Review of compliance

Frimley Park Hospital NHS Foundation Trust Frimley Park Hospital	
Region:	South East
Location address:	Portsmouth Road Frimley Camberley Surrey GU16 7UJ
Type of service:	Acute services with overnight beds
Date of Publication:	November 2011
Overview of the service:	Frimley Park Hospital provides a full range of district general hospital services for the population of north east Hampshire and West Surrey. The catchment population is around 400,000 people. Frimley Park Hospital has 746 beds and since 1996, the hospital has incorporated a Ministry of Defence Hospital unit.

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

Our current overall judgement

Frimley Park Hospital was meeting all the essential standards of quality and safety.

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 to check whether Frimley Park Hospital had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider and checked the provider's records.

What people told us

During our previous visit in July 2011, we spoke to patients in a variety of ward settings, including elderly care, a stroke ward and the pre and post natal ward within maternity services. We received many positive comments from these individuals in relation to the care received. Patients indicated that they were treated as individuals, with personalised care.

Information was said to be regularly supplied by staff and that patients were kept informed regarding their progress and changes in treatment plans. Patients felt that they received care that was delivered with dignity and respect.

On our follow up review we did not ask people to comment on the service as we were reviewing improvements to the nursing processes that were in place.

What we found about the standards we reviewed and how well Frimley Park Hospital 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

The provider has taken the necessary measures to ensure that people receiving treatment and care are respected and that personal preferences and wishes are taken into account.

Overall, we found that the provider is now meeting this essential standard.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

The provider has made a number of changes to the processes for reporting incidents, which has improved the timeliness of reports.
Overall, we found that the provider is now meeting this essential standard.

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 did not ask people using the service to comment on this outcome on this occasion, as we were reviewing improvements to nursing processes only.

Other evidence
At our previous inspection we found that Frimley Park NHS Foundation Trust had ensured that there were measures in place for staff to provide treatment and care that was respectful of the needs and maintained the dignity of each
Individual patient. People had been provided with information to assist them in making decisions about their treatment and care. Patients expressed their choices; however, we could not see how these choices were always followed.

The provider sent us an action plan detailing how it would address this area of concern. We asked the provider to demonstrate the improvements made and how they had measured the impact on care for people using the service.

We were sent information detailing how the introduction and use of a booklet titled 'This is me' had been progressed. This booklet had been designed to identify the individual needs of patients who had a cognitive impairment, such as dementia. Information to be completed would take into account the person's preferences, expression of views and

demonstrate respect of their individual rights. Heads of nursing and matrons were given responsibility for ensuring that the use of this booklet was introduced and complied with.

We were told that two audits to check the use of the booklet had taken place. Results of the audit had been discussed and recorded in minutes provided to us from the trusts quality board meeting. Copies of the results were provided to us for review. These detailed the wards on which the audit was carried out, the number of care records checked and compliance with the required completion of this record. Where the booklet was not in evidence, actions to improve this were outlined. For example on each ward there was said to be a member of staff acting as a 'dementia champion,' who would be expected to raise awareness. Further auditing was said to be planned for this area.

In addition to this measure, the provider advised that they had started to review the care planning process in all ward areas. This was planned as a measure to ensure that care plans were being individualised, taking into account each person's personal needs. We were advised that a group had been set up with a lead matron appointed to take this forward and representations from all clinical specialities. It was expected by the provider that actions would be taking place in December as a result of work within the group.

Our judgement
The provider has taken the necessary measures to ensure that people receiving treatment and care are respected and that personal preferences and wishes are taken into account.
Overall, we found that the provider is now meeting this essential standard.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

The provider is compliant with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We did not ask people using the service to comment on this outcome.

Other evidence
Following our previous inspection we had identified a concern related to the speed at which incidents were reported to the external agencies involved in monitoring patient safety.

As part of our follow up review we analysed the information that the Commission had related to reporting times of notifications to the national patient safety agency, (NPSA). We observed that there had been an improvement in this. In the most recent quality and risk profile (QRP) for this trust, produced in October 2011, the data shows that Frimley Park reported 50% of their notifications to the NPSA within 22 days. Previously it was 36 days in the June 2011 QRP. This reporting is better than the average of 31 days. The trust reported 50% of their deaths and severe harm incidents within 23 days when previously it was 44 days in the June 2011 QRP. This is better than the average of 30 days.

The provider advised us of the measures that had been taken to improve reporting times. We were told that during July 2011 the reporting of information was made to the NPSA on a weekly basis. To check this, the trust commenced monitoring through the patient safety manager. The level of compliance with this was described as being excellent.

In addition to this managers had been made aware of their responsibilities for sending incident forms to the risk office within an agreed time frame. This was said to have an impact on reporting times. To check this daily reviews were being carried out by the governance manager. The outcome of these checks suggested that improvements had been made.

The last measure, which was said to be in progress related to the use of the electronic reporting system. We were told that all other areas, such as operating theatres, pathology and the day unit would have access to this system by March 2012.

Our judgement
The provider has made a number of changes to the processes for reporting incidents, which has improved the timeliness of reports.
Overall, we found that the provider is now meeting this essential standard.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
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