and safety. Some staff told us that at times, covering the wards took priority over training.
- Staff on the stoke ward told us that 66% of staff had had falls awareness training and that plans were in place to ensure all staff received this training.
- Ward managers received monthly reports showing the status of their team's training and we saw that any areas of underperformance were recording on their risk register.
- Overall for the service, mandatory staff training was 78% slightly below the trust target of 80%.

Assessing and responding to patient risk

- The hospital used the trust's National Early Warning Score (NEWS) tool to record patient's observations at regular intervals and calculate an overall score designed to alert nursing staff when a patient was showing signs of deterioration. Based on the scoring matrix, a review by a doctor would then be requested. We saw that wards carried out regular audits on the completion of the NEWS assessments: for example, Creaton ward showed 100% compliance for August 2014.

- The hospital was implementing an electronic system for recording patient observations based on the NEWS tool; this electronic recording system was used on most wards. Staff said they had had training on how to use the system and how to input patient observations onto handheld devices. All patients' electronic observations were accessible to senor nurses via a desktop computer at the nurses' station and this also sowed when each patient was due to have the next set of observations taken and recorded. This electronic data was available to doctors throughout the hospital; however this electronic system did not automatically make a referral to a doctor to review the patient if their NEWS score indicated a review was needed. Nurses would make the referral and record this on the patient's written notes. Staff said doctors carried out reviews for patients when required quickly.
- On Creaton ward, Health care assistants confirmed they had had training in how to use this system to record patients'' observations. Staff told nearly all wards in the hospital were now using this electronic system for recording patients' observations.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if any shifts were not covered. Senior staff said they would carry out a risk assessment if their ward was short staffed and escalate to senior managers. Staff said at times nurses and Health Care Assistants (HCAs) would be asked to work on other wards to cover. Senior nurses were able to tell us their ward's staffing vacancy position and at what stage the recruitment process was at. Staff said recruiting new nurses was a lengthy process at times and was not always successful.
- Benham ward had a bed capacity of 26 patients. When we visited, there were four qualified nurses on duty with two healthcare assistants. The ratio of qualified nurses to patients was therefore better than 1:7. The unit was short of a supernumerary co-coordinator, but staff told us this had been escalated to the site supervisor, in accordance with trust procedures.
- Staff told us that recruitment of new staff had improved, and that the trust had successfully recruited new nurses from overseas.
- Creaton ward had a bed capacity of 26 patients and when we visited, senior staff told us the qualified nurse to patient ratio was normally 1:8 at nights. We found that there were two, not three qualified nurses on duty, and two healthcare assistants. Staff on this ward told us that staff recruitment and retention was a concern, but that staff worked very well together to ensure patients' needs were met when they were short staffed. We observed that all patients in this ward were receiving appropriate levels of care and support at the time of our visit.
- We visited this ward again during the day and noted that the ward was fully staffed for both qualified nurses and healthcare assistant (with four qualified nurses and four healthcare assistant on duty when we visited).
- We attended the handover meeting between night and day site supervisors and noted that ward staffing levels concerns were discussed and that plans were put in place to flex staff around between wards to minimise any potential impact on patient care.
- Staff on the stroke ward told us that agency nurse usage was 16% for the previous month.
- Staff on Creaton ward told us the ward had eight WTE qualified nursing vacancies and six healthcare assistant WTE vacancies. Senior nurses told us any staffing levels concerns were escalated to the matron and the clinical site supervisor. The ward was carrying out an assessment of patients' dependency levels in order to link the results of the dependency audit to the planned staffing levels.
- In the trust Board meeting minutes for 25 September 2014, it was reported that staffing data had been submitted and that overall 27% of wards were staffed at over 90% for day & night shifts. Nurse to patient staffing ratios were calculated at 1:8 and longer term recruitment plans were in place.

Medical staffing

- The overall trust vacancy rate for doctors was reported as 4.6 %, a reduction from 6.7% in June 2014.
- The hospital had six stroke specialist consultants providing an effective level of cover throughout the week.
- Staff on the wards we visited said that there was an effective out of hours cover by doctors.

Major incident awareness and training

- The trust had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents, such as bad weather or illness.

Medical care (including older people's care)

- Patient safety information was collated and audited, and feedback was given to ward teams on a monthly basis.
- Staff were aware of emergency protocols and fire safety risks. Staff told us that fire drills were carried out routinely.
- Firefighting equipment was available and had been tested regularly.

Are medical care services effective?

Requires improvement

Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Performance and outcomes did not meet trust targets in some areas. Most staff said they were supported effectively, but there were limited opportunities for regular formal supervisions with managers. Staff appraisals' compliance had significantly improved since the last inspection. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes. Staff uptake of mandatory training was below the trust's target. Multi-disciplinary worked was effective staff told us.

Evidence-based care and treatment

- In the Board meeting minutes on 25 September 2014, the medical director reported that the latest Standardised Hospital Mortality Indicator was down below 100 and for the rolling year was significantly lower at 108. The minutes of this meeting reported that crude mortality remained one of the lowest in the region.
- Staff carried out accurate, comprehensive assessments, which covered most health needs (clinical needs, mental health, physical health, and nutrition and hydration needs), and social care needs. They developed care plans to meet some identified needs. The care plans that were in place were mostly regularly reviewed and updated. People's care and treatment was mostly planned, and delivered in line with evidence-based guidelines.
- Wards carried out local audits on a monthly basis, including the safety thermometer audit, which looked at prevalence of pressure ulcer, falls, urine infections associated with catheters and whether VTE assessments had been completed.
- During our previous inspections on 16 and 17 January 2014, we saw that the lead Intensive Therapy Unit (ITU) consultant had recently reviewed the Intensive Care Society Core Standards for Intensive Care Units which were published in November 2013. The consultant had completed an analysis of any areas that required improvement to meet those standards in December 2013. We reviewed the analysis which identified gaps against the standards including a medical consultant not being immediately available 24 hours a day and consultant work patterns to deliver continuity of care not being in place. However we did not see evidence of what actions had been identified to address the gaps and comply with the standards. The analysis was therefore not robust as there was no evidence as to how the compliance would be achieved. We spoke with the nurse in charge of intensive care who was unsure what the standards were and whether there were any plans in place to address the areas requiring improvement.
- During our inspection of 23 September 2014, we spoke with three senior and two junior nurses in the intensive care unit. All were aware of the Intensive Care Society Core Standards for Intensive Care Units and how it impacted their service. We were shown a document dated May 2014 which described each standard within the Core Standards document and analysed where the ITU was with each. Against each area that needed to be developed, there was a brief improvement plan, a person who was responsible for ensuring improvements were made by a specific date. This gap analysis had been developed by the senior ITU team, led by the consultant in Critical Care.
- It was clear from this document and from speaking with staff that although there were some longer term items still being progressed, for example recruitment of specialist doctors, significant improvements had been made to ensure the unit met the required standards. All the staff we spoke with were aware of the gap analysis and the work going on to ensure that the service improved.

Pain relief

- Generally, wards had effective systems in place to assess and provide pain relief for patients.
- Patients generally told us they received appropriate pain relief when required.

Nutrition and hydration

- Mealtimes were protected within the ward areas we inspected. This meant that patients could eat their meals without interruption, and staff could focus on providing assistance to patients who were unable to eat independently.
- Patients on Creaton ward told us the food was generally very good and that they had a choice.

Patient outcomes

- Staff on the stroke ward told us that the hospital's performance in the SSNAP was now above the national average. The percentage of patients admitted to the stroke ward within four hours of arrival was no 81%. The hospital provided 12 hyper acute/acute stroke beds.
- In the Board meeting minutes for 25 September 2014, it was reported that the Nursing and Midwifery Quality Dashboard (QuEST) showed a slight improvement of 79% compliance against last month 77%. This dashboard recorded the results of a range of patient safety and quality audits undertaken by each ward, including whether key risk assessments had been completed, patients observations had been completed and medication audits.
- In the Board meeting minutes for 25 September 2014, it was reported that the In 2014/15 there had been local Commissioning for Quality and Innovation (CQUIN) for Mortality and Morbidity (M&M) meetings at a trustwide and directorate level. Compliance with Quarter 1 of the local M&M CQUIN was on schedule. The Trust had participated in 100% of national audits.
- In August 2014, 96% of stroke patients were cared for more than 90% of their stay on a stroke ward, which was above the trust target of 80%.
- In August 2014, 83% of suspected stroke patients had a CT scan within one hour of arrival which was significantly above the trust target of 50%.
- The Sentinel Stroke National Audit Programme (SSNAP) performance for the period January to March 2014 showed the trust was performing at band D overall .

Competent staff

- We spoke with nine staff who confirmed they had received a recent appraisal whereby they had the opportunity to meet with the manager or supervisor to discuss their performance and discuss any future career aspirations or training. All told us they found the process useful and that the trust supported their training needs. This meant that staff were supported in relation to their responsibilities, to deliver care to patients appropriately.
- All staff on the Coronary Care unit had had an appraisal and staff told us this was linked to their ongoing learning and development needs.
- All but six staff on Creaton ward had had an annual appraisal and these remaining six appraisals had been booked. Staff said they received good informal supervisions and had formal supervision every six months.
- We saw from the trust's records for August 2014 that the number of staff that had had an appraisal in the medical directorate was now 69%. This was reported upon in the trust's Board meeting on a monthly basis.
- In the trust Board meeting minutes for 25 September 2014, the medical director reported that for the period 1 April 2013 to 31 March 2014 the Trust had 257 doctors with a prescribed connection to the organisation and the trust had undertaken 208 appraisals. The trust had 32 Appraisers and that there was a need for further recruitment of Appraisers and to support the managing of the appraisal system. Plans were in place to address this.

Multidisciplinary working

- We observed the 10am safety huddle meeting that was attended by senior nurses from all ward areas and clinical specialities. We saw that key areas regarding staffing levels, bed capacity, patients ready for discharge, and patient safety concerns were discussed for all clinical specialities. Staff told us doctors attended the safety huddle when they could. Portering staff said they rarely attended the safety huddle but that plans were in place for a representative to attend.
- There was a multidisciplinary collaborative approach to care and treatment that involved a range of professionals, both internal and external to the organisation. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

Medical care (including older people's care)

- Meetings on bed availability were held to determine priorities, capacity and demand for all specialities.

Seven-day services

- The stroke ward had seven day cover by specialist stroke consultants.
- The trust had a doctor on-call rota for evenings and weekends, and ward areas had appropriate levels of doctor cover out of hours. There was a consultant on-call rota operated by the trust for out of hours.
- A matron was on duty at night and acted as the clinical site supervisor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable.

Are medical care services caring?

Good

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. People we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Overall medical inpatient services at the hospital were caring.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care. Staff in all roles put significant effort into treating people with dignity. Patients generally felt supported and well-cared for. Staff responded compassionately to pain, discomfort, and emotional distress, in a timely and appropriate way.
- Patients that we spoke to told us that staff were very kind and that they didn't have to wait for support when they needed it.
- People's dignity was respected whilst they were being supported with personal care tasks, and that dignity curtains were used when staff were assisting patients.
- People told us that staff answered their call bells in a timely fashion, and generally we saw people had access to call bells and staff responded promptly.
- Staff were able to tell us how the needs of people from culturally diverse backgrounds were met.
- The interactions we observed between staff and patients were positive and caring.
- The average inpatient Friends and Family test (FFT) score for August 2014 was 62 which was below the trust target of 70. Staff were given information on this via monthly team meetings.

Understanding and involvement of patients and those close to them

- All staff we observed communicated respectfully and effectively with patients.
- Some patients we spoke with across all wards visited said they were not aware of their care and treatment plans. Some had not seen them.
- Care plans and risk assessments we looked at had not been signed by the person or their representative.
- Patients we spoke with said that they had been informed of their conditions and treatment plans. Staff kept people informed of any changes.
- Staff told us that capacity assessments were carried out by doctors, not nurses.
- Relatives said they were generally kept well informed of how their relative was progressing.
- All wards had appropriate signs in place so that people would know which members of staff were their named nurse and doctor.

Emotional support

- Visiting times met the needs of the relatives that we spoke to. Open visiting times were available to relatives if patients needed additional support from their relatives.
- Patients said the hospital's chaplaincy service was easy to access and provided good support.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement

There was an elevated demand on bed availability at times, and the trust had escalation plans in place. Services met the needs of patients. The hospital had taken significant action to monitor the number of patients moved out of hours. The practice of sending patients medication via taxis had now ceased and people received their medicines as part of the discharge process. There was a lack of activity for some other patients. We observed a multidisciplinary integrated approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacists. Information was available for patients regarding how to make a complaint.

Service planning and delivery to meet the needs of local people

- Staff told us that the trust was producing a winter pressure plan designed to manage the increase in demand for hospital beds over the winter period. Elements of the plan were to enhance the Integrated Discharge team, to have access to 23 step down nursing beds at an adjacent nursing home for older people, introduce seven day working for therapists, and to engage with local charities to offer support for older people that would be self-funding for care home places.
- The trust was also in the process of planning for a for the new discharge lounge which would provide room for four beds and ten chairs plus ancillary accommodation in an area adjacent to an exit on the ground floor with good ambulance and vehicular access.

Access and flow

- We spoke to the senior nurses in the hospital's Control Room and staff now had a real time view of the current bed capacity within the hospital via the trusts electronic bed management system. We were told how the hospital had appropriate escalation beds available when there was pressure on beds. The Clinical Site Manager showed us the system in place to monitor bed capacity and patient flow issues, and told us there was a risk assessment process in place for any patient that required to be moved at night. Trust policy was not to move patients after 10pm at night, unless there was a clinical need to do so. If a patient had to be moved for a non clinical reason after 10pm, then the reason why was explained to the patient, they were asked if they wished to register a complaint and a risk assessment form was completed. The night of our visit, there had been only one patient moved after 10pm and we noted that this was for a clinical reason as the patient was transferred to a high dependency bed. For the previous 22 days, we looked at the site supervisors records of night moves and noted that 36 out of 40 patient moves in this period had been risk assessed. Staff were also told us how they could challenge the necessity of any such move if they considered it would be detrimental to the patient.
- The trust corporate scorecard report for August 2014 showed there had been 36 patient moves out of hours: in July this had been nine and in June it had been 31.
- During the inspection we carried out on 16 and 17 January 2014, nurses, doctors and porters told us that patients were often transferred between wards late at night. This included elderly patients and those diagnosed with dementia. We found no evidence that an assessment of the risk to the wellbeing of vulnerable patients this practice presented or of the potential impact on ward staffing. We were told by night staff that patients had been transferred as late as 3:00 a.m. and that where patients were elderly or had mental health issues this usually meant that a member of ward staff had to provide 1:1 care as those patients became distressed and disorientated, which had disturbed other patients. We asked to look at ward transfer records but found they did not record the times at which patients were transferred, only the dates; nor did they record the number of patients moved at night.
- During our inspection of 23 September 2014, we spoke with two porters about this practice, one told us he was quite new and hadn't worked at night. The other told us he had not worked during the night for some time and although this practice used to be common place, was unsure what procedures were in place now with regards to moving patients during the night.
- We also spoke to a senior porter, who showed us the records for all patient moves made to the portering service. Dates and times of the requests and patients moves were being recorded.

- We observed a handover meeting between the night and day site supervisors and saw that patient flow and bed capacity issues were discussed. Patients ready for discharge were from ward areas were identified and the use of any escalation beds was highlighted.
- Prior to the inspection we carried out on 16 and 17 January 2014 we had received information that patients were being discharged without medication prescribed by the hospital. This was then later sent to them by taxi. This was confirmed during the inspection. Patients had received medication which had not been explained to them. This meant that patients may have not been aware of any special requirements relating to taking medicines or their side effects. When we reviewed the governance arrangements for this practice, we found that the hospital had not ensured that the practice was clearly set out in the guidance and policy documentation. For example, the guidance stated where a taxi is required to deliver discharge medicine a signature was required from the taxi driver. However, the guidance did not specify whether the signature was to confirm collection from the hospital, or delivery of the medication to the patient. We also found that some of the documentation was out of date. We issued the hospital with a warning notice which required the hospital to make improvements by 30 June 2014. The hospital sent us an action plan and told us that this practice had now ceased.
- During our inspection on 23 September 2014 we spoke with pharmacists and ward staff. They told us that they had been uncomfortable with the practice of sending medicines to patients' homes after they had been discharged. However, the process started in an effort to expedite patients' discharge from the hospital and had become custom and practice, particularly when there was pressure to admit patients and there were too few available beds.
- We saw the recently updated medication policy, dated May 2014 and a standard operating procedure relating to the prescribing and dispensing of patients take home medicines. Both described the process for ordering patients take home medicines and the process for ensuring they were given directly to the patients following them being explained.
- The pharmacist and pharmacy technician explained that the process for dispensing take home medication had been completely reviewed since our last inspection. This had included efforts to ensure take home medicines were dispensed in a timely manner. We were shown a number of audits demonstrating that the time taken to dispense medication had been reduced from 109 minutes at the beginning of 2014, to 49 minutes in July 2014. This meant patients were not kept waiting for medicines for an unreasonable amount of time and thereby reducing the time they needed to be kept in the hospital.
- The pharmacists told us that taxis were no longer used to take patients medicines to their homes. This was supported by several nursing staff we spoke with and a healthcare assistant who told us' "That business with the taxis taking tablets has stopped." A ward sister said, "We never liked doing it, but patients didn't like waiting, we needed the bed for someone else and it all started just to get around that problem. The procedure for getting take home medicines has really improved, it's so much quicker."
- We spoke with two patents who were waiting to go home. Both told us that they had their take home medicines and they had been explained by a nurse or pharmacist.
- As part of our inspection we visited the discharge lounge. This is an area where patients await transport once they are ready to go home and was adjoined to Victoria ward.
- The nurse in charge told us there could be up to twenty patients in the discharge ward at once, which made it very crowded. However, when we visited, there were two patients waiting. One told us they had been there for two hours and had another two or three hours to wait until their relative was due to collect them. There were some comfortable chairs and a small television. There were no facilities to make beverages, although the nurse told us that tea and coffee could be made in the adjoining ward. Toilet facilities were also shared with the ward.
- We noted that the area was situated away from the main hospital wards on the second floor. This meant that patients had to be transported to wait some way from the ward areas.

Meeting people's individual needs

- We noticed that most of the patients on Victoria Ward were elderly, some appeared to be frail. The nurse in charge told us the ward looked after patients who were deemed medically fit for discharge, but were awaiting placements in care or residential homes as they were

not able, due to their conditions, for example frailty or dementia to return to their own homes. The average length of stay was four weeks, although some patients had stayed for as long as ten months.

- We noticed there was no stimulation for these patients, for example televisions or radios in the bays. As many of the patients on Victoria ward were living with dementia, the staff had arranged amongst themselves that a box of activities such as puzzles and other items were available so that that people could reminisce, which is helpful for people with dementia. However, there was no activities co-ordinator to facilitate activities to stimulate or maintain patient's independence but there was Occupational Therapy provision on the ward and the team regularly attended to assess patients' mobility and equipment needs. There were no special facilities for people with dementia, such as bright signage to assist with orientation.
- Although there was a physiotherapist shared with another ward, the nurse in charge told us that they often did not get to the ward at all and if they did, it was always late in the afternoon, which did not leave enough time for many patients to have therapy so that their motor skills could be maintained
- This meant that elderly, frail and confused people who were in patients for several weeks or longer had no stimulation, which is essential to physical and mental well-being and furthermore, their privacy and dignity was compromised.
- Staff told us that the hospital provided extra staff when patients living with a dementia needed a one to one: we observed these requests were discussed at the handover meeting between the night and day site supervisors and the trust had systems in place to respond to these requests for extra staff.
- We saw that assistive technology (in the form of sensor mats) was being used to minimise the risk of falls for frail older patients.
- The hospital had access to a translation service, which staff told us was effective and met people's needs. Posters were on display about how to access this service.
- No mixed sex accommodation breaches had been reported for the past three months.

Learning from complaints and concerns

- People generally knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them, or their representatives, to provide feedback about their care however, complaints procedure leaflets were not always readily available in ward areas. Most areas we visited had posters clearly on display regarding the trust's complaints procedures or the Patient Advisory Liaison Service (PALS). We did see a variety of information posters in the hospital's main corridors regarding complaints procedures

Are medical care services well-led?

Requires improvement

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, with information boards for staff to highlight each ward's performance. The visibility and relationship with the management board was reported as effective. The trust had enhanced its governance and risk management and quality management systems and had taken significant steps to record and review all areas of risk. The trust had taken appropriate action to meet the requirements of the warning notice served after the last inspection and had plans in place to address the outstanding areas of risk. Board meeting minutes reflected the progress that had been undertaken.

Vision and strategy for this service

- Senior staff spoke positively about the vision and strategy that the board had for the ongoing development of the medical care service.
- Some staff were able to tell us about the trusts vision and values.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.

Governance, risk management and quality measurement

- In our previous inspection in January 2014, we found that there were inappropriate governance arrangements for prescribed medication to be sent to patients after discharge including a lack of detail for the process within trust guidance and policy documentation. The

trust had taken action and told us that this practice was discontinued once verbal feedback was received on 17th January 2014.There was now a process embedded within the trust giving express guidance that medication is no longer to be sent by taxis. The updated Medicines Management Policy (NGH-PO-249) had been amended to reflect this guidance and was available on the trust intranet for all staff to access and there were regular audits to gain the assurance that the practise has ceased.

- In our previous inspection, we had found that actions taken in accordance with identified risks on the risk register that had been on there for some time were insufficient. For instance mandatory training (health and safety and slips, trips and falls) had low attendance figures and a serious incident report had identified staff training in health and safety to be low where specialising in the care of the elderly. The trust told us that they had taken action and they had reviewed its target for mandatory training and increased this to 80% compliance rate by October 2014, increasing to an 85% target by March 2015. In May 2014, the overall compliance rate for attendance at mandatory training was 78.1%. This had been maintained at 78% for August 2014, nearly at the trust target of 80%. Part of the on-going work included regular updates to all managers advising them of the training dates and how to book staff onto the courses. There was an update on compliance with the Mandatory Training figures given at both the Integrated Healthcare Governance Committee and the Clinical Quality and Effectiveness Group, to enable the organisation to monitor progress. Furthermore, updates were given to each ward advising of their individual compliance rates.
- In our previous inspection, we had found that there were ineffective governance systems around the movement of patients at night. Ward transfer records did not record the times of transfers or how many patients were moved at night. There was no evidence that this had been discussed as an issue at Board level or that any audits had been carried out to assess the impact. The trust had addressed this by implementing a standard operating procedure so that patient moves both in hours and out of hours were risk assessed and recorded and regularly tracked by the Site Management Team. A risk assessment was to be completed before any patient was moved and a rationale was documented if a ward move is deemed necessary. An update report on ward transfers was submitted to the Integrated Healthcare Governance Committee in May 2014 and the trust had also produced a patient information leaflet advising patients that they may be required to move wards and giving an explanation as to why this may be necessary and also details of who to contact should they wish to ask any questions or give feedback on their experience. The trust monthly corporate scorecard now recorded the actual number of patient moves out of hours.
- Previously we had found that there was ineffective management of the stroke imaging pathway, specifically the identified risks posed to patients admitted with a suspected stroke. The trust told us that the stroke imaging pathway has been reviewed and disseminated. Roles and responsibilities had been agreed and the trust had confirmed that the pathway was in place and working effectively. We saw that the trust reviewed the protocol for acute stroke nurses to request CT head scans for suspected stroke patients in March 2014, and that monthly progress was reported on the trust's corporate scorecard. In August 2014, 83% of suspected stroke patients had a CT scan within one hour of arrival which was significantly above the trust target of 50%.
- In our previous inspection, we had also found that robust analysis of Intensive Care Society Core Standards for the Intensive Care Units was not in place which addressed what actions would be implemented as a result of the identified gaps in the service as compared to the national core standards. The trust told us that a report was presented to the Integrated Healthcare Governance Committee in June 2014. This report outlined details of the trust's further review of the original gap analysis and demonstrated the actions that had been taken to address the deficits and further ongoing actions that had been planned.
- In our previous inspection, although the Chief executive had identified the follow up of action plans as a concern, there was no evidence as to how the trust planned to address this issue. The trust told us that there was a robust process for the review and follow up of all action plans with the progress of all action plans being actively monitored... A revised pathway demonstrating the process had been developed and had been presented to the trust Board and to the Clinical Quality and Effectiveness Group. The Serious Incident Group met weekly to review the Serious Incident action plans and supporting evidence. In

addition the Group provided constructive challenge to the Care Group and Directorates on whether the presented evidence demonstrated that the recommendations and actions had been implemented. Completed action plans were presented quarterly to the trust's Commissioners through the Serious Incident Assurance Meeting.

- In the trust's Board meeting minutes for 25 September 2014, it was reported that all action plans produced during the reporting period had been reviewed by the Serious Incident Group and uploaded to the trust's electronic risk management system. 75% of agreed action plans were either completed or were on target for completion within the timescale. It was envisaged that all historic action plans will be closed by the end of September 2014.
- In our previous inspection, we found that there was no evidence to show what actions were taking place to address the low number of staff that had received an up to date performance development plan (PDR). The trust told us that there was a regular audit of appraisals with performance management where areas of non-compliance had been identified. A new appraisal process had been launched and ensured that compliance with appraisal was 64% in June 2014 and had improved to 69% in August 2014. Reports and updates were regularly submitted to trust Board, the Integrated Healthcare Governance Committee and to the Clinical Quality and Effectiveness Group to ensure progress was maintained.
- Senior nurses attended the twice daily safety huddle meetings where areas of risk, including staffing pressures, were raised and plans put in place to address the concerns to minimise the potential impact on patient care and treatment.
- We looked at the system the hospital was using for risk assessing patients requiring to be moved at night. We saw that the risk assessments had been completed in full and that a log of all such moves was being maintained. Staff told us that this risk assessment process had commenced two months prior to our visit. We noted that the hospital was auditing the completion of these risk assessments and that in August 2014, 93% of all such moves had been risk assessed which was below the trust target of 100%. We looked at a recent report to the trust's board regarding night moves. We also saw that the clinical site supervisors had an effective audit system in place to check the completion of risk assessments for all patients requiring a move at night.
- Staff were aware of the hospital's governance system and explained the role of the Board's governance subcommittee, called the Integrated Healthcare Clinical Governance committee.
- The trust was maintaining a central risk register which contained 43 separate areas of risk. We noted that the risk register dated 10 September showed that out of the 37 risk areas that were due to be reviewed monthly, 75% of these had been reviewed within the previous month. The risk register included the risk of patient moves at night and had been opened as a risk on the register on 17 March 2014. We noted that there were defined actions in place to reduce the risk and that the initial risk rating of 15 (high risk) would be reduced to a residual risk rating of six (medium risk) once the actions had been implemented. However, we noted that the last recorded date that this risk had been reviewed was 2 May 2014 and the register stated that this should be reviewed on a monthly basis.

Leadership of service

- Staff told that senior managers and the Chief Executive were more visible now on the wards. Staff we spoke with were aware of the findings of our previous inspection and what key messages had been cascaded down from the Executive team. Staff were able to tell us what the actions had been taken to address some of the concerns from the last inspection, for example, risk assessments for night moves, maintenance of equipment and staffing levels. This showed that there was clear communication about the key priorities for the hospital across the staff team.
- The trust's Board meeting minutes for 25 September 2014 recorded the progress made on the trust's high level action plan to meet compliance with the findings of the January 2014 inspection.
- Staff on the wards we visited all said that local ward leadership was good and effective.
- Staff told us that generally, they were well supported by their managers.

Culture within the service

- Most staff reported an improvement in effective communication to and from the trust's board.

Medical care (including older people's care)

- Staff in the portering service felt able to raise concerns with senior managers and had highlighted concerns about the position of the discharge lounge and had suggested the lounge be sited in a central position in the hospital recently.
- Staff on the medical wards we visited reported good team working and morale, despite staffing pressures at times. They felt able to escalate issues to senior managers and that they would be listened to. Staff told us team meetings were generally held regularly and any action points for the team were minuted.
- In the Board meeting minutes for 25 September 2014, it was reported that for the financial year to date the rate for sickness absence rose slightly to 4.25%. In month sickness absence for August 2014 had increased by 0.26% to 4.32% which was above the trust target.

Public and staff engagement

- Innovation was encouraged, but staff told us that they were not always able to recommend changes, due to time pressures.
- Wards displayed performance boards that showed the patients' feedback responses for the previous month.
- Patient stories were heard at the monthly trust Board meetings.

Innovation, improvement and sustainability

- Staff generally had objectives focused on improvement and learning as part of their appraisals
- Innovation was encouraged, but staff told us that they were not always able to recommend changes, due to time pressures.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should continue to embed effective training and staff appraisals systems in place to ensure trust targets are met
- The trust should continue to monitor the capacity and demand of the ED to ensure all patients are assessed within the 4 hour target time.
- The trust should continue to review all areas of patient risk and ensure all areas of risk highlighted on the corporate risk register are reviewed within the prescribed timescales.

The trust should continue to monitor all out of hours patient moves and embed the risk assessment process to achieve its target for 100% completion of these risk assessments.