Agenda Item: 10

TRUST BOARD – 27 FEBRUARY 2013

RISK & QUALITY COMMITTEE – 20 FEBRUARY 2013
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Risk & Quality Committee (RAQC) meeting of 20 February 2013.
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. To improve continuously the quality of all aspects of our services ☑ 2. To consolidate acute services for complex or serious conditions onto a single site ☑ 3. To work with colleagues in primary care to expand local access to specialist acute services ☑ 4. To maintain the pre-eminence of Mount Vernon as a tertiary Cancer Centre, and to provide more cancer care locally
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board. Any major financial implications of matters considered by the RAQC are always referred to the FPC.
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance.
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	Chair of RAQC
PRESENTED BY:	Chair of RAQC
AUTHOR:	Governor Support Officer
DATE:	February 2013

RISK AND QUALITY COMMITTEE (RAQC) – 20 February 2013

EXECUTIVE SUMMARY REPORT TO BOARD – 27 February 2013

Matters Referred from Board / Committees

The RAQC considered a request from the Board that future reports to the Board should include more detailed reference to the assurances received and discussions by the RAQC on the quality and safety indicators within the floodlight scorecard, with the aim of assuring those members of the Board who did not attend RAQC that appropriate assurances on these areas had been received. The RAQC acknowledged this, noting that some of the indicators receive particular focus on alternate months in line with the annual cycle and when the new quarterly data is available.

Floodlight Scorecards & SHA Quality Indicators

The RAQC received the floodlight scorecard for month 10 (January 2013).

In relation to patient safety it was noted that drug errors / administering has failed year to date, so that the indicator will remain red for the rest of the year. Emergency screening has fallen below 95%, and an exception report detailing the reasons and an action plan were considered within the Infection Control Monthly Report later on the agenda. The RAQC heard that two grade 3 pressure ulcer cases had been removed since production of the floodlight as they had been deemed unavoidable.

In relation to patient experience, the results of the final quarterly survey are awaited and will be included in the next Patient Experience report to the Committee. As this is a quarterly indicator, results are unchanged from last month. In relation to Involvement in Decisions, it is hoped that forthcoming customer care training will improve performance against the indicator. In relation to Medication Side Effects, it was noted that this often related to medication which had been used over a long period of time. In relation to Who To Contact After Discharge, the RAQC heard that discharge booklets are being printed and re-order / re-use levels will be monitored. The difficulties associated with ensuring that patients absorb the significant amount of information presented to them – and the need for reminder processes - were highlighted.

The RAQC also heard that high demand in December and January had meant the A&E 4-hour target indicator was red for these months: bed-flow issues had also been a factor in the increase in breaches. The Committee heard that work was being done to better understand the nature of the demand, including how much derived from the Ambulance Service. Focused work was also taking place in relation to clinical efficiency to improve performance in this area.

Trust Operating Plan – Improvement Priorities 2013/14

At the request of the Board, the RAQC considered proposed improvement priorities. It was noted that feedback had been received from the Strategic Health Authority, which had requested that some be made more 'SMART': the SHA had also requested patient experience as a separate indicator, meaning 6 indicators would be produced rather than 5.

The RAQC emphasised the need for simple language, and alignment between the improvement priorities and quality account indicators. It was also noted that the short timescale for planning had meant the Trust's usual consultation processes had not been able

to be followed. The RAQC agreed that the timescales set external to the Trust had been too short.

The RAQC agreed that the Company Secretary, Director of Nursing and Medical Director should review how the targets could be more 'SMART', and subject to this, approved the improvement priorities.

Proposed floodlight indicators 2013/14

The RAQC considered proposals to review the detail of the Trust level floodlight indicators and divisional indicators so that these map the Monitor Risk Assessment Framework and NHS Outcomes Framework for 2013/14, to enable more integrated reporting.

The RAQC agreed the proposal, and endorsed the use of the Outcomes Framework headings, which are written in a patient-centred way. It was agreed that the Company Secretary and Director of Operations would further consider the format for a revised floodlight.

Draft internal audit plan

The RAQC considered the draft internal audit plan for 2013/14 and was invited to comment on the proposed areas of work focus.

The RAQC commented that the workforce items - quite high risk – were not scheduled to be audited until 2014/15, whereas Portering – lower risk - was scheduled to be audited in 2013/14. The RAQC agreed that it may be beneficial to use the workforce days and OCH audit days together, and to amalgamate the workforce planning items.

The RAQC also considered that there could be more audit focus within divisions: the gap between admission and first consultant review was suggested as an audit area and noted that Incident Tracking belonged within Patient Safety/Governance rather than Health & Safety.

The comments of the RAQC will be collated with those of the Audit Committee and Executive Committee, ahead of a meeting between the Audit Committee members (Non-Executive Directors) and internal audit in March.

End of Life Strategy - progress

The RAQC received a report summarising progress in implementing the Trust's End of Life Strategy. The importance of appropriate end of life care was set in the context that approximately 54% of the local population will die at one of the Trust's hospitals, compared with only 5% at a local hospice. The Trust is therefore the most significant provider of terminal care for the local population.

The RAQC heard about key areas of work in relation to end of life care. In relation to the Liverpool Care Pathway, the Committee heard extensive auditing had taken place on the use, and appropriateness of use, of the LCP within the Trust: no evidence of inappropriate use had been discovered, and the audits had shown that the Trust was following good practice. Concern was expressed about the risk that, following recent adverse publicity around the use of the LCP, medical decision-making could become weighted towards the opinions of relatives rather than ensuring the best means of dying for terminally-ill patients.

The RAQC also heard about the forthcoming use of the AMBER care bundle – a tool for managing clinically unstable patients whose outcome is uncertain. This will be rolled-out across the QEII and the Lister over the next 12-18 months, with outputs being evaluated subsequently.

The RAQC was content with the assurances provided around the use of the LCP and the evidence arising from the audits, and recommended that work should be undertaken with the media to attempt to dispel the misconceptions around its use.

CQC Registration Application – Renal Services

The RAQC considered key dates regarding the provision of a new renal services satellite dialysis unit in Bedford, and was invited to approve the submission of an application to the CQC to register the unit as a new location where the Trust will carry out the regulated activity of 'treatment of disease, disorder or injury.'

The RAQC approved the submission of the application to the CQC.

CQC Review of Compliance Report – Lister Hospital

The RAQC received the report of the unannounced CQC inspection, carried out on 6 & 7 December 2012 at the Lister Hospital site, and noted the assurance it provided that the Trust had met all 5 of the essential standards.

The positive report, which included favourable comments from patients and staff, was welcomed. The RAQC was particularly pleased to note the high level of awareness amongst staff of whistleblowing procedures and protocols for safeguarding vulnerable adults and child protection, as reported on page 10; and also particularly welcomed the findings in the report relating to mandatory safeguarding training levels (74% of staff had completed safeguarding training during the October to December 2012 period).

The RAQC agreed that the positive messages arising from the report should be communicated widely. The report is appended.

Medical Director Report

The RAQC received the Medical Director report. Concerns arising from the Clinical Governance Strategy Committee about reported difficulties in locating documents on the Knowledge Centre were noted, and the Committee heard that work is being done on content management. The RAQC also heard that Datix web has been set up to capture details of 'being open' for all incidents causing harm, in response to the forthcoming duty of candour requirement to be open with patients after causing harm.

The RAQC noted the mortality trajectory, and that HSMR has remained below 100 for each month in the current financial year. SHMI figures are higher as the indicator lags, and also because of the impact of the funded hospice at the Mount Vernon Cancer Centre. The RAQC welcomed the news that the latest SHMI data showed an improved position to 110.8 and was no longer an outlier. In relation to CQUIN pathway monitoring it was noted that there have been improvements in HSMR for every pathway. There have been no new CUSUM alerts since December 2012.

The Medical Director also updated the RAQC on the positive outcome of the recent Postgraduate Dean's Performance Review Visit in January.

The RAQC noted the update.

Workforce Report – New Template

The RAQC considered a new draft format for future workforce reports to the Committee. The new format for the report is intended to provide comprehensive workforce information to support decision-making processes, and to reflect a clearer link between workforce data and the *Our Changing Hospitals* programme.

The RAQC welcomed the new format, and in particular the proposed inclusion of information around performance against the pay budget. It was recommended that additional detail on workforce productivity / efficiency is provided; the RAQC also highlighted the importance of selecting measures which reflect strategic targets.

The RAQC approved the new workforce report template.

Francis Inquiry

The Committee received a summary of the key findings and recommendations arising from the Francis Inquiry, and considered the implications for the Trust of the proposed NHS-wide changes recommended by the Inquiry.

The RAQC agreed that the Trust already implements much of the good practice which had been recommended, and heard that further work would be undertaken at a granular level to evaluate the Trust's performance against individual recommendations, and to consider how the Inquiry's recommendations should be reflected in future policies.

The RAQC noted the key recommendations arising from the Francis Inquiry and welcomed proposed further debate around the implications of the report at Board and a future Board development session.

Research and Development Strategy mid-year review

The RAQC received a mid-year review of the Research and Development Strategy 2012/13. Key areas of development were noted, including national proposals to reduce the number of research networks and proposed changes represented by the new ACoRD (Attributing the Costs of Non-Commercial Portfolio Research) guidance, which may have an impact on availability of funding to support research. In relation to the Key Performance Indicators for 2012/13 it was noted that the majority of these are 'green', with some 'amber'. The Committee also heard that a statutory Good Clinical Practice (GCP) inspection by the Medicines and Healthcare Products Regulatory Agency (MHRA) has been notified: a portfolio of evidence is being prepared and it is expected that the inspection will take place towards the end of the year.

The RAQC noted the update.

Infection Control monthly report

The RAQC received its regular report on infection prevention and control performance for the month of January 2013, and performance over the previous 11 months.

It was noted that two un-related cases of C.Difficile had been reported in January, but that the trajectory remains on target. Trajectory for MRSA bacteraemia also remains on target, with no cases of hospital-acquired MRSA Bacteraemia in the month. Emergency MRSA screening compliance fell below 95% and an exception report detailing the causes and action plan to address these was provided.

It was noted that there had been a downward trend in specimen testing for C.Difficile in November and December 2012, but that the trend was now upwards again.

The RAQC noted the update.

Patient Safety Accountability Structures

Following a request at the 23 January 2013 meeting for further assurance regarding lines of accountability in relation to patient safety, the RAQC received further information on reporting structures and lines of accountability for patient safety. It was clarified that the Director of Nursing and Medical Director are the executive leads for this area (and responsible for

setting the strategy in relation to patient safety); however, the Board retains joint responsibility (with Executive portfolios set out in the Corporate Assurance Map) and all Trust staff have a role in ensuring patient safety, with responsibility cascading down through divisions. There is also accountability through the Patient Safety Committee (chaired by the Director of Nursing) and the Clinical Governance Strategy Committee (chaired by the Medical Director). Non-Executive Directors were invited to attend a divisional performance review, in order to see the practical operation of the way in which Trust staff are held to account for patient safety.

Dyan Crowther, Committee Chair
Non-Executive Director

Inspection Report

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

Lister Hospital

Coreys Mill Lane, Stevenage, SG1 4AB

Tel: 01438314333

Date of Inspection: 06 December 2012

Date of Publication: February 2013

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	East and North Hertfordshire NHS Trust
Overview of the service	Lister Hospital is part of East and North Hertfordshire NHS Trust. The hospital provides medical and surgical services across a range of general wards and specialist units as well as accident and emergency services for adults and children.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning 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 6 December 2012, 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 and talked with staff.

What people told us and what we found

People spoken with told us they had experienced care and treatment that met their needs at the Lister hospital and had been involved, where possible, in decisions about this. One person told us they had seen a consultant or a doctor everyday during their stay and who explained clearly to them before and after any procedure or treatment. They said, "They speak to me, they always explained what was to happen, why, the risks and the expected outcomes, I cannot fault that."

We found people's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others. People who use the service were also protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We spent time on three wards during our visit and spoke with five patients about staffing levels. Most of the people we spoke with told us that there were adequate staff in place to meeting people's needs on a day to day basis.

During our inspection visits on 6 and 7 December 2012 we saw records that showed that staff at the trust worked to continuously improve the quality of all aspects of their services through the review of progress against organisational performance priorities and strategies.

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

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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's care and treatment was planned and delivered in line with their individual assessed needs. Patients spoken with confirmed their needs had been assessed and their plan of treatment, or changes to it, had been discussed with them.

One person told us, "I was referred by my GP. I had a pre-op meeting with staff involved who explained what would happen and the risks of the procedure. Staff were very good, they rang my wife twice to tell her I was still in recovery, there was really good communication. Staff checked me regularly and asked if I needed pain relief. I am very happy with the care." Another patient told us they had seen a consultant or a doctor everyday during their stay and who explained clearly to them before and after any procedure or treatment. They said, "They speak to me, they always explained what was to happen, why, the risks and the expected outcomes, I cannot fault that."

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We looked at patient records both in paper and electronic formats. Assessments were completed to identify risks relating to nutrition, falls, moving and handling and pressure areas. A care plan was in place where a risk was identified. The patient's risk of developing blood clots in deep veins [VTE] was considered. It was recorded on their drug chart along with any medicines prescribed to manage this. This meant that staff had information on how to support the person safely.

Staff told us that they attended handover each shift to hear about how each patient was currently. Staff were allocated particular patients to support during that shift. They were given up to date printed information regarding each of those patients. The staff had responsibility to check each patient regularly throughout the shift rather than waiting for patients to call for assistance. This system of 'intentional rounding' looked at pain, personal care, positioning and possessions such as having things that were important to the patient close by them. It also reviewed any equipment in place to support comfort and safety and included asking the person if they needed anything. Patients we spoke confirmed this. A

staff member told us the system supported continuity of care and effective monitoring of patients.

We spoke with a health care assistant, four nursing staff and three doctors. They told us that all patients were assessed daily by a registrar or consultant. They also told us that there were effective systems in place with senior medical support readily available to review patients when they became unwell.

We saw that staff recorded outcomes of their regular patient checks and informed more senior staff of any concerns. A traffic light system to record outcomes of routine nursing observations identified where a patients' condition deteriorated. Nursing staff told us that in this circumstance they would contact the registrar and a critical outreach team was also available on weekdays to provide additional support. They told us these systems worked effectively when they needed it. We saw that this had occurred in practice during our visit and immediate medical support was obtained for the patient.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

A hospital of this size supports and accepts transfers and discharges of patients with changing care and treatment needs on a daily basis and the majority of these happen smoothly. However we were aware of a very small number of cases over the past year where the transfer processes had not provided a wholly seamless pathway for people transferring from an independent sector health care facility within the grounds of the Lister Hospital site. Patient care and outcomes were not compromised in any of the instances, however, we wanted to establish if there had been any learning and corresponding improvements made.

We found that the trust had a hospital discharge and transfer planning policy, which had been reviewed and issued in June 2012. This policy contained a specific flowchart regarding the transfer of patients from the independent sector treatment centre into the acute trust facility. We also saw the trust policy for a recently revised policy for dealing with clinical handover over patients. This set out the expectations and requirements of effecting safe transfers of patients across different clinical teams within the trust.

We saw a number of other trust policies, which supported the management of patient care pathways for those who had not required emergency care and treatment. One such policy was in relation to those people who were waiting for assessment and treatment and was reviewed bi-annually and updated as required. This policy described how the trust managed access to its services and ensured fair treatment to all patients. It included a relevant section about the interrelation between the trust and the independent sector health care facility.

We reviewed the transfer of information forms used for patients who were discharged back to a residential or nursing care home, along with a copy of the discharge GP letter which accompanied the person. These contained all relevant information about the individual's stay in hospital and any ongoing treatment or medication requirements. Staff explained that the discharge process involved discharge letters being generated electronically and given to the patient on discharge. A copy of the discharge letter was sent electronically to the individual's doctor.

We also saw that patient monitoring had been reviewed and was being improved through

the introduction of the National Early Warning Score system across the trust. This, when embedded, was aimed to improve the quality and consistency of care and treatment through timely recognition of changes in patients to inform decisions regarding their treatment plans.

We also spoke with staff from the Critical Care Outreach team who currently cover both the Lister and Queen Elizabeth II Hospital sites. The staff explained how this team supported all clinical teams within these two sites, including the independent sector health facility via an escalation protocol. We saw records that demonstrated two unannounced trial runs of the emergency escalation procedures between these two facilities had been completed to ensure that access was unimpeded following a previous problem with access. The records showed that the trial runs had been completed effectively and necessary improvements actioned.

Staff spoken with on the day of inspection were able to indicate their understanding of and role within each of the respective policies mentioned. This demonstrated that the trust had both taken action to make improvements in ensuring transfer processes were effective but also that they were embedded within the trust as everyday practice.

Staff reported that cooperation and communication with other providers of health care was essential to the effective and safe transfer of patients and had accordingly developed and maintained solid partnership working to achieve this.

We spoke with someone who had experienced a transfer from another facility into the trust and they told us they were happy with the process. They indicated that the process and reasons had been explained to them and their relatives and they had felt involved throughout the process.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Over the course of our two day inspection in December 2012, we spoke with a number of staff across different disciplines who worked in various areas of the hospital. This included health care staff, nurses, medical and surgical consultants and junior doctors. All of those we spoke with were clear about what issues they should report and also their role in ensuring alerts were raised swiftly to keep people safe. They were able to explain what was meant by whistle blowing and we saw organisational procedures and policies for safeguarding vulnerable adults and child protection as well as those to follow should a staff member feel the need to whistle blow. Staff spoken with knew where and how they could access the relevant and supporting policies.

Our records confirmed that staff at the trust appropriately reported safeguarding concerns to CQC and to Hertfordshire County Council as required and that this happened in a timely manner. Where safeguarding meetings were held, representatives from the trust had attended and their contributions had demonstrated an appreciation that effective safeguarding was everyone's responsibility.

Safeguarding training was a mandatory element of staff training within induction programmes and annual training updates for all staff across the trust. The most recent data relating to staff training showed that 74% of staff had completed this training during the October to December 2012 period.

We spoke with the lead nurse responsible for adult safeguarding and also the lead nurse with child protection responsibility at the Lister Hospital. We were shown the safeguarding adults self assessment and assurance framework. Staff at the trust used this to monitor how they carried out their safeguarding responsibilities and identify and action any areas for continual improvement. This showed a proactive approach to preventing abuse and protecting patients transferring within the care of the trust as well as when they were discharged.

The lead nurse for child protection provided us with information about the care and protection strategies for children including the pre-birth policy. We saw how staff at the trust were supported to assess and identify child protection issues, regardless of whether they worked with children routinely or not. The trust had a designated suite to support

multi-agency child protection work.

We looked at the care and treatment of nine children and eight adults subject to some safeguarding concerns and tracked their care and what the staff at the trust did to safeguard them. These records showed the importance of relationships and communication across clinical teams within the trust and also with external agencies. The hospital discharge team acted as the liaison regarding safeguarding issues and facilitated contact with inter-agency systems. Transfer letters seen showed appropriate detailing of patient needs to ensure ongoing appropriate and safe care for people being discharged.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We spent time on three wards during our visit and spoke with five patients about staffing levels. Most of the people we spoke with told us that there were adequate staff in place to meeting people's needs on a day to day basis. One patient said, "The nurses have been very good, they come quickly if I ring." Another patient told us that when patients had been admitted during the night, when staffing levels were lower than during the day, this had resulted in a delay in getting pain relief as staff were busy with the new patients.

We saw evidence that the overall staffing level as well as staff skills mix had been assessed and reviewed throughout the site. This had been adjusted where it was viewed that there were insufficient qualified staff on each shift. Nursing staff on the wards we visited were aware of what their staffing levels were meant to be and actions to take if these were not in place. Staff spoken with told us that, while they did not have time to sit and chat with patients generally, they had time to complete their tasks and talked with patients then and during the regular planned observations of patients.

Staffing levels were also considered at weekly meetings to take into account cover for staff training and annual leave. Reviews took place of annual leave allocations and allocations of bank shifts. This was to ensure that there a mix of both regular, bank or agency staff on duty at all times, including at weekends to ensure a good skills mix. It was also to ensure that staff were treated fairly and with equity.

An electronic system of four weekly rotas was in place to ensure planning for adequate overall numbers of staff. Information was completed by specific dates so that staff could apply to cover additional shifts or outside cover could be arranged. A system was also in place to report and escalate any short term staff shortages that might occur to ensure adequate staffing levels were maintained.

Staff spoken with told us they had had suitable access to training and felt overall that there were adequate numbers of nursing and medical staff to meet people's needs. Medical staff told us that were suitably supported and there were effective senior medical support systems to review patients when they became unwell.

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 service that people receive.

Reasons for our judgement

During the inspection on 6 and 7 December 2012 we looked at how staff at the trust assessed and monitored the quality of their service provision. We looked at the content of a large variety of policy documents, for example the patients safety strategy, complaints and claims policy, quality governance and risk management strategy and the organisational development strategy.

Following this we then looked at how staff at the trust managed risk through the Board Assurance Framework. We viewed quality assurance documents and performance review reports for each of the hospital's four divisions; surgery, medicine, clinical support and women's and children's. This was to establish if the policies were being implemented and whether the aims of the policies were being achieved. Examples of the quality assurance documents viewed included a number of Director of Nursing and Patient Safety Reports which were sent to the Risk and Quality Committee. These reports showed staff at the trust worked to continuously improve the quality of all aspects of their services through the review of progress against organisational performance priorities and strategies.

We also viewed the internal audits for dealing with complaints as well as some specific examples to establish if the provider has regard to the views of those who complained. The examples we viewed evidenced that staff at the trust took the management of complaints seriously and developed strategies for improvement of care and treatment, if indicated. The provider may find it useful to note that although all the complaints viewed showed that people had received feedback on their complaint, it was not always possible to track the outcomes in terms of corrective action.

We also looked at proposals to change working practices developed by staff at the trust to improve complaints handling following performance returns and patient complaints experience survey results. This showed that staff at the trust had regard to people's views and opinions and worked to improve the quality of their services.

We viewed documents about falls prevention and the patient experience steering group minutes. Both of these documents demonstrated the commitment of staff working at the trust to listening to people's views and improving the patient experience by adopting preventative and proactive ways to improve service delivery.

We examined the active risk register for the Lister hospital, which demonstrated how staff at the trust firstly identified areas of risk and then sought to mitigate this through accountable action planning and monitoring. We viewed a number of other risk assurance documents such as the VTE assessments, monitoring and high risk medication incidents and adverse incident reporting. We saw that there were risk register and performance action plans with integral timescales for completion in place to mitigate against the risks identified. We saw that these were routinely monitored to ensure patient safety, compliance and improved outcomes and practice.

In viewing the quality assurance documents we saw the staff at the trust gathered information about the safety and quality of their service from a variety of relevant sources. This was submitted, where required, to the mandatory national data collection system. Staff at the trust used the findings from the audits completed, both internally and those undertaken at a national level, to drive improvement and reduce risk to people who use their services.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk