**Inspection Report**

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

## The Christie NHS Foundation Trust

<table>
<thead>
<tr>
<th>Address</th>
<th>Tel: 01614463000</th>
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<tbody>
<tr>
<td>550 Wilmslow Road, Withington, Manchester, M20 4BX</td>
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<tr>
<td>Date of Inspection: 10 January 2013</td>
<td>Date of Publication: February 2013</td>
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We inspected the following standards as part of a routine inspection. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
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<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>✓</td>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
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<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
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<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✓</td>
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<tr>
<td>Staffing</td>
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<tr>
<td>Supporting workers</td>
<td>✓</td>
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<tr>
<td>Complaints</td>
<td>✓</td>
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## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>The Christie NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Overview of the service</td>
<td>The Christie NHS Foundation Trust is a large national specialist cancer centre, treating over 40,000 patients a year. The main hospital is in Manchester, and there are radiotherapy centres in Oldham and Salford. The trust serves a population of 3.2 million people across Greater Manchester and Cheshire, and 26% of patients are referred from across the UK.</td>
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<tr>
<td>On the day of our inspection the main hospital had 173 inpatient beds.</td>
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<tr>
<td>Type of service</td>
<td>Acute services with overnight beds</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
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<tr>
<td>Surgical procedures</td>
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<td>Treatment of disease, disorder or injury</td>
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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'.

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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 10 January 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

During our inspection we visited the Young Oncology Ward (YOU), ward 4 (clinical oncology ward for patients receiving radiotherapy and chemotherapy), ward 10 (surgical oncology ward) and ward 12 (for patients receiving radiotherapy and chemotherapy). We spoke with 11 staff members, including ward managers, nurses and healthcare assistants. We also spoke with seven patients.

The patients we spoke with commented positively about all aspects of their care and treatment. Their comments included "I ask lots of questions and they don't make you feel stupid", "You cannot fault the nurses. They do over and above what should be done" and "It is a specialised hospital, I am getting the best".

We saw evidence that doctors fully discussed patients’ options with them and gave them time to consider what their preferred treatment option was. In the records we looked at we saw patients had given their consent prior to any treatment or procedure commencing.

The staff we spoke with said they felt well supported at work, and they had an annual appraisal meeting with their manager. We saw that their mandatory training was usually up to date, and they had the opportunity to attend other training courses to increase their skills. Ward managers said they were able to access staff at short notice, and these would usually be from their team on the ward or trust bank staff.

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.

Patients’ privacy, dignity and independence were respected. Patients’ views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

The most recent NHS Inpatient Survey results were published in April 2012. The trust scored better than most other trusts taking part in the survey for the questions about being given enough privacy when being examined or treated (9.7 out of 10), for being treated with respect and dignity (9.7 out of 10), for doctors not talking in front of them as if they weren’t there (9.1 out of 10) and for being involved as much as they wanted to be in decisions about their care and treatment (8.5 out of 10). The most recent NHS Outpatient Survey results were published in February 2012. The trust also scored better than most other trusts taking part in the survey in the same areas.

The results of the latest National Cancer Patient Experience Survey were published in August 2012. The hospital was rated in the best 20% of hospitals for patients definitely being involved in decisions about their care and treatment and patients always being treated with respect and dignity by staff.

The trust also carried out their own monthly patient surveys. The latest results were from November 2012. All of the 170 patients who responded gave positive responses about the level of privacy, respect and dignity they were given, the level of involvement in decisions and the courtesy and helpfulness of staff.

We visited the Young Oncology Unit (YOU) during our inspection. When we arrived at the unit at 9.10am the wards were in darkness and it was very quiet. Staff explained that the young people on the unit often preferred to stay up late and stay in bed longer in the morning. The policy was to keep the lights off until 10am and let patients sleep until then unless this would have a negative effect on their treatment.

The trust had pages on the social network Internet sites Facebook and Twitter. We saw that these were only accessible for patients on the YOU, and they were used as a source of information for young people, particularly around subjects they may find difficult to discuss with their parents or other people involved in their care.
There were some single rooms on the YOU and wards for male and female patients. Staff said that although patients slept in different areas according to their gender they tended to mix and spend time in communal ward areas during the day. The patients we spoke with confirmed this was what they preferred to do. The unit had an ‘oasis’ area. This was a games room, which had a pool table, computers and computer games and a juke box, and a television room with a large screen television. Patients were able to watch Pay for View sports matches as monetary donations had been made to the unit for this purpose. There was also a music room with a piano, keyboards, guitars and a drum kit. Patients told us they liked to spend time in the oasis area, especially when their friends visited. It meant they could spend quality time away from the ward.

Very close to the YOU was Victoria House. This had six bedrooms and was used for families who wanted to stay close to patients in the YOU. Up to 13 people could stay overnight, and there were some single rooms to make it easier for siblings to also stay. There were laundry and cooking facilities in Victoria House. Staff told us that young people on the unit asked for food ‘like they had at home’, and this facility meant parents could make what they knew their children would like.

We observed staff treating patients with dignity and respect on all the wards we visited. Staff spoke discreetly with patients, and curtains were always pulled around beds when support was being provided. We saw evidence that most staff had received training in equality and diversity.

The patients we spoke with said they were listened to, their questions were answered, and their choices about the kind of care they preferred were respected. One patient said “I ask lots of questions and they don’t make you feel stupid” and “All the staff are approachable. They are like a family. They help me when I need it”. Another patient, who had been nervous as this was their first stay in hospital, told us “It was all really organised, they knew my name which was nice and my bed was ready”. Comments about the staff included “Staff are fantastic, from the cleaners and tea ladies to the nurses and doctors”.

We spoke to a patient who was due to go home. They told us “Doctors and nurses keep me up to date, I have been involved in my discharge plan”. Another patient commented that the doctors were ‘very down to earth’. They said “[My consultant] is on my level, and he has the same sense of humour as me too”.

We looked at a selection of patients’ records. It was noted if the patient preferred to be called anything other than their forename. We saw that staff tried to involve patients in decisions and discussions about their care and treatment. If they did not want to be involved, we saw evidence that they tried to involve them at a different time, approaching the subject in a different way. We saw an example of a patient requiring treatment but who was concerned about missing an important family event. We saw that the implications of delaying treatment had been discussed, but the patient had the final decision about when their treatment began, and they were able to arrange this around the family event.

In June 2012 the trust stopped using Do Not Attempt Resuscitation (DNAR) forms and an Allow a Natural Death (AaND) form was introduced. Three of the patients’ records we looked at contained these forms. It was recorded where the patient had been involved in the discussion about this decision, and the level of intervention that would be given should the patient’s health decline. The trust carried out an audit of AaND forms and the results were available in October 2012. Although the standard of completion varied, in 95% of forms audited discussions with the patient and/or their relatives had been recorded.
Consent to care and treatment  

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

During our inspection we looked at the computerised and clerical records of eight patients on the Young Oncology Unit (YOU), ward 4, ward 10 and ward 12. We saw that in all cases patients had signed forms to formally give their consent for specific procedures to be carried out. It had been recorded that the procedures, intended benefits, side effects and risks had been explained to the patients prior to them signing the consent forms. These were specific to each patient. Where patients had signed a consent form during a pre-operative assessment, they were asked again immediately prior to their operation if they still gave their consent.

We saw examples of patients being unsure if they wanted certain procedures to take place. In these cases the healthcare professional recorded what their professional opinion was, what advice had been given and what concerns the patient had. Patients were given further appointments so they could discuss their preferred treatment or procedures in more detail when they had had the chance to consider their options.

The Christie NHS Foundation Trust has a psycho-oncology department to provide psychiatric assessment and counselling to adult patients who have acute or chronic psychological problems. We saw an example of a patient speaking to a member of the psycho-oncology team because they felt pressured into making a decision about a procedure. The discussion was documented, and we saw the staff member had spoken with them a few days later when they had had the time to think more about it. On this occasion the patient felt able to give their informed consent.

We saw evidence that 80% of staff had received training in obtaining consent to treatment. In addition, 74% of staff had up to date training in the Mental Capacity Act 2005. We spoke with 11 staff members including ward managers, nurses and healthcare assistants. All the staff we spoke with had received training in the Mental Capacity Act 2005. They all had a good understanding of the steps to follow if there were concerns about a patient's capacity to make a decision. In addition we saw a flow chart in a staff room of steps staff could follow to assess someone's capacity.

The trust carried out an audit of consent in June 2012. During the audit 88 consent forms were reviewed from within the chemotherapy, radiotherapy, surgery, haematology and procedures specialities within the trust. We saw that in all cases there was evidence that
information for the named treatment or procedure had been provided to the patient. In addition information, for example about risks and benefits of treatment and procedures, was described on 97% of the signed consent forms.

The patients we spoke with said staff always asked their permission before carrying out care or treatment. One patient said that a relative had asked to speak with medical staff, but they would not disclose any information without the patient's permission. Another patient said they were surprised staff asked permission before carrying out any care, and made reference to being in hospital a long time ago when nurses told them what they would do.

The most recent NHS Inpatient Survey results were published in April 2012. The trust scored better than most other trusts taking part in the survey for the questions about being given enough information on their condition or treatment, being given information about what would happen during an operation and the risks and benefits. The results of the latest National Cancer Patient Experience Survey were published in August 2012. The hospital was rated in the best 20% of hospitals for staff giving a complete explanation of the purpose of tests and what would happen during them.
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.

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

Reasons for our judgement

The most recent NHS Inpatient Survey results were published in April 2012. The trust scored better than most other trusts taking part in the survey for the questions about having confidence and trust in the doctors treating them (9.7 out of 10), for how good the overall care was (9 out of 10), for getting the answers they could understand from the doctor when they asked important questions (9.2 out of 10) and for feeling staff did all they could to control pain if they were ever in pain (9.1 out of 10). The NHS Outpatient Survey results, published in February 2012, also showed the trust scoring better than most other trusts for some questions, in particular for doctors being aware of patients' medical history (9.5 out of 10), and how good the overall care was (9.2 out of 10).

The results of the latest National Cancer Patient Experience Survey were published in August 2012. The hospital was rated in the best 20% of hospitals for patients being given information about what they should do after discharge, and who they should contact if they were worried after being discharged from hospital. They were also in the best 20% for patients being given written information about the possible side effects from treatment. The survey showed that 90% of patients rated their care as ‘excellent’ or ‘very good’, which was above the national average of 88%. However, the hospital was in the bottom 20% for patients being offered a written assessment and care plan.

We looked at a selection of patients' records on the four wards we visited. We saw that health and care records were recorded both electronically and in paper format. The medical records we saw were very detailed and gave a full medical history for the patient. They were regularly updated, sometimes several times a day. We saw that one patient was concerned about continuing their exercise regime while they were in hospital. The doctor explained to them the benefits of certain kinds of exercise and recommended they used a popular video game console as part of their physiotherapy rehabilitation. It was clear that patients' health and welfare needs had been fully considered when their treatment was being planned.

We saw that medical records contained information about all possible treatments and procedures, and the benefits and risks of these were considered. Discussions with patients were recorded, and records showed that people's emotional as well as medical needs had been considered. If the doctor thought the patient would benefit from speaking to someone else about their condition, for example a member of the psycho-oncology team, this had been arranged.
The nursing care files identified patients' needs and referred to a care plan. The provider may like to note that these care plans, for example in relation to falls or pressure ulcers, were generic and kept in a separate place to other records. This meant that information specific to patients' individual needs was not available.

We saw that an evaluation of each patient's care was completed at least twice a day. If a patient needed to have their food and fluid intake and output monitored the charts were well completed and up to date. Staff told us they were issued with a handover sheet at the start of each shift. This gave a brief summary of each patient's current needs.

All the patients we spoke with were complimentary about the staff. One patient said they had complete confidence in the doctors, adding "They've really tried hard for me". Other comments included "You cannot fault the nurses. They do over and above what should be done", and "It's brilliant here, nothing is too much trouble for the staff".

Patients also said they were happy with the care they received. Some of their comments were "It is a specialised hospital, I am getting the best", "I get more than good quality care and support. It is excellent. I have never found this quality of care in other hospitals", "My oncologist has been brilliant. He always has time to discuss issues with me and my [family member]", and "This stay has been great. I wouldn't want to go anywhere else".

The trust used the Commissioning for Quality and Innovation (CQUIN) tool to assess their performance in various aspects of providing harm-free care. We saw the results up to November 2012. Since April 2012 there had only been one occasion when one of the 16 quality requirements within the tool was not rated as 'green' (fully meeting the requirements).
Cooperating with other providers

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

Our judgement

The provider was meeting this standard.

Patients’ 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 spoke with ward managers and staff about their liaison with other providers, particularly in relation to patients being discharged from hospital. The staff we spoke with had a good understanding of the discharge process and the other agencies involved.

We were told that in most cases staff were responsible for the discharge of their own patients. However, when a patient had complex health care needs the trust's discharge team, called the Community Link Team, were involved. The Community Link Team ensured that the appropriate support and equipment were in place ready for a patient's discharge home.

Staff told us that every patient benefited from at least one multi-disciplinary team (MDT) meeting each week. Their needs were discussed with specialists, including the trust's occupational therapists, physiotherapists and the Community Link Team. Staff from other services, such as social workers and district nurses, were also routinely involved. We heard that a district nurse referral was made for all patients prior to their discharge. Staff also told us they worked closely with hospices in the area to make sure patients could access their support if it was required.

As part of the inspection we visited the Young Oncology Unit (YOU). Inpatients on this unit were primarily between the age of 16 and 24. Two social workers were based on the unit. Each patient was allocated a key worker. The key worker was either a social worker or a paediatric community liaison nurse. We also saw that staff from CLIC Sargent, a charity that offers support to children and young people with cancer and their families, had staff based on the unit.

The patients we spoke with confirmed the trust worked closely with other providers. One patient, who had been in the hospital previously, said "They make sure when you are home you have the proper facilities". Another told us about the arrangements that had been put in place, including moving and handling support equipment being provided, for when they were discharged.
Safeguarding people who use services from abuse

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

Our judgement

The provider was meeting this standard.

Patients were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We saw that the trust aimed for all staff to have awareness training in safeguarding adults and children. On 31 December 2012 99% of staff were up to date with this training. Some staff were identified as needing a higher level of safeguarding training. Not all of this was up to date, but we saw that the number of staff who had received training had increased during the month of December 2012.

The trust had a multidisciplinary group for safeguarding adults and safeguarding children. These groups of staff looked at issues relating to the provision of care for the most vulnerable patients. We saw that in order for expert knowledge to be shared the groups had amalgamated in the previous year. This also increased the access to help out of hours if a problem arose.

We spoke with 11 staff members during our inspection. They all told us they had received recent training in safeguarding adults and children. The staff we spoke with had a good understanding of safeguarding procedures. Two staff gave us examples of where they had identified a safeguarding issue. They both told us they escalated their concerns to the safeguarding lead in the hospital. On one occasion the lead was not available. We were told that there was a procedure to follow if the safeguarding lead was not available, and in this case a deputy was contacted who attended the ward very quickly and made appropriate referrals to the relevant social work team.

We visited the Young Oncology Unit (YOU). Inpatients on this unit were primarily between the ages of 16 and 24. Younger children attended the unit as day patients, and at times they had to stay overnight. Staff told us about the arrangements on the ward when younger patients were present, and we saw that if they stayed overnight they had a single room away from the main wards.

The most recent NHS Inpatient Survey results were published in April 2012. For the question relating to patients not being threatened by other patients or visitors during their hospital stay the trust scored better than most other trusts taking part in the survey, with a score of 10 out of 10. The patients who we asked told us they felt safe on their ward.
<table>
<thead>
<tr>
<th>Staffing</th>
<th>✔️ Met this standard</th>
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<tr>
<td><strong>There should be enough members of staff to keep people safe and meet their health and welfare needs</strong></td>
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**Our judgement**

The provider was meeting this standard.

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

**Reasons for our judgement**

The most recent NHS Inpatient Survey results were published in April 2012. For the question about patients feeling there were enough nurses on duty to care for them the trust scored better than most other trusts taking part in the survey. The results of the latest National Cancer Patient Experience Survey were published in August 2012. The hospital was in the best 20% of hospitals for always or nearly always having enough nurses on duty.

We visited four wards during our inspection. We spoke with the ward managers who explained minimum staffing levels were set for each shift. They told us that staffing could be increased if they had a particularly busy period or if more patients required a higher level of care. They also said they were able to access staff at short notice, for example if a staff member was ill.

We spoke with staff on all four wards. They confirmed that even though the wards were busy they could usually cover absences at short notice. They said some of the ward staff were willing to work extra shifts, and if the ward could not provide cover the trust had their own bank staff who they could call on. Only occasionally did they have to use the NHS Professionals Agency for extra staff.

We were given an example on the Young Oncology Unit (YOU) of a planned admission of a child with a rare illness. Staff told us they rearranged their shift patterns for the period the child was a patient so there were always staff with appropriate paediatric experience on duty. They said the treatment was complex and they were able to avoid using agency staff who may not have had the same level of experience as existing staff on the YOU.

The patients we spoke with confirmed they rarely had to wait for assistance. They all said they had a nurse alarm call button, and if they used it staff attended to them quickly. Patients also told us that all staff, including doctors, nurses and health care assistants, had time to spend with them discussing any concerns and explaining treatments. One patient told us staff were flexible and put the patients first. They said "If you are not well and they are going off duty, they will stay with you. They don't pass you over to the next shift".
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.

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

Reasons for our judgement

During our inspection we spoke with 11 staff members including ward managers, nurses and healthcare assistants. All the staff we spoke with said their mandatory training was up to date. They said this was monitored by their managers, and they received a training update each month by email so they could see if any courses needed to be booked. We saw evidence that training was also monitored at trust level.

Staff told us that they were able to access other more specialised training, and they were encouraged to increase their skills in their areas of work. Two staff members said they were studying for a degree and the trust were supporting them in this.

Staff told us that if a staff member returned to work after a long period of absence, for example when returning from maternity leave, they were supernumerary for a period while they made sure their mandatory training was up to date. We spoke with a nurse who was new to the role. They described the in depth induction programme and training they received. They also said they had the support of a preceptor nurse and had regular one to one meetings with them.

The staff we spoke with all said they had had an appraisal meeting with their manager within the previous year. They said they did not usually have formal meetings on an individual basis throughout the year, but they did have regular ward meetings with their manager. They said they felt well supported at work and they could request a meeting with their manager if they felt they needed one.

The results of the 2012 NHS Staff Survey had not been published at the time of this inspection. The results from 2011 showed an above average score, when compared to other trusts, for support from immediate line managers. The score for having an appraisal in the last 12 months was below average. We saw that the trust monitored how many staff had had an appraisal and had an up to date personal development plan in place, and on 31 December 2012 nearly 80% were up to date. The trust confirmed that informal meetings were held between managers and their staff, and clinical supervision could be accessed if it was required.
Complaints

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The most recent NHS Inpatient Survey results were published in April 2012. For the question about patients noticing posters or leaflets explaining how they could complain about the care they received, the trust scored better than most other trusts taking part in the survey.

The patients we spoke with during our inspection told us they felt they could raise concerns about any aspect of their care, treatment or support. However, they told us they had no reason to complain. One patient told us that staff from the NHS Patient Advice and Liaison Service (PALS) could visit patients on the ward to assist them if they had any concerns they wanted escalating.

We spoke with staff who knew the procedure for handling complaints. One ward manager told us they always assisted patients who wanted to raise concerns. They gave an example of a patient who was given Internet access so they could raise their concerns by email. They told us that within 40 minutes of them sending the email a staff member from the complaints team had visited them so they could discuss their concerns in person and respond appropriately.

During our inspection we saw that leaflets telling people how they could complain or raise concerns were available on wards and in public areas throughout the hospital. These explained who people could complain to, including how to raise concerns anonymously, and how their complaint would be responded to. The leaflet informed people they could be supported to raise concerns or make a complaint by PALS or the Independent Complaints Advocacy Service (ICAS). Information was also given about people being able to ask the Parliamentary and Health Service Ombudsman (PHSO) to investigate if, after going through the trust's complaints procedure, they felt the final response was not satisfactory.

We saw evidence that the trust monitored their complaints and kept a record of any actions that were taken in response to complaints that had been made. The latest information provided by the PHSO, in their review of complaints handling in the NHS in England for 2011-12, shows that six people took their complaint to the ombudsman after going through the The Christie NHS Foundation Trust's own procedure. The PHSO did not accept any of these for investigation. They can only investigate if they have the legal power to do so, if the complaint has completed the local complaints procedure, and if there is an indication of administrative fault or service failure from the trust.
About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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

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

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

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

You can tell us about your experience of this provider on our website.
How we define our judgements

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

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

- **Met this standard**
  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **Action needed**
  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **Enforcement action taken**
  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
### Glossary of terms we use in this report

#### Essential standard

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

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<td>Records</td>
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#### 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.