

Investigation report

**United Lincolnshire Hospitals
NHS Trust**

Pilgrim Hospital

October 2011

About this report

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services. The Commission has the power to conduct an investigation into the provision of NHS care under s48(1)(2)(a) of the Health and Social Care Act 2008. It does so where there is evidence of a significant problem that affects a whole care economy.

This report should be read in conjunction with the review of compliance reports conducted by CQC in February and June 2011 and published on the CQC website. These reports provide further details of the United Lincolnshire Hospitals NHS Trust's performance in meeting the essential standards of quality and safety detailed in section 20 of the Health and Social Care Act 2008.

The terms of reference outline the need for the investigation to provide further assurance on the trust's systems for protecting people against the risks of inappropriate or unsafe care or treatment. This report focuses primarily on the quality of care and the safety of patients at Pilgrim Hospital through detailing the trust's arrangements for managing clinical incidents, complaints and adult safeguarding concerns.

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Summary

Our investigation at the United Lincolnshire Hospitals NHS Trust focused on the areas of concern raised by us in our reviews of Pilgrim Hospital during February and June 2011, and our ongoing monitoring of compliance with the essential standards of quality and safety.

We also considered wider organisational issues highlighted in previous external reviews carried out at the trust, which had identified elements of poor quality care.

The trust, one of the largest in England with a number of hospitals that are geographically dispersed, is in one of the most rural counties in the country. The trust has gone through a period of significant change and turnover of its leadership in recent years. The current chief executive has been in post since August 2010.

Our key findings

Although there have been some recent positive developments, the issues identified below pose a current risk to patients of being exposed to poor care. There have been some improvements in leadership arrangements and the implementation of systems and processes to identify, assess and manage risks. However, there is a need for significant improvement in the experience of patients, performance management, staff training and quality assurance of practice.

The trust will need to develop an action plan that ensures it will implement substantive change and improve the quality of the patients' experience across the organisation. Our local compliance team will monitor the implementation of this action plan.

- We found that the trust's systems for monitoring the quality of care and the experience of patients were not adequately developed.
- The recruitment and retention of substantive medical and nursing staff remains a challenge. Due to the problem in recruiting permanent staff, the trust has had to rely on the appointment of locum, bank and agency staff which has contributed significant additional costs to the trust's annual expenditure.
- Clinical errors and the delivery of poor quality care in some areas has resulted in a number of formal complaints being made to the trust. There has also been a number of serious incidents at the hospital. These have taken the trust some considerable time to investigate, respond to and resolve, and the learning from these has been minimal.
- Strong cultural issues were found that have been a barrier to progress within Pilgrim Hospital. We found evidence of significant efforts being made by the

senior management team to change the culture, so that it supports new ways of working to deliver a high standard of care in all areas of Pilgrim Hospital.

- The current leadership has introduced tighter management accountabilities to help deliver improvements. We found that a range of systems have been put in place to strengthen front line management and leadership. The new initiatives to promote a stronger safety culture and patient-centred care are beginning to take effect.
- The trust, SHA and PCT relied to some degree on what people told them about the care they received in Pilgrim Hospital, without rigorously auditing and testing that this was an accurate reflection of good quality outcomes. People's views should have been triangulated with evidence from other sources including observations, review of records and speaking with staff.
- We found that the trust, SHA and PCT did not always have performance data that was specific to individual hospitals within the trust. This made it a challenge to identify and focus on risks that were specific to Pilgrim Hospital.
- The trust did not act on all recommendations made in previous external reviews.
- The trust did not share the findings and recommendations of previous external reviews with CQC.
- The trust has recognised and begun strengthening programme management and co-ordination of its improvement activity.
- The patient safety team is providing a range of training and mentoring support to staff, to build their capabilities and understanding of the required professional standards.

Recommendations for the trust

As a result of this investigation, we have a number of recommendations that the trust must fulfil. These will feed into a further formal review of compliance of the trust, which we will carry out in due course.

Management of risk and serious incidents:

The trust must:

1. Fully implement recommendations made by all relevant external reviews and reports and monitor the impact on outcomes for people.
2. Ensure tighter governance and oversight of the performance of the different hospitals in the trust to achieve a consistently high standard of care, review the effectiveness of preventative actions and promote early identification of organisational risks.

3. Ensure there is an effective recruitment strategy in place to minimise the need for locum medical staff and further reduce use of its agency nursing staff.
4. Develop ways of further reducing sickness absence.
5. Improve and maintain its capacity to investigate serious incidents.
6. Continue to improve its approach to the reporting and learning from the investigations of all serious incidents.
7. Make sure its board is fully and regularly appraised of serious incidents and issues concerning the safety of patients, including the outcomes of investigations and implementation of lessons learned from such events.
8. Continue to develop its risk register and update the Board Assurance Framework to enable regular discussion of this at trust board meetings.
9. Ensure that it provides clear communication to patients and patient representatives on how it has used their feedback to improve the delivery of care.

Management of complaints:

The trust must:

10. Respond to complaints within the agreed timeframe.
11. Fully investigate complaints.
12. Strengthen its focus on the experience of people making a complaint.
13. Ensure there are clear actions and learning from every complaint it receives.
14. Make sure its board receives regular monitoring information on the management of complaints and scrutinises when required.

Effective management of safeguarding and abuse:

The trust must:

15. Continue to urgently address and maintain its management, oversight and scrutiny of safeguarding arrangements.
16. Strengthen arrangements for addressing staff conduct and ensure relevant professional bodies are fully and promptly informed of such concerns.
17. Strengthen the mental capacity act requirements, including deprivation of liberty safeguards in line with the statutory framework.

18. Ensure that all relevant staff receive pertinent training and regular updates in safeguarding adults and that competence is assessed.
19. Ensure that learning from the outcomes of investigations and complaints relating to safeguarding are shared across the organisation.
20. Develop and implement its quality assurance of adults safeguarding activity.

Recommendations for the local health care community

We also make some recommendations for the wider local health care community.

NHS Lincolnshire (the PCT) should:

- Take a more rigorous approach to their appraisal of assurance including making more robust checks of patient's experience.
- Take a more rigorous approach to their performance management of complaints and patient safety at the trust.
- Ensure there are effective performance management arrangements in place within the trust for safeguarding adults.

NHS East Midlands (the SHA) should:

- Assure itself that PCTs are commissioning high quality services that meet the needs of the population and that they hold providers to account for performing against their contracts.
- Ensure the trust has strong action plans to address and prevent future recurrence of the issues highlighted in recent NHS Ombudsman investigation reports.
- Seek assurance of the effectiveness of the trust's arrangements for safeguarding adults.

Background to the investigation

The trust

The United Lincolnshire Hospitals NHS Trust (the trust) has three main hospitals, one of which is Pilgrim Hospital in Boston, and four other sites where it provides services. It is one of the largest NHS trusts in England and has some unique complexities as a result of the distances between its main hospitals.

The trust provides acute, elective and specialist health care and employs about 7,800 staff. The main commissioner of services is NHS Lincolnshire, the primary care trust (the PCT). The trust serves a population of about 750,000 people. It treats more than 180,000 accident and emergency patients, nearly half a million outpatients, and almost 100,000 inpatients each year.

Pilgrim Hospital was opened in 1976 and has 450 beds serving South and South East Lincolnshire. It provides all major specialties such as maternity care, cancer services, intensive care and operates a major 24-hour A&E service. The Adult Psychiatry Department on the site is managed by Lincolnshire Partnership NHS Foundation Trust.

Previous performance

Until November 2008 NHS East Midlands, the strategic health authority (the SHA), judged the trust to be performing well against all major targets and on course to move towards NHS foundation trust status. The Healthcare Commission's Annual Health Check of the trust was "good" in 2007/08 and "fair" in 2008/09.

The trust began to experience a significant increase in emergency admissions and high demand for its clinical services. At the end of 2008/09, the trust had failed to meet waiting times targets for A&E and for referrals to treatment.

In the light of this, the SHA carried out a review of clinical governance, the safety of patients and patients' experience. While this did not identify any significant concerns to the safety of patients or the quality of care, it did find some areas where the organisation had failed to meet patient demand or reflect up-to-date health care standards. These included delays from point of referral to treatment, waiting times in A&E at Pilgrim Hospital, and access to elective or planned surgery in areas such as orthopaedics.

The SHA review reported a number of serious concerns about the trust's leadership, decision-making and governance arrangements. The review made 42 recommendations for improvement. Some of these recommendations also required action by the PCT.

The trust had high turnover of chief executives in its first decade as a new trust. There were a number of clinical and senior managerial posts that had not been filled substantively or where there were outstanding issues to be resolved.

The Lincolnshire Assurance Board was established to support the delivery of improvements. It was chaired by the SHA's chief executive and included representatives from the PCT and the trust. The SHA at this time was providing additional support to the trust to assist in its delivery of financial and performance targets. The Assurance Board operated from October 2009 until May 2010.

When it registered with CQC as part of the new system of regulation under the Health and Social Care Act 2008, the trust declared compliance with all regulations apart from regulations 17 (respecting and involving people who use services) and 23 (supporting workers). The trust submitted an action plan to become compliant with these two regulations by 31 July 2010 and 31 October 2010 respectively. We registered the trust with no conditions. We followed up the two areas of non-compliance as part of planned reviews in July 2010 and February 2011.

The current CEO joined the trust in August 2010 and set out a comprehensive agenda for transforming the trust. Over the past year all line management positions at every level have been reviewed and restructured. A number of new appointments have been made to executive, managerial and clinical leadership roles. As a consequence, teams and directorates are at various stages in embedding their leadership and management of change.

CQC regulatory action

During February 2011, CQC carried out a review of compliance at Pilgrim Hospital. We found that the trust was not compliant with 12 of the 16 essential standards of quality and safety. There were major concerns in two areas: care and welfare of patients, and meeting nutritional needs.

We found that:

- Care and treatment was not planned and delivered in such a way as to meet patients' individual needs and ensure their welfare and safety. Patients were not protected from the risks of inadequate hydration and nutrition and they were not always receiving safe and coordinated care.
- The trust did not always fully investigate incidents and complaints. There was a build-up of investigations that took too long to investigate and bring to a close. There were delays in reporting the outcomes of incidents and in some cases the quality of reports was not good enough to support and embed learning and improvement.
- There was a lack of effective multi-disciplinary team working and gaps in professional standards in some areas of health care delivery.
- The maternity block was in a very poor state of repair and had not been adequately maintained.

- Not all staff were able to safeguard patients as they lacked a good understanding of the Mental Capacity Act.
- Not all staff were appropriately supported to do their job and there were not enough staff on duty to care for the needs of patients.

We issued two statutory warning notices, requiring compliance by 31 May 2011 with the standards on care and welfare of patients and meeting nutritional needs. Additionally, we set 10 compliance actions with a requirement that the trust take action to address those areas.

Following our report, members of the public contacted us to share their own experiences of receiving care at Pilgrim Hospital. Most were people wishing to complain or report a poor experience of care in the hospital. A number of concerns were referred to the local authority local safeguarding team to be investigated in co-operation with CQC in its regulatory role; others we passed to the trust to be addressed through their internal complaints procedure. We continue to monitor the outcome of how the concerns are being addressed by the trust.

In April 2011, we were made aware of a specific number of concerns about the care of older people in one of the wards at Pilgrim Hospital. We shared these concerns with the local authority safeguarding team and a subsequent police investigation took place. The outcome of this is not yet known.

We conducted a further review at Pilgrim Hospital in June 2011. We judged it to be compliant in meeting patients' nutritional needs (a significant improvement on the February 2011 finding) and in meeting the employment requirements relating to its workforce. However, we found major concerns in the hospital's management of medicines and moderate concerns in the care and welfare of people who use the service.

During 2010 and 2011 there had been a number of risk summits about the trust where the PCT, the SHA, CQC and other regulators had come together to share information about the performance of the trust. Other organisations such as the Health and Safety Executive, the Audit Commission and the NHS Counter Fraud and Security Management Service had raised concerns about the trust's performance in relation to staff training

Given the history of the trust, including external reviews, the level of organisational change and our view that improvements were still required in key service areas, we carried out this investigation to assess the trust's capacity and capability to deliver essential standards of quality and safety.

How we carried out the investigation

We announced the investigation on 16 June 2011. The terms of reference are shown in Appendix A.

Our investigation team conducted their work on site at Pilgrim Hospital during July 2011. The team of four included one expert external adviser.

As part of the investigation we:

- Held a focus group, which included the Patient Council.
- Analysed relevant external reviews.
- Reviewed data from CQC reviews and inspections.
- Reviewed a wide sample of trust, SHA and PCT documents, including complaints and compliments, serious incidents and safeguarding alerts.
- Interviewed trust staff – including medical and nursing staff, senior managers and trust board members.
- Interviewed frontline staff and those with lead roles for the management of complaints, serious incidents and safeguarding children and adults
- Interviewed staff from the PCT and the SHA.
- Interviewed staff from the Local Authority Safeguarding Team and Lincolnshire Constabulary Public Protection.

Main findings

The management of risk and serious incidents

What are the key performance issues for the trust to address in building its capacity to manage risks?

Previous external reviews raised concerns about the trust's leadership, culture, professional standards, quality assurance and governance arrangements. These reviews reported that improvements were needed at both strategic and operational levels to secure appropriate admission, safe use of clinical procedures, good nursing care and timely discharge arrangements.

The trust has struggled to consistently meet national targets in key areas relating to service delivery – for example, patients were waiting longer for treatment at the trust than at other NHS trusts. Additionally, patients stayed longer in the trust's hospitals compared to many other trusts.

The trust has a challenging cost improvement programme to achieve and recognises the need to expand its activity levels and upgrade the quality of some of its facilities. The trust is only one of nine organisations in England that reported an overspend against its financial allocation at the end of 2010/11. This amounted to a deficit of £14.2 million and was due to a number of factors, including growth in emergency admissions, the high cost of locum cover and non-achievement of its efficiency targets.

The trust has significant challenges in recruiting a workforce with the required level of experience and expertise to meet the diverse range of services provided at Pilgrim Hospital. There has been a high usage of locum doctors and a high usage of bank and agency nursing staff. Sickness absence has also been high in some clinical areas. There has been a high level of senior manager vacancies resulting in some managers holding extremely large portfolios with others covering posts on an interim basis. This meant that clinical leadership, management capacity, and expertise was over-stretched in some key areas.

The trust faces a significant challenge in developing its capacity to become a foundation trust. The scale of the changes required is outlined in a recent external review of the board's effectiveness. This review highlighted a number of improvements to strengthen its strategic direction, performance management and focus on quality. One person told us:

'I think the realisation is now coming that if we are to become a foundation trust, there is no room for insular working on the different hospital sites.'

We found gaps in reporting back to the trust board on progress in delivering improvements. There was limited review of the impact of preventative actions taken to address risks. Tighter governance and oversight of the performance of the different hospital sites was required to achieve a consistently high standard

of care and promote early identification of risks to patients and to the wider organisation.

The trust board recognises the importance of developing stronger reporting through appropriate committees. It is working to strengthen the focus and visibility of board members and senior managers on each hospital site. New governance arrangements were introduced in April 2011 and are now being refined and embedded.

Are there robust systems in place for identifying, assessing and managing risk?

Patient safety

The trust is required to monitor and analyse its risk activity, in accordance with the essential standards of quality and safety, NHS Litigation Authority Risk Management standards and the National Patient Safety Agency reporting requirements. The incident reporting rate remained fairly stable between January 2010 and June 2011. While the trust has taken action and improved its management of infection control and severe grade pressure sores resulting in a reduction in reported incidents, the causal factors underpinning a number of other incidents have not yet been effectively tackled. One person told us:

'I am really concerned about some of the historical serious incidents because I think there is a lot of learning that still requires cascading throughout the organisation.'

The PCT took over lead responsibility for the management of serious incidents from the SHA in February 2010. The PCT found that the trust was not reporting all relevant serious incidents. The PCT set out the reporting, escalation and review systems it required the trust to have in place in April 2010. It continued to re-visit the standards over subsequent months. Monthly serious incident meetings were set up to assess and monitor progress involving the risk managers of respective organisations.

During 2010, despite a number of assurances being given to the PCT, the trust failed to address the backlog of investigations. In June 2010 the PCT established a new system of quarterly patient safety meetings involving senior managers of both organisations. These meetings additionally tracked the trust's progress in managing serious incidents. They also focused on complaints and other matters relating to the management of risk including consultant cover, effectiveness of clinical practice and health and safety concerns. Concerns were also raised by the PCT about the quality of investigations. One person told us:

'There's been a period of hiatus where we are escalating concerns and we get assurance, but then things don't necessarily seem to be systematised in the way that we would like to see.'

The trust introduced a weekly tracker system into its monitoring arrangements in June 2010 to inform its management of delays in investigating incidents. This had limited impact in addressing the backlog and ensuring such incidents were promptly and fully investigated. In December 2010 the trust acknowledged problems in identifying staff competent to undertake investigations of serious incidents as a key factor underpinning its poor performance. One person told us:

'The quality of investigations on some occasions has left questions about capacity but there may have been some capability issues as well.'

The PCT concluded that the trust's failure to address this presented an unacceptable risk and required the trust to address this as a matter of urgency; CQC and the SHA were informed of this in March 2011. The trust continued to struggle to deliver the required standards during the early months of 2011. The PCT and trust worked together as part of the 2011/12 contract arrangements and used the CQUIN (Commissioning for Quality and Innovation) payment framework, which enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. The PCT used this framework to both penalise and incentivise performance. It required the backlog of outstanding investigations to be completed by the end of September 2011. The trust took on additional support and cleared the backlog as required.

One person told us:

'I think the PCT have demonstrated they're not afraid to be tough and put in sanctions if they think what they've commissioned isn't being delivered and that safety is not the highest priority.'

We found that standards of practice and reporting of such incidents was still evolving at the time of our investigation. The trust has recently taken action to identify lead staff responsible for investigations and has provided them with additional training. Early feedback denotes that the trust is now meeting its targets in this area.

In June 2010 the PCT identified a significant concern through their own monitoring arrangements and directly from GPs about the quality and timeliness of discharge letters to inform GPs about changes to patient's care and treatment, including medication. Only 54% of letters were sent out from Pilgrim Hospital within the required timescale in August 2010. The average length of delay from a sample of GPs followed up was judged to be approximately 18 days in November 2010. This placed patients at high risk of their personal safety being compromised, as evidenced in a number of serious incidents and complaints. One person told us:

'The trust has given us various assurances about what they are doing to raise the issue with their clinical teams, but we haven't seen that much improvement.'

In September 2010 data provided to the CQC identified that the trust had a significantly high mortality rate for patients undergoing intestinal operations. We asked the trust to provide an analysis of 20 patient case notes to identify if sub-standard care was a contributory factor to their deaths. While the internal review found limited evidence of substandard care, the trust did identify the need to ensure palliative care procedures were properly followed. It also highlighted the need to improve use of the trust's "track and trigger" system to respond to patients with deteriorating health. These remained areas where the trust needed to continue to develop its standards and practices in order to strengthen its focus on prevention.

Serious incidents

The trust reported two 'never' events (things of so serious a nature that they should not happen) in the period 2010/11. These were an incident of wrong site surgery and a swab retained post operatively. We found that these incidents denoted significant gaps in the quality of clinical care and oversight of practice. The never events were reported in the risk management report to the governance committee in November 2010. This forum reported to the governance and assurance committee, which was chaired by a non-executive director. They had not been adequately reported to the trust board as some trust board members were unaware of these incidents.

Analysis of documents demonstrated significant weaknesses in the trust's response and the management of serious incidents at Pilgrim Hospital. For example, in April 2010 the hospital closed one of its wards due to a shortage of trained nursing staff. Despite regular progress chasing by the PCT it took over a year for the PCT to receive a full report of this incident. Some incidents related to staff not working within recommended guidelines or pathways of care.

Between November 2010 and February 2011 there were four serious incidents of delayed or failed diagnosis in emergency care services. There were three serious incidents concerning treatment or procedures relating to planned care and a further two concerning the implementation of care. The management approach was not sufficiently robust to prevent the likelihood of such incidents recurring.

Some of the data on risk had historically been provided on a pan-trust basis (across all hospitals) resulting in inadequate evaluation and tracking of risk at a specific hospital or business unit level. One person told us that prior to the arrival of the current CEO:

'Nobody was sure about the accuracy and reliability of management information.'

We found there were weaknesses in the way the trust identified, controlled, monitored and communicated information about risks. Throughout the timeline of this investigation, there continued to be incidents concerning failure to

diagnose critical conditions, patient deterioration management, medication management, communication and escalation of concerns between teams.

The trust board received information from time to time about specific incidents, complaints and issues highlighted in its risk register. Patient stories were regularly shared with the Board and provided some positive examples of innovative practice as well as promoting awareness of things that had gone wrong. The board recognised the need to improve its scrutiny of incidents in March 2010. Reports were submitted to sub-committees of the board, however; this had not resulted in a regular agenda item at board meetings. The more recent trust board meetings demonstrate improved scrutiny of this area.

We found some instances of effective challenge of organisational performance by board members, including non-executive directors. Board members sought further assurance about the findings of an audit undertaken by the trust in May 2010 into the quality of care provided. This highlighted specific concerns about the care provided at Pilgrim Hospital. However, the board had not been kept informed of the outcome of any follow up checks made to assess progress.

We found that the trust's risk register was not robust and the trust recognised that it was not fit for purpose. We found it had become a long list of issues, some of which had not been addressed for some time. There was considerable variation in the level and impact of risk highlighted and a lack of clear priorities and contingency actions. These matters were being addressed at the time of the investigation. Changes are being implemented to require a higher level of ownership and accountability by directorate managers, with further escalation to senior managers if problems can not be resolved at a local level.

We found a large number of reviews of clinical activity had not been undertaken within the required timescale. For example, the trust reported that 80% of its annual reviews of clinical risks were overdue in Pilgrim Hospital's medical and A&E services, and 91% were overdue in its surgical services. This is being addressed as a priority by the new medical director.

Quality and patient experience

The Lincolnshire Assurance Board was set up in response to the recommendations of the SHA report on the 'Quality and Safety of Patient Care at ULHT' in July 2009. It began in October 2009 and met monthly, with two meetings in January, and concluded in May 2010. Its work programme aimed to support the trust in tackling:

- System issues relating to its performance in meeting A&E, waiting time and cancer targets.
- Quality issues focusing in particular on infection control issues.
- Specific projects such as diabetic retinopathy (screening for sight loss in people with diabetes) bowel screening, breast screening and the stroke pathway.

- Organisational capacity and capability.
- The development of a clinical strategy.

The trust continued to experience ongoing difficulties in a number of areas despite the additional support that had been allocated by the SHA. The Lincolnshire Board continued to report low assurance with respect to the trust's emergency care, cancer care and elective surgery activities. The trust's lack of robust performance information was seen to be a barrier to mapping and implementing change. There was limited focus on the performance of individual hospital sites and the need for specific strategies to address local problems.

People we interviewed were unclear of the impact of the Lincolnshire Assurance Board in delivering improved outcomes. They reported that gaps in the trust's capacity at a senior level meant that limited progress was possible until its senior management and leadership capacity gaps were addressed. The trust is still working to reach and sustain the required levels of performance in these areas at the time of our investigation. One person told us:

'There were some aspects of the report that we got on and did. There were some of the recommendations that stood still because the people to lead the changes weren't around.'

The PCT routinely reported to its own board on the trust's performance in meeting NHS performance framework targets in areas such as waiting times, winter pressures and mixed sex accommodation breaches. It produced quarterly patient safety and safeguarding reports to inform the PCT board of matters relating to safeguarding children and adults, complaints and the management of serious incidents it was aware of that related to the delivery of care in the trust. The learning points about the trust's performance were shared with the PCT board. We found that the PCT's focus on quality did not sufficiently strengthen awareness of the effectiveness of care delivered at each of the trust's hospital sites.

The PCT used feedback from patient surveys to help it understand the patient experience. It commissioned Lincolnshire Local Involvement Network (LINK) to seek patients' views of each of the trust's hospital sites in April 2010. The report identified some serious concerns regarding the quality of care provided at Pilgrim Hospital. These included the length of time waiting for appointments, the standard of care, and a lack of respect and dignity being shown to patients. There were a number of negative comments about hospital discharge arrangements.

The trust shared the results of a quality audit it had undertaken with its own board and the Lincolnshire Strategic Safeguarding Adults and Dignity Board in June 2010. The trust acknowledged that prior to this it did not have a systematic approach for monitoring the effectiveness of support to patients. The audit found that the care provided at Pilgrim Hospital was poorer than other trust hospitals in a number of areas, including the length of time taken to respond to patients' requests for assistance. It also highlighted some concerns about how

ward staff related to each other. Gaps in the skill sets and competences of some nursing staff were also identified as concerns.

The trust recognises the need to be more systematic and responsive in its systems for finding out about peoples' experiences. The trust's patient experience audit programme 2011/12 outlines a number of new approaches to learning from patients. We found that the trust has given priority to strengthening its capacity in this area. However, there is limited evidence yet of improvements made by the trust as a result of such feedback.

Members of the Patient Council are on the trust board, governance committees and a number of working groups. Patient Council members are involved in auditing the quality of services and seeking feedback from patients. They have been involved in monitoring 'productive ward' arrangements (a new system to support better organisation of ward-based activities) and 'Dignity in Care' developments. They are undertaking a survey of the levels of support given to patients who need help with eating and drinking. We found that although Patient Council representatives are active in a number of areas and enthusiastic about their responsibility for championing the needs of patients, they do not have a clear understanding of how the trust has been able to use their work, including actions taken as a result of the surveys they have undertaken.

The trust's board considers the findings of national and local patient survey results and peer reviews and tracks areas of improving or deteriorating performance. The National Cancer Peer Review (June 2011) identifies the need for the trust to improve its focus on patient experience. This has been highlighted as a priority in the trust's new arrangements to strengthen auditing of patient experience. The board members required action plans to be put in place to address areas of poor performance identified in national inpatient surveys.

The trust had not previously paid sufficient attention to engaging with its workforce. It is now seeking to strengthen the involvement of staff in shaping the development of new models of service delivery and sharing of good practice. We found examples of how the new management is seeking to learn from staff feedback to improve support to patients and to them as care givers. The trust is establishing Site Partnership Forums at each of its hospital sites to strengthen consultation and liaison on issues relevant to each site. There is an improved focus on ensuring ward and business unit meetings take place on a regular basis to strengthen systems for communication and information sharing.

We found that the trust is seeking to strengthen its focus on peoples' experience and views about the quality of its services. We found the trust is working to strengthen its engagement with staff to secure their involvement and ownership for the quality of their services. Some of this activity is relatively recent, so we are unable to assess its impact in bringing about the level of cultural change required

Focus on risk and actions to deliver improvements

The PCT has used its Commissioning for Quality and Innovation (CQUIN) payment framework to drive improvements in areas where the trust's performance falls below the required standard. There are some examples of positive outcomes in areas such as infection control, the management of pressure sores and improving the timeliness of response to people who require surgery to mend a broken hip.

The PCT recognised the need to seek alternative methods of assuring the quality and safety of services provided by the trust and began a programme of 'Walk the Patch' visits in 2007. In April 2011, when the SHA and the PCT visited Pilgrim Hospital they found examples of effective and timely care and treatment. However, they identified that this was not consistently delivered on the wards they visited. They highlighted a particular need for nursing staff to have a better understanding of their patients' histories and needs. They found some gaps in ward staff awareness of systems to support improved care and monitoring of the wellbeing of patients. One person told us:

'I know when the CQC inspectors went to visit the wards they actually found that the patients and relatives were quite positive about their experience, but it wasn't until they really drilled down into it by matching perhaps a profile of a patient against a risk assessment versus anything that might have happened to them that they identified concerns about the quality of care. I think the issue for us is how we get to know what is really going on.'

The 'Walk the Patch' visit to Pilgrim Hospital in June 2011 concentrated on the trusts systems for managing discharge letters to GPs. The PCT found inconsistencies in the delivery of the required standards, including issues concerning working practices, team working, management oversight and audit arrangements. There was an inadequate focus on the risk to patients and, on some wards, having a backlog of work had become 'accepted' practice; this information was shared with the CQC. Poor performance in similar areas had been initially identified as a high risk by the PCT in August 2010. The PCT had continued to raise this as an issue in further meetings with the trust, with limited evidence of improvements being made.

Following the June visit, the new medical director provided a full list of the backlog of work relating to delayed discharge letters, for every ward to the PCT. This identified that improved practice was required in A&E, the Clinical Decisions Unit and the Paediatric wards. The medical director set an improvement target to fully address the backlog by December 2011 and promote the required standards of communication. The PCT reported this as a positive response from the trust in its approach to improving the quality and reliability of its management information. Further review of the trust's progress in clearing its backlog of work is planned by the PCT.

The trust is starting to improve its identification of the human and organisational failures underpinning its serious incidents. It is working to implement stronger systems to support improvements in safety and quality in the areas of:

- Diagnosis of injuries and critical conditions
- Patient deterioration management
- Operating theatre and surgical practices
- Communication and escalation between teams
- Medication management
- Behaviours of staff including motivation and professional competences.

The trust is also taking action to improve the availability and accuracy of performance information. This is resulting in a more open and challenging culture to drive forward improvements. One person told us:

'Now we know exactly what our information is, warts and all. We know the bad news as well as the good news and so I'm very confident that what we do know, albeit in many areas not ideal, at least we know it is accurate'

The trust's senior managers have given a high priority to strengthening processes for the management of risk at strategic and operational levels. New governance and reporting structures are being developed to promote clear accountabilities at hospital and middle management levels. In addition to the Quality and Safety committee, six new branch governance committees have been established in recent months to strengthen awareness and learning across the organisation. The trust recognised common themes underpinned its analysis of clinical incidents, complaints and safeguarding adult issues and is working to deliver a co-ordinated response to support effective alignment of its systems.

The trust is working to develop a 'Ward to Board' scorecard to enable detailed analysis and benchmarking of ward performance. Board members began structured 'safety walkarounds' to improve their understanding of how the safety of patients is promoted at ward and directorate level in September 2011. Training is being provided to support their work in this area.

The trust's board is working to strengthen its assurance arrangements so that it is able to satisfy itself, external organisations and local people of its capability to deliver and sustain improvements. Regular performance clinics covering all clinical business units and directorates were implemented in May 2011. It recognises the need to prevent further deterioration or stagnation of its performance. It has introduced a more rigorous approach to tackling areas where the required target or level of performance has not been achieved.

The trust is reviewing its risk management strategy and risk assessment procedures. It is establishing a Risk Moderation Group to provide a higher level of challenge to the quality and rating of risk assessments. Branch and business units within the hospital are now expected to review and act on all risks under their direct control. The trust is also providing additional training to assist managers promote a strong culture of patient safety within the organisation.

There are a number of work streams to embed a culture of safety within the day-to-day activities of the trust. Some of these are detailed in a later section of this report. There is significant drive from within and outside the trust to address delays in completing complaints and serious incident investigations. The trust's senior managers are working closely with CQC, the PCT and the SHA to secure the delivery of better standards of performance. There is a programme of work to raise the awareness of staff about their responsibilities for managing risks and addressing gaps in individual skill or team working practices. Senior managers are working to create open and transparent processes for raising concerns and reporting progress to achieve higher standards of safety, service effectiveness and patient experience.

Managers are working to strengthen their support to frontline teams and are engaging closely with the delivery of action plans. The impact of the trust's 'Lessons Learned' group had not been as effective as it needed to be in promoting the required change in staff behaviours and practices. It is being revitalised to support stronger reflection on professional practice and strengthen preventative approaches. This includes an improved focus on the competences and behaviours of staff, with tighter performance management of their work. A number of patient experience audits are being implemented to deliver regular feedback on satisfaction levels and areas for improvement across a wide range of the trust's activities. It is intended that the outcomes of these will be routinely fed back to directorate managers and trust board members.

The new arrangements aim for a more collaborative approach in assessing and weighting risk and ensuring that gaps in organisational capacity are addressed through agreed business cases. The Governance Committee plans to challenge the robustness of the risk register at each of its meetings as an integral part of its duties in relation to risk management.

Conclusion

We conclude that the trust's systems for identifying, assessing and managing risk were not sufficiently robust. There was minimal learning from incidents, some staff did not take ownership of personal and professional accountabilities, and preventative actions were weak. New approaches to the management of risk require stronger levels of ownership and accountability at all management and professional levels within the trust.

We found that, while the PCT and SHA had recognised the trust's poor performance in a number of areas, they had not been able to lever sufficient influence to secure improvements in a timely manner. Both organisations needed to further develop their systems to focus more on the direct experience of patients and checking that the assurance given was secured by evidence of improved outcomes.

We found current evidence of stronger leadership and management of risk. However it is too early to evaluate the impact of recent changes and the robustness of preventative measures.

The management of complaints

Are complaints managed well?

In August 2010 the trust commissioned an external review of emergency care services at Pilgrim Hospital. It concluded that there were specific concerns about the reporting, quality and timeliness of complaints investigations. It highlighted that the trust did not have a sufficiently strong grip of the root causes of complaints, and that learning from complaints and preventative measures needed development.

In February 2011 we found that, while the trust had systems in place to deal with complaints, not all people using the service or staff were aware of how to raise a complaint. We also found that people did not always get a response to their complaint within set timescales and investigations were not always sufficiently thorough or robust.

We found that the trust had not responded in a timely manner to the issues of concern raised by some complainants. Trust board members were alerted to the trust's lack of compliance with the essential standards in March 2010. The trust estimated it had a backlog of 20 complaints in May 2010. The board minutes recorded complaints as an area of concern in August 2010. A weekly escalation system was put in place to advise senior managers of complaints that exceeded the required timescales. The PCT had been tracking trends in complaints made about the trust. The SHA had received feedback on the two complaints that had been reviewed and upheld by the NHS Ombudsman in 2010/11. One related to the care of an older person at Pilgrim Hospital. The Ombudsman found significant failings in the care the trust provided.

A relatively high number of complaints concerned the care of people who were older or those at the end of their lives. These included a lack of dignity being shown to people. There were a number of complaints about A&E and the Clinical Decision Unit. These highlighted the need to pay attention to identifying and monitoring risks to patients as they moved between wards or were discharged.

The trust recognised that it was failing to meet the required standards and introduced a new complaints procedure during 2010. Management information was strengthened to provide a clearer picture of areas of risk and trends. However, we found there remained lengthy delays in some complaints being brought to closure, despite a fall in the number of complaints being investigated under formal procedures. The external organisation commissioned by the trust is to include a further review of the complaints process to address the continuing difficulties that have been identified.

The PCT, in its contract review and patient safety meetings with the trust, identified the management of complaints as an area of growing concern, given their feedback from local GPs and identification of complaints in follow-up investigations of serious incidents. The PCT checked and received assurance

from the trust that action was being taken to resolve issues within the required timescale in September 2010. The PCT also began to actively track individual complaints where it had identified ongoing delays. In March 2011 the trust was required to submit copies of the trust's responses to complaints, following a review by the PCT of some of the complaints

At the time of this investigation, the trust reported that they had approximately 50 complaints that had not been addressed within the required timescales. Trust staff were struggling to respond to new complaints, while at the same time attempting to address the backlog. The trust has commissioned an external organisation on a short-term basis to provide additional capacity and expertise in this area.

As part of our investigation, we looked in detail at six complaints. They showed the need for improvement in the following areas:

- Awareness of the needs of newly admitted vulnerable patients
- Missed diagnosis
- End of life care and decision-making processes
- Staff attitudes
- Hospital discharge arrangements
- Improved levels of support to people with dementia.

Complaint investigations undertaken by the trust identified poor record keeping by ward staff and clinicians in some cases. An analysis of complaints demonstrated gaps in the basic standards of care and decision making. Lack of adherence to the required protocols and pathways of care, including informing local GPs in a timely manner of changes to an individual's care, was a significant concern.

The trust recognised the need to reinforce its performance standards and to strengthen management oversight and accountabilities for managing complaints. This included a requirement for directorate managers and clinical leaders to undergo further training in June 2011. The purpose of this was to identify a dedicated skilled group of staff capable of delivering a patient-focussed response to complaints.

We found the trust is working to strengthen the accountabilities of managers. For example, it has included complaints as a key area in individual managers' performance to ensure a more timely and effective response to complaints. All complaints are now risk rated to ensure they are managed at the right level by people with authority and expertise to investigate and make any required changes.

We found that the revised complaints process is clear and supports good initial engagement with patients and their families in assessing the level of concerns and identifying improvement actions. Patients and their families are advised that any future care would not be compromised by their having made a complaint.

The Independent Complaints Advocacy Service is seen to be an important source of support by patients. It is clearly referenced in the trust's documentation and information leaflets.

The complaints planning tool provides a structured framework for identifying a lead investigator and for tracking the progress of the complaint. There is evidence of improved levels of accountability in recent complaints investigations.

The trust has raised awareness about how to make a complaint. There are leaflets in a range of formats and information on the trust's website. The trust received relatively low numbers of complaints from its communities whose first language is not English. It recognised the need to improve its understanding of any reasons for this and implement any actions.

The trust was not strong on focusing on the experience of complainants, in particular there was a lack of input relating to sampling patient satisfaction with the complaints process, following up of complainants who had 'dropped out' before the process was completed, and repeat complainants. The complaints manager is working to develop a central system for tracking all improvement actions with analysis of how they had been followed up including lessons learned and changes made to frontline practice. Patient stories were being proactively used to improve staff awareness and sensitivity to patient's needs.

The trust board previously had received complaints reports on an ad hoc basis. Complaints formed a core part of the board's agenda from May 2011. Governance arrangements are being finalised to secure better alignment of complaints with the work of other committees.

The trust's Quality Account 2011/12 (an annual statement of the trust's performance in delivering care to local people) sets ambitious targets to improve the complaints management process. The trust's risk management strategy (June 2011) seeks to promote wider organisational learning from complaints. The trust is regularly reviewing the outcomes of complaints at both the quality and safety governance committees.

Conclusion

The management of complaints and learning lessons for the trust have been weak, and the new arrangements have not yet made any improvements in the way complaints are managed. The PCTs arrangements for monitoring complaints management did not secure all of the required improvements.

The management of safeguarding and abuse

Does the trust have robust systems in place to protect and prevent harm to patients?

In 2010, the Ofsted annual children's services assessment rated the trust as 'performs excellently'. The PCT and SHA have undertaken some work with the trust in assessing the robustness of its arrangements for safeguarding children. Their focus on the trust's arrangements for safeguarding adults was less well-developed. The PCT had identified under-reporting of safeguarding adult activity in September 2010. Safeguarding issues were identified in a few clinical incidents where there had been concerns about the professional conduct of staff. Safeguarding adults training had been highlighted, in meetings between the PCT and the trust, as an area for development. The PCT and SHA requested that the trust take action to raise standards in these areas.

Despite allegations of poor practice having been identified through serious incidents and safeguarding adult procedures, few staff raised concerns through the trust's whistleblowing procedures. Some concerns raised by staff were locally managed. Follow-up work undertaken by CQC and Lincolnshire Council demonstrated a lack of robust systems for employee management and found that the outcomes and recommendations were not always appropriate.

There was evidence of relatively few such concerns being formally followed up by the trust through its disciplinary or employee capability procedures. Where there were concerns about the professional conduct of staff, these had not been reported to the relevant professional bodies in a full and timely manner. We found that the trust had not robustly addressed matters relating to the professional conduct of its staff at Pilgrim Hospital.

The trust introduced a new safeguarding adult policy and procedures in January 2011. This provided basic instruction to staff about abuse and their responsibilities for reporting concerns. There is a need for further guidance on supporting people with specific needs, including people with learning disabilities and people with mental health needs or dementia. The trust has recently introduced a new section into patient case notes to enable ease of recording and identification of safeguarding children and adult issues.

The trust has implemented an e-learning package to introduce staff to safeguarding adult issues. This is mandatory for all staff in the trust working with vulnerable adults. There is work required to identify other forms of training and to ensure that staff responsible for investigating concerns have appropriate levels of authority, knowledge and skills to fully investigate and address the underlying issues. The trust has a training strategy, but it requires further development for those staff who require more than the mandatory minimum, to ensure staff receive the level of training they need to improve the protection and safety of patients. One person told us:

'We have an action plan to achieve compliance around adult safeguarding, but we still have work to do to ensure our workforce understand the triggers for adult safeguarding in the same way as they do for children.'

Arrangements for safeguarding children within the trust are developing well. The named safeguarding children's nurse has a programme of work to ensure front line staff are alert to, appropriately report and receive training in managing child protection issues. The trust has a network of children's champions that promote a shared and consistent response to concerns about the safety and wellbeing of children. The trust has a safeguarding children competency framework to support continuous professional development. It recognises the need to ensure a stronger focus on safeguarding issues in staff supervision. Training is provided at a number of levels and take-up is audited at a departmental level.

Wards and departments that have regular contact with young people and their families have assessed their performance and developed safeguarding plans to enable achievement of the required standards. The trust has developed a risk assessment tool to aid decision-making when a young person is placed on an adult ward. This aims to support appropriate joint working between paediatric and other specialist staff. The focus of safeguarding children work has been expanded to include prevention in areas such as self-harm and addressing the needs of young carers.

The trust is working to strengthen its focus on and leadership of the safeguarding agenda. The named safeguarding children and adult post holders have recently been incorporated into the trust's new governance structure. The trust board has recently adopted a new framework for ensuring staff receive the level of safeguarding training they require. The trust plans to establish a new post of Head of Safeguarding in recognition of the need to raise its profile and to strengthen its systems for partnership working, performance management and quality assurance of practice. One manager told us:

'I want to know about every active case and alert so that I can hold and track what happens to them.'

The recent appointment of a named professional for safeguarding adults provides the trust with some additional capacity to drive forward improved standards of practice in this area. The post holder's priorities include improving information management about safeguarding incidents and ensuring safeguarding procedures are appropriately followed. The trust is beginning to put in place systems to improve its awareness of areas of risk and trends. There is further work required to ensure that the outcomes and learning from investigations are widely promoted. The trust has yet to develop a system of quality assurance of safeguarding adult activity.

Partner agencies reported delays and issues relating to the quality of information and engagement by the trust in joint investigation work prior to the appointment of the safeguarding adult co-ordinator. The safeguarding adult co-

ordinator is seen by social services and the police to be supportive and effective in contributing to the assessment of risk and implementing protective actions by partner organisations.

The trust has focused on promoting stronger personal and professional accountabilities for keeping patients safe. All the trust's new or revised policies and procedures are assessed in terms of their impact on safeguarding children and adults. A generic safeguarding obligation has been written into the job descriptions of all trust staff. Recruitment arrangements comply with safe employment requirements. However, the trust does not have a system for reviewing Criminal Records Bureau checks of people who had been employed for some time. Some checks have been made on those staff working with the most vulnerable people.

The named children's safeguarding nurse has developed a new flagging system to ensure appropriate checks are made of risks to children and young people by A&E services. Auditing of quality of safeguarding records within children's records has commenced but needs to be widely implemented.

A number of safeguarding allegations indicate the need for better recording of care and risk on most of patient records. The new patient records introduced across the trust from April 2011 include body mapping as a routine activity to improve the assessment and monitoring of bruises and pressure ulcers.

The trust has recently revised its dignity in care policy. A network of patient well-being champions are working to promote patient dignity. The trust has launched new dignity pledges promising that patients' dignity will be respected at all times. Each member of staff is required to uphold the pledges, and patients are asked to speak out if they feel the pledges are not being met.

Conclusion

The trust did not have clear or robust systems to provide assurance of its activity in safeguarding adults. Management information was poor and did not provide a clear picture of incidents, trends or repeat incidents. We found management oversight and scrutiny of safeguarding adult activity, including outcomes and sharing of lessons learned was under developed. The trust has taken recent positive actions to ensure people are protected. However, further work is required to raise standards of practice in this area.

Additional findings

Culture

The culture of Pilgrim Hospital has been a key causal factor behind its poor performance and failure to deliver the required standards and improve the patient experience. The hospital has lacked stable management, clear vision and strategic direction to support the effective management of change. This contributed to the development of a variety of local systems and processes within Pilgrim Hospital. Staff described their history as doing things “the Boston way”. This was exemplified in a lack of definition of key roles and responsibilities and unclear accountabilities for the delivery of care. One person told us:

‘There is a massive culture issue to address here. It is going to take really strong leadership and management. Incidents of poor performance and poor care have got to be challenged all the time, consistently, and people have got to feel the impact of that.’

There has been a weak focus on involving patients and securing their input in developing their plan of care. A number of incidents resulted from a lack of proper processes and team working to support effective verbal or written communication with patients and their families and within the ward team. This contributed in some cases to a lack of appropriate safeguards to consistently keep patients safe.

We found there had been a lack of organisational focus on and rigour in promoting shared ownership, strategic direction and joint working. Quality and safety had not been embedded in the trust’s overall strategy and performance management frameworks. Some frontline staff had a low level of awareness and had not kept up to date with the required standards in the delivery of care. The focus on the safety of patients was largely reactive. Investigations of incidents denoted examples of poor clinical engagement and multi-disciplinary working to provide effective seamless care. They denoted weak decision making and failure to challenge peers. One person told us:

‘We’ve got some hot spots in certain specialities where the different professional groups perhaps don’t work as well together as they ought.’

We found insufficient rigour in the management of essential quality monitoring systems, such as staff appraisals and audits of clinical practice. The lack of robust challenge of personal and organisational performance had been an accepted feature of previous management practice. An example of this was the management of staffing on shifts – although there has been a system in place, the staff had generally over ridden the system and made their own decisions about how to staff areas to suit themselves. There was a lack of monitoring of the impact of staffing on outcomes for people. The trust’s management acknowledged that they have to find a way to understand what was happening and why.

We found evidence of significant efforts being made by the senior management team to change the culture so that it supports new ways of working to deliver a high standard of care in all areas of Pilgrim Hospital. One person told us:

'I think the culture is one that is moving towards a can do culture, and one where people are really keen to see the organisation succeed.'

Leadership

The current chief executive is determined to raise standards and is highly motivated to transform the quality of hospital provision in Lincolnshire. He and his management team are working to address gaps in the knowledge, expertise and capacity of the workforce. He has appointed a number of new senior managers and professional leaders with a level of experience and competences required to drive improvements in the trust's performance. The executive team and middle managers are working to establish a new organisational culture centred on personal and professional accountabilities for the quality and safety of care provided by the trust. One person told us:

"We are in the foothills with a long haul still ahead of us"

We found that there has been a 'root and branch' review, led by the chief executive, of the trust's priorities, organisational resources and capabilities to identify the level and depth of improvements required. The scale of changes planned and now being implemented is significant.

We found that there is targeted work at Pilgrim Hospital to address its legacy of poor performance. Efforts have been made to demonstrate stronger and more visible leadership. For example, trust board members now have specific responsibilities and take part in 'walk the floor' initiatives. We found a range of systems have been put in place to strengthen front line management and leadership. We also found that the hospital has strengthened its senior management capacity and presence on the Pilgrim site.

The trust has a large number of action plans relating to improvements required in many areas of its activities. The impact of these actions in delivering improved outcomes is an area for ongoing scrutiny by the trust's Board and governance committees. The trust has recognised the need to strengthen programme management and co-ordination of its improvement activity. It has identified gaps in its current organisational capacity and is working with the SHA and PCT to address this and speed up its management of change.

New developments in frontline practice

The trust has implemented a number of developments in wards and clinical areas that seek to improve front line practice and the experience of patients.

While it is too early in the implementation of these initiatives to measure any sustained improvements in care, there is encouraging progress in some areas.

Patient Safety Express Programme

The Patient Safety Express Programme (a national initiative to promote higher standards of patient safety) is seeking to implement new working practices to support a strong safety culture within the trust. We received positive feedback from staff that the programme has been helpful in improving their awareness, confidence and competence in managing risks. One person told us:

'If something goes wrong for patients we have a duty to try and find out why – so that we can change our systems and prevent the mistake from happening again.'

We found a clear programme of work to embed new systems to strengthen the trust's approach to prevention and risk management. There is a growing focus on the skills and knowledge required by hospital staff to deliver safe care. The patient safety team is providing a range of training and mentoring support to staff to build their capabilities and understanding of the required professional standards.

Priorities for improvement include work to reduce the incidence of risks to people from falling. Frontline staff are now required to routinely carry out a falls risk assessment following a patient's admission to their care and put in place plans to minimise any risk. There are other work streams to improve practice in preventing and managing pressure ulcers and ensuring early identification of the risk of blood clots. Additionally, work is taking place to strengthen systems for managing patients whose health is deteriorating and for managing medication. These initiatives are aiming to address the identified weaknesses in organisational practices highlighted in complaints, serious incidents and safeguarding adult concerns.

The Patient Safety Express team is working with ward and directorate staff to assist them in understanding their shared responsibility for working together in keeping people safe. There are regular meetings with ward staff to assess progress and identify areas that require further work. Audits of practice are undertaken to identify the reliability and impact of risk assessments and whether a suitable plan of care has been developed and implemented. This provides important feedback to managers about the effectiveness of care interventions.

The Take Note project

The Take Note Project was implemented across the trust from April 2011. It requires nursing, medical and allied health professional to use a single, shared record. New record-keeping formats have been developed to make tracking of the delivery of care and management of risks easier.

We found that the new paperwork is well structured and clearly identifies professional responsibilities and accountabilities for the delivery of care. There is a strong focus on identifying and managing risk. The new record pulls

together a range of risk assessment tools to provide a comprehensive analysis of patient needs and vulnerability.

Escalation requirements are clearly outlined to support prompt referral to senior or specialist staff of patients whose health is deteriorating. New care plan documents aim to support improved monitoring of the level of care that patients need and are given.

This new project is an important element of the trust's work to build a strong patient-centred and safety culture across the organisation. The trust has yet to evaluate its impact in delivering improved communication, joint working arrangements and better outcomes for patients.

Hourly care rounds

The new hourly care rounds, introduced in April 2011, are reported by frontline staff and others to be working well. They told us the new process is effective in assisting them to better plan and manage their workload. They reported a reduction in number of verbal complaints from people about having to wait to get the help they needed.

This new initiative aims to ensure regular checks of patient wellbeing and encourages staff to build their relationship with patients. Staff told us the new system had strengthened their professional accountabilities and was leading to improvements in patient safety and comfort. One person told us:

'Matrons are checking with the patients that staff are actually carrying out their care plan and doing what they need to do, because that's the important thing.'

Appendix A: Terms of reference for the investigation

1. The Care Quality Commission (CQC) has the power to conduct an investigation into the provision of NHS care under section 48 (1) (2) (a) of the Health and Social Care Act 2008. The criteria under which CQC will conduct an investigation are at Appendix A of the enforcement policy. The exercise of this power would permit CQC to raise concerns with the Secretary of State for Health under the formal power under section 48 (5) of the Act.

2. The CQC will carry out an investigation into the systems and procedures that are in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment, these will include:
 - a. Systems and processes for identifying, assessing and managing risk.
 - b. Complaints and comments made by people using the service and their representatives.

Internal investigations carried out in relation to the conduct of people employed.
 - c. The analysis of incidents that resulted or had the potential to result in harm to people.
 - d. The systems for service improvement by learning from adverse events, incidents, errors and near misses. This should also include using information from safeguarding concerns to identify non-compliance or risk of non-compliance and decisions made to return to compliance.
 - e. The conclusion of external reviews relating to the service.
 - f. The systems for seeking the views of people using the service and their representatives.
 - g. The systems for seeking the views of staff.
 - h. The systems for assessing and monitoring outcomes for people.
 - i. The procedures followed in the management of abuse and the systems to monitor these.
 - j. Any other matters which CQC considers arise from, or are connected with, the matters above.

3. The investigation will involve speaking to patients, relatives and frontline staff and observing care delivered at this location. It will also involve gathering evidence through examination of records, speaking with internal and external stakeholders and requesting written statements. When appropriate CQC will work in partnership with other agencies to gather evidence, this may include the SHA and the PCT.

4. An investigation under the Act gives CQC the option to look at the provision of health care across a local system. In order to ensure that recommendations made are deliverable it will be necessary to review the role and function of the PCT and the SHA and their capacity to performance manage and support the trust in making and sustaining the necessary improvements.
5. CQC may take enforcement action at any time during the investigation if there is evidence of major concerns and risks to people.
6. The compliance manager will act as the sponsor of this investigation and will use the findings to inform the ongoing monitoring of compliance. This will ensure that any evidence and recommendations made will feed into a review and the appropriate regulatory actions can be taken, this may include enforcement action if required. The investigation team will be independent of the compliance team and will therefore review the effectiveness of previous compliance actions.
7. The investigation will focus on two periods:
 - 1 January 2010 to 1 April 2011.
 - 1 April 2011 to date.

This will ensure that evidence in any improvements will be clearly identified.

8. The evidence gathering period of the investigation will run over a period of not more than four weeks.
9. CQC will publish a report on the findings of the investigation, and will make recommendations as appropriate to the Trust and other relevant bodies.