Review of compliance

Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ

Region:	North West
Location address:	
Type of service:	Acute services
Date the review was completed:	20 December 2010
Overview of the service:	Mid Cheshire Hospitals NHS Foundation Trust is a provider of acute hospital services in south east Cheshire. These services are provided from three locations. The Victoria Infirmary in Northwich and the Elmhurst Immediate Care Centre in Middlewich are community hospitals with the Victoria Infirmary incorporating a minor injury unit. Leighton Hospital is a

	medium sized district general hospital located on the outskirts of the town of Crewe and is the management base for the trust.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Mid Cheshire Hospitals NHS Foundation Trust was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Care and welfare of people who use services
- Management of medicines
- Complaints

How we carried out this review

We reviewed all the information we hold about this provider, talked to people who use services, talked to staff and checked the provider's records.

What people told us

A small number of people who complained to the trust about treatment raised concerns about the manner in which their complaints had been dealt with.

We were told by people who had used the maternity service that they felt they had not received safe and appropriate care during a high risk pregnancy.

They suggested that the treatment received did not identify risks associated with them as an individual and say how they should have been treated in response to those risks.

What we found about the standards we reviewed and how well Mid Cheshire Hospitals NHS Foundation Trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

The trust has not ensured that some women with high risk pregnancies receive safe and appropriate care together with treatment and support that meets their needs.

However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by February 2011. We will ask the trust to keep us informed on a monthly basis of the progress of their Maternity Service Action Plan.

- Overall, we found that improvements are needed for this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

The trust has not ensured that some patient safety alerts, rapid response reports and patient safety recommendations disseminated by the National Patient Safety Agency and which require action have been acted upon within required timescales.

However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by April 2011. We will ask the trust to keep us informed of the progress of their action plan for the Pharmacy Department.

We will also ask the trust to forward the National Patient Safety Agency (NPSA) Central Alerting System (CAS) progress report each month until April 2011.

- Overall, we found that improvements are needed for this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

The trust has provided evidence of compliance with this outcome and we have evidence that they have responded to complaints about their complaints process.

- Overall, we found that Mid Cheshire Hospitals NHS Foundation trust was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with outcome 4: Care and welfare of people who use services

This concern only relates to the regulated activity of Maternity and midwifery services.

Our findings

What people who use the service experienced and told us

We were told by a small number of people who had used the Maternity Department that they felt they had not received safe and appropriate care during high risk pregnancy.

They suggested that the treatment received did not identify risks associated with them as an individual nor say how they should have been treated in response to those risks.

We looked at the results of the most recent survey of women's experiences of maternity services where the trust was assessed as performing as expected except for post natal care where survey results were worse than expected.

Other evidence

As a result of a specific complaint made to the trust they commissioned an independent review of a specific serious untoward incident that had taken place in the Maternity Department. This report raised a number of issues about both antenatal care and management during labour at the trust. Some of these issues

concerned the management of high risk pregnancies.

In response to this report, the complaint, their own serious untoward incident report and root cause analysis the trust developed a Maternity Service Action Plan in November 2010.

This plan identified a number of concerns together with the actions to be taken in order to change practice. Key issues identified were:

- No agreed pathway was in place for women with high risk factors such as epilepsy, obesity and hypertension.
- There were no guidelines for women with risk factors in pregnancy.
- There was no overall high risk pathway in place.
- Conflicting advice was given to women.
- There was no ratified policy for telephone advice.
- There was no official audit programme for monitoring stillbirth rates.
- Antenatal screening for foetal growth restriction required enhancement.

Some of the actions to resolve these issues were noted as already completed and where this had been done the trust provided us with good evidence that it was so. This gives us confidence in the trust's ability to complete the other actions which have completion dates no later than February 2011.

Our judgement

The trust has not ensured that some women with high risk pregnancies receive safe and appropriate care together with treatment and support that meets their needs.

However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by February 2011. We will ask the trust to keep us informed on a monthly basis of the progress of their Maternity Service Action Plan.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us

Information from our internal monitoring system known as the quality and risk profile did not give rise to concerns and neither did responses to the inpatient and outpatient surveys with results being "similar to expected"

There was no relevant information available from neither the local involvement networks nor the overview and scrutiny committee.

Other evidence

The trust provided us with their National Patient Safety Agency (NPSA) Central Alerting System (CAS) Progress Report of September 2009. This reports showed that of the seven alerts that had not been resolved all but one related to medicines management.

Management of NPSA alerts

It was clear from the report and accompanying documentation that the trust had a robust system for dealing with these alerts and any failure to implement them is recorded at an appropriate level. All breached alerts are noted in both a monthly exception report and a quarterly report to the trust's governance committees.

The trust told us that items requiring escalation to board level are done so by the Medical Director and that in the case of the outstanding alerts regular meetings take place between the Director of Pharmacy and the Patient Safety Manager.

Pharmacy related NPSA alerts

The trust told us that unlike some other NHS organisations they only close the alert when the action plan is completed rather then when the plan has been agreed. Nevertheless the data provided showed that some alerts had been going on for more than two years beyond their expected closure date.

The progress report of September 2010 demonstrated that there were nine outstanding alerts related to medicines management. It was noted that the more recently issued alerts are being addressed in shorter timescales than previously.

Effectiveness of the Pharmacy Department

Examination of the trust's internal monthly report on breached alerts raised concerns that much of the outstanding work was because of failures to develop and implement policies within the Pharmacy Department

We asked to the trust to comment and they provided us with comprehensive documentation showing that the trust had become aware of deficiencies in the Pharmacy Department in 2008 and as a result had asked an external company to perform a review for them.

This review published in January 2009 found that there was work to be done to bring the trust up to an appropriate level of pharmacy practice. The report also noted examples of good practice and that most of the developments expected in government "vision" papers were in place although some were not yet fully developed.

The report proposed an action plan made up of three phases to be completed in the financial years 2009/10, 2010/11 and 2011/12. The issue of non compliance with NPSA CAS alerts was recognised in the review and was addressed by the proposed action plan.

The first phase required the introduction of a new departmental structure together with the recruitment of key staff laying the foundations for the improvements. Much of the reorganisation allowed routine work to be done by pharmacy technicians releasing qualified pharmacists to lead in clinical work.

The second phase was intended to further enhance the pharmacy staffing through additional recruitment and reorganisation and would allow the organisation to reach a "Silver Standard" judged appropriate by the report for a provider of its nature.

The third phase was judged optional and would bring the trust to a "World Class Standard."

We were shown evidence that the first phase had been completed on time in the spring of 2010 and that the board had authorised progress to phase 2. We have seen further evidence that this second stage is progressing to plan.

Our judgement

The trust has not ensured that some patient safety alerts, rapid response reports and patient safety recommendations disseminated by the National Patient Safety Agency and which require action have been acted upon within required timescales.

However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by April 2011. We will ask the trust to keep us informed on a monthly basis of the progress of their action plan for the Pharmacy Department.

We will also ask the trust to forward their National Patient Safety Agency Central Alerting System Progress Report each month until April 2011.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us

Information from our internal monitoring system known as the quality and risk profile did not give rise to concerns with the information from our National Patient Safety Agency partner body being “as expected”. Our own inpatient survey found that patients’ knowledge of the complaints process from leaflets and posters provided by the trust was similar to expected from this type of organisation

Information from enter and view visits made by the local involvement network noted that complaints procedures were prominently displayed in those trust locations visited.

However a small number of people who had cause to complain to the trust about their treatment had raised concerns about the manner in which their complaints had been dealt with.

Other evidence

We asked the trust to tell us what they were doing to meet the outcomes required by this essential standard by sending us their own assessment of compliance.

This document provided evidence that satisfied the outcomes detailed in the essential standards of quality and safety. The information provided in this document was compared with the trust’s complaints procedures which are available to the

public on their website.

We asked the trust about how it managed complaints where the outcomes were not to the satisfaction of the complainants. They told us that they had reviewed and changed practice in response to issues that had arisen. We were told that improvements had been made to ensure that meetings with complainants were accurately recorded and that quality checks were made. We were also told that specific training was to be provided for staff who attended meetings with complainants.

The trust also told us that it has introduced a new system to ensure that complaints are more closely linked to risk governance if a serious untoward incident is identified.

Our judgement
The trust has provided assurance that current practice is compliant with this essential standard and we have evidence that they have responded to complaints about the complaints process.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Maternity and midwifery services.	9	4: Care and welfare of people who use services
	Why we have concerns: The trust has not ensured that some women with high risk pregnancies receive safe and appropriate care together with treatment and support that meets their needs. However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by February 2011. We will ask the trust to keep us informed on a monthly basis of the progress of their Maternity Service Action Plan.	
Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Maternity and midwifery services Termination of pregnancies Family planning	13	9: Management of medicines
	Why we have concerns: The trust has not ensured that some patient safety alerts, rapid response reports and patient safety recommendations disseminated by the National Patient Safety Agency and which require action have been acted upon within required timescales. However we are confident in the trust's progress in delivering an action plan that addresses the underlying issues by April 2011. We will ask the trust to keep us informed on a monthly basis of the progress of their action plan for the Pharmacy Department. We will also ask the trust to forward their National Patient Safety Agency Central Alerting System Progress Report each month until April 2011.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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