Inspection Report

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

Arrowe Park Hospital

Arrowe Park Hospital, Arrowe Park Road, Wirral, CH49 5PE

Tel: 01516785111

Date of Inspections: 21 November 2013
20 November 2013
19 November 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Wirral University Teaching Hospital NHS Foundation Trust
Overview of the service	Arrowe Park Hospital is situated in the Upton area of Birkenhead, on the Wirral peninsula. It is one location of Wirral University Teaching Hospitals NHS Foundation Trust and is one of the biggest and busiest acute trusts in the North West, serving patients across the Wirral peninsula and surrounding areas. They provide a full range of 'acute' health services for adults and children, an Accident & Emergency (A&E) unit, a Maternity Unit and a Walk-In Centre.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Long term conditions services Rehabilitation 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 Nursing care 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 19 November 2013, 20 November 2013 and 21 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health and reviewed information sent to us by local groups of people in the community or voluntary sector.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We were accompanied by two specialist advisors, one for theatres and one for governance.

What people told us and what we found

We spoke with patients, relatives and staff at this inspection. We visited three wards and the theatre department. Most of the patients and relatives spoke positively about their experience and care they received. They provided comments such as:
"I'm treated very well. Staff treat me with love and kindness. We're on friendly names. There is a close bond between myself and staff. They give me a choice of meals. I'm always asked what I'd like to eat. They do ask me if I like the food",
"I think she's getting the care and support she needs here".

We found that when patients were admitted their needs were assessed and a plan of care was put into place. We found that the care plans were standardised and sometimes inflexible to patients needs when variances were identified. We found that patients who had a diagnosis of dementia were supported and cared for with a comprehensive assessment and care plan that met their needs. We found that discharge planning was generally effective.

We looked at staffing levels and support for staff. We found that staff on one ward

experienced stress due to staffing levels. We were satisfied measures had been implemented to ensure suitable staffing and support on this ward. We found elsewhere that generally staff were appraised, trained and supported to undertake their roles effectively.

The trust had a robust governance framework in place that included systems and processes in place for monitoring the quality of services and risk management.

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

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

We found that generally patients and relatives were well cared for and treated with dignity and respect. We observed care on the wards and theatre departments over a few hours during our visits. Staff were observed assisting patients to the toilet and lounge areas. We noted that discreet help was provided and that staff spoke to patients in a calm quite tone. Curtains were pulled closed prior to any care being provided. We observed staff treated patients as individuals and gained consent when undertaking any procedures or care. One patient did comment that they thought the environment was not conducive to privacy as the curtains did not prevent discussions being overheard.

Staff we spoke with were able to describe how they would care for patients with dignity and respect. They gave examples such as they would ask them how they wanted to be addressed, made sure they were covered, drew curtains when personal care was provided, made sure doors were closed, and if assisting patient to the toilet they would ask if they wanted them to wait outside. Staff were able to discuss equality and diversity including awareness of dietary preferences for different cultures and religions.

Patients and relatives that we spoke with told us they were treated well and with dignity and respect. Comments included:
"They (staff) talk to you in a proper manner and always knock on doors before coming in. In the bay I'm in they close the curtains and speak in a quiet manner. We're all women on the ward. I haven't seen any men anyway",
"Staff always knock on my door. They close all the window curtains, shut the door and lock it when I'm having treatment. They speak in quiet voices when talking about my personal information. They take calls from my relatives and have been hugely flexible with visiting times. My wife was able to stay with me the night before my operation".

Records demonstrated patients and relatives (where appropriate) had been consulted and were involved in patient care. This was confirmed by patients and relatives that we spoke with, however most told us they had not seen their care plan but had been asked personal information during their assessment. Patients and relatives told us they were generally given information regarding their care, treatment and stay, although this was mostly verbal

information. One patient said:
"I was asked about my religious beliefs and my dietary requirements. I was asked if I wanted my elected relatives to have information and they were able to speak directly with the consultant both before and after my operation".

We saw evidence of information regarding the trust, wards, systems for giving feedback and information regarding reporting concerns of abuse was displayed prominently around the hospital. Some of the patients we spoke with told us they had received information regarding the ward they were staying on verbally and in writing. We saw that written information was provided on various conditions, operations and investigations. We saw evidence in records that information and leaflets had been given to patients and that surgical patients were informed of risks and benefits of their procedure. There was access to information relating to different religions and religious preferences, hospital chaplains visited the wards regularly and were available to give advice. Translation services were also available.

We observed on one ward a junior doctor examining a patient without a chaperone. They explained the procedure and asked permission to perform the examination; however they did not offer the services of a chaperone. We established this was usual practice. The trust showed us a chaperone policy that was in draft form and not yet published. This policy stated that all patients should have the opportunity to have a chaperone during any consultation or procedure. The provider may find it useful to note that patients' privacy and dignity was not always respected when carrying out examinations. The policy should be introduced and complied with to ensure patients privacy and dignity is maintained during examinations or consultations.

We noted that in the theatre recovery areas the environment was not conducive towards maintaining privacy and dignity. We observed that different sexed patients with differing levels of consciousness were nursed together in the same bay. On discussion with staff it emerged that due to the limited size of recovery area mixed sexed patients were required to be nursed together but better use of screening and curtains could be made.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We found that when patients were admitted to hospital their needs were assessed and a plan of care was put into place. Assessments reflected individual patients' needs and included general and specific assessments such as risk of falls, pressure ulcers, bed rail use, modified early warning score (MEWS) and nutrition. Where risks were identified a specific plan of care was documented. Assessments seen included those undertaken by nursing, medical and other allied healthcare professional staff. Patients told us that staff usually checked with them on a frequent basis that the care given was suitable and that they were comfortable and had their needs met. This is important as assessing a patients needs is considered to be the first step in the process of providing support to meet their individual needs. It provides information that is critical to the development of a plan of action that enhances patient experience and welfare.

We found that daily records of care were mostly all accurate and up to date in the wards we visited. We did note that the care plans were standardised and were sometimes inflexible to patients needs when variances to the care plans were identified. Patients were checked on a minimum of two hourly to make sure they were clean, comfortable, had a drink (where appropriate) and call bell to hand. They were asked if they were in any pain. These quality and safety checks ensured patients were comfortable and had their essential needs met.

In the theatres we visited we found that the records of care were mostly accurate and up to date. The swab boards (these recorded the swabs used during the operation and ensured the amount used equalled the amount disposed of) were kept up to date and theatre registers were completed in timely manner. This is important to ensure the safety of patients who undergo operations under a general or local anaesthetic. The world health organisation (WHO) safe surgery checklist had been introduced at the trust and we found evidence that it was used consistently and appropriately. This enabled health care professionals to minimize common and avoidable risks that may risk the care and welfare of surgical patients. Staff spoke enthusiastically about the implementation of the WHO checklist. Comments included:
"It's brilliant"
"It has been a big help".

We found that the 'Peri-operative Record' booklet had not always been completed accurately with one section of this record not being completed in most of the cases we looked at. We were told this section was a repetition of information already completed and therefore it was not used frequently. A revision of the peri-operative record was underway.

We found that patients who had a diagnosis of dementia were supported and cared for with assessment and care planning that met their needs. These patients were identified by a blue forget me not flower on the ward board to alert staff to their specific needs. The patient and family were asked to complete a 'This Is Me' booklet that was kept on the end of the bed. This was a tool used for caring for people with dementia to inform staff about their needs, preferences, likes, dislikes and interests to enable individualised care and support. We observed that patients with dementia were well cared for. We observed good interactions between patients and staff with staff treating patients in a kind, caring manner. Staff were responsive to patients' needs. On Ward 24 an additional member of staff had been provided to care for a group of patients who had dementia. As well as providing physical care, they engaged the patients in reminiscence and doing their hair. The trust was in the process of employing an activity coordinator and setting up an area for older patients to attend for therapeutic activities.

On the elderly care wards records demonstrated that all patients had a holistic assessment and daily multi-disciplinary team meetings were held to enable expert advice and planning. There was a strong focus on enablement, for example physiotherapists were ward based and every patient was also seen by an occupational therapist. Staff promoted independence by identifying what patients were able to do before they were in hospital and encouraging them to maintain those skills. There were systems in place to ensure that the requirements of the Mental Capacity Act and Deprivation of Liberty legislation were met. One patient had had an assessment of mental capacity and was awaiting a multi-disciplinary best interests meeting.

Patients told us they were treated well and had their needs met. Relatives told us patients with dementia were well cared for. Some comments made included:
"The nurses are very good and look after me well".
"They (staff) do involve relatives on this ward. Dementia patients are treated with care and vigilance".
"Even with his confusion they have looked after him well".

We found that some patients and their relatives had concerns regarding the number of moves experienced from one ward to another. One patient had been moved from different departments and wards four times over a short period of time. This may be confusing for some patients and if, as in some cases we found, the moves were carried out during unsocial hours, patients welfare was at risk.

We spoke to staff on the wards and theatres. Staff were generally positive about the care they provided to patients and felt patients were safe and well cared for at this hospital. One medical staff member said they thought the standard of care and treatment was good and would be happy for their family members to be treated here. Another allied healthcare professional and member of the ward multi-disciplinary team said they thought the care was good and medical and nursing staff listened to what they said and generally followed their advice.

We found that staff were trained in life support skills at varying levels appropriate to their roles. Staff we spoke with on the wards and departments confirmed they had up to date life support skills training. Management confirmed staff were up to date. There was

appropriate emergency equipment located on the wards and departments that was suitable for purpose.

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

We found that the trust co-operated with other providers in the discharge planning of patients in their care. We spoke to patients, relatives and staff. Patients told us they felt discharge planning was mostly appropriate, however some concerns were made in respect of untimely organisation of packages of care by local social services whom the trust liaised with to ensure safe discharges. This led to a delay in the discharge from the hospital of the patient. Patients told us they had been asked and given permission for their personal information to be shared with other professionals including social workers in order to plan their discharge. They generally thought that discharges were planned effectively. However we spoke to one patient who had been waiting to be picked up by the ambulance transport service since earlier that morning. They had since been informed they would be taking her home about 4pm which concerned them a little as it was getting dark and cold to go back home on their own.

We spoke with the integrated discharge team who led the co-ordination of patient discharges from the hospital. They detailed the work they had undertaken to improve discharges and prevent delays. We saw evidence to demonstrate that discharges had improved over the last twelve months and had resulted in a fall in the number of delayed discharges from the hospital. However there were still concerns around late discharges. The trust policy is to not discharge patients before 7.30am or after 9.30pm; most patients and relatives felt this was too late in the day to be discharged.

Staff told us discharge planning commenced at admission and we saw evidence in the records that this happened. Staff explained that discharge planning started at admission and the need for social services input was identified on admission. We were told the patient's home details were checked and any social services involvement noted as part of the assessment process. Discharges were discussed daily at the ward meetings with patient review and updating of where the patient was in respect of their discharge plan. Discharge co-ordinators visited the wards on a daily basis and staff reviewed discharge plans with them. They referred patients to them as necessary if they were nearly ready to be discharged or earlier in the case of needing more complex discharge panning.

We saw that the hospital had made arrangements with the local mental health trust for two

dementia nurse specialists to see all the patients with dementia to advise on nursing care, discharge planning and liaise with patients' families and community mental health services. Social workers often attended ward rounds and also carried out assessments of patients to determine what care packages would be needed on discharge.

On the surgical ward we visited we saw evidence of discharge planning commenced on admission. There was an estimated length of stay for specific procedures and as a result discharge needs and support was planned early with evidence of patient and relative involvement. Staff confirmed that most discharge plans involved referrals to the district nurses for post hospital care. There were no concerns raised in respect of discharge planning on the surgical ward.

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 introduced this outcome during the inspection due to concerns raised in respect of suitable staffing levels on ward 14.

Ward 14 is a surgical ward specialising in urology. In April this year the ward bed capacity size was increased to 36 beds. This caused concern for the staff as they did not feel they were sufficiently staffed for 36 beds. This was confirmed by the Director of Nursing who instigated a plan which included closing 6 beds. A staffing review was undertaken resulting in the staffing levels to be deemed sufficient for a 30 bedded ward. Over the following few months due to pressures across the hospital the 6 beds were re-opened and closed again on a number of occasions. During the times when the beds were opened and used to care for patients staff reported incidents of unsafe care due to insufficient staff.

Staff we spoke with at the time of the inspection told us that generally they felt patient care and safety was not compromised when the ward was operating at 30 beds, however they had great concern that these beds would reopen and this would lead to unsafe care due to insufficient staffing levels. We were assured by the Director of Nursing that these beds would not be reopened at all and in fact the beds had been removed from the ward. We saw evidence of the staffing review that demonstrated the staffing levels had been reviewed and agreed as safe for 30 beds. We saw evidence that agreement to a business case for a specialist nurse and medical staff based on the ward had been agreed and recruitment was underway.

Further concerns were raised as there was a high sickness level on this ward which if not covered would result in staff shortages.

We spoke to the Director of Nursing, Medical Director and the Surgical Matron regarding these concerns. We received assurance that the staffing issues were being addressed at this time. We received assurance that the ward would remain as a 30 bedded ward only and the space for 6 beds would not be used in the case of a hospital wide bed shortage. We were satisfied that as a 30 bedded ward the staff levels were appropriate. We were told about plans to ensure good leadership was in place in the form of an experienced matron who would oversee staffing levels on a daily basis and ensure shortfalls were promptly addressed.

Patients on ward 14 told us they were well cared for however they noticed staff were sometimes very busy and rushed off their feet. We were told staff usually responded quickly even if it was just to tell them they would be back to attend to them shortly.

Staff told us they did not believe patient care was unsafe however they felt that they could only provide basic care and were not able to enhance patient care because they did not have the time to do this. One staff member told us:
"I would love to sit with a patient for a while".

The provider may find it useful to note that overall we found safe staffing levels on ward 14 had been compromised when the extra 6 beds had been used and staff were not adequately supported with their concerns by appropriate leadership. We found that staff levels were suitable for a 30 bedded ward as long as support was effective and absences were covered appropriately.

On the other wards we visited we found there were suitable numbers of staff. We found that on the elderly care unit staffing levels had recently been uplifted and staff told us that extra staff were made available in the case of increased acuity or dependency of patients. Staff were satisfied with the staffing levels.

Within the theatres visited we found that they were well staffed and staffing levels ensured good, safe patient care. We saw that additional staff were deployed for fast-turnover operation lists. We found that skill mix and staffing numbers were considered to be appropriate by staff and managers that we spoke with.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who generally were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We assessed this outcome due to concerns raised with us prior to the inspection of a bullying culture that was allegedly emerging in the trust. We found no evidence of a bullying culture at the trust. Staff we spoke with had no concerns regarding bullying.

We found that patients received care, treatment and support from staff that generally were competent to carry out their roles and responsibilities. The trust had a system in place to ensure all staff received a comprehensive induction that took account of recognised standards for hospitals. We spoke with a number of staff. They told us about the induction process and how they were clear about the trust and the wards aims and objectives. Competency based assessments were undertaken prior to new staff working unsupervised.

We spoke with staff and managers who confirmed that learning and development needs were identified based on the needs of patients and the skills required from staff to ensure that the service met essential standards of quality and safety. All staff had a learning and development plan in place from induction and monitored through appraisals. This was based upon the needs identified and how those needs would be met. For example staff working on the care of the elderly wards received dementia care training and updates. Each department had a learning and development plan which fed into a trust wide programme of training and development in order to meet statutory, mandatory and professional requirements. We found that appropriate resources were available and that staff were supported in their training and development.

Staff we spoke with confirmed they were up to date with their mandatory training. We saw how mandatory training was monitored and managed. We saw that if staff did not meet their mandatory training targets this would be performance managed by their line manager and that they could be demoted for a period of time until they had achieved their mandatory training targets. We saw training statistics and were satisfied that mandatory training was on target for compliance by the end of the year.

Most of the staff we spoke with told us they were well supported and they were clear about their lines of accountability. They told us they felt supported by their peers and managers. The trust had arrangements in place for ensuring all staff had to complete an annual

appraisal. Staff told us this was a positive experience and one they welcomed. We spoke with staff about supervision, and found that mostly they received informal supervision through team daily clinical meetings and regular ward or departmental team meetings. We were told that regular ward meetings did not take place on ward 20, however we saw minutes of meetings for this ward that demonstrated some meetings had taken place. The provider may find it useful to note that formal clinical supervision in line with professional regulators and professional bodies requirements were not in place in all areas we visited. Medical staff received formal supervision; however we found that nursing staff did not receive formalised clinical supervision.

Staff on two wards and theatres we visited told us they felt supported by their manager and felt confident that they could raise any concerns they may have without fear of reprisals. One staff member told us:
"It's a good place to work".
A departmental manager told they felt it is a good organisation to work for and that senior managers listen to staff and act on concerns.

We were advised that key ways for staff to raise concerns was directly with their manager, the executive team via the "informal walk around" or through incident reporting. Generally staff told us that the trust was a good organisation to work for and that senior managers listen to staff and generally acted on concerns. The exception to this was on ward 14.

The provider may find it useful to note that staff on ward 14 had not been suitably supported through their concerns in respect of staffing levels. We found that they lacked good leadership and there was a lack of communication from senior managers through to the ward staff in particular around addressing their staffing level concerns. Staff were concerned about extra beds being used which would increase work pressure on them. Reassurance had been given at a senior level that the beds would not be used and plans were in progress to support the ward staff with experienced supportive management however this had not been effectively communicated to staff. Staff were consequently exhibiting signs of stress in the work place. This meant that there may be a risk that patients may not receive safe care due to staff not being properly supported to undertake their role.

We received assurance that plans were in place and implemented to ensure the ward was suitably managed and staff would be supported by effective senior staff. The issues had been identified by senior managers and actions implemented. An experienced matron was now covering the unit. We established that they were implementing support mechanisms, review of skill mix on the ward and staff shortfall planning.

We found there were a number of initiatives underway to ensure board members and senior managers visibility in the trust, and to promote effective communication. Examples included: the "15 step challenge", "you said we did", "listening into action" and a briefing bulletin from the chief executive entitled "trust information exchange". Staff spoke positively about these initiatives.

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.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We found that overall the trust had a robust clinical governance framework in place that included monitoring the quality of services provided, obtaining feedback from patients, the public and staff and risk management.

We found that a significant amount of work had taken place in the last 12 months improving governance, assurance and performance management systems. We were told about work undertaken with the board to develop processes to ensure greater clarity, efficiency and accountability. Governance and assurance committees had been restructured. We saw that a new assurance framework had been established with a separate board of directors' assurance framework policy. These were available on the intranet. Within the assurance framework clear lines of accountability were seen. Board meetings had been reduced from monthly to quarterly and we were told that the quality of the meeting was evaluated at the end of each meeting.

We looked at the systems in place for clinical audit. The clinical audit forward plan was approved by the clinical governance group and we saw evidence of the plan monitored quarterly by the clinical governance team. The audit forward plan clearly described the priority categories for audit to ensure that clinical audit projects contributed to the overall priorities of the trust and provided assurance of the quality of care. Audit priorities were categorised with priority one and two audits being those 'must do' audits that were mandated nationally by NICE or internal priorities across all divisions. Priorities three and four were managed at a local divisional level.

At ward/department level, ward managers carried out regular audits of various aspects of care and hygiene. Feedback was given to staff and action plans were devised if any areas were not meeting required standards. We saw how a new patient focussed audit tool had been implemented for these ward level audits. These audits monitored key quality areas for patient care and safety and were reported on by ward or unit. We saw examples of the nursing and midwifery audit results presented and displayed in wards /departments and discussed at various team, departmental and governance meetings.

The trust participated in the national clinical audit and confidential enquiries programme. In the last year (2012/2013) the trust participated in 79% of national clinical audits and 100% of national confidential enquiries of which they were eligible.

There was a concerns and complaints policy and procedures in place. We were told that the chief executive would look at and respond to every formal complaint that was received. We saw evidence of a complaints log. This was seen to monitor compliance with the complaint policy and procedures and demonstrated where the chief executive had been involved and quality assured the process and response. Trend analysis was undertaken and reported to the executive team and board quarterly through the complaints, litigation (claims), incidents, patient advice and liaison service and patient experience (CLIPPE) reports

The complaints procedure and how to raise concerns or complain was promoted throughout the hospital. We saw that leaflets on the complaints procedure were available on the wards and staff knew what to do if a complaint was raised. Minor concerns were addressed by the ward manager, but if more serious concerns were raised patients or relatives were referred to the complaints procedure. The Patient Advice and Liaison Service (PALS) functioned effectively in the trust feeding information to the patient experience, quality and safety committees.

The trust participated in the national in patient survey which was conducted annually. We saw evidence of trend analysis of the results with monitoring of action plans and implementation of initiatives to improve areas of concern. Results were compared with previous years to analyse where improvements had been made and where improvements were still needed.

The trust participated in the new model 'friends and family' test which was designed to improve patient care and identify the best performing hospitals in England. Uptake of the survey had been low at the trust and we were told work continued to ensure friends and family test compliance.

We saw evidence that demonstrated there was an emerging focus on patient experience. The quality improvement strategy (2013-2016) set out the three dimensions to quality of which patient experience was one. There was an executive director who led on patient experience and a patient and family experience group. We were told and saw evidence of a new practice where patient stories were told at the beginning of all senior meetings (e.g. board meetings, quality and safety committee). We were told by senior staff that these were "very powerful" and helped them understand patient's experiences.

We saw examples of a number of patient focused initiatives. These included afternoon tea on the wards with cake and tea served in cups and saucers, serving meals so that courses were brought out separately rather than all at one time, reminiscence pods for patients with dementia and a trial of open visiting times.

The trust participated in the national NHS staff survey. We saw evidence of an action plan developed in response to the most recent staff survey. We were informed that work was on-going to look at the challenges and issues.

The trust had last year commenced the 'Listening into Action' scheme to help understand staff concerns and issues and change ways of working to improve patient experience and safety. The scheme involved listening to staff (with a variety of methods employed to do this) to understand what was important to them, what obstacles they had and what the

priorities of action were in order to ensure patients benefitted from changes made. Staff we spoke with were extremely positive about their involvement with this.

Members of the board of directors, including some non-executive directors, frequently walked around the hospital and gave a presence to staff to encourage them to communicate with them at all levels. This had been received positively by staff.

We saw the reporting systems for incident reporting and risk management. Divisional management team meeting minutes confirmed that incidents were reviewed monthly with lessons learnt and action planning evident. These were then escalated and informed through divisional quality and risk groups and the quality and safety committee. Depending on the nature and severity of the incident root cause analysis took place. We saw evidence in the examples we studied of root cause analysis and lesson learnt disseminated to relevant staff.

Quality and safety issues along with patient experience issues were seen within the CLIPPE report which was reported to the board quarterly. The CLIPPE report brought together key issues related to complaints, claims, incidents and patient experience. It provided a picture of where, when, what had happened, the scale/level of the issue and where improvements were needed. The CLIPPE report facilitated learning and enabled effective improvements in the quality of services to be implemented.

We saw evidence that demonstrated the trust had undertaken significant work in response to lessons learnt from the Francis report (The Francis report of the Mid Staffordshire NHS Foundation Trust public enquiry identified numerous warning signs that should have alerted the system to the problems that were developing at the trust). We saw evidence of the summarised report which was discussed within divisions and departments and at a trust wide workshop. This resulted in an agreed action plan and organisational improvement plan.

We found that the trust reported a large number of incidents when compared with similar trusts nationally. However it was also acknowledged that although there were a large number of reported incidents, the majority were reported as low or no harm. This meant that the trust had a good open reporting culture yet patients' risk of harm was lower when compared nationally against similar trusts. We saw the annual incident report to the board with trend analysis and action plans implemented.

We spoke to staff who told us they received training in incident reporting and that managers fed back results of trend analysis and action plans. One person told us that as a result of trend analysis in patient falls staffing levels had been reviewed and increased and this had led to a reduction in related incidents. In the theatre department we discussed serious untoward incidents. Staff were able to tell us the actions taken to avoid a repeat.

We saw that the trust had a risk management strategy and policy. The risk management group report into the board assurance committees of the quality and safety committee and the finance, performance and business development committee.

The trust risk register (risks of rating 15 or above) was also reviewed as part of the inspection. This was a large document that was difficult to navigate as issues and actions were not always aligned within the register. We were told that divisions only referred to their relevant section of the register however overall monitoring and management of the register was undertaken by the quality and safety department. The trust had a robust process for reporting and monitoring risk. Risks were identified in a range of ways

including change projects, external reviews/inspections, complaints, external guidance (such as NICE guidance) and internal reviews. We tracked an example of an identified risk in performance against quality and safety standards of ward 14. We had identified an issue during the inspection and evidence demonstrated these issues had been identified as a risk and were reviewed on the risk register monthly. This provided assurance that risks were identified whenever and wherever they arose. Monthly reports were sent to divisional management team (DMT) meetings detailing all incidents and risks. There was a clearly defined process for escalating risks through the reporting structure with standing agendas that included anything that needed to be escalated to the next committee within the structure. Depending on the grade of the risk there was also regular reporting to the executive management team, the risk management group, and the board.

We were advised that the trust had received the outcome of an external audit of the risk management system on the first day of our inspection (19 November, 2013). We looked at the report and found that generally the outcome was positive with no major issues identified. We saw the annual risk management report that was presented to the board.

The trust had a raising concerns policy (whistle blowing). There was evidence of audit of the policy with action plans in place to improve compliance with the policy. As a result a revised policy was being implemented. Monitoring of concerns raised took place through the various committees and was overseen by the board.

The trust had systems in place to act on and monitor any safety alerts that were received.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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