Northampton General Hospital NHS Trust

Danetre Hospital, Daventry

Quality Report

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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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Summary of findings

Overall summary

Danetre Hospital was one of three community hospital sites where Northampton General Hospital NHS Trust provided services on an inpatient ward. Danetre Hospital Inpatient Ward was a 28-bedded ward providing rehabilitation following discharge from Northampton General Hospital. The hospital also provided palliative care, dedicated stroke care and a service for patients who needed 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 hyperacute 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 Corby Community Hospital.

We found the medical service on the inpatient ward at Danetre 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. 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.

The ward staff operated in three teams each specialising in a field of care; this enabled staff to develop their knowledge and they continually sought ways to improve patient experience; for instance, one team had achieved the Gold Standard for palliative care.

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 nurses. The trust was in the process of recruiting more staff.

There were arrangements in place for the safe administration and handling, storage and recording of medication. However, there had not been an allocated pharmacist to 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 prior to the inspection and also checked on a range of patient feedback and survey information. We spoke with patients during the inspections who reported that they were happy with the care and treatment on the ward and staff were kind. We saw examples of compassionate care. 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.

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 had 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.

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. A recognised nursing tool was used to calculate staffing levels and skill mix. 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. The ward staff operated in three teams each specialising in a field of care; this enabled staff to develop their knowledge to improve patient experience. They continually sought ways to improve patient experience; for instance, one team had achieved the Gold Standard for palliative care.

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. Because staff were working in three specialist teams, they could concentrate on recognising and meeting patients' particular care and treatment needs.

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, Northampton General Hospital. Similarly, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from the acute hospital. In addition, the ward provided subacute medical care and had designated palliative care beds. We found that 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. There was no bereavement support in place. Staff would give support as part of the care provided, but there were no arrangements or link to external bereavement services.

Summary of findings

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 investigation 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, which encouraged innovation and motivation. The trust had introduced new documentation and tools, including observation charts, to monitor patients. However, staff were experiencing difficulty because some aspects of the care documentation were designed for use in an acute setting rather than in a community hospital. Performance audits showed some poor performance and staff felt scores on performance did not always reflect practice and that care was being given, just not recorded appropriately. 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 for about six months. 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 tool, the Hurst Nursing Workforce Planning Tool, to assess need. It had been noted that not all shifts achieved the recommended skill mix, and recruitment was taking place to address this. Three general practices provided medical support; each held a lead role for the three specialist teams on the ward. External specialist teams from across the trust and the local hospice provided additional support and advice.

The ward was clean, well maintained and appropriately equipped. 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. Quality assurance systems ensured ward cleanliness, and equipment met appropriate guidelines and standards.

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. The ward operated in three teams each specialising in a field of care; this enabled staff to develop their knowledge and apply it to patient care. They continually sought ways to improve patient experience: for instance, one team had achieved the Gold Standard for palliative care.

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. They had specialised within three teams, so that they could concentrate on recognising and meeting patients' particular care and treatment needs.

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

Summary of findings

rehabilitation services for patients needing nursing and medical support after discharge from the acute hospital. In addition, the ward provided subacute medical care and had designated palliative care beds for end of life care. We found that 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. There was no bereavement support in place. Staff would give support as part of the care provided, but there were no arrangements or links to external bereavement services.

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, which encouraged innovation and motivation. The trust had introduced new documentation and tools, including observation charts, to monitor patients. However, staff were experiencing difficulty because some aspects of the care documentation were designed for use in an acute setting rather than in a community hospital. Some aspects of audit data showed poor performance and staff felt scores on performance 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 Adult Inpatient Survey, CQC, 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 Danetre Hospital, we found that the service scores were 92 for October and 90 for November 2013. The December inpatient newsletter celebrated the test score of 100% for patients likely or extremely likely to recommend the unit.

The hospital was given a score of 5 stars (out of 5) from contributors to NHS Choices, although there were no reviews for the period January to December 2013. 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 Danetre 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 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 not necessarily appropriate for a community hospital service.
- There were no formal arrangements in place to provide multifaith spiritual support.
- There were no bereavement services or links with external bereavement services.

Good practice

Our inspection team highlighted the following areas of good practice:

- Staff being supported to study for further qualifications to enhance the skill base within the ward.
- The multidisciplinary team working successfully in partnership to improve outcomes for patients.
- The palliative care team having achieved the Gold Standard for palliative care in June 2012.

Requires improvement

Danetre Hospital, Daventry

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, pharmacist, 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 Danetre Hospital, Daventry

The services on the inpatient ward at Danetre Hospital were provided by Northampton General Hospital NHS Trust (NGH). The inpatient ward was a 29-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 and end of life care. There were six beds dedicated to stroke rehabilitation and six beds for palliative care.

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 admission to the acute hospital, so providing 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 16 January 2014.

We spoke with 10 members of staff including the matron, ward sister, trained nurses, support workers, physiotherapists and the general practitioner for the ward. We also spoke with three patients, observed the care of patients throughout the ward and checked six 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 Danetre Hospital were provided by Northampton General Hospital NHS Trust (NGH). The inpatient ward was a 28-bedded ward and provided a programme of rehabilitation, nursing and medical care from a multidisciplinary specialist therapy team. This was a nurse-led service with support from three general practices.

The ward was on the first floor of the hospital. It had 16 en suite single rooms and three four-bedded bays. Six beds were dedicated to stroke rehabilitation and six to palliative care. There was access to café facilities in the building and patients were encouraged to use these as part of the rehabilitation programme.

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 for about six months. 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 nurse staffing and patient 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. Three general practices provided medical support; each held a lead role for the three specialist teams on the ward. External specialist teams from across the trust and the local hospice provided additional support and advice.

The ward was clean, well maintained and appropriately equipped. 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. Assurance systems ensured ward cleanliness, and equipment met appropriate guidelines and standards.

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

Requires improvement

Medical care (including older people's care)

team working throughout the ward and with trust specialist teams. Outcomes for patients were good. The ward operated in three teams each specialising in a field of care; this enabled staff to develop their knowledge and apply it to patient care. They continually sought ways to improve patient experience: for instance, one team had achieved the Gold Standard for palliative care.

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. They had specialised within three teams, so that they could concentrate on recognising and meeting patients' particular care and treatment needs.

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 the acute hospital. In addition, the ward provided subacute medical care and had designated palliative care beds. We found that 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. There was no bereavement support in place. Staff would give support as part of the care provided, but there were no arrangements or links to external bereavement services.

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, which encouraged innovation and motivation. The trust had introduced new documentation and tools, including observation charts, to monitor patients. However, staff were experiencing difficulty because some aspects of the care documentation were designed for use in an acute setting rather than in a community hospital. Some aspects of audit data showed poor performance and staff felt scores on performance 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.

Requires improvement

Medical care (including older people's care)

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 Danetre Hospital showed that from April 2013 to December 2013 there were three new pressure ulcers, five 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. On the inpatient ward there had been 20 cases of urinary tract infections in the past year, although actions had been taken to address this, such as more detailed risk assessment, and the incidents were declining (NGH community hospital incident data, 16 January 2013).

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. One serious incident investigation report involving a pressure ulcer grade 3 concluded the ulcer was unavoidable, and lessons learned to improve practice in the future included better body mapping (Serious incident report, 25 October 2013). 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 three sets of staff meeting minutes for each staff group, nursing, care support and therapists; each 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.

Systems, processes and practices

There was a system in place to reduce or eliminate risk that 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 patients' 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. The ward was designed to offer single rooms and bays with a small number of beds; we found it clean, light and well organised. 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 (NHS QuEST ward trend analysis, October, November and December 2013). When shortfalls occurred, staff were alerted to improve procedures, such as visitor use of hand gel on entry to the ward (NHS QuEST audit, October 2013). Assurance systems ensured ward cleanliness and that 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.

Medicines 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 or potential for abuse. Apart from one area, these were well organised and records were well maintained. We found that between May 2012 and August 2013 there had been no allocated pharmacist to review prescribing practices and arrangements, and to offer support. Information showed that patients were not always receiving medication that they had been prescribed were occurring each month without an explanation recorded, and in September 2013 there were nine cases representing 25% of patients on the ward (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.

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 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 six 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.

Staffing levels

Nurse staffing and patient dependency levels were assessed using a recognised nurse staffing tool, the Hurst Nursing Workforce Planning Tool. Some shifts were not always meeting the ratio of one registered nurse to eight beds that the trust wanted to achieve, although it was acknowledged the ward was currently over establishment for registered nurses at 113% (Medical director's quality report, 31 October 2013). There remained vacancies for healthcare assistants bands 2 and 3 and an occupational therapist (NGH community nursing staffing spreadsheet, 17 January 2014). Staff reported the lack of an occupational therapist was having an impact on the discharge of patients and adding to some delays. The trust was recruiting at the time of the inspection.

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 occurring, 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 had been 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 a stroke (care pathway) and dementia care.

The palliative care team had been awarded the Gold Standard for an evidence-based approach to optimising care for patients approaching the end of life.

Performance, monitoring and improvement of outcomes

Ward arrangements

The ward was organised into three teams, one of each providing care for patients with subacute medical conditions, rehabilitation and palliative care. This enabled staff to specialise, and develop knowledge and experience. For instance, there was good support for staff to undertake specialist training including degree level courses, and three healthcare assistants have achieved foundation degrees in palliative care and one in health and social care.

Audits

Monthly audits were taking place using the NHS Safety Thermometer assessment tool and the recently introduced tool known as QuEST (Quality, Effectiveness, Safety, and Team Review Results). 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.

Requires improvement

Medical care (including older people's care)

Care and treatment records

We examined three sets of patients' records and found assessments including risk assessments completed appropriately and 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. Observations were expected at a four-hour frequency; staff reported that this was not necessary with their patients and twice daily was more appropriate. Doctors were signing the backs of charts to agree the variation. Staff felt the conflict between what was expected by the template 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). The director of nursing confirmed this practice within an interview and believed that the staff should comply with policy and undertake observations at four-hourly intervals.

Staff, equipment and facilities

Mandatory training

The inpatient ward at Danetre Hospital was not meeting the trust target of 75% for mandatory training, scoring 71%, 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, equality and diversity levels 1 and 2 and manual handling two-yearly refresher training. The target was not met for refresher fire training (59%), infection prevention and control (55%), information governance (53%) and health and safety including risk management (62%) (NGH screenshot data, 17 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. 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 or an ambulance arrived to transfer them to NGH should this be required.

IT and facilities

The facilities within the unit were well maintained and of a good standard. There was regular maintenance and requests for repair were promptly dealt with. However, 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, "This is the best place I have ever worked for team working, and I have worked in a number of places, here and abroad. Outcomes for patients and care is good; many patients and their families do not want them to return home."

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 Danetre Hospital.

Since April 2013, patients have been asked in Friends and Family Tests whether they would recommend 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 Danetre Hospital displayed the results of the tests

Medical care (including older people's care)

on the ward notice board. The service scored 92 in October and 90 in November 2013. The December inpatient newsletter celebrated the test score of 100% for patients likely or extremely likely to recommend the ward.

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 Danetre Hospital.

Involvement in care and decision making

Patients told us they were well cared for and found the staff kind and considerate, although one person said that some members of staff could be a little distant at times. There was a positive attitude on the ward and patients and staff commented on this. Patient feedback led to actions for improvement and we saw recorded on the ward notice board how the service could improve in accordance with the comments. Patients reported that they appreciated the environment, which was clean and met their needs, and that the food was good.

Trust and communication

Patients confirmed that they were involved in all decisions about their care and that they were 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 took feedback from patients seriously and we saw on the ward notice board comments made by patients on suggested improvements and action taken by staff in response. This meant that staff were involving patients in decisions about their care and treatment but also on how to improve the service on the ward to benefit other patients and visitors.

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. One patient said, "I have not felt this safe and looked after since I was a child with my parents."

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, Daventry and surrounding towns and villages. The hospital provided care closer to home for patients fit for discharge from the acute hospital, Northampton General Hospital, but with a clinical need for rehabilitation services as well as continuing nursing and medical support for subacute medical conditions. 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. Palliative care for symptom control and end of life care were also provided. The ward did not provide respite care.

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, needed 24-hour nursing and medical support, and had the potential for rehabilitation.

Medical support

The ward was nurse-led with GP support from three general practices. Each general practice led on each care group: subacute medical, rehabilitation and palliative care. The GP leading on palliative care attended the weekly multidisciplinary team meeting with the consultant oncologist, who was based at Northampton General Hospital. The GPs worked Monday to Friday and one visited the ward daily. At all other times, staff called the 'Out of hours' service for medical support and advice. In an emergency situation with a deteriorating patient, the staff would call the 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.

Medical care (including older people's care)

Bereavement
The inpatient ward did not have any specific bereavement services for patients or their families. Staff supported individual patients and families as part of their general care, but did not have any arrangements in place to further support families after bereavement.

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.

The staff reported that local ministers would visit the hospital and offer spiritual support, but there was no access to support for different faiths. 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. 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.

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 19.6 days for elective cases and 23.7 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, 18 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 (Medicine division risk register, 08 March 2012). In addition, there had been some issues identified about the quality and coding of community hospital discharges, and these was being monitored (Medical director's quality report, 31 October 2013).

Staff said that they planned for discharge at admission, or within a short space of time once diagnosis had been confirmed. The multidisciplinary team work between hospital staff and the local authority was reported as good, and, when a patient needed to be discharged quickly, this was generally achieved. 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. Staff reported there had been few complaints but each one was had been investigated and the lessons

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learned were shared with staff at team meetings. There had been seven complaints since April 2013. We were shown the details of one complaint and how this had been referred for investigation.

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.

The trust was to stop providing services in the community hospitals by April 2014. The staff and 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 Danetre Hospital, which had been identified and recorded on the risk register on 2 September 2009. In addition, the trust's own monitoring systems had also identified that some patients were not receiving their prescribed medication, without explanation and against trust policy (Medicine risk register, 08 March 2012). 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. The trust 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 10% (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. The poor performance on completing appraisals was on the medicine division register, and had been since 8 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 inpatient ward at Danetre Hospital was not meeting the trust target of 75% for mandatory training, scoring 68.97%, with varying degrees of attendance at different courses. 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 also being linked to increments in salaries. The aim was to link attaining increments with completing mandatory training, with an appraisal arranged three months before the increment date. This was expected to increase attendance at mandatory training, but it did not address the backlog of appraisals.

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 Danetre Hospital, although staff confirmed that they had been encouraged by the ward management to take part.

Requires improvement

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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. New initiatives to drive patient care and job satisfaction were actively encouraged, as shown by the Gold Standard for the palliative care team. Staff 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 three sets of staff meeting minutes for each staff group: nursing, care support and therapists; each 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 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 to base decisions on. 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 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 by appropriately trained staff. Regulation 23 (1) (a).

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).