The Christie NHS Foundation Trust
The Christie NHS Foundation Trust

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<th>Region:</th>
<th>North West</th>
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<tr>
<td>Location address:</td>
<td>550 Wilmslow Road Withington Manchester Greater Manchester M20 4BX</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<tr>
<td>Date of Publication:</td>
<td>November 2011</td>
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<td>Overview of the service:</td>
<td>The Christie NHS Foundation Trust is a specialist acute service, treating more than 40,000 patients a year. They were the first UK centre to be officially accredited as a comprehensive cancer centre. The Christie is based in Manchester and serve a population of 3.2 million across Greater Manchester &amp; Cheshire. They provide: Radiotherapy, chemotherapy,</td>
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specialist surgery, diagnostics and support services.
Our current overall judgement

The Christie NHS Foundation Trust was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 5 October 2011, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We reviewed information that we hold from patient surveys. The majority of information reviewed was rated as better than expected (compared to similar organisations). We visited the hospital on 5th October 2011 and spoke to a number of patients. Those whom we spoke to told us that they felt they were always treated with dignity and respect, that staff always spoke to them and explained what was happening and asked permission before carrying out any care. Comments were made by patients that we spoke to such as: "They always draw the curtains when staff want to speak to you or give care" "Everything regarding care is explained and if I do not understand then it is repeated to ensure that I do. Sometimes the information is backed up with leaflets but I look for guidance from them (they are the experts) to make my decision" "I am very satisfied with the care that my child receives and appreciate that I am kept informed and can seek further clarification"

It was noted that all the patients we spoke to said that they were not aware of their care plan. They also told us that they were never anxious about their care nor did they ever feel unsafe.

What we found about the standards we reviewed and how well The Christie NHS Foundation Trust was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
Overall we found that The Christie NHS Foundation Trust was meeting this essential standard, however improvements were needed. Patients and their relatives were not regularly involved in decisions about their care or were aware of their own care plans. There is a lack of consistent training in equality and diversity and the Mental Capacity Act.

**Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights**

Overall we found that The Christie NHS Foundation Trust was meeting this essential standard, however improvements were needed. Patients and their relatives were not regularly involved in decisions about their care or were aware of their own care plans. There is a lack of consistent training in equality and diversity and the Mental Capacity Act.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Overall we found improvements are needed for this essential standard. We found that safeguarding training varied dependent on role and area worked in. There were inaccuracies in recording training attendance and training records demonstrated that not all staff required had received up to date training in safeguarding or the Mental Capacity Act. Staff had a varied knowledge and understanding of safeguarding and their responsibilities.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Overall we found that The Christie NHS Foundation Trust was meeting this essential standard. However improvements are needed as training and development records were not accurately maintained and records demonstrated there was not full compliance with training needs amongst staff. There was evidence that staff returning to work after absence were not receiving update training or information.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

Overall the Christie NHS Foundation Trust is meeting this essential standard. We found evidence that monitoring of the quality of care and service provision is well planned, takes place regularly throughout the hospital and involves different grades of staff. Risk management processes are evident and applied to care of the patients.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 28 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.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any...
action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
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 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We visited the hospital on 5th October 2011 and spoke to a number of patients. Those whom we spoke to told us that they felt they were always treated with dignity and respect, that staff always spoke to them and explained what was happening and asked permission before carrying out any care.
Comments were made by patients that we spoke to such as:
"They always draw the curtains when staff want to speak to you or give care"
"Everything regarding care is explained and if I do not understand then it is repeated to ensure that I do. Sometimes the information is backed up with leaflets but I look for guidance from them (they are the experts) to make my decision"
"I am very satisfied with the care that my child receives and appreciate that I am kept informed and can seek further clarification"

We reviewed information that we hold from patient surveys. The majority of information reviewed was rated as better than expected (compared to similar organisations). A good level of information was reported in the Care Quality Commission, Survey of Adult Inpatients 2010. Two pieces of information were rated as worse than expected, these related to lack of discharge information and choice of admission dates.
However the National Cancer Patient Experience Survey 2010 demonstrated better performance in these areas.

Patient questions:
Were you given clear written information about what should / should not do post discharge - 86% responded positively  
Did staff tell the patient who to contact if worried post discharge - 95% responded positively  
In this survey The Christie scored particularly well with questions relating to the ward nurses, hospital care and treatment and information given before leaving hospital and home support  
It was noted that all the patients we spoke to said that they were not aware of their documented care plan. One issue noted was that one person said staff were not aware of his interests or what he liked to do such as reading the daily newspapers and that these were only available to him when relatives visited and brought them to him.

**Other evidence**

We reviewed information that we hold on the provider and found that for this outcome there was a low risk of concerns. We visited the hospital on 5th October 2011. We looked at patient records, risk assessments, care plans and spoke to staff. We found that care is planned following individual assessment using a computer package to enable nursing staff to identify patient needs and risks then plan their care and treatment accordingly. We noted that admission information and assessments included noting patient's religious/spiritual/ cultural needs, next of kin and family details and name preferences or aliases. We observed that psychological and social assessments were undertaken. Evidence was observed of action being taken where issues were identified and this being incorporated into the individual care plan.

We observed a sample of care records both on the intranet system and paper records. These were generally found to be completed appropriately, dated, timed and signed correctly however some evaluation records did not reference to the care plan they were evaluating against.

We noted that care records contained little evidence of involvement of patients and/or relatives in care and treatment choices and information given. Consent to treatment records were evident as were consent to the use of bedrails. Communication sheets were also seen however these contained little information to say that patients and those close to them were involved in care and treatment decisions. There was some evidence of medical staff recording conversations with patients regarding their treatment and evidence was seen in the form of do not attempt resuscitation orders (DNAR). Of the two we observed both demonstrated that the DNAR order had not been discussed with the patient or family. The trust showed us audits that they had undertaken with reference to DNAR orders. Generally it was found that these orders are present, signed and held with patient notes, however it has been identified that there is a risk that DNAR forms are being completed but not being discussed with the patient or their family. Re audits of this issue demonstrated that some improvement had taken place however in the 2010 audit there was still only 24% of patients being informed and 31% of relatives informed of the DNAR order given by medical staff.

Patients interviewed told us that they were not aware of their care plans nor had they been involved in making decisions regarding their care. The social assessment included discharge planning. We were told in the Care Quality Commission, Survey of Adult Inpatients 2010 that the proportion of respondents to the survey who stated that before leaving hospital, they were not given written information about what they should/should not do after leaving hospital was much worse than expected.

We spoke to staff and were shown a variety of written information and leaflets that are given to patients and family before, during and on discharge. The Christie provides
comprehensive booklets which includes full information for discharge on a number of conditions / treatments undergone. The booklets contain a wide range of information including checklist for going home, contact details and numbers, general precautions and much more. These booklets are entitled “Going home and the future”. We were also shown a small card entitled “Christie hotline”. This information card is given to patients on discharge and gives information on what to do and who to contact in urgent situations.

We were told how the trust conduct their own internal quality monitoring surveys of patients, one of these being the "One day – every patient" scheme where on a particular day all current inpatients were asked to give their views on their experience. We observed survey results for August 2011, in this survey 88% of those interviewed said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

Training records could not demonstrate that all staff are currently up to date with training in equality and diversity and the Mental Capacity Act. It was noted that training for these topics is currently under review with less frequent update training proposed. We observed during our time on the wards that people’s privacy and dignity was maintained by staff caring for them. We noticed that staff wore name badges and uniforms indicating who and what role they were. We observed patients being treated respectfully; dignity was maintained by the use of single sex bays and areas of the wards, toilets and curtains for screening. The hospital operates protected mealtimes policy and it was observed on the day that this was enforced.

Our judgement

Overall we found that The Christie NHS Foundation Trust was meeting this essential standard, however improvements were needed. Patients and their relatives were not regularly involved in decisions about their care or were aware of their own care plans. There is a lack of consistent training in equality and diversity and the Mental Capacity Act.
Outcome 04:
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
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We visited the hospital on 5th October 2011 and spoke to a number of patients. Those whom we spoke to told us that they felt they were always treated with dignity and respect, that staff always spoke to them and explained what was happening and asked permission before carrying out any care. Comments were made by patients that we spoke to such as:
"They always draw the curtains when staff want to speak to you or give care"
"Everything regarding care is explained and if I do not understand then it is repeated to ensure that I do. Sometimes the information is backed up with leaflets but I look for guidance from them (they are the experts) to make my decision"
"I am very satisfied with the care that my child receives and appreciate that I am kept informed and can seek further clarification"
It was noted that all the patients we spoke to said that they were not aware of their care plan. One issue noted was that one person said staff were not aware of his interests or what he liked to do such as reading the daily newspapers and that these were only available to him when relatives visited and brought them to him.

Other evidence
We reviewed information that we hold on the provider and found that for this outcome there was a low risk of concerns. The majority of information reviewed was rated as similar as or better than expected (compared to similar organisations). There was one positive comment that relates to staff patient interaction. None of the information we had was rated as worse than expected.
Other information we reviewed from the Care Quality Commission: Survey of NHS Staff
2010/2011 Key Findings showed us that for staff feeling satisfied with the quality of work and patient care they are able to deliver, and percentage of staff agreeing that their role makes a difference to patients was better than average when compared to other trusts for this key finding.

We visited the hospital on 5th October 2011. We looked at patient records, risk assessments, care plans and spoke to staff.

We found that care is planned following individual assessment using a computer package to enable nursing staff to identify patient needs and risks then plan their care and treatment accordingly. We noted that admission information and assessments included noting patient's religious/spiritual/ cultural needs, next of kin and family details and name preferences or aliases.

Risk assessments were individualised and included risk of pressure sores, use of bed rails, risk of malnutrition, moving and handling risks, ability for activities of daily living, psycho-sexual and social risk assessments.

Evidence was observed of action being taken where issues were identified and this being incorporated into the individual care plan.

We observed a sample of care records both on the intranet system and paper records. These were generally found to be completed appropriately, dated, timed and signed correctly however some evaluation records did not reference to the care plan they were evaluating against. There was evidence in the records we looked at that risk assessments and care plans were reviewed on a weekly basis

We noted that care records contained little evidence of involvement of patients and/or relatives in care and treatment choices and information given. Consent to treatment records were evident as were consent to the use of bedrails. Communication sheets were also seen however these contained little information to say that patients and those close to them were involved in care and treatment decisions. There was some evidence of medical staff recording conversations with patients regarding their treatment and evidence was seen in the form of do not attempt resuscitation orders (DNAR). Of the two we observed both demonstrated that the DNAR order had not been discussed with the patient or family. The trust showed us audits that they had undertaken with reference to DNAR orders. Generally it was found that these orders are present, signed and held with patient notes, however it has been identified that there is a risk that DNAR forms are being completed but not being discussed with the patient or their family. Re audits of this issue demonstrated that some improvement had taken place however in the 2010 audit there was still only 24% of patients being informed and 31% of relatives informed of the DNAR order given by medical staff.

It was noted that the trust uses the care pathway for end of life care know as the Liverpool Care Pathway. This was observed in place for patients requiring end of life care and is a nationally renowned pathway to provide excellence of care on an individualised basis to those patients coming to the end of their lives in all care settings.

Patients interviewed told us that they were not aware of their care plans nor had they been involved in making decisions regarding their care.

We observed patients being treated respectfully; dignity was maintained by the use of single sex bays and areas of the wards, toilets and curtains for screening. We observed that the protected mealtimes policy was strictly implemented.

The social assessment included discharge planning. We were told in the Care Quality Commission, Survey of Adult Inpatients 2010 that the proportion of respondents to the survey who stated that before leaving hospital, they were not given written information about what they should/should not do after leaving hospital was much worse than expected.
We spoke to staff and were shown a variety of written information and leaflets that are given to patients and family before, during and on discharge. The Christie provides comprehensive booklets which includes full information for discharge on a number of conditions / treatments undergone. The booklets contain a wide range of information including checklist for going home, contact details and numbers, general precautions and much more. These booklets are entitled "Going home and the future". We were also shown a small card entitled "Christie hotline". This information card is given to patients on discharge and gives information on what to do and who to contact in urgent situations.

We were told how the trust conduct their own internal quality monitoring surveys of patients, one of these being the "One day – every patient" scheme where on a particular day all current inpatients were asked to give their views on their experience. We observed survey results for August 2011, in this survey 88% of those interviewed said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

We observed and were told by staff that notifications and safety alerts were dealt with by the ward managers or deputies. We saw evidence that these are dealt with and have timescales for action and action plans where needed.

There is a full risk management incident/ accident and near misses policy and procedures in place. All relevant information is feedback through department and ward meetings and monitored on the quality indicators dashboard. Training was evident for various roles in accidents/ incidents and risk management. Evidence demonstrated that not all staff are appropriately trained in basic and life support skills.

**Our judgement**

Overall we found that The Christie NHS Foundation Trust was meeting this essential standard, however improvements were needed. Patients and their relatives were not regularly involved in decisions about their care or were aware of their own care plans. There is a lack of consistent training in equality and diversity and the Mental Capacity Act.
Outcome 07: Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

<table>
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<th>Our judgement</th>
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<tr>
<td>There are minor concerns with Outcome 07: Safeguarding people who use services from abuse</td>
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<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>We reviewed information that we hold on the provider and found that for this outcome there was one piece of information that we had relating to this outcome. The proportion of respondents to the adult inpatient survey (2010) who stated that they felt threatened during their stay in hospital by other patients or visitors – was similar to expected compared to similar organisations.</td>
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<td>We spoke to patients when we visited and those we spoke to had not received any information from staff in relation to safeguarding. They did say that they never felt threatened or unsafe and that they were always treated and spoken to with respect. One person said &quot;even in embarrassing moments (incontinence) I felt I was treated with great respect&quot;.</td>
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<tr>
<td>Other evidence</td>
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<td>There was one piece of information that we held on this provider relating to this outcome. The proportion of respondents to the adult inpatient survey (2010) who stated that they felt threatened during their stay in hospital by other patients or visitors – was similar to expected compared to similar organisations.</td>
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<td>Our information also shows that required notifications to the National Patient Safety Agency (NPSA) show steady low numbers with no discernable trends or peaks visible and that the provider reports at a quicker than national timescale.</td>
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<td>We were told by the trust that they were mostly compliant with this essential standard. In the provider compliance assessment document the trust identified four areas for improvement including review of policy and guidance for the prevention and management of violent or abusive behaviour (violence policy), conflict resolution</td>
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training needs analysis, review of safeguarding policies, development of safeguarding information leaflet / poster for patients and relatives, and review of policy around deprivation of liberty. We were told that all these actions would be completed by the end of December 2011.

We visited the trust and obtained further written evidence from them demonstrating compliance with this standard. We saw information in the form of policies and procedures for staff including – what to do if you are worried that a child/adult is being abused or neglected, prevention and management of violent or abusive behaviour and flowcharts for reporting a safeguarding concern in respect of vulnerable adults or children.

We were told that during 2011, the existing format and materials in respect of safeguarding vulnerable adults and children have been reviewed including stratifying the education and training for safeguarding into four levels. We spoke to staff and to safeguarding leads who described the different levels of training they had received. All staff are required to receive basic training in safeguarding that is approximately 30 minutes in duration and gives information regarding the different types of abuse and signs of abuse. Different grades of staff receive further training dependent on their role.

During the visit we observed the training matrix for one ward that we visited. The training records were not accurate with a lack of information (40% of staff) as to whether they were compliant with safeguarding training or not. The records also demonstrated that approximately 10% of staff were out of date whilst 50% were compliant with up to date training in safeguarding children and adults.

We asked staff about their understanding of safeguarding, some responded with details that showed they had a good understanding of safeguarding and their role whilst other staff did not understand what safeguarding was or were able to describe what they should do when scenarios were given to them.

We found that safeguarding training varied dependent on role and area worked in. There were inaccuracies in recording training attendance and training records demonstrated that not all staff required had received up to date training in safeguarding or the Mental Capacity Act. Of those we spoke to staff had a varied knowledge and understanding of safeguarding and their responsibilities.

Safeguarding leads had a clear understanding of their roles and responsibilities.

We were told that the trust links in and participates with the local safeguarding boards and referrals were made through the safeguarding leads.

Mandatory training includes violence and aggression (prevention). Ward training records observed demonstrate that 61% of staff were compliant with having received this training.

**Our judgement**

Overall we found improvements are needed for this essential standard. We found that safeguarding training varied dependent on role and area worked in. There were inaccuracies in recording training attendance and training records demonstrated that not all staff required had received up to date training in safeguarding or the Mental Capacity Act. Staff had a varied knowledge and understanding of safeguarding and their responsibilities.
Outcome 14: 
Supporting staff

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke to patients when we visited the hospital, those we spoke to told us that they were never anxious about their care. Staff acted promptly and appropriately and examples were given of staff who were not able to do a procedure informing someone who could and addressing the issue correctly.
Comments were made such as:
"I always receive my medication on time and my blood tests are always done as scheduled"
"When I developed a rash I informed the nurse who examined it and informed the doctor immediately"

Other evidence
We reviewed information that we hold on the provider and found that for this outcome the majority of information risk rated the provider as similar to or better than expected. There were two pieces of information that were tending towards worse than expected relating to staff suffering work-related stress in last 12 months - and staff experiencing physical violence from staff in last 12 months as reported in the Care Quality Commission, Survey of NHS Staff 2010
Other information we reviewed from the survey findings showed us that for staff job satisfaction, effective team working and staff recommendation of the trust as a place to work or receive treatment, this trust was better than average when compared to other trusts for this key finding.
We visited on 5 October 2011 and spoke to managers, staff, looked at training and supervision policies and procedures and records.
The trust presented evidence to demonstrate compliance with this outcome. Minutes of
the risk committee (June 2011) demonstrated training needs analysis, risk assessment and recommended actions for changes in key training elements. We saw evidence of the training and education committee whose key role is to review, advise on and endorse the education and training elements of The Christie policies, standard operating procedures, training packages and competency documents. We were told that the trust has a corporate and local induction. Staff that we spoke to confirmed that they had received an induction program for their area and corporate induction which included policies and procedures. The preceptorship for non medical healthcare professional's policy (June 2011) states that The Christie Hospital NHS Foundation Trust is committed to providing effective preceptorship programs to relevant health care professionals to ensure they receive the appropriate support to develop their confidence and competence during the early months in their new clinical role, to the ultimate benefit of patient care.

This policy relates to all non medical staff joining the trust as band 5 new entrants following professional registration including Registered Nurses, Radiographers, Physiotherapists, Occupational Therapists, Pharmacists, Health Care Scientists, Dieticians, Speech and Language Therapists. We were told that it also applies to any registrant returning to work after a prolonged period out of the profession. Staff whom we spoke to confirmed that they had a period of preceptorship when they first joined the trust, however it was commented upon that a staff member had recently returned from maternity leave and although they had an informal meeting on return they had not received a formal induction back into work or informed of any changes implemented whilst on leave.

The clinical supervision policy (for nurses and allied health professional) (July 2011) describes how clinical supervision is available for registered nurses and allied health professionals within the trust and aims to enhance standards and facilitate professional development. Clinical supervision is recommended but not compulsory for registered nurses and allied health professionals. There are a number of different formats that clinical supervision can take. Currently uptake of clinical supervision is not monitored however the trust does hold a database of clinical supervisors and is planning to conduct an audit of clinical supervision.

We were told that the learning and development needs of staff are identified using the PDR process. Staff that we spoke to confirmed that they receive an annual appraisal at which training needs are discussed and planned. The trust also has a study leave policy and process to support staff who wish to take accredited courses, higher education training and National vocational Qualifications (NVQ’s). We saw evidence that demonstrated that training and development is recorded and monitored at ward and department level. Staff we spoke to informed us that ward managers are responsible for monitoring training attendance. Records we observed showed varying compliance rates for the various training and personal development plan sessions, however we were told that these live records were in need of updating by adding recent training activity.

All children using the service are cared for by nursing staff holding a pediatric qualification. We visited the young oncology unit where staff confirmed they had received specific training in pediatrics and child safeguarding.

We were told that the trust offers an Employee Assistance program (EAP) to all of its staff and volunteers. Other methods of staff support were evident such as human resources policies and procedures for whistle blowing, bullying and harassment, grievance, health and wellbeing and respect at work. Staff whom we spoke to told us they felt well supported by their respective managers and enjoyed working at the trust. They told us they were well supported and had opportunities to undertake further
training.
The trust has a professional registration policy in place (May 2011). This provides a process for ensuring registration checks are made at appointment, annual re-registration checks are undertaken, agency workers registration checks are undertaken and management of non renewal of registration.
Evidence was seen on one ward we visited that all the nurses' registrations were monitored and up to date. We saw a verification of registration policy audit (August 2010- July 2011). This demonstrated that in the 12 months of the audit there had been no occasions where staff had not re registered or their registration had lapsed and therefore no need to take action.

Our judgement
Overall we found that The Christie NHS Foundation Trust was meeting this essential standard. However improvements are needed as training and development records were not accurately maintained and records demonstrated there was not full compliance with training needs amongst staff. There was evidence that staff returning to work after absence were not receiving update training or information.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement
The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>We spoke to patients when we visited. Those we spoke to were not aware of questionnaires or being asked their views on the quality of service and care. We did however see evidence of patients participating in a number of surveys, both national and internal.</td>
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<td><strong>Other evidence</strong></td>
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<td>We reviewed information that we hold on the provider and found that for this outcome the majority of information risk rated the provider as similar to or better than expected. There were two pieces of information that were tending towards worse than expected relating to the proportion of returned questionnaires (the total number of valid pre-operative questionnaires received compared to the number of Finished Consultant Episodes) and consistency of reporting to the National Reporting Learning System. We visited on 5 October 2011 and saw evidence of quality monitoring systems in place. The trust undertakes a number of satisfaction / patient experience surveys and has a full clinical audit program. The audit program includes externally required audit alongside internal local audits which are prioritised by divisions, disease groups and individual clinicians. Priorities for the core programme were agreed and audit leads identified within each division to work with the clinical audit team to implement the agreed programme. There are risk management procedures that include monitoring of incidents/ accidents/ notifications/ complaints. The systems are supported by policies and procedures that are reviewed on a regular basis. There was evidence in the board reports of serious untoward incident reviews and monitoring.</td>
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Staff interviewed were able to describe the types of audits that were undertaken at ward level and those they were involved with linked to their roles. We were told by staff that feedback on incidents, audits and surveys is given at ward meetings (confirmed that these take place monthly) and displayed on notice boards where applicable. Local quality monitoring occurs at ward and department level. Evidence was seen of the ‘dashboard’ for clinical indicators that included recording and monitoring of infections, patient experience, complaints, staff training, and hand hygiene.

On the ward we visited we found that the documentation audit for care indicators (falls, food and nutrition, observations, pain, medicines and pressure area care) had scored 100% for the last two months data.

Two monthly ward assessments are also undertaken by ward managers, estate personnel, matrons and infection control team. These audit the environment. Consistent scores of over 90% and frequently 100% were seen for the ward we visited. Action plans were observed for any areas requiring improvement.

When we visited the hospital we found that the trust carries out a number of surveys to monitor the quality of services. These are undertaken either locally by the trust itself or as part of national health service surveys. It was observed that national survey results are analysed and performance is compared to that of similar service providers nationally. Overall the trust performed well in comparison to similar trusts. Overall the trust performed better this year (2011) than in the previous year's survey results. We saw evidence of action plans in response to survey results. For example an action plan for June 2010 for the results of the outpatient survey 2010, action plan for inpatient survey results 2011.

We saw internal surveys that had been conducted on a regular basis such as "One day – every patient" (current in patients on a particular day asked their views regarding their experience), governor initiative – collecting patient experience (August 2010- August 2011) and Senior Nurse WalkRound – Nutrition (June 2011). We saw evidence of the patient experience committee's annual work plan that included auditing and reporting specific topics throughout the year, including nutrition, privacy and dignity and hygiene. There is a complaints policy and procedures in place with monthly monitoring of complaints by ward and department. It was noted within the education and training committee meeting minutes (April 2011) that currently there is no training for investigating complaints, incidents and claims and it was acknowledged that this is essential. During discussion with the ward manager it emerged that relevant complaints or incidents are investigated by the ward managers and they felt confident doing so. Information regarding how to complain was seen displayed by the wards and in different departments. We looked at a sample ward information leaflet that is under development and noticed that this did not contain information about how to complain within it. It was advised that complaints information is included into this ward information.

**Our judgement**

Overall the Christie NHS Foundation Trust is meeting this essential standard. We found evidence that monitoring of the quality of care and service provision is well planned, takes place regularly throughout the hospital and involves different grades of staff. Risk management processes are evident and applied to care of the patients.
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.

<table>
<thead>
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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 to us within 28 days of the date that the final review of compliance report is sent to them.

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 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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
<td>The general public</td>
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