Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Royal Preston Hospital

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Date of Inspections: 18 November 2013
15 November 2013
14 November 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Cleanliness and infection control	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✖ Action needed

Details about this location

Registered Provider	Lancashire Teaching Hospitals NHS Foundation Trust
Overview of the service	Royal Preston Hospital is the largest hospital of Lancashire Teaching Hospitals NHS Foundation Trust. The hospital provides acute medical services to a local population of almost 400,000 people as well as specialist services to a wider population of people across Lancashire and Cumbria. There are a number of specialist services provided from the hospital including neurosurgery and neurology, cancer services and plastic surgery. The hospital has a busy accident and emergency department which includes a Major Trauma Unit.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 November 2013, 15 November 2013 and 18 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with other regulators or the Department of Health and talked with local groups of people in the community or voluntary sector. We were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

What people told us and what we found

This was an unannounced inspection carried out over several days. During the inspection we visited a variety of areas including the hospital's accident and emergency (A&E) department, the medical assessment unit (MAU), rapid assessment unit (RAU) and a number of medical wards.

We spoke to 31 people who were either using the service at the time of our inspection or had recent experience of it. We also spoke with over 40 staff members who included domestic assistants, nurses, health care assistants, doctors and senior managers.
The vast majority of discussions we held were very positive. Most people who were using or who had recently used the service, expressed satisfaction with their care and treatment. However, we did receive a small number of negative comments. The things people told us included:

"I have had absolutely first class care. They have all been brilliant!"

"The staff have been very kind and caring."

"I cannot thank them enough. They have been wonderful."

"The doctors have been fine and the nurses have been very friendly."

"The bay in A & E wasn't very private, people can hear everything!"

"They need to improve the way they communicate with patients!"

''I felt forgotten about while I was waiting but when I did see the consultant he was brilliant.''

During the inspection we looked at the care people received and how their welfare was promoted. We found that the vast majority of patients received safe and effective care that met their needs. However, we also found people's experiences were variable in relation to having a lot of ward moves or not being on the correct ward to meet their needs.

We inspected the area of cleanliness and infection control and found the Trust had good arrangements in place to help ensure that people were cared for in a clean, hygienic environment and were protected from the risk of infection.

We assessed staffing levels. We found there were safe staffing levels in most areas and that the Trust had implemented a number of positive measures to maintain safe staffing levels. However, we did find that not all areas of the service used procedures for responding to unexpected, short notice requirements effectively.

Arrangements for the monitoring of quality and safety were assessed. We saw there were good processes in place that enabled managers to monitor standards, identify risk and respond appropriately to adverse incidents.

We looked at how the Trust enabled people to raise concerns and their processes for responding. We found this area was in need of improvement.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The majority of people who used the service experienced safe, effective care. However, there was potential for the quality of people's care to be compromised if they were being cared for in the wrong environment or experienced excessive or unnecessary ward moves.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Throughout this inspection we consulted 31 people who were either using the service, or had very recent experience of it. The majority of feedback we were given was positive and most people expressed satisfaction with the care and treatment they had received. People's comments included:

"They were excellent! They took her straight in to resuscitation and she was seen by a doctor straight away. They kept a strict eye on her and explained everything. I felt at ease after talking to the consultant and knew she was in good hands. Everyone who attended her was attentive. I couldn't have asked for a better service."

"They asked me all the right questions and made me feel at ease. I was given some painkillers to take there and then."
People spoke very highly of staff at the hospital and told us they had been treated with kindness and respect. One patient said, "Every nurse and doctor I have seen has been absolutely wonderful." Another commented, "I cannot fault the staff at all, they are so busy but always so kind and caring."

Where people expressed an element of dissatisfaction, there were two very clear themes. These were around ward moves and communication. A number of patients told us they had been moved around wards more times than they felt necessary. This was also a concern that had been raised with Healthwatch Lancashire, on several occasions.

Two people being cared for on the RAU (Rapid Assessment Unit) told us they had been moved late at night and had been transferred onto wards and then back to the RAU. One patient described being woken up at around Midnight. "I woke up to see people packing up

my things. I was very disorientated, a nurse told me they were moving me here. It's very frustrating."
Another person described his experience as 'being pushed from pillar to post'. He commented, "It is a bind when you just get settled and then have to move somewhere else." This patient went on to explain that he had paid ten pounds for a television card to allow him to watch television on his previous ward, which he had lost due to being moved back to the RAU.

We saw one patient arrive on the MAU (Medical Assessment Unit) with a porter. He was told by the sister that there was no bed available for him. Eventually the staff took him into one of the examination rooms, with another patient.

We spoke with managers about the concerns raised by some patients in relation to excessive ward moves. It was recognised that the transfer of a patient to an alternative ward was sometimes necessary and in their best interests. However, in some of the cases we looked at and following discussion with staff, there was no apparent reason for some of the moves. Unnecessary bed moves could result in a lack of continuity of care as well as potential discomfort and disorientation for the patient.

Managers told us this was an area that had been identified for development and a number of measures had been put in place to improve patients' experiences in terms of ward moves. However, it was apparent from our discussions with some patients, that these had not yet been fully effective.

One patient who was dissatisfied about being moved also felt staff had not communicated with him well. "I came by ambulance on Tuesday at Midnight. I was here first, then I went to MAU (Medical Assessment Unit) but the next day they brought me back down here. I don't know why, I wish someone would tell me what's going on. I was taken for an xray and I didn't know why. I had to ask the girl who was doing the xray. They need to improve in communication."

Whilst the inspection was ongoing, the Care Quality Commission received letters from three people raising concerns about a lack of communication from the Trust. In two of the cases, the people were waiting for outpatient appointments which had been cancelled. They had waited for several months and felt the Trust could have communicated with them better throughout this period.

However some patients we spoke with did feel staff had communicated with them well during their stay. One patient told us that staff had explained everything to him the previous day but because he had been disorientated, they had taken the time to go through things with him again. He commented, "It was all a bit of a blur yesterday, so they have explained everything again today."

Throughout the inspection, we visited a number of wards and observed how staff provided care and interacted with patients. The majority of our observations were very positive and we saw many examples of very good care being provided in a kind and caring manner. We observed staff responding to patients' requests in a timely manner and addressing them with patience and respect.

On one ward we visited, staff had arranged for an older couple who were both patients, to be admitted to the same ward. We spoke with some of their family members who told us they were 'absolutely delighted' with the care that had been provided at the hospital.

We spoke with staff carrying out a variety of roles including health care assistants, junior doctors and consultants who without exception, demonstrated clear values and commitment towards good patient care. One senior nurse commented, "I have worked all over the country and this is the best place for patient care that I have worked at."

However, we did identify some concerns through our observations. We saw that the majority of patients appeared clean and comfortable and had their call bells within reach. Although we did see three call bells out of patients' reach. We spoke to one of these patients, who was on the MAU, and asked her if she knew how to request help if she needed it. She was not aware of the call bell.

On the morning of our first visit we met a patient on the RAU who appeared quite confused. This patient was quite mobile and needed close monitoring as he was disorientated. Staff told us that the patient needed enhanced care (one to one monitoring) to keep him safe but we saw this was not always being provided. The patient was regularly attempting to leave the unit and staff told us they were struggling to support him safely.

We examined the care plan that related to this patient and found his assessment document had not been updated to take account of the recent deterioration and that his confusion had first been noted more than twelve hours before we first saw him. There was no evidence that this person's care and management had been altered as a result of his deteriorating condition.

On the morning of the first day of our inspection, the accident and emergency department had a fairly low number of people waiting to be seen and the flow through the department was good. We spoke to people in the majors area, all told us they had been seen quickly on arrival and been given adequate pain control, though one person did tell us that it had 'taken a while'. Other comments included:

"There were other people being treated and I saw some people waiting, but patients like my wife who required urgent treatment, got seen straight away."

"We were seen within minutes of arriving. I feel like he is in good hands."

Staff were also generally complimentary about the way patient flow was managed through the Accident and Emergency Department. One senior nurse told us, "It is very busy but there are good processes in place to move patients on as well as communicating with them while they are here."

We spoke to three paramedics who conveyed people to the department. They told us that 'the vast majority of the time' they found the process of bringing in patients straightforward. They said they felt staff communicated well and told us they worked effectively to escalate the most unwell patients through the system as a priority. One of the paramedics told us, "This is one of the better ones (emergency departments) in the area."

We examined the cubicles in the 'majors' and 'minors' area. These were clean and tidy, though staff told us that when the department was very busy, 'people had to wait in corridors' although they said this did not happen very often. Staff told us they tried to move people through the system quickly to make sure they did not wait for long.

Other processes to assist effective patient flow following their transfer from A&E included an electronic beds management system and daily staff huddles, during which full reviews

of bed availability would take place.

We examined the pathway for people who were referred by the GP because they had a condition that meant they could be treated and sent home. We were told the area where people were seen in these circumstances was the Rapid Assessment Unit (RAU). We spoke to people who were currently admitted to this ten bedded unit. We spoke to 5 people whose condition did not seem to fit the patient profile for the unit. Three people told us they had been previously admitted to the medical assessment unit (MAU) and then moved from there to the RAU.

When we spoke with staff, we found that some people had been moved from the majors area in the emergency department, up to the MAU, in preference to those people who had waited in the RAU for up to three days. It was unclear as to why this was the action taken.

We looked at a number of patients' care records to assess how their needs and risks to their wellbeing were managed. We found patients' records were quite well organised and contained a manageable amount of information to guide staff in providing care.

Various assessments were seen, which included assessment of risk in areas such as falling, pressure sores and nutrition. There were detailed risk assessments for areas of complex need such as mental state, agitation and confusion. The assessments were complete in most of the records we saw.

We spoke with one patient who was assessed as being at high risk from developing pressure sores. We saw that a special mattress had been provided to help reduce this risk and the patient was also able to confirm that she was provided with regular pressure relief. We also looked at the care plan of one patient who had been assessed as very high risk in the area of nutrition. Records showed that during his short stay, he had managed to gain some weight, demonstrating good nutritional support.

However, we did note some gaps in care planning which included that of a patient with diabetes. The patient's records were not complete in relation to the support he needed to manage his diabetes. He told us that the day before he had mistakenly eaten some jam which was high in sugar, as he assumed the staff member who gave it him was aware of his condition. He told us, ''I should have managed it myself but I was really confused and disorientated.'' He was concerned that his blood sugar levels were 'through the roof.'

Staff we spoke with were generally complimentary about the risk assessment and care planning processes. One nurse told us, ''The documentation is very good as it prompts you to take everything into account.'' The nurse also felt that the processes for recognising a patient's sudden deterioration were also very effective.

There was evidence in all the patients' records viewed that people had been seen by appropriate medical staff and/or referred to other professionals as necessary and in a timely manner. A number of nursing staff we talked with were highly complimentary about the support provided by consultants, particularly in the emergency department.

Records showed patients were supported by a variety of professionals such as dietitians and physiotherapists and we were told by staff on all units and wards that access to such professionals was readily available. One ward sister told us, ''The team work is exceptional. It helps us to provide seamless care.'' A doctor in the emergency department commented, ''We have a fantastic relationship with diagnostics which means people get all

the tests they need really quickly."

We were advised by managers of a new process, which had been implemented across the Trust to improve outcomes for patients, who had been in hospital for over 21 days or had experienced six ward moves or more. The process involved an enhanced approach to multi disciplinary care planning, to help ensure that any improvements that could be made to a patient's care and treatment plan were implemented.

There were procedures in place to help ensure patients' wellbeing and safety was maintained in the event of an emergency or major incident. In general, staff we spoke with demonstrated a good understanding of the procedures and said they were confident they would be effective if required.

There were processes in place to check emergency equipment on a daily basis, to ensure it was safe for use and working effectively. However, we saw that the cubicles in the majors area of the A&E department had some very dated ventilator equipment attached to the wall. The majors area is not often used for patients with such a high level of care requirement and we asked staff to explain why this equipment was there. We were told it was only to be used in case of a major incident where many people may require artificial ventilation. The equipment varied most significantly from the ventilators being used in the resuscitation area and this had the potential to cause confusion amongst staff.

Staff had organised for the equipment to be checked and serviced by an engineer, who had documented it was compliant by placing a yellow sticker on the device. Unfortunately, this sticker had been placed over a crucial oxygen gauge making it almost impossible for staff to use the ventilator effectively without removing the sticker. There was also no documentation to inform staff as to the circumstances in which this equipment should be used. We discussed our observations with managers at the time who agreed to deal with the equipment immediately. The provider may wish to examine processes for checking emergency equipment in light of these findings.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Appropriate guidance had been followed which helped to protect people from the risk of infection.

Reasons for our judgement

During this inspection we visited the Accident and Emergency (A&E) department and five wards. We noted that all the wards and departments we viewed appeared to be clean and in a good state of repair. Most areas viewed were clutter free and well organised. However, we did see some ventilators on the A&E department, which had single use oxygen tubing attached, some of which was unsealed and trailing along the floor. This represented an infection control risk to people and as such, was pointed out to managers, who agreed to deal with it immediately.

We saw that clinical waste was being disposed of in the correct manner and there were ample clinical and general waste bins provided, which were not overfilled. We also noted that bins for the disposal of needles and sharp medical devices were not overfilled.

There were sufficient hand washing facilities and paper towels available on the wards and hand gel dispensers appropriately placed at entrances to all wards and departments. Those we checked, were working properly and were adequately filled.
Staff members we saw throughout the inspection, were appropriately dressed, in accordance with the Trust's infection control policy. We noted that staff observed good hand hygiene practice in all the wards and departments we visited.

There was a good amount of information available for patients, staff and visitors regarding precautions they should take. This included clear signage to remind people to use hand gels when entering a ward or department. Information regarding cleaning schedules with a clear list of planned activities, was also posted in each area we visited.

We asked some of the patients and relatives we spoke with about their views of cleanliness and hygiene within the hospital. Without exception, they were very complimentary about this area. Their comments included, "They were particular with hygiene, they wore gloves and washed their hands all the time." And, "The place looked clean and really organised." Another patient who had been in hospital for several days said, "I see them cleaning all the time, they seem to always be doing something and from what I've seen, they always wash their hands."

We spoke with a number of staff throughout the inspection who carried out a variety of roles including doctors, nurses and domestic workers. Every staff member we asked about infection control procedures, demonstrated a clear understanding of the area and was able to confidently describe the processes they should follow. One junior doctor commented, ''They are very hot on that here! Everyone knows it's an important issue.'' Nursing staff were very complimentary about the support provided in this area. They described frequent visits on their wards from infection control specialists and also explained that advice was available throughout the day and night if they needed it.

Records demonstrated that all staff were provided with training in the area of infection control at the start of their employment. There were clear systems in place for the induction and support of new staff in the domestic department, which included a mentoring and observed practice system. This helped to ensure staff worked in a safe and effective manner. It was pleasing to see agency staff employed within the Trust, were also provided with a similar induction.

Staff training was updated on an annual basis. However, we were advised there were processes in place to provide additional training to any staff member who required it and that the training could be adapted to support a staff member's particular development needs. Staff told us that they found the training in infection control useful and confirmed it covered sufficient detail. One domestic worker described being supported to complete national vocational training, as well as the Trust's own courses. She said, ''The training is very good. It's not just the facts. They help you understand why it's important to do things in certain ways.''

We were able to confirm that staff involved with patient care were provided with training which included aseptic non touch techniques (ANTT), a tool which helps to prevent infections in health care settings.

A domestic supervisor described his very detailed training portfolio and told us that the domestic role was a complex one, which he said 'wasn't just about cleaning'. He commented, ''Our role has evolved but so has the training to support us.'' He was clearly very knowledgeable and competent in the area of infection control.

As well as routine cleaning schedules, we saw there were processes in place to respond to any unplanned requirements such as spillages or infection control incidents. There was a 24 hour response team in place, who were able to attend an area at short notice as well as provision for the completion of special, deep cleans where necessary. We were advised by managers that additional staff resources had been allocated to the response team as part of the Trust's winter plan.
There were clear protocols in place providing staff with guidance in supporting patients with infectious diseases. The Trust's dedicated infection control team were involved in all identified cases, carrying out daily visits to the patient and observing the procedures taken.

There were processes in place to monitor outbreaks of infectious diseases and where appropriate, detailed analysis was carried out to examine the cause and identify any incidents where correct procedures had not been followed. As part of the overall governance of the service, all outbreaks were reported to the head of patient safety, through the Trust's incident reporting system.

Following recent breaches of the Trust's national trajectory of Clostridium Difficile (C Diff)

cases, an action plan had been implemented. As a result, domestic services and cleaning systems had been reviewed. Audit processes had been strengthened and a peer review had taken place at the service, carried out by an external organisation. The action plan was being monitored by the Trust's Infection Control Committee, which was a group composed of Directors, Clinicians, Managers, Senior Nurses and experts in Infection Prevention and Control.

Comprehensive infection control audit processes were in place as well as a variety of systems for monitoring the standards of cleanliness within the hospital. A dedicated team were employed to carry out checks and observe standards. In addition, managers also carried out regular checks by visiting various wards unannounced and observing standards through initiates such as the 'Ward of the week' and the Trust's internal CQC style inspections. One domestic worker told us, "They monitor is all the time! They give us scores. I make sure I always get good scores!"

We were also able to confirm that where a shortfall in standards was identified, through the audit and quality monitoring standards, there were processes in place to ensure they were addressed. This included the requirement of an action plan by the ward and a revisit by the quality team, within a set timescale to ensure that necessary improvements had been made.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

Positive measures were in place to help maintain safe staffing levels but not all areas of the service benefitted from them.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

As part of this inspection we examined staffing levels within the service. We spoke with patients about their experiences and their views of staffing levels. The vast majority of patients told us they felt they had seen ample numbers of staff on duty. Their comments included:

"There are plenty of staff about. I'm surprised."

"There are definitely enough staff around."

"I'm more than happy. I've had really good care and never been left waiting for anything."

However, one patient, who was on the Rapid Assessment Unit (RAU) did express some concerns about the staffing levels there. He commented that another patient who was confused had been very unsettled. He complained that the patient had not been monitored carefully through the previous night. He said, "It's not their fault (the staff). There aren't enough of them to cope with all the people on here."

This patient's view was supported by our observations on the RAU. On the first day of our inspection we found the unit to be very busy with a number of people in beds and a large number of people in chairs who had been sent by their GPs. Staff on the unit appeared to be under pressure and two staff members told us they were struggling to cope. We asked one worker if this situation was normal and they said that it was, 'more often than not.'

We also noted that a patient who was in need of enhanced care because he was confused and frequently attempting to leave the unit, was not receiving this. We spent 20 minutes on the patient's bay observing. We saw that a staff member checked on him for a few minutes during this time, the rest of the time, he was unsupported.

We discussed the situation with managers from the Trust. There was a difference of opinion as to whether additional staff support had been provided to help support the

patient and we received conflicting information in relation to that point. However, we were able to confirm the patient was not receiving enhanced support when we carried out our observations there.

It was established that the RAU was not operating as it had originally been intended, which was as a short stay unit. Managers told us they had recognised this and changes to the way it operated were due to be implemented. Managers agreed to look at staffing levels in the interim, to ensure they were in line with the needs of patients being cared for on the unit.

In discussion, managers told us comprehensive staffing and skill mix reviews were carried out regularly across the service. This information was supported by staff who we spoke with. The A&E matron advised us that such a review had taken place within the department she managed and that as a result, staffing levels had been increased. We were advised some of the additional posts were still to be appointed.

The Trust have recognised challenges in relation to the increasing number of patients requiring enhanced care and large vacancy rates, which are issues for many services across the country. In response to these challenges, a number of measures have been introduced to help ensure safe staffing levels are maintained.

We saw such measures included a process whereby additional staff could be requested by a particular ward, to help support a patient requiring enhanced care because for example, they were at high risk of falling. However, some staff we spoke with told us these requests were not always met and this information was supported by notifications we had received from the service over recent months. We did note that requests for additional staff members and their outcome, were closely monitored by managers. We were advised at the time of our inspection, that approximately 66% of requests had been met in the previous quarter.

We were also able to determine that staffing levels across the Trust were closely monitored by senior managers through the Trust's incident reporting system and unannounced inspection on wards by managers. These inspections included examination of the area and discussions with staff and patients. During daily management meetings, the overall situation in terms of capacity and staffing, was monitored to help anticipate any potential problems.

Further measures taken to support safe staffing levels included considerable investment in additional nursing staff as well as pro-active recruitment activity by the Trust, such as their attendance at job fairs and overseas recruiting. Improvements to HR processes had also been implemented to help ensure staff who were selected, were able to start their posts as soon as possible.

The information provided by senior managers was supported by staff from most areas, who in general, felt staffing levels were adequate. Many staff members we spoke with felt that there had been recent improvements in staffing levels. Their comments included, "There have been a lot of new starters so numbers have come up." And, "I don't think we can say we are understaffed. The other thing is that if we have agency staff, they are usually the same faces. That helps a lot because they know how we do things."

Staff that we spoke with were also generally complimentary about the skill mix of staff and availability of senior clinicians. One staff member in A&E commented, "We have a strong

consultant presence. They are on site until midnight and then on call. This means junior medical staff receive a good level of support as well."

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of the service that people received.

Reasons for our judgement

All NHS organisations are required to have a comprehensive programme of quality monitoring and improvement in place. Trusts refer to the processes of quality assurance as 'governance'. We examined systems for monitoring the quality of the service and looked at how the Trust ensured that their governance arrangements resulted in the continuous improvement of patient care.

Arrangements were in place to monitor quality at ward and department level. In addition, there were processes that enabled senior managers to monitor performance across the Trust.

At ward level, various aspects of quality and performance were constantly monitored. Audits were in place that assessed safety, quality and performance in areas such as equipment, stocks and cleaning, as well as those areas directly related to the wellbeing of patients such as falls, pressure sores and nutrition.

We saw that all wards had performance boards describing their performance in relation to important areas of patient care, as well as information about complaints and feedback. In all the areas we visited, ward performance boards were up to date and highly visible.

There was a process in place, whereby unannounced inspections were carried out on wards. The inspections, which were conducted by senior managers, focused on the essential standards of quality and safety. In addition, they included gathering the views of staff and patients. We saw that following an inspection, a ward would be given a report and rating. Any areas identified as needing improvement would be addressed in an action plan. We also noted follow up inspections were carried out in all cases, to ensure improvements had been made.

In addition to the unannounced inspections, we were advised that executive directors carried out weekly walkabouts, during which they would visit wards on an unannounced basis and speak with patients and staff about their views of safety and quality.

Trust wide performance results were available to senior managers, which also enabled the user to drill down to specific areas. Action and improvement plans were monitored by the executive team, to help ensure required improvements were achieved.

The Trust's quality assurance processes included clinical audits. Clinical audit is a process of reviewing care and outcomes for patients against a set of criteria or standards. Some of these standards are nationally agreed and some are defined by the Trust. We saw that the Trust continuously monitored outcomes of clinical audits and responded quickly if audits indicated that an area needed to be investigated in more detail.

We saw evidence the Trust monitored mortality ratios and alerts using Dr Foster Intelligence's (DFI) information systems. Evidence was available to demonstrate that where risk was identified, the Trust were quick to respond by carrying out detailed reviews.

Patients were asked about their views of the service in a variety of ways including an electronic survey which examined their experience of using the service and the care they had received. The Trust patient feedback system included a requirement for ward managers to monitor performance and identify improvement actions for any serious negative responses.

We saw some examples of changes that had been made within the service as a result of patient feedback. Through the 'You said, We did' system various improvements had been made including an increase in the number of wheelchairs available for patients' use and a wider choice of sandwiches.

Effective learning from adverse incidents, near misses and complaints was evidenced. Governance arrangements had been reviewed to include three improvement groups. Their roles were to ensure lessons were learned and resulted in improved safety, effectiveness and patient experience.

We saw an example of improvements implemented as a result of learning from adverse incidents and complaints. The operation of the discharge lounge within the service had been completely reviewed and a number of improvements made. The changes had resulted in patients who were waiting to leave the hospital receiving a much improved standard of care and support.

A number of staff that we spoke with commented on recent improvements in the Trust's Datix system. This is a system used for reporting concern incidents and near misses. We were advised there had been some recent investment in the system which would enable managers to have clearer oversight across the service.

There are a number of national performance targets in place which most services are required to meet. In recent quarters the Trust had missed some of these targets, mainly in relation to waiting times, referral to treatment times and infection control targets. We discussed the areas with senior managers, who shared with us detailed action plans, which had been implemented as a result of the missed targets. These demonstrated that time had been taken to understand the performance issues and identify the necessary improvements. The effectiveness of the action plans was being monitored on an ongoing basis.

Detailed plans had been put in place to enable the service to cope with the increased

demand for their services in the winter months, that had been anticipated. These included increased GP support and improved utilisation of community services. In addition, increased consultant led ward rounds and enhanced social care services had been implemented to help in achieving effective patient flow and discharge.

A senior staff member from each department made up the Winter Intensive Support Team. This team met on a daily basis to review demand and capacity and ensure that services continued to be delivered safely and effectively.

The majority of staff we spoke with felt there was good communication from senior managers at the Trust. People told us they felt their opinions were valued and described them in ways such as 'approachable' and 'supportive.' One senior nurse commented, ''This Trust is very supportive to nurses. My experience of the managers has been very positive so far.''

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

Improvements were required to help ensure that people who made complaints received satisfactory support and were provided with appropriate responses.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with some patients about their understanding of the Trust's complaints procedure. Very few patients had enquired as to the processes they needed to follow to make a complaint, although the majority told us they knew where to find the information should they require it.

When touring the hospital we looked for information about complaints in the form of posters for example, but did not see any in the wards or departments we visited. We spoke with managers who told us complaint information was included in bedside packs for patients. However, people using outpatient or A&E services would not have access to these.

We had discussions with some people who had used the Trust's complaints procedure. For some people, their experiences had been less than satisfactory and they had felt that they had not received adequate communication from the Trust while waiting for a response. In one example, we saw that a complainant had waited eight months for a response. We noted that the issues raised were very complex and had required detailed investigation. However, this contact showed us a record of calls and emails they had made throughout their wait, to the Trust's customer care department, some of which, they had not received a response to. They told us that they would have found the process much less stressful if the Trust had updated them on a monthly basis while they were waiting for a formal response.

Another person that we spoke with had wished to make a complaint and contacted the Trust's complaints department. They explained that the department had advised her that they needed to make their complaint in writing. They were unable to do this due to their disability and contacted the Care Quality Commission for advice. We talked with the head of customer service about this person's experience. It was acknowledged that the advice they had been given was not acceptable and agreed to reiterate to all staff, the importance of providing adequate support to enable people to raise their concerns.

The majority of staff we spoke with were able to describe the Trust's complaints procedure

and tell us how they would support a patient to raise concerns. However, we were aware of one example where a staff member had failed to follow the correct procedure when responding to a verbal complaint. This had resulted in the complainant receiving a very poor response to the concerns they had raised. This had been identified by the Trust who had taken action to help ensure the situation did not occur again.

We were advised that all complaints received at the Trust were risk assessed so any urgent issues relating to a patient's welfare could be referred through the correct safeguarding channels. However, during the inspection, we noted one such example of a complaint received by the Trust that was not referred through safeguarding procedures for a period of two weeks. This meant there was a delay in investigating the urgent issues relating to the patient's care.

Senior managers we spoke with advised us that the area of complaints management had been identified as being in need of improvement. It was acknowledged that the experiences of people using the process had been variable, as had the standard of some of the responses provided.

At the time of our inspection, an updated procedure had been presented to the Trust's board for approval, which included a number of improvements in relation to how complaints were to be investigated and how the Trust would communicate with complainants.

Managers were also able to provide evidence that extra investment had been made in the area, including the recruitment of additional staff to support people making complaints and to help ensure they received timely communication and responses.

We saw there were processes in place to ensure all complaints were monitored so that any themes or trends in relation to a specific area or department for instance, could be identified. Senior managers told us this monitoring took place so there could be greater emphasis on lessons learned and the communicating of such lessons to staff throughout the Trust.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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 activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Not all service users were protected against the risks of receiving unsafe care or treatment. Regulation 9(1)(a)(b)(i)&(ii)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not always sufficient arrangements in place to ensure sufficient staff were available to safeguard the health, safety and welfare of service users. Regulation 22.
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met:

This section is primarily information for the provider

Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	The system for receiving, handling and responding to people's complaints was not always effective which resulted in unsatisfactory outcomes for some people who made complaints. Regulation 19(1)&(2)(a)(b)&(c)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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