Northampton General Hospital NHS Trust

Corby Community Hospital

Quality Report

Corby Community Health Complex
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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
Medical care	**Requires improvement**

Summary of findings

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Overall summary

Corby Community Hospital was one of three community hospital sites where Northampton General Hospital NHS Trust provided services on an inpatient ward. Corby Community Hospital Inpatient Ward was a 22-bedded ward providing rehabilitation following discharge from the acute hospital, Northampton General Hospital. The hospital also provided a service for patients with subacute medical conditions who required an enhanced level of care that could not be provided at home.

Northampton General Hospital NHS Trust was an acute trust with 800 consultant-led beds, and provided general acute services for a population of 380,000. It also provided hyper acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, which had a population of 691,952. The trust was an accredited cancer centre and provided cancer services to a wider population of 880,000 who lived in Northamptonshire and parts of Buckinghamshire.

Northampton General Hospital NHS Trust also provided services at Isebrook Hospital and Danetre Hospital.

We found the medical service on the inpatient ward at Corby Community Hospital to be generally safe because there were assessment and reporting systems in place to identify risk, take action and learn lessons from incidents and complaints. Staff felt informed about incidents and able to report concerns. They followed national and best practice guidelines. There was good multidisciplinary team working throughout the ward and with trust specialist teams across the trust. Outcomes for patients were good.

Nurse staffing and patient dependency levels were assessed using a recognised tool. There were vacancies, which were covered either by staff on the ward doing additional hours or by bank and agency staff nurses. The trust was in the process of recruiting more staff. A consultant specialist in the care of the older person visited the ward twice weekly for a ward round and multidisciplinary team meeting. In addition, a full-time staff grade doctor worked Monday to Friday 9am to 5pm. In addition to this, the urgent care centre, based on the Corby site, provides doctor cover from 5.30pm to 8pm Monday to Friday and then on Saturday and Sunday also from 8am to 8pm. Outside these hours and at weekends, the countywide 'out of hours' service was called to support the medical needs on the ward.

There were arrangements in place for the safe administration and handling, storage and recording of medication. However, there had not been an allocated pharmacist on the ward to oversee and review medicine and prescribing arrangements. This meant that patients were at risk of not receiving appropriate treatment, possible medication errors occurring and necessary reviews of medication not taking place. The trust had employed a locum pharmacist who was due to start by the end of January 2014.

Analysis of infection rates in the trust showed them to be within expected limits. The ward was clean and there were arrangements in place for ward cleaning and decontamination of equipment. We found gels, aprons and gloves were in good supply and waste appropriately dealt with. There were assurance mechanisms in place to identify when standards for cleanliness and infection prevention needed improving.

We sought the views of the public at a listening event before the inspection and also checked on a range of patient feedback and survey information. We spoke with patients and a relative during the inspection who reported they were happy with care and treatment. The relative praised the staff highly and, despite living some considerable distance from the hospital, had been kept fully informed and involved.

There were clear clinical, organisational, governance and risk management structures in operation. Staff had confidence in the ward managers and felt well supported. However, not all staff had completed their mandatory training or been given an appraisal. This meant that the trust could not be assured that staff were up to date with their skills and knowledge to appropriately meet patients' needs. Issues over the lack of a pharmacist for the ward and non-completion of training and appraisals had been known to the trust for a significant time, with insufficient action taken to address the issues.

Summary of findings

We found that the trust had breached Regulation 13 (medication) and Regulation 23 (staff support and training) for the regulated activity 'Treatment of Disease, Disorder and Injury'.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Patients received safe care and were protected from harm because there were systems for assessing risk and identifying, investigating and learning from patient safety incidents. Staff were confident about raising concerns and reporting incidents. Staffing levels were calculated using a nationally recognised dependency tool (this assesses the care needed for a patient based on their medical condition). It had been noted that not all shifts achieved the recommended skill mix, and recruitment was taking place to address this. Shortages of staff on shifts were covered by ward staff doing additional hours and by agency staff. A full-time staff grade doctor worked Monday to Friday. In addition to this the urgent care centre, based on the Corby site, provides doctor cover 5.30pm to 8pm Monday to Friday and then on Saturday and Sunday also from 8am to 8pm. For the remainder of the time (evenings, nights and weekends) staff called the 'out of hours' service for medical support. However, there had been a lack of specialist oversight of the medication arrangements because no pharmacist had been allocated to the ward.

Are services effective?

Good

Services were effective, and designed to meet the needs of patients on the ward. Staff followed national and best practice guidelines. There was good multidisciplinary team working throughout the ward and with trust specialist teams. Outcomes for patients were good. Staff continually sought ways to improve patient experience.

Are services caring?

Good

Patients were positive about their experience and found staff kind and caring. We saw several examples of compassionate care. Patients reported they liked the food and we saw positive interactions between patients and staff. The local ward results from the Friends and Family Test were consistently good, but staff were not complacent and continued to seek ways to improve patient experience.

Are services responsive to people's needs?

Good

The services on the ward responded to the needs of the local population by providing a 'step-up' facility with enhanced care to patients from the community, in order to reduce the need for admission to the acute hospital. Similarly, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from Northampton or Kettering General Hospitals. In addition, the ward provided medical and nursing care for patients with subacute medical conditions. We found that

Summary of findings

there were no formal arrangements in place for spiritual or multifaith provision. Local ministers supported the ward but their support was not always appropriate and staff had to ask individual patients and their families where to obtain the help needed for their particular faith.

Are services well-led?

Requires improvement

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigations and complaints. Staff had confidence in the ward managers and felt well supported. They were given the opportunity to develop their specialist knowledge and skills. However, staff were experiencing difficulty with some of the care documentation introduced by the trust and felt performance ratings did not reflect practice. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and a failure to complete appraisals had been known to the trust for a significant time but insufficient action had been taken to address these issues.

Summary of findings

What we found about each of the main services in the hospital

Medical care (including older people's care)

Requires improvement

We found the medical service was safe because there were systems in place to identify risk, take appropriate action and learn lessons from any incidents or areas of poor performance. Staff were confident about how to report incidents and felt well informed. However, we found the medication arrangements had not been reviewed by a pharmacist since May 2012. This was because there had been no pharmacist allocated to the ward during this time. A locum pharmacist was expected to start by the end of January 2014.

Staffing levels were calculated using a nationally recognised dependency tool (the Hurst Nursing Workforce Planning Tool). It had been noted that not all shifts achieved the recommended skill mix and recruitment was taking place to address this. Shortages of staff on shifts were covered by bank and agency staff. A consultant visited the ward twice a week for ward rounds and multidisciplinary team meetings. A full-time staff grade doctor worked Monday to Friday. In addition to this, the urgent care centre, based on Corby site, provides doctor cover 5.30pm to 8pm Monday to Friday and then on Saturday and Sunday also from 8am to 8pm. For the remainder of the time (evenings, nights and weekends) staff called the 'out of hours' service for medical support.

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Summary of findings

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigations and complaints. Staff had confidence in the ward managers and felt well supported. However, staff were having difficulty with some of the care documents including observation charts recently introduced by the trust, and felt scores on ward performance audits did not always reflect practice. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and a failure to complete appraisals had been known to the trust for a significant time but insufficient action had been taken to address these issues.

Summary of findings

What people who use the hospital say

Northampton General Hospital NHS Trust performed 'about the same' as other trusts for all 10 questions in the CQC Adult Inpatient Survey for 2012. The survey covered the whole of the trust, with no specific information on individual community hospital locations.

For the Friends and Family Test, the overall performance for the trust was in line with the score for England. At Corby Community Hospital, we found that the service scored 63 for October and 67 for November 2013.

The trust was given a score of 3.5 out of 5 stars from contributors to NHS Choices, with the main positive factors being excellent care, professional staff and being treated with respect and dignity. However, people raised issues about waiting times, communication and misdiagnosis. There was no specific information available on individual community hospital locations, including Corby Community Hospital.

Areas for improvement

Action the hospital MUST take to improve

- Address the lack of a pharmacist allocated to the ward to review and advise on the medication arrangements.
- Ensure staff are up to date with mandatory training.
- Review the appraisal process to ensure staff are appraised annually.

Action the hospital SHOULD take to improve

- Care record templates and audits were based on an acute hospital setting and were not necessarily appropriate for a community hospital service.
- There were no formal arrangements in place to provide multi-faith spiritual support.

Good practice

Our inspection team highlighted the following areas of good practice:

- Staff proactively seeking out opportunities to improve patient experience.
- The multidisciplinary team working successfully in partnership to improve outcomes for patients.

Requires improvement

Corby Community Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

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

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

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

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

Background to Corby Community Hospital

The services on the inpatient ward at Corby Community Hospital were provided by Northampton General Hospital NHS Trust (NGH). The inpatient ward was a 22-bedded ward and provided a programme of rehabilitation from a specialist therapy team for people with clinical needs requiring 24-hour nursing and medical care. In addition, the ward provided nursing care for patients with subacute medical conditions.

The ward provided continuing support and care closer to home, offering help with rehabilitation and recovery from stroke. The aim was to provide care closer to home for patients fit for discharge from the acute hospital, with a clinical need for medical rehabilitation, offering a 'step-down' facility or had subacute medical needs. The ward also offered care to patients referred directly from the community with the aim of providing care and treatment in order to prevent the need for their admission to the acute hospital. This was known as a 'step-up' facility.

The ward was supported by a multidisciplinary team including nursing, medical and therapy staff.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

The inspection team inspected the following core services at this site:

- Medical care (including older people's care)

Before our inspection, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 17 January 2014.

We spoke with eight members of staff including the matron, service development facilitator, trained nurses, support workers, a physiotherapist and an occupational therapist. We also spoke with three patients and one relative, observed the care of patients throughout the ward and checked four personal care and treatment records.

We held a listening event where patients and members of the public shared their views and experiences of the hospital trust services.

The team would like to thank all those who attended the listening event and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Requires improvement

Medical care (including older people's care)

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

Information about the service

The services on the inpatient ward at Corby Community Hospital were provided by Northampton General Hospital NHS Trust (NGH). The inpatient ward was a 22-bedded ward and provided a programme of rehabilitation, nursing and medical care from a multidisciplinary specialist therapy team. Most patients were older people who needed support with rehabilitation. The ward had designated two beds for GP referrals.

The management and staff on the ward were keen to develop the service and raise awareness of the care and support that were available. The nursing team had developed enhanced nursing skills to improve care provision and to be able to admit more complex cases; referrals were increasing.

Summary of findings

We found the medical service was safe because there were systems in place to identify risk, take appropriate action and learn lessons from any incidents or areas of poor performance. Staff were confident about how to report incidents and felt well informed. However, we found the medication arrangements had not been reviewed by a pharmacist since May 2012. This was because there had been no pharmacist allocated to the ward during this time. A locum pharmacist was expected to start by the end of January 2014.

Staffing levels were calculated using a nationally recognised dependency tool (the Hurst Nursing Workforce Planning Tool). It had been noted that not all shifts achieved the recommended skill mix and recruitment was taking place to address this. Shortages of staff on shifts were covered by bank and agency staff. A consultant visited the ward twice a week for ward rounds and multidisciplinary team meetings. A full-time staff grade doctor worked Monday to Friday and the remainder of the time (evenings, nights and weekends) staff called the 'out of hours' service for medical support.

Services were effective, and designed to meet the needs of patients on the ward. Staff followed national and best practice guidelines. There was good multidisciplinary team working throughout the ward and with trust specialist teams. Outcomes for patients were good. Staff continually sought ways to improve patient experience.

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Requires improvement

Medical care (including older people's care)

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The services on the ward responded to the needs of the local population by providing a 'step-up' facility with enhanced care to patients from the community, in order to reduce the need for admission to the acute hospital, Northampton General Hospital. Similarly, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from Northampton or Kettering General Hospitals. In addition, the ward provided medical and nursing care for patients with subacute medical conditions. We found that there were no formal arrangements in place for spiritual or multi-faith provision. Local ministers supported the ward but their support was not always appropriate and staff had to ask individual patients and their families where to obtain the help needed for their particular faith.

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigations and complaints. Staff had confidence in the ward managers and felt well supported. However, staff were having difficulty with some of the care documents, including observation charts recently introduced by the trust, and felt scores on ward performance audits did not always reflect practice. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and a failure to complete appraisals had been known to the trust for a significant time but insufficient action had been taken to address these issues.

Are medical care services safe?

Requires improvement

Safety and performance

An analysis showed that Northampton General Hospital NHS Trust (NGH) was reporting the expected number of incidents compared with similar trusts. This meant that staff were identifying and reporting patient safety incidents appropriately. They were confident about how to use the procedures for reporting.

Performance

An analysis of incidents on the inpatient ward at Corby Community Hospital showed that from April 2013 to December 2013 there were seven new pressure ulcers, six incidents of patients falling, and no cases of venous thrombo-embolism (blood clot). However, the trust's total percentage of patients with a catheter contracting urinary tract infections had been consistently above the average for England. The inpatient ward at Corby had had 11 cases of urinary tract infections in the past year, five involving patients with a catheter. Actions had been taken to address this, such as more detailed risk assessment (NGH community hospital incident data, 16 January 2013).

Pressure ulcers

Patients identified at risk of pressure ulcers were referred to the trust's tissue viability team. There had been problems with delays in accessing support from this team because they had been under capacity, which had led to up to two-day waits. This had improved. There was recently a problem with accessing pressure-relieving mattresses: the supplier was unable to provide any and there was a time delay until an alternative source could be found. The ward had received several high risk pressure relief mattresses on loan on a semi-permanent basis to avoid ordering delays in the future.

Falls

The ward layout made observing patients difficult and staff were concerned that a combination of the layout and low staffing levels was adding to the risk of falls. To alleviate this problem, agency staff were undertaking one-to-one supervision of patients identified at risk and a falls strategy had been developed, including having a falls champion who reviewed all patients after a fall (Summary of serious falls at Corby Community Hospital since May 2013). Daily

Medical care (including older people's care)

acuity and dependency level assessments were undertaken with strict escalation practices. Falls were a standing agenda item at every ward team meeting, when incidents and performance were discussed (Ward staff meeting minutes, December 2013). Falls incidents were displayed on the falls prevention board and staff had attended training on the prevention of falls, slips and trips. An action plan had been developed to reduce or eliminate falls on the ward. Actions taken included weekly updates to a patient's fall care plan, weekly urinalysis, lying and standing blood pressure monitoring, and medication review. This action plan was reviewed on 16 January 2014, and showed improvement and a reduction in falls (Action plan following serious falls, dated 5 December 2013).

Staffing levels

Nurse staffing and patient dependency levels were assessed using a recognised nurse staffing tool, the Hurst Nursing Workforce Planning Tool. Staff were concerned about staffing levels particularly early in the morning and on a late shift. Staff sickness levels were also a factor. Some shifts were not always meeting the ratio of one registered nurse to eight beds (Medical director's quality report, 31 October 2013).There also remained vacancies for healthcare assistants bands 2 and 3 (NGH Community Nursing Staffing spreadsheet, 17 January 2014). While the ward manager was keen to recruit to enable a coordinator role from Monday to Friday, this was not yet funded.

Learning and improvement

Staff were aware of how the ward was performing and the number of incidents taking place, and were keen to continually improve care to patients. All serious incidents were investigated and reports shared with staff so that lessons could be learned. We examined four serious incident investigation reports, two relating to falls and two to grade 3 pressure ulcer incidents. All four investigation reports captured details of incidents, factors influencing practice and actions to improve it, such as more accurate documentation on pressure areas assessment to be discussed at the next ward meeting. We saw one set of ward minutes and found learning points from incidents recorded and a standing agenda item for the management of falls (Minutes of ward team meeting, December 2013). This meant that there was an open and honest reporting culture, and keenness to learn lessons to improve care and reduce harm to patients.

Systems, processes and practices

There was a system in place to reduce or eliminate risk. This began with the assessment of the patient on admission, when plans were put in place and then developed with support from specialist teams across the trust, such as the falls team. We examined three sets of patient records and found that in all of them risk assessments were completed and up to date.

Infection prevention and control

Analysis of infection rates in the trust showed them to be within expected limits. We found the ward clean. Arrangements were in place for cleaning the ward and individual items of equipment. Staff knew how to decontaminate medical equipment and we observed this in practice. Hand gels, aprons and gloves were in good supply. There were effective systems in place for the classification, segregation, storage and handling of waste. Monthly monitoring included environmental cleanliness and hand hygiene; audit results recorded good standards (QuEST ward trend analysis, October, November and December 2013). Assurance systems ensured ward cleanliness and equipment met appropriate guidelines and standards, such as the Department of Health Code of Practice on the prevention and control of infections and related guidance (Health and Social Care Act 2008). This meant staff could be confident that the environment and equipment were appropriately cleaned and safe before any patient contact.

Medicine management

Arrangements were in place for the safe administration, handling, storage and recording of medication. We examined medicine storage areas and records, including medication under strict controls because of their effect and potential for misuse. Apart from one area, these were well organised and records were well maintained.

We found there had been no allocated pharmacist since May 2012 to review prescribing practices and arrangements, and to offer support (NGH patients with omitted medicines data spreadsheet, 22 August 2013). Although we did not find any evidence that harm had come to patients as a result, this put patients at risk of not receiving appropriate treatment and possible medication errors occurring. At the time of the inspection, there was still no allocated pharmacist but a locum had been employed and was due to start at the end of January 2014.

Requires improvement

Medical care (including older people's care)

Monitoring safety and responding to risk

Performance was audited, monitored monthly and the results advertised on the ward notice board. Staff were made aware of any risks to patients as part of the handover process, and there was a range of mechanisms in place for sharing lessons learned and actions to be taken following poor ward performance or incidents. In addition, there were general risk assessments taking place for practices on the ward including risks in the environment. We saw 16 general risk assessments across a number of issues including infection prevention, moving patients and use of computer equipment. The records demonstrated ongoing risk assessment taking place on the ward and actions taken to mitigate risks. Staff were aware of the risk assessment procedure and actions resulting from them.

Anticipation and planning

We found at ward level that safety was a high priority, and staff continually aimed to improve patient safety within their area. However, when risks to patient safety had been identified, and action required at divisional or trust level, this had not consistently been taken. The lack of an allocated pharmacist for the ward had been recorded on the medicine division risk register since June 2011 with no action taken to address the issue (Medicine division risk register, 2012). This put patients at risk because there was no pharmacist oversight to reduce the risk to patients of receiving inappropriate treatment or possible medication errors, nor to review antibiotic prescribing.

Are medical care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Clinical audits

We found there was little information about outcomes to clinical audits for the ward. We were informed by the matron that information was collected from the ward to be included in the audit of stroke patients but they had not yet heard the results.

Where applicable, we found care practice was being carried out in line with national guidance, for instance with the care for patients who had had a stroke (care pathway) and dementia care.

Performance, monitoring and improvement of outcomes

Audits

Monthly audits were taking place using the Safety Thermometer assessment tool and a recently introduced tool known as QuEST. These are NHS tools designed for front-line healthcare professionals to measure a snapshot of potential harms to patients such as falls, pressure ulcers and infections. QuEST ward trend analysis showed that scores were good, with only a small number of areas with continuous poor performance: bed rail assessment, daily review by a doctor and noise at night (QuEST ward trend data analysis, October, November and December 2013). The matron explained that not all the indicators on the audit were appropriate for the community setting and so scores would be consistently poor: for example, patients would never see the patient safety video because there were no bedside televisions on the ward.

Care and treatment records

We examined three care and treatment records and found patient assessments including risk assessments were completed appropriately and were up to date. Regular reviews of patients' conditions were taking place and record keeping was audited monthly. The documentation used was provided by the trust, including nutrition and fluid observation charts. Staff felt the conflict between what was expected by the documentation and what was appropriate for patient care was resulting in misleading performance data, which was demotivating to staff and meant that the trust management was not receiving robust and accurate information on the service (QuEST, November 2013).

Staff, equipment and facilities

Mandatory training

The ward was not meeting the trust target of 75% for mandatory training, scoring 73%, with varying degrees of attendance at different courses. The target was achieved for safeguarding children and young people level 1, safeguarding vulnerable adults level 1, manual handling 2-year refresher training and equality and diversity levels 1 and 2. The target was not met for refresher fire training (69.23%), infection prevention and control (69%), information governance (58%) and health and safety including risk management (61%) (NGH screenshot data, 17

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Medical care (including older people's care)

January 2013). This meant that patients were at risk because staff might not have all the necessary skills and knowledge to ensure the care provided met appropriate standards of quality and safety.

Equipment

We examined the emergency medical equipment for the ward and found it appropriately maintained with records showing it was checked daily. The ward did not store medication used in resuscitation. Staff knew the location of the emergency equipment, how to use it and their responsibility in checking and maintaining it. This meant that staff would be able to appropriately support patients until specialist medical assistance arrived, or an ambulance to transfer them to NGH, should this be required.

IT and facilities

The community hospital IT systems were not totally compatible with the main trust system. This meant access to the trust's website and databases was slow or difficult at times. Staff reported how frustrating this was, and that it could cause distractions and delays when caring for patients. Actions required to address the lack of an integrated IT system had been rated as red (the highest risk). Project work was in progress to resolve the problem, but no dates were specified for completion on the action plan (Integrated Healthcare Governance Committee meeting minutes, 19 December 2013).

Multidisciplinary working and support

Multidisciplinary team work was integral to the operation of the ward. Each of the specialist teams worked positively together. There were weekly meetings and we found evidence of outcomes from these in three patient care records. Staff spoke with enthusiasm about team working. One physiotherapist said, "The team working here is excellent."

Are medical care services caring?

Good

Compassion, dignity and empathy

Patient feedback

Analysis of data from the Adult Inpatient Survey, CQC, 2012, showed that the trust scored about the same as other trusts in all 10 areas of questioning. There was no site-specific information for the inpatient ward at Corby Community Hospital.

Since April 2013, patients have been asked in Friends and Family Tests whether they would recommend the hospital wards to their friends and family if they needed similar care or treatment. The trust scored 68 out of 100 in the inpatient tests for July, August and September 2013, which was generally in line with the average for England. The inpatient ward at Corby Community Hospital displayed the results of the tests on the ward notice board. The ward scored 63 for October and 68 for November 2013.

The trust was given a score of 3.5 out of 5 stars from contributors to NHS Choices, with the main positive factors being excellent care, professional staff and being treated with respect and dignity. However, people raised issues about waiting times, communication and misdiagnosis. There was no specific information available on individual community hospital locations, including Corby Community Hospital.

Involvement in care and decision making

Patients told us they were well cared for and found the staff kind and considerate. Staff were encouraging and helped motivate patients to improve, through support with rehabilitation. There was a positive atmosphere on the ward and patients and staff commented on this. Patient feedback led to actions for improvement. Patients appreciated the environment, which was clean and met their needs, and the food was good.

Trust and communication

Patients confirmed they were involved in decisions and given information about their condition and treatment. They reported that staff were always willing to spend time explaining procedures to them, and that they felt comfortable asking questions. Staff encouraged patient feedback on how to improve the service on the ward.

Requires improvement

Medical care (including older people's care)

We spoke to one relative, who lived some distance away from the hospital. They reported how impressed they had been at the level of communication. The felt completely involved, with regular telephone call updates. They praised the staff highly and said they would recommend the service to others.

Emotional support

We saw staff of different disciplines talk with patients in an encouraging, kind and compassionate manner. Staff responded to buzzers promptly and we observed that privacy and dignity were maintained during intimate procedures. Staff supported both the patients and their families. Patients reported that they felt well looked after by the multidisciplinary team.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The ward provided services mainly for people from Northampton, Kettering, Corby, and surrounding towns and villages. The hospital provided care closer to home for patients fit for discharge mainly from Northampton or Kettering General Hospitals, but with a clinical need for rehabilitation services as well as continuing nursing and medical support. This was seen as a 'step-down' facility. The unit also admitted patients from the community for care and treatment, in order to reduce the need for admission to the acute hospital. This was seen as a 'step-up' facility.

Services were provided by a multidisciplinary team consisting of qualified specialist nursing, therapy and medical staff. There was an admission criterion, which was used to identify patients who could benefit from being admitted to the unit, needed 24-hour nursing and medical support, and had the potential for rehabilitation.

Medical support

A consultant specialist in care of the older person visited the ward twice weekly for a ward round and multidisciplinary team meeting. In addition, a full-time staff grade speciality doctor worked Monday to Friday 9am to 5pm. In addition to this the urgent care centre, based on Corby site, provides doctor cover 5.30pm to 8pm Monday to Friday and then on Saturday and Sunday also from 8am to 8pm. Six doctors covered the ward between them; three were contracted by Northampton General Hospital and three by Kettering General Hospital. Outside these hours and at weekends, the countywide out-of-hours service was called to support the medical needs on the ward. In an emergency situation with a deteriorating patient, the staff would call an ambulance using the 999 service. Staff reported that there were few delays with ambulance arrivals and they had no concerns about patients when using either the out-of-hours service or 999.

Care and treatment records

The ward used the early warning sign (EWS), a tool to measure if a patient's condition deteriorates with each observation being scored. The scores are added together and compared with a scale, which enables staff to identify if a patient's condition worsens or improves. Audit results showed that in November 2013 89% of EWS observations were done at the requested time, with 84% of calculations correct. In December 2013, the audit results showed this had fallen to 53% but a higher percentage of scores were calculated correctly at 94%. The ward management explained that the tool was designed for an acute hospital setting and that patients were generally in a stable condition. However, the director of nursing confirmed that the documentation was designed for acutely ill patients who needed more frequent observations. However, the staff were expected to follow trust policy and complete the records with the required frequency (QuEST, November and December 2013). This meant that patients were at risk because of confusion over the use of the scoring tool and the poor calculation of results. Staff might not identify that a patient's condition was deteriorating in order to ensure medical attention was given appropriately.

Spiritual support

There was no formal chaplaincy arrangement with the trust for the patients on the ward. The staff reported that local ministers would visit the hospital and offer spiritual support, but not all faiths were represented. Ward staff would ask the patient and their families whom to contact and individual arrangements would be made on a case-by-case basis. Staff reported that there were very few patients who could not be supported by local ministers.

Medical care (including older people's care)

However, there could sometimes be a delay in obtaining spiritual, cultural and emotional support, while arrangements were put in place to support patients and their families.

Vulnerable patients and capacity

Safeguarding

Staff were aware of how to identify safeguarding concerns and confident using trust safeguarding policies and procedures, including the whistle-blowing policy. They felt comfortable about raising concerns and felt their views were listened to on the ward. They were up to date with safeguarding training (NGH screenshot data, 17 January 2013). This meant that they understood how to recognise potential or actual abuse and act appropriately to safeguard patients and others visiting the ward.

Mental capacity

Staff were aware of the Mental Capacity Act 2005, and the need for best interest assessments. They were able to describe the process for assessing capacity and confirmed that assessments were carried out on the ward. There were no patients at the time of the inspection subject to a mental capacity assessment or who had any Deprivation of Liberty Safeguards in place.

Dementia

The trust was introducing a dementia strategy, which involved staff taking on the role of dementia champions. The role started in December 2013 and was supported by the Dementia Care Action Committee. Training was scheduled for February 2014. A Dementia Care Focus Group had been established. The draft dementia pathway had been completed and sent out for consultation (Integrated Healthcare Governance Committee, December 2013).

We found staff aware of the strategy and patients were screened and assessed on admission. Patients diagnosed with dementia were identified by a butterfly symbol placed on the ward notice board and at their bed heads. Each person diagnosed had a patient profile developed based on their known likes, dislikes and activity patterns.

Leaving hospital

Patients tended to stay longer on the ward than they did at the acute hospital. The average was 31.8 days for elective cases and 51.6 days for non-elective. The trust average for elective cases was 4.8 and 5.3 for non-elective (NGH average length of stay by speciality group and ward, 1 April 2013 to 31 December 2013, data spreadsheet,16 January 2014).

Staff reported delays were generally due to accessing appropriate care packages in the community and organising assessment for nursing home care. The problems with delayed discharges had been known to the trust since September 2011 (Risk register general medicine, 8 March 2012). In addition, there had been some issues identified about the quality and coding of community hospital discharges, and these were being monitored (Medical director's quality report, 31 October 2013).

Staff said that they planned for discharge at admission, with a progress review within two weeks. The multidisciplinary team work between hospital staff and the local authority was good, with the social services care manager based on the ward. Problems were mainly experienced when patients needed complex packages of care. The delays in discharge meant that patients were staying longer in hospital than they needed to, which could have an impact on their morale and independence.

Learning from experiences, concerns and complaints

All complaints were dealt with at the time, if raised on the ward. There had been no formal complaints received in the past 12 months. Staff reported that, should a complaint be received, it would be investigated and shared at ward team meetings.

Are medical care services well-led?

Requires improvement

Vision, strategy and risks

There had been a change in leadership at the trust, with half the executive directors, chair and chief executive appointed in the past few months. Many posts were interim and there were two new chief operating officers. The leadership team was establishing new ways of working, and introducing new strategies and initiatives. Quality and safety had become priorities for the trust and new monitoring processes had been introduced. Staff were aware of the new priorities and challenges.

Requires improvement

Medical care (including older people's care)

The trust was to stop providing services in the community hospitals by April 2014. The staff and the inpatient provision would transfer to another provider. Staff generally accepted the changes, including their transfer to a new employer, although none of the staff knew any details of what the new service configuration would look like and mean to them. This caused some anxiety and frustration.

Governance arrangements

There was a clear organisation structure in place, with services in the community hospitals aligned to the medicine division. There was a corporate risk register, with divisional risk registers held locally. Risks that scored a higher rating were considered by the trust board. We found that some high-rated risks could stay on the risk register a significant time without action being taken. This was the case for pharmacy support at Corby Community Hospital, which had been identified and recorded on the risk register on 2 September 2009, which was before it even became part of the hospital trust. However, no action had been taken to address this. The lack of response put patients at risk of inappropriate treatment and exposed them to medication errors. It did not offer appropriate support to the management and staff locally on the ward.

Appraisals

The ward was not meeting the trust target for appraisals, which was 80%. Performance data was based on the number of personal development plans received within the learning and development department; this stood at 53.85% (NGH screenshot data, 17 January 2014). Staff and management agreed that the numbers actually completed were higher, but the plans were not yet logged onto the system. A new process had been introduced whereby appraisals would no longer need to be submitted in paper form, which was expected to improve performance figures. Appraisals were being linked to increments in salaries and completion of mandatory training, with an appraisal to be arranged three months before the increment date. The poor performance with completing appraisals had been on the medicine division register since 08 May 2011. Without an effective appraisal process, the trust could not be assured that its staff were competent to carry out their duties and receive the necessary support and development opportunities: both factors that could have an impact on staff retention (Medicine risk register, 08 March 2012).

Mandatory training

The ward was not meeting the trust target of 80% for mandatory training, scoring 72.65%, with varying degrees of attendance at different courses.

Leadership and culture

There were only two key findings in the 2012 NHS Staff Survey when the trust performed within expectation or better.

- The percentage of staff that received equality and diversity training in the past 12 months.
- The percentage of staff that said hand washing materials were always available.

The trust performed within the bottom 20% of trusts for 24 of the 28 key findings. There was no site-specific information in the survey for the inpatient ward at Corby Community Hospital, although staff confirmed that they had been encouraged by the ward management to take part.

Patient experiences, staff involvement and engagement

Local feedback on patient experience showed high satisfaction from patients and families. There were consistently high scores from the Family and Friends Test and patients were happy with their care.

Staff felt supported by management at ward and matron levels and were encouraged to develop their skills and experience. They felt well informed about ward performance and new developments, and able to contribute to improving the service.

Learning, improvement, innovation and sustainability

All serious incidents were investigated and reports shared with staff so that lessons could be learned. Staff were kept informed through ward performance data on the notice board, staff meetings and news bulletins, as well as learning from incidents within the trust as a whole. We saw one set of staff meeting minutes, which contained performance analysis and learning outcomes. This meant that there was an open and honest reporting culture, and keenness to learn lessons to improve care and reduce harm to patients.

The nursing documentation was provided by the trust, including nutrition and fluid monitoring. Staff were monitored for the completion of these documents against

Medical care (including older people's care)

trust policy and guidance. However, they reported that some of the guidelines and protocols were not appropriate in the community hospital setting, which led to poor performance results. This meant that the trust senior management were not always given robust and accurate information on which to base decisions. This was having a demotivating impact on staff on the ward (QuEST, November 2013).

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Requirements related to the management of medicines. People who use services were at risk of receiving inappropriate treatment because there was no dedicated pharmacist review and oversight of the management of medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Requirements relating to workers. People who use services were at risk of not receiving care and treatment because the provider had not made suitable arrangements for the appraisal of nursing and care staff. Regulation 23 (1) (a).