### Review of compliance

Mid Staffordshire NHS Foundation Trust  
Weston Road  
Stafford  
ST16 3SA

<table>
<thead>
<tr>
<th>Region:</th>
<th>West Midlands</th>
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| Location address: | Stafford Hospital  
Weston Road  
Stafford  
ST16 3SA |
| Type of service: | Acute service |
| Regulated activities provided: | Treatment of disease, disorder or injury  
Assessment or medical treatment for persons detained under the 1983 Act  
Surgical procedures  
Diagnostic or screening procedures  
Maternity and midwifery services |
| Type of review: | Planned review |
| Date of site visit (where applicable): | Not applicable |
| Name of site(s) visited (where applicable): | Stafford Hospital |
Review of compliance

Date of publication: October 2010
Information for the reader

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<tr>
<td>Author</td>
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Care Quality Commission

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Introduction to our 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 that 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. This is called Guidance about compliance: Essential standards of quality and safety.

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

When we make our judgements about whether services are meeting essential standards, we will 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, 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 actions | These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people. |
How this report is presented

On page 6 below, there is a summary that shows whether the essential standards about quality and safety that were checked during this review of compliance are being met. The section on each outcome is set out in this way:

<table>
<thead>
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<th>Outcome</th>
<th>Judgement</th>
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<tbody>
<tr>
<td>XX: The outcome number and title</td>
<td>Whether the service provider is compliant, or whether we have minor, moderate or major concerns about their compliance</td>
</tr>
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</table>

Following the summary, there is a detailed section on the outcomes for each of the essential standards that we looked at. The evidence that we used when making our judgements for each one is set out in the following way:

Outcome XX (number):
Outcome title

Details of the outcome, taken from our Guidance about compliance: Essential standards of quality and safety.

What we found for the Outcome

Our judgement

Our judgement about whether the <service/provider> meets the outcome described in the Guidance about compliance: Essential standards of quality and safety, or whether there are minor, moderate, or major concerns in relation to compliance.

Our findings

A summary of the evidence and findings used to reach our judgement, related to regulated activities as appropriate.

At the end of the report you will find details of:

- Any improvement and/or compliance action(s) that the service provider should make to maintain or achieve compliance with the essential standards of quality and safety.
- Any formal enforcement action that we are taking against the service provider.
Summary of findings for the essential standards of quality and safety

The table below shows the judgement that we reached for each of the essential standard outcomes that we reviewed.

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<thead>
<tr>
<th>Outcome</th>
<th>Judgement</th>
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<tbody>
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<td>1: Respecting and involving people who use services</td>
<td>Minor concern</td>
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<tr>
<td>2: Consent to care and treatment</td>
<td>Compliant</td>
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<tr>
<td>4: Care and welfare of people who use services</td>
<td>Minor concern</td>
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<tr>
<td>5: Meeting nutritional needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>6: Cooperating with other providers</td>
<td>Compliant</td>
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<tr>
<td>7: Safeguarding people who use services from abuse</td>
<td>Minor concern</td>
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<tr>
<td>8: Cleanliness and infection control</td>
<td>Compliant</td>
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<tr>
<td>9: Management of medicines</td>
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<tr>
<td>10: Safety and suitability of premises</td>
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<tr>
<td>11: Safety, availability and suitability of equipment</td>
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<td>Outcome</td>
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<td>17</td>
<td>Complaints</td>
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<tr>
<td>21</td>
<td>Records</td>
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**Summary of key findings:**

- **Outcome 1** - We found the trust routinely seeks assurance as to whether people who use the service understand their care and treatment. Individual privacy and dignity are maintained during provision of care and the trust has made progress on developing its processes for patient engagement. However, this outcome was assessed as a minor concern because the processes for respecting and involving people who use the service are not fully embedded.

- **Outcome 2** - The documentary evidence presented by the trust demonstrates compliance and people who use the service are supported to give consent for examination and treatment.

- **Outcome 4** - The documents presented by the trust demonstrated that it has made progress towards resolving issues reported as part of the 12 month review. Minor concerns remain because its action plans have not yet been implemented.

- **Outcome 5** - The documents presented by the trust demonstrated compliance and people who use the service are supported to have adequate nutrition and hydration.

- **Outcome 6** - The documents presented by the trust demonstrated compliance with this outcome of cooperating with other providers.

- **Outcome 7** - The trust has arrangements in place to safeguard people who use services from abuse but commentary from the safeguarding board indicates that timeliness of reporting could be improved. For this reason a minor concern exists as people who use the service should be protected from abuse, or the risk of abuse, and their human rights are to be respected and upheld.

- **Outcome 8** - The documents presented by the trust demonstrated compliance with this outcome of cleanliness and infection control.
• Outcome 9 - Our findings lead us to have a moderate concern in the management of medicines. There are inconsistencies in practice and the standard of record keeping on the wards. There has been a significant year on year increase in the number of medication related incidents reported. The reasons for this and the trust’s response to gaps in practice identified following recent audits are not clear, however the trust will address these issues through further audits and action plans.

• Outcome 10 - We have a minor concern for this outcome. The trust provided a provider compliance assessment and the results of audits which reflect gaps in compliance against this standard in relation to waste segregation. However, there are no direct impacts on patient outcomes and appropriate actions are being taken.

• Outcome 11 - This outcome remains a minor concern due to the action plan not yet being implemented so people who use the service are not yet able to be fully assured that any equipment they need is available.

• Outcome 12 - We found that the trust has the elements of a comprehensive recruitment and selection arrangements in place, but these are not formalised in agreed policies. It did not provide us with any information about how it is assured that all recruitment checks are routinely undertaken. We therefore have minor concerns about this outcome.

• Outcome 13 - We found that the trust is continuing to recruit to its vacant nursing posts and its nurse to patient ratios continue to indicate that the numbers of nurses are sufficient to ensure that patient needs are met. It is taking action to respond to specific areas of concern. It needs to continue to tackle the high numbers of nurses being absent due to sickness. The trust needs to continue to work to resolve its medical staffing issues within surgery, accident and emergency and other specialties. It also needs to complete its review of its arrangements for managing the hospital at night. Due to the high numbers of nurses being absent due to sickness and also the number of medical staffing vacancies this outcome is a minor concern.

• Outcome 14 - We found that the trust ensures that new staff do attend an induction and that staff are attending the corporate mandatory training day. It has created a programme of conflict resolution training for staff. However, it did not provide us with any information about how it is assured staff receives all the training they need. The trust still needs to ensure that supervisory or peer support arrangements are in place for all staff involved in delivering care, treatment and support. The trust has made very good progress in ensuring that staff are appraised and is improving the quality of the appraisals. The trust is aware of the concerns staff have about raising concerns and is continuing to promote Whistleblowing. We have minor concerns because the trust has not provided any information about how it is assured staff receive all the training they need, and we have moderate concerns because it has not put a comprehensive supervision system in place. This means that overall; we have a moderate level of concern for this outcome.

• Outcome 16 - We reported on this outcome in July 2010 when the registration condition was removed. We did not seek any additional evidence.

• Outcome 17 - We have moderate concerns for this outcome. The trust’s complaints system is not effective because staff involved in complaints are not fully trained in their roles and investigations are not completed in a timely manner. The trust need to take action to address these issues.

• Outcome 21 - We have a minor concern in this outcome. The completeness and quality of records is not consistent and people who use the service need to be confident that their personal records are accurate, fit for purpose, held securely and remain confidential.
From the time of the initial registration of the trust, until the planned review, some changes have occurred in the outcomes. Five of the outcomes are now compliant (Outcomes 2, 5, 6, 8 and 16). Five of the outcomes were initially compliant, but our judgement is now a minor concern leading to improvement action (Outcomes 1, 7, 10, 12 and 21). Outcome 17 was initially a minor concern but our judgement is now a moderate concern leading to compliance action. Three outcomes were initially a moderate concern but evidence now leads us to make the judgement that these outcomes are a minor concern, leading to improvement action (Outcome 4, 11 and 13). Outcome 9 was initially compliant but the evidence leads us to make the judgement that this outcome is now a moderate concern leading to compliance action and Outcome 14 was initially a major concern but the evidence leads us to make the judgement that this outcome is now a moderate concern, leading to compliance action.

The trust has declared non-compliance in some of the areas of several outcomes, this is where the trust acknowledges there is further work to be planned, implemented and sustained improvements embedded.

We have identified areas of non-compliance in 11 of the 16 essential standards of quality and safety we reviewed. Whilst we have eight minor concerns and three moderate concerns, we have concluded that we would want to support the delivery of long term improvements through ongoing compliance monitoring of the trust and close working arrangements with key stakeholders such as the Primary Care Trust, Strategic Health Authority and Monitor who will also undertake their own responses.

We are assured that with our continued ongoing compliance monitoring and support to the trust from key stakeholders the current management team at the trust do have the capability to make the necessary improvements. We expect the trust to demonstrate improvements through the implementation of robust action plans during December 2010.

We have identified a range of improvement and compliance actions following our review. We have requested a written response from the trust, setting out the actions it proposes to take to make the necessary improvements to meet the essential standards of quality and safety.

We will follow up and monitor the delivery of the improvement and compliance actions identified in this report with a Responsive Review in December 2010 to ensure the improvements have occurred. We will escalate the regulatory action to the next level should the trust fail to make the improvements and meet their action plan timescales and trust board statements.

**Background to review of compliance:**

When the trust applied to register under the Health and Social Care Act 2008 at the start of 2010, it told us that it was compliant with all the quality and safety regulations except those relating to Outcome 4 (care and welfare of service users), Outcome 11 (safety, availability and suitability of equipment), Outcome 14 (supporting workers), Outcome 16 (assessing and monitoring the quality of service provision) and Outcome 17 (complaints).

We registered the trust with conditions for Outcome 4, Outcome 11 (two conditions), Outcome 14 and Outcome 16. We also registered the trust with a condition for Outcome 13 (staffing). We did not impose a condition for Outcome 17 because we were satisfied that the trust’s plan would deliver the necessary improvements. However, we said that we would monitor closely compliance with this outcome.
In spring 2010, we undertook a detailed 12 month review to assess the progress that the trust had made in implementing the recommendations of the Healthcare Commission investigation report, published in March 2009. This review included a series of unannounced and announced site visits to the trust during March and April 2010.

We published our report in July 2010 and the planned review commenced in August using information from these site visits and the new evidence requested from the trust.

At the 12 month review we also assessed the trust’s progress with the five registration conditions that ‘expired’ on 1 April 2010. We found that the trust had provided sufficient assurance of compliance and all the conditions could be removed, although minor concerns remained for Outcome 4 and 11. We did not assess progress with the registration condition relating to Outcome 14, which was due to ‘expire’ on 30 June 2010.

For this planned review of compliance with all sixteen of the essential standards of quality and safety, we asked the trust to make its own assessment of compliance by completing our ‘provider compliance assessments’ (PCA) for most of the outcomes. The PCA asks trusts to assess their compliance using a four point scale, as follows:

- **Green** means that evidence available at the time of assessment shows the outcome is met.
- **Yellow** means that the outcome is mostly met, the impact on people is low and action required is minimal.
- **Amber** means the outcome is mostly met, the impact on people is medium and action required is moderate.
- **Red** means the outcome is at risk of not being met, the impact on people is high / significant and action is required quickly.

We also asked for some specific information. We reviewed the information the trust sent us.
What we found for each essential standard of quality and safety

The section below details the findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

Further detail about each of the outcomes described below can be found in the Guidance about compliance: Essential standards of quality and safety.
Outcome 1:  
Respecting and involving people who use services

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.

Those acting on behalf of people who use services:
- Understand the care, treatment and support choices available to the people who use services.
- Can represent the views of the person using the service by expressing these on their behalf, and are involved appropriately in making decisions about their care, treatment and support.

This is because providers who comply with the regulations will:
- Recognise the diversity, values and human rights of people who use services.
- Uphold and maintain the privacy, dignity and independence of people who use services.
- Put people who use services at the centre of their care, treatment and support by enabling them to make decisions.
- Provide information that supports people who use services, or others acting on their behalf, to make decisions about their care, treatment and support.
- Support people who use services, or others acting on their behalf, to understand the care, treatment and support provided.
- Enable people who use services to care for themselves where this is possible.
- Encourage and enable people who use services to be involved in how the service is run.
- Encourage and enable people who use services to be an active part of their community in appropriate settings.
What we found for Outcome 1

Our judgement

There are minor concerns with Outcome 1: Respecting and involving people who use services

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.

The trust has provided evidence to demonstrate that it routinely seeks assurance as to whether people who use services understand their care and treatment. For example, patient surveys recently indicated that a majority of patients (89%) had access to staff to seek information and ninety six percent stated they had their medication explained to them on discharge.

As part of the site visit we undertook in April 2010, patients stated they understood the plan for their care. An independent assessment by the Strategic Health Authority (SHA) in February 2010 demonstrated an improvement in provision of information to help patients understand the care and treatment and in involving patients in decisions about their care and treatment.

During site visit observations in April 2010, we were satisfied that individual privacy and dignity were maintained during provision of care. The Patient Environment Action Team (PEAT) assessment scores in February and March 2010 indicated that privacy and dignity was satisfactory at both sites.

The trust has published statements on equality and diversity and these are currently being updated. The trust has made progress on developing its processes for patient engagement. It has demonstrated how issues arising from surveys are followed up by various groups in the organisation. The trust has identified areas for improvement and is further developing its mechanisms to ensure that patient comments and complaints are routinely sought in a variety of ways and that these views influence how services are delivered.

In conclusion, we found the trust routinely seeks assurance as to whether people who use the service understand their care and treatment. Individual privacy and dignity are maintained during provision of care and the trust has made progress on developing its processes for patient engagement.

This outcome was assessed as a minor concern because the processes for respecting and involving people who use the service are not fully embedded.
Outcome 2:
Consent to care and treatment

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

This is because providers who comply with the regulations will:
- Have systems in place to gain and review consent from people who use services, and act on them.
What we found for Outcome 2

Our judgement

The provider is compliant with Outcome 2: Consent to care and treatment

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.

The trust has provided written policies and processes to demonstrate that arrangements are in place for obtaining consent for treatment. These documents include decision making processes for people unable to give consent. Training and policies are reportedly made available. However, it is unclear from the evidence presented that the trust routinely monitors that these processes are adhered to or that it tests that staff understand the process of consent.

The trust has presented audit evidence (February 2010) to suggest that there is poor compliance with the policy on resuscitation and decisions not to resuscitate patients are not always well communicated to patients or their families. However, there is evidence that the trust is now closely monitoring this in order to improve compliance.

Radiography operating procedures (undated) indicate that arrangements for consent and checking patients are in place but no evidence was presented to demonstrate that patients routinely receive information about risks and benefits prior to the procedure.

The trust has presented evidence that its consent policy has been audited annually in 2007, 2008 and 2009/10. The report of the 2008 audit (December 2008) included a comparison between the 2007 and 2008 results and an eight point action plan. The report of the 2009/10 audit is currently in draft format. It includes a comparison between the 2008 and 2009 results and a three point action plan. The audits all reviewed adherence to the trust's consent policy in relation to documentation, timeliness of seeking consent, provision of information and responsibility for seeking consent.

Some of the key findings from the 2009/10 audit are: of the 249 case notes reviewed in the audit, all were authenticated with a completed consent form within the case note folder. This is a slight improvement on 2008, when consent forms could not be found in 2/262 cases and on 2007, where consent forms could not be found in 30 cases. About thirty five percent of records showed that the consent process had started at least the day before the operation (a similar result to 2008 but an improvement on 15% in 2007). Ninety one percent of people had been given general information about their procedure (an improvement on both 74% in 2008 and 86% in 2007) and 96% of people had been given information about the risks and benefits of the surgery (an improvement on both 65% in 2008 and 84% in 2007). Consent was sought by consultants in 54% of cases, compared with 59% in 2008 but 47% in 2007. Overall, the 2009/10 results were generally better than the 2008 results, with particularly good results for the provision of information.

In conclusion, the documentary evidence presented by the trust demonstrates compliance and people who use the service are supported to give consent for examination and treatment.
Outcome 4: Care and welfare of people who use services

People who use services:
• Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

This is because providers who comply with the regulations will:
• Reduce the risk of people receiving unsafe or inappropriate care treatment and support by:
  o assessing the needs of people who use services
  o planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met
  o taking account of published research and guidance
  o making reasonable adjustments to reflect people’s needs, values and diversity
  o having arrangements for dealing with foreseeable emergencies.
What we found for Outcome 4

Our judgement

There are minor concerns with Outcome 4: Care and welfare of people who use services

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.

In our July 2010 report, we judged that outcome 4 was a minor concern and stated that these concerns would be followed up as part of the August planned review of compliance. In July 2010 we reported that there had been little improvement in managing the time patients remain in the accident and emergency (A&E) department. Flows through the hospital were impacting on A&E and this needed further improvement. The trust also needed to undertake further work to streamline the arrangements for patients attending as medical emergencies.

We have reviewed progress in this area. The trust has stated that a focus on the whole system has improved the performance against the four hour target. The trust has provided an action plan that demonstrates it is working with the local primary care trust and social services to improve patient discharge processes and hence improve flows through the hospital. The action plan encompasses actions for A&E, Acute Medical Unit (AMU), Surgical Assessment Unit (SAU), bed management, medical staff and clinical support and identifies that some actions are complete, with others still to be completed.

In April 2010 we visited medical wards (10, 11) and surgical wards (6, 7, and 8) and observed that patients had a documented plan of care and assessment. We found that risk assessments were undertaken relevant to individual patient needs for example nutritional assessment, risk of falls. However, we found that documentation of the impact of risk assessments was not always clearly consolidated and evaluated within care plans. In most cases, staff were making the correct interventions following a risk assessment. However, this was not always the case. For example, there was evidence of some patients, who had been assessed as being at risk of developing pressure sores, not having the appropriate pressure relieving mattress or device. We have reviewed progress in this area, and we have received documentary assurance that the trust now has mechanisms in place to ensure that staff can access pressure relieving devices and that this access is being monitored.

In April 2010, we also visited A&E, AMU and SAU to review procedure for managing patients admitted as emergencies and we reported that the A&E department has strong clinical leadership and is adequately staffed and equipped. We found that patients had good access to A&E consultants and that the procedures for managing care and welfare of people admitted as surgical emergencies was good.

In April 2010 we spoke to patients in each of the areas visited and they told us that they understood their plan of care.

We found that the trust monitors basic aspects of care through the quality ‘dashboards’ on the wards and the patient ‘comfort rounds’ (which have been in place since 1 March 2010). At ward level, there is a focus on documenting risk assessments in patient records and ensuring that this is done for nutritional requirements, risk of developing a pressure sore, and risk of falls. This is audited regularly and we observed that compliance with risk assessment is generally good across all areas.

We reported in our 12 month follow up review that the trust needed to improve its planning and utilisation of theatres in order to ensure that patients having surgery were not subject to
unnecessary delays in operations. We have reviewed progress in this area. The trust has provided an action plan that demonstrates that actions to improve more efficient use of theatre time are due for implementation in September 2010.

In conclusion, the documents presented by the trust demonstrated that it has made progress towards resolving issues reported as part of the 12 month review, as detailed above. Minor concerns remain because its action plans have not yet been implemented.
Outcome 5:  
Meeting nutritional needs

People who use services:
- Are supported to have adequate nutrition and hydration.

This is because providers who comply with the regulations will:
- Reduce the risk of poor nutrition and dehydration by encouraging and supporting people to receive adequate nutrition and hydration.
- Provide choices of food and drink for people to meet their diverse needs making sure the food and drink they provide is nutritionally balanced and supports their health.
What we found for Outcome 5

Our judgement

The provider is compliant with Outcome 5: Meeting nutritional needs

Our findings

In the provider compliance assessment, the trust assessed itself as compliant in most aspects of this outcome except they noted themselves to be yellow in 5A (this means that the outcome is mostly met, the impact on people is low and action required is minimal), the trust recognise further work is to be completed with training and nurse handovers.

During a site visit in April 2010 we were satisfied that patients were supported to receive adequate nutrition and hydration. There was evidence that patients were risk assessed and their individual nutritional needs were identified and documented by the nursing staff.

The trust has provided evidence that the ward staff are responsible for identifying patients who are at risk of poor nutrition intake, poor hydration or swallowing difficulties. Ward managers and matrons are now responsible for evidencing the ward progress with nutritional audits and these results are displayed at the entrance to each ward on designated dashboards.

The trust has provided up to date evidence of the nutritional audits carried out between April 2010 and June 2010 which demonstrate ongoing monitoring and signs of ward level improvement. The audits have been introduced to reduce the risks associated with poor nutrition and dehydration, by monitoring the support people receive.

The trust has told us that it does monitor to ensure that its ‘nil by mouth’ policy is complied with. It audited this in August 2009, November 2009 and May 2010, with the recent audits showing that patients are not being fasted unnecessarily prior to surgery. Results showed that 98.1% of people had been compliant with the nil by mouth standard.

During the site visit in April 2010 patients told us that they had been asked if they had any dietary preferences on admission, they were given a choice of meals and drinks at meal times and hot and cold drinks were available at all times. During periods of observation we found patients did have access to water and they saw evidence of the ‘red tray’ meal time support system in operation. Patients confirmed that they did have support if they needed it.

The PEAT results for the 2010 assessments carried out at the site in February and March indicated that the food was ‘good’. The trust provides food and drink for people to meet their diverse needs, making sure that the food and drink they provide is nutritionally balanced and supports their health.

In conclusion, the documents presented by the trust demonstrated compliance and people who use the service are supported to have adequate nutrition and hydration.
Outcome 6: Cooperating with other providers

People who use services:
- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

This is because providers who comply with the regulations will:
- Cooperate with others involved in the care, treatment and support of a person who uses services when the provider responsibility is shared or transferred to one or more services, individuals, teams or agencies.
- Share information in a confidential manner with all relevant services, individuals, teams or agencies to enable the care, treatment and support needs of people who uses services to be met.
- Work with other services, individuals, teams or agencies to respond to emergency situations.
- Support people who use services to access other health and social care services they need.
What we found for Outcome 6

Our judgement

The provider is compliant with Outcome 6: Cooperating with other providers

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.
The trust has demonstrated that people who use services receive safe and coordinated care, treatment and support where more than one provider is involved or they are moved between services.
The trust has provided evidence that it is working in cooperation with social services and the primary care trust (PCT) to improve its arrangements for discharging patients from hospital. In addition, the latest national inpatient survey (June 2009) indicates that the trust is better than average for reducing delays to discharge. The trust also has a working protocol with the local mental health trust to ensure access to crisis resolution services for patients in A&E.
The trust has not provided assurance as to whether information is shared effectively with all relevant services to enable care, treatment and support of people who use services.
We interviewed stakeholder organisations as part of the 12 month follow up review in April 2010 and received positive assurance that the trust is working well with the West Midlands Ambulance Service NHS Trust. During site visits in April 2010 we interviewed ambulance staff who gave positive feedback about joint working arrangements within the Stafford Hospital A&E department.
We found that local organisations such as University Hospital of North Staffordshire NHS Trust and the West Midlands SHA are working closely with the trust to ensure that services are adequately staffed. Acute stroke services are no longer provided at the trust, however if any patient is diagnosed with a stroke post admission then their care is managed in collaboration with other hospitals.
The trust provided evidence to demonstrate that it has written processes for working with others to respond to major incidents and emergency situations in accordance with the Civil Contingencies Act 2004. However, no assurance was provided that these processes work well in practice or that staff understand their role.
The trust has told us that it now has a Transferring Patients Policy and a Transfer of Care/Discharge Policy and to support these policies it has a Transfer of Care and Discharge - Checklist. In the case of patient transfers, transfer checklists have been introduced to assist the ward staff in transferring essential information to other health professionals.
To ensure that people leaving the hospital can be confident that their care will continue to be delivered, the trust has told us it holds multi-disciplinary meetings and has a referral system to the district nursing services and the evening services.
In conclusion, the documents presented by the trust demonstrated compliance with this outcome of cooperating with other providers.
Outcome 7: Safeguarding people who use services from abuse

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

This is because providers who comply with the regulations will:
- Take action to identify and prevent abuse from happening in a service.
- Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.
- Ensure that Government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.
- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
- Only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services.
- Understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- Protect others from the negative effect of any behaviour by people who use services.
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.
What we found for Outcome 7

Our judgement

There are minor concerns with Outcome 7: Safeguarding people who use services from abuse

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.

The trust has provided documentary evidence of how it minimises the risk and likelihood of abuse in both adults and children, by providing training to support staff in identifying signs of abuse and to respond appropriately when abuse is suspected. A training audit of July 2010 indicates that attendance at training is monitored. Evidence presented shows a high degree of compliance with training that makes staff aware of their personal responsibilities. Data presented by the trust as of 9 August 2010 shows that at least seventy two percent of staff in each of the directorates has received core safeguarding adults training and that across the trust, 95% of eligible staff have receive level 1 safeguarding children training. The 2009/10 annual report from Stoke and Staffordshire Safeguarding Board confirms that there is good compliance with adult protection induction training in the trust.

The trust is working with the relevant agencies for safeguarding. Staff training is based on local guidance about safeguarding and minutes demonstrate the trust participates in the Stoke and Staffordshire Safeguarding Board for adults and in the Staffordshire Safeguarding Children Board Meetings. The training slides provided as evidence include the use of appropriate restraint and deprivation of liberties safeguards.

The results of Staffordshire Safeguarding Children Board annual health check on safeguarding arrangements at the trust have been received for 2009/10 and were reported in the trust board minutes stating that the trust is now fully compliant with its response under the Children’s Act 2004.

The trust has a comprehensive list of policies that take account of relevant legislation and include processes for reviewing and monitor safeguarding incidents. The trust has provided documentary evidence of learning from one safeguarding incident in A&E and this evidence indicates that improvements in routine monitoring have been made.

The trust has not provided information to demonstrate that training is effective and that staff is reporting safeguarding issues appropriately. The trust has arrangements in place to safeguard people who use services from abuse but commentary from the safeguarding board indicates that timeliness of reporting could be improved.

In conclusion, for this reason a minor concern exists as people who use the service should be protected from abuse, or the risk of abuse, and their human rights are to be respected and upheld.
Outcome 8: Cleanliness and infection control

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
## What we found for Outcome 8

### Our judgement

The provider is compliant with Outcome 8: Cleanliness and infection control

### Our findings

The trust did not provide a provider compliance assessment for this outcome.

In July 2009, we inspected the trust against the Code of Practice on healthcare-associated infections and related guidance. During that inspection, there was no evidence that the trust had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

In July 2010, we reported that arrangements are in place at ward level to monitor the quality and safety of services and to make sure that action is taken when risks are identified. Each ward is expected to undertake a monthly audit of its performance against a number of indicators. These include infections rates; and the results are displayed at the entrance to all wards for everyone to see. Ward sisters are expected to produce action plans, which must also be displayed, to quickly address any failings. Matrons hold ward sisters to account for making sure any necessary improvements are made.

The trust has a process to identify and manage people who are admitted with or who develop an infection in hospital. The trust has a cohort ward for managing patients with infectious diseases.

When we visited in April 2010 the trust was found to be managing an outbreak of norovirus. Wards were closed to new admissions and there were clear protocols for minimised the risk of cross infection and spread to other areas. Hand gel and hand washing notices were visible in all clinical areas visited by the assessors.

We visited wards and A&E in April 2010 and found patient environments to be clean and well maintained. PEAT scores were reported as good and the trust’s data shows that it has sustained low levels of hospital-acquired infection over the last 12 months. This information is published on the trust website.

The trust has provided good evidence of mandatory training (see outcome 14) and prevention and management of infection is a component of this training.

In conclusion, the documents presented by the trust demonstrated compliance with this outcome of cleanliness and infection control.
Outcome 9: Management of medicines

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

This is because providers who comply with the regulations will:
- Handle medicines safely, securely and appropriately.
- Ensure that medicines are prescribed and given by people safely.
- Follow published guidance about how to use medicines safely.
What we found for Outcome 9

Our judgement

There are moderate concerns with Outcome 9: Management of medicines

Our findings

In the provider compliance assessment, the trust assessed itself as yellow for all aspects of this outcome.

There are systems in place to support safe practice in the management of medicines. The trust has a range of policies, procedures and clinical guidelines established, accessible to staff. There is routine pharmacy support provided to wards, and dedicated pharmacy support is provided to the acute medical unit. There is a Prescribers Medicines Management Code against which all prescribers are held to account.

There is a programme of ongoing training and competency assessments for all staff involved in the prescribing and administration of medication. The training data provided does not give clear information on the coverage of attendance at training.

There are governance and reporting systems in place to monitor the safety of medicines management in the hospital. Medication errors are reportable through the trust’s incident reporting system. In the event of a medication error, the trust has a clear process of review and staff support in place.

The Medicines and Therapeutics Committee (MTC) & Safe Medicines Practice Group (SMPG) monitor to ensure that best practice and national guidance in medicines management is followed. The SMPG reviews all medication incidents reported and the learning identified. For 2009/10, there was a total of 403 adverse incidents reported in the trust. This was a significant increase on 339 incidents reported in 2008/09. The trust is considering the reasons for this and what action it needs to take. The trust has provided some evidence of learning from incidents reviewed. An example of this was the introduction of the new drug chart in response to a range of medication related incidents during 2009.

There are systems of routine audit in place to monitor the safety of medicines management in the hospital. Regular ward level audits are completed, including missed doses, drug storage and controlled drugs. Examples of previous audits completed included allergy recording, compliance with the trust venous thromboembolism (VTE) policy. The use of antibiotics is regularly audited. We have not seen a formal medicines audit programme or evidence across all the audits of outcomes and actions taken.

The trust completed a general ward based audit of prescriptions in April 2010. A total of 87 sample prescriptions were reviewed. The prescriber could not be identified in over fifty percent of prescriptions. Forty five percent of prescriptions had a recording error. There were six interventions of major concern, reflecting the wrong medication or the wrong dose. The recommendations from this audit included regular re-audit, the use of signature stamps and consideration of e-prescribing. No information on the progress with the proposed audit programme or other recommendations has been provided.

As part of our site visits in March and April 2010 we reviewed elements of practice in this area. There were gaps in the recording of medication identified during our review of related documentation. We talked to patients on the wards who confirmed that they received their medication when they needed it and did not have any concerns. We heard that access to pain relief was good.
In conclusion, our findings lead us to have a moderate concern in the management of medicines. There are inconsistencies in practice and the standard of record keeping on the wards. There has been a significant year on year increase in the number of medication related incidents reported. The reasons for this and the trust’s response to gaps in practice identified, following recent audits are not clear, however the trust will address these issues through further audits and action plans.
Outcome 10: Safety and suitability of premises

People who use services:
- Are in safe, accessible surroundings that promote their wellbeing.

This is because providers who comply with the regulations will:
- Make sure that people who use services, staff and others know they are protected against the risks of unsafe or unsuitable premises by:
  - the design and layout of the premises being suitable for carrying out the regulated activity
  - appropriate measures being in place to ensure the security of the premises
  - the premises and any grounds being adequately maintained
  - compliance with any legal requirements relating to the premises
- Take account of any relevant design, technical and operational standards and manage all risks in relation to the premises.
## What we found for Outcome 10

### Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

### Our findings

In the provider compliance assessment, the trust assessed itself as compliant for most aspects of this outcome with further work to take place with training where they marked themselves as yellow. In April 2010, we found that trust the premises were safe and accessible and suitable for the purpose of delivering care. The exception was one medical ward where it had been identified that there is a need to improve observation in some areas.

The PEAT 2010 environment score identified that the trust was overall 'good' at Stafford and Cannock Chase Hospitals. The trust has provided evidence that hospital environment is monitored by environmental audits involving infection control, housekeeping and estates staff.

Hospital security are supported by CCTV, lockable facilities for patients and staff. Security staff are visible on the hospital site. The trust is able to offer specific rooms available within the hospital for prayer, quiet areas for relatives, pastoral care and children.

The trust provided evidence that they audit compliance with legal requirements relating to the premises for example fire safety and provided evidence of fire risk assessments being carried out. They also told us that they give fire training to all the staff on the site and a full induction is completed and signed on commencement of their employment.

The trust provided evidence that they monitor the safety of patient care through clinical risk groups meetings and patient safety group meetings where they discuss any reported incidents to avoid situations arising again.

Following outside agency audit results waste disposal handling and the policy are under review and audits are now structured at ward and department level to address the identified issues. Training in this area has been identified as being required by this source.

PEAT scores for privacy and dignity were noted as was acceptable in the 2010 assessment, these scores being reduced in two areas, confidentiality and modesty, dignity and respect.

In April 2010 we observed privacy and dignity being maintained in most areas, witnessing the use of screens, support at meal times and privacy of conversations. Emergency and individual bedside call bells were in place throughout the hospital to ensure safety of patients at all times and to assist them to gain support as needed. We also saw that patients had their call bells accessible and patients told the assessors that the staff responded quickly to them when called.

The trust forwarded business continuity plans which support staff in the event of system failures and plans for evacuation and major incident situations are in place.

In conclusion we have a minor concern for this outcome. The trust provided a provider compliance assessment and the results of audits which reflect gaps in compliance against this standard in relation to waste segregation. However, there are no direct impacts on patient outcomes and appropriate actions are being taken.
Outcome 11: Safety, availability and suitability of equipment

People who use services:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

This is because providers who comply with the regulations will:
- Make sure that equipment:
  o is suitable for its purpose
  o is available
  o is properly maintained
  o is used correctly and safely in line with manufacturers’ instructions
  o promotes independence
  o is comfortable.
- Follow published guidance about how to use medical devices safely.
What we found for Outcome 11

Our judgement

There are minor concerns with Outcome 11: Safety, availability and suitability of equipment

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for most aspects of this outcome except for 11A, where audits are taking place on planned maintenance programmes. In our report of July 2010 we reported that outcome 11 was a minor concern because we found that although the trust had processes in place to ensure that equipment is maintained, these were not well co-ordinated and the assurance framework required to effectively demonstrate and monitor compliance with this regulation was still developing. In addition, we observed patients who were at risk of developing pressure sores but who did not have access to pressure relieving devices. Staff also raised concerns about access to pressure relieving equipment. We commented that the trust must ensure that sufficient pressure relieving devices are routinely available and since our visit the trust has stated that this has been addressed.

The trust has provided evidence that there are processes now in place to ensure that staff can access pressure relieving devices when required for patients at risk of developing pressure sores (as outlined at outcome above). The evidence presented includes; the proposal for the hire of pressure relieving equipment from August 2010, as this recognises the shortfalls identified in the twelve month review and provides analysis of static and electric mattress access and provision being noted. The trust provided evidence of the full monthly rental report from May to August 2010 which demonstrates that the trust monitors where the rented transair mattresses are in the trust and their duration of use.

There is now a rental of equipment poster sited in the hospital (August 2010) which provides information to staff about how to access pressure relieving devices, including out of hours. There is a four hour delivery window standard in place to ensure that the appropriate equipment is being used without delay.

The trust has produced an action plans to further improve compliance with this outcome. This action plan indicates that the trust has now introduced key performance indicators in order to monitor compliance as stated in its progress update of 14 July 2010. The trust has also identified the need to introduce an equipment library for the site to monitoring and improve access by ward staff to the available equipment. A pilot of this system will run for six months from September 2010.

In conclusion, this outcome remains a minor concern due to the action plan not yet being implemented so people who use the service are not yet able to be fully assured that any equipment they need is available.
Outcome 12: Requirements relating to workers

People who use services:
- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

This is because providers who comply with the regulations will:
- Have effective recruitment and selection procedures in place.
- Carry out relevant checks when they employ staff.
- Ensure that staff are registered with the relevant professional regulator or professional body where necessary and are allowed to work by that body.
- Refer staff who are thought to be no longer fit to work in health and adult social care, and meet the requirement for referral, to the appropriate bodies.
What we found for Outcome 12

Our judgement

There are minor concerns with Outcome 12: Requirements relating to workers

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for all aspects of this outcome.
The trust sent us copies of documents that set out how the recruitment and selection process will work in detail. These included the recruitment and selection policy and guidelines; the pre-employment and employment checks policy; the professional registration policy; the policy for the recruitment and management of 'bank' staff; and templates for job descriptions and person specifications. However, these were all marked as ‘draft’.
The trust told us that applicants are scrutinised by the recruitment manager and the whole process from advert through short listing, interviewing, appointment and identity checks, right to live and work and qualifications are subject to legislation that protects the employer and employee. The trust told us that at the stage of interview all the qualifications, skills, knowledge and experience are checked, original certificates seen and photocopies are taken. Where appropriate, applicants are tested at interview. Qualifications and professional registration are checked by recruitment staff prior to the applicant being accepted into the role. The trust told us that each personnel file contains a checklist of the documentation to be included in the file.
The trust told us that all staff complete a ‘model declaration form A’ in accordance with exemptions to the ROA (Rehabilitation of Offenders Act) 1974. This asks applicants about investigations or warnings they may have received from a range of bodies. Any staff awaiting the outcome of the CRB check is able to work supervised by an appropriate member of staff. All staff provides several forms of identity, including photo identity where possible. Where appropriate, staff undergoes CRB checks at the relevant level (standard or enhanced). All staff must provide references from previous employers and undergo occupational health assessment followed by the Trust induction.
The trust assured us that all these checks are undertaken before the staff start work. However, it did not provide us with any information about how it is assured that all these checks are routinely undertaken.
In conclusion, we found that the trust has the elements of a comprehensive recruitment and selection arrangements in place, but these are not formalised in agreed policies. It did not provide us with any information about how it is assured that all recruitment checks are routinely undertaken. We therefore have minor concerns about this outcome.
Outcome 13: Staffing

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

This is because providers who comply with the regulations will:
- Make sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people.
What we found for Outcome 13

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

In the provider compliance assessment, the trust assessed itself as ‘yellow’, recognising areas of non compliance against this outcome. It explained it has medical staffing vacancies and it told us about the action it is taking to fill them.

The trust presents workforce reports to its board each month. These show that the nursing vacancy rate has increased slightly month on month from the April 2010 report (7.54%) to the July 2010 report (8.24%). However, the trust is still actively recruiting to nursing posts and had 701.57 whole time equivalent (wte) registered nurses and midwives in post in June 2010. This is 35.02 wte more than in March 2009. Nursing vacancies are covered by the use of temporary nursing staff, with over ninety percent of requests filled. The internal nurse ‘bank’ covered seventy five percent of requests with staff. The nursing sickness rate continues to be above the overall trust rate and fluctuates. It decreased from January 2010 (6.25%) to March 2010 (5.63%), increased in April 2010 (6.12%) and decreased in May 2010 (5.83%).

A report from the local primary care trust said that the trust had repeated its examination of its nurse to patient ratios in June 2010 and the results showed that the staffing numbers are about right. The trust also told us it is changing the leadership on one ward in order to improve nursing care.

The trust told us there are still short and long term medical staff absences within the surgical service but these are being covered and a long term strategy for the service is being developed within the local health economy. The service is monitoring the situation closely so any other action that becomes necessary can be taken promptly.

There are also medical vacancies in the accident and emergency department, elderly care, other specialties within acute medical services, radiology and haematology. The trust has covered many of these vacancies on a short term or temporary basis and is actively recruiting to most of them. It may be difficult to fill some of the posts that are in specialties in which there is a national shortage of doctors.

The trust told us its review of its arrangements for managing the hospital at night has not yet been completed. It has a protocol in place to use if, for example, two junior doctors are absent. This would involve the transfer patients if necessary. It has not had to use this protocol yet.

The trust told us a theatre matron had taken up post on 10 May 2010 and a number of initiatives are underway to address staffing shortfalls in theatres. The trust needs to ensure that the changes it is making to staffing within theatres mean those theatre sessions are available when needed.

We have found that the trust is continuing to recruit to its vacant nursing posts and its nurse to patient ratios continue to indicate that the numbers of nurses are sufficient to ensure that patient needs are met. It is taking action to respond to specific areas of concern. It needs to continue to tackle the high numbers of nurses being absent due to sickness.

The trust needs to continue to work to resolve its medical staffing issues within surgery, accident and emergency and other specialties. It also needs to complete its review of its arrangements for managing the hospital at night.

In conclusion, due to the high numbers of nurses being absent due to sickness and also the number of medical staffing vacancies this outcome is a minor concern.
Outcome 14: Supporting workers

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

This is because providers who comply with the regulations will:
- Ensure that staff are properly supported to provide care and treatment to people who use services.
- Ensure that staff are properly trained, supervised and appraised.
- Enable staff to acquire further skills and qualifications that are relevant to the work they undertake.
What we found for Outcome 14

Our judgement

There are moderate concerns with Outcome 14: Supporting workers

Our findings

In the provider compliance assessment, the trust assessed itself as compliant except for supervision, where it explained that formal models of peer and group clinical supervision are being explored and are to be incorporated into a new policy and that the draft clinical supervision policy will be ratified by December 2010.

The trust presents workforce reports to its board each month. These show that, earlier in the year, the trust introduced a system in which staff are not put on the payroll unless they have attended induction. There was one hundred percent attendance at induction in June 2010. Ninety two percent of staff had attended the corporate mandatory training day by the end of June 2010. The post-graduate dean undertook a survey of junior doctors in the summer, which identified that there were issues with protected teaching time in some areas. The trust’s tutors will be addressing this with the relevant educational supervisors. The trust told us it had developed key trainers to support the delivery of conflict resolution training and it had created a programme of training for staff.

The trust told us it is creating a single learning and development plan to bring together its various separate plans and it will do this by 1 January 2011. Staff are able to access information about the training and support that is available to them via its internal website but the trust did not provide us with any information about how it is assured that staff receive all the learning and development opportunities they need to carry out their roles and keep their skills up to date.

The trust told us that, although it had put a supervision support structure in place, this was being reviewed further by the Director of Nursing and would be completed by 31 December 2010. It also needed to draw up a policy to underpin its supervision framework, which it would do by 1 December 2010. Its supervision arrangements for nurses and midwives include certain staff such as matrons and ward sisters having specific responsibilities for supervising nursing practice, supervision for midwives in line with national requirements and perceptorship for new nurses. Formal models of peer and group clinical supervision is being explored and is to be incorporated into a new policy.

The trust also sent us information that showed the vast majority of the doctors in training had clearly identified consultants/educational supervisors.

The trust’s board workforce reports show there has been improvement in the appraisal rate and ninety percent of staff had had an appraisal by the end of June 2010. The trust plans to audit the quality of appraisals and is piloting new appraisal paperwork in July 2010. One of the trade unions it recognises has offered support to roll out training for people who are being appraised.

The trust’s board workforce reports and the report from the local primary care trust included some information about Whistleblowing. The trust has revised its Whistleblowing policy and established a Whistleblowing line. In July 2010, it noted that three people had used the Whistleblowing line and other staff had also come forward. There are, however, still concerns about confidentiality and victimisation.

In conclusion, we found that the trust ensures that new staff attend induction and that staff are attending the corporate mandatory training day. It has created a programme of conflict resolution training for staff. However, it did not provide us with any information about how it is assured staff receives all the training they need.
The trust still needs to ensure that supervisory or peer support arrangements are in place for all staff involved in delivering care, treatment and support. The trust has made very good progress in ensuring that staff are appraised and is improving the quality of the appraisals. The trust is aware of the concerns staff have about raising concerns and is continuing to promote Whistleblowing.

We have minor concerns because the trust has not provided any information about how it is assured staff receive all the training they need, and we have moderate concerns because it has not put a comprehensive supervision system in place.

In conclusion, this means that overall; we have a moderate level of concern for this outcome.
Outcome 16:
Assessing and monitoring the quality of service provision

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.

This is because providers who comply with the regulations will:
- Monitor the quality of service that people receive.
- Identify, monitor and manage risks to people who use, work in or visit the service.
- Get professional advice about how to run the service safely, where they do not have the knowledge themselves.
- Take account of:
  o comments and complaints
  o investigations into poor practice
  o records held by the service
  o advice from and reports by the Care Quality Commission.
- Improve the service by learning from adverse events, incidents, errors and near misses that happen, the outcome from comments and complaints, and the advice of other expert bodies where this information shows the service is not fully compliant.
- Have arrangements that say who can make decisions that affect the health, welfare and safety of people who use the service.
## What we found for Outcome 16

### Our judgement

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

### Our findings

We reported on this outcome in July 2010 when the registration condition was removed. We did not seek any additional evidence.
Outcome 17: Complaints

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

This is because providers who comply with the regulations will:
- Have systems in place to deal with comments and complaints, including providing people who use services with information about that system.
- Support people who use services or others acting on their behalf to make comments and complaints.
- Consider fully, respond appropriately and resolve, where possible, any comments and complaints.
What we found for Outcome 17

Our judgement

There are moderate concerns with Outcome 17: Complaints

Our findings

The trust did not provide a provider compliance assessment for this outcome.
In April 2010 we found that the trust was taking action to improve services as a result of individual complaints or concerns. The complainant was being engaged within three days of receipt of a complaint being received and involved in identifying the issues to be investigated. There were many examples of learning identified and actions agreed to improve services for patients. These were mainly at a local level but there were examples of trust wide application of learning where a positive impact for the experience of patients across the trust was demonstrated.
The trust has recognised their failings in this outcome and we agree this is of moderate concern.
The trust failed to meet the previous action plan timescales and they have stated that the way in which they deal with complaints needs to improve significantly and as a matter of urgency.
The trust has submitted an action plan named ‘Improving the quality & timeliness of complaint responses’. This states one of the actions is to be ’Complaints responses to meet national standard of 28 days maximum response time’
The complaints regulations provide scope to set timescales for completion of the investigation and response based on the ‘complexity of issue’. The trust process includes a risk assessment and grading of the complaint which, if adopted to include a timescale window, would assist in prioritisation and setting more realistic timescales when agreeing terms of reference with the complainant.
Although the 12 month review identified a much improved approach to reporting of complaints, the reporting and monitoring of learning and actions taken following complaints is still not as complete as it could be. The trust was recommended to continue with the development of reporting through the clinical quality dashboard and an integrated approach to reporting across complaints, incidents, PALS and near misses and this has been carried out.
The trust has recognised that the quality of responses from all grades of staff within the divisions requires improvement. They noted that too often, responses were mechanistic, defensive, lacking in apology, and did not answer the questions being asked by the complainant. To date, the Trust has not yet invested in training for key personnel within the divisions to support staff to improve complaints responses.
A proposal from this action plan is that the Healthcare Governance Committee receives monthly reports on progress against the delivery plan, with escalation of outstanding risks to the Board as appropriate.
It was also noted that the trust needs to show evidence of improvement by giving some priority attention to the linkage of complaints with safeguarding of children and adults. This is to ensure that the opportunities to identify vulnerable adults and children and take appropriate action are actioned. There is some evidence that safeguarding referrals are being made however no statistics were produced at this time.
In conclusion, we have moderate concerns for this outcome. The trust's complaints system is not effective because staff involved in complaints are not fully trained in their roles and investigations are not completed in a timely manner. The trust need to take action to address these issues.
Outcome 21: Records

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

This is because providers who comply with the regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
- Securely destroy records taking into account any relevant retention schedules.
What we found for Outcome 21

Our judgement

There are minor concerns with Outcome 21: Records

Our findings

In the provider compliance assessment, the trust assessed itself as compliant for most aspects of this outcome except for the introduction of new case notes and the changes to be implemented in this area.

The trust has identified shortfalls in this outcome and has an action plan to improve identified issues. The actions commenced in September and are due for completion on 23 December 2010. The trust has identified through its audit activities that personal patient records need to improve in terms of the quality of documentation such as ensuring signatures are identifiable. Snapshot audits have also provided evidence of some misfiling of patient results.

The trust has identified a need to improve filing and will introduce new case notes. Its action plan outlines that all staff will be trained in recording, handling and filing of new case notes and indicates an intention that ongoing compliance with good records management will be monitored.

There are processes in place to ensure that data is held confidentially. A data quality policy (April 2010) outlines how data must be managed in accordance with the data protection act. During site visits to wards in April 2010, we found that patient records were appropriately stored on wards. Where staff to patient interactions were observed confidentiality was observed to be appropriately protected.

The trust has provided a policy that outlines secure destruction of medical records and relevant retention schedules to ensure patient records are kept for the correct amount of time.

In conclusion, we have a minor concern in this outcome. The completeness and quality of records is not consistent and people who use the service need to be confident that their personal records are accurate, fit for purpose, held securely and remain confidential.
## 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.

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<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<td>Treatment of disease, disorder or injury</td>
<td>Regulation 17</td>
<td>Outcome 1</td>
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<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>Why we have concerns</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Because the processes for respecting and involving people who use the service are not fully embedded.</td>
<td>People who use services are assured that the trust's processes for patient engagement are effective and influence service planning and delivery.</td>
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<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
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<tr>
<td>Maternity and midwifery services</td>
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</tbody>
</table>

| Treatment of disease, disorder or injury | Regulation 9 | Outcome 4                                         |
| Assessment or medical treatment for persons detained under the 1983 Act. | Why we have concerns | The outcome for people that should be achieved |
| Surgical procedures | Because action plans relating to discharge and the use of theatres have not yet been implemented. | People who use services receive the services they need in a timely manner. |
| Diagnostic or screening procedures | | |
| Maternity and midwifery services | | |

<p>| Treatment of disease, disorder or injury | Regulation 11 | Outcome 7                                         |
| Assessment or medical treatment for persons detained under the 1983 Act. | Why we have concerns | The outcome for people that should be achieved |
| Surgical procedures | Because safeguarding issues are not always reported in a timely manner. | People who use services are assured that the trust raises safeguarding issues in a timely manner. |
| Diagnostic or screening procedures | | |</p>
<table>
<thead>
<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 15</th>
<th>Outcome 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Why we have concerns</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>Because the trust is not segregating waste properly.</td>
<td>People who use services are assured that waste is disposed of appropriately.</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
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</tbody>
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<table>
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<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 16</th>
<th>Outcome 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Why we have concerns</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>Because action plans have not yet been implemented.</td>
<td>People who use services are assured that any equipment they need is available.</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
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<tr>
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</tbody>
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<table>
<thead>
<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 21</th>
<th>Outcome 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Why we have concerns</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>Because the trust’s arrangements are not formalised in agreed policies and the trust has not shown how it is assured that all recruitment checks are routinely undertaken.</td>
<td>People who use services are assured that the trust has formal recruitment and selection procedures and has carried out the relevant checks when staff are employed.</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
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<tr>
<td>Maternity and midwifery services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 22</th>
<th>Outcome 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Why we have concerns</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons</td>
<td>Because there are still high numbers</td>
<td>People who use services are assured</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 23</td>
<td>Outcome 14</td>
</tr>
<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td><strong>Why we have concerns</strong></td>
<td></td>
<td><strong>The outcome for people that should be achieved</strong></td>
</tr>
<tr>
<td>Because the trust has not shown how it is assured that staff receive all the training they need.</td>
<td></td>
<td>People who use services are assured that staff are properly trained.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment of disease, disorder or injury</th>
<th>Regulation 20</th>
<th>Outcome 21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why we have concerns</strong></td>
<td></td>
<td><strong>The outcome for people that should be achieved</strong></td>
</tr>
<tr>
<td>Because the completeness and quality of records is not consistent.</td>
<td></td>
<td>People who use services are assured that their personal records are accurate, fit for purpose, held securely and remain confidential.</td>
</tr>
</tbody>
</table>

The provider must send us 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 report should be sent within 28 days of this report being received.

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

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 13</td>
<td>Outcome 9</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>How the regulation is not being met</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>There are inconsistencies in practice and the standard of record keeping on the wards.</td>
<td>People who use services are assured that medicines are prescribed and documented accurately.</td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td>Maternity and midwifery services</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 23 (1)</td>
<td>Outcome 14</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>How the regulation is not being met</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>The trust has not put a comprehensive supervision system in place that is monitored and reviewed.</td>
<td>People who use services are assured that staff can talk through any issues about their role, or about the people they provide care, treatment and support to.</td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td>Maternity and midwifery services</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 19 (1)</td>
<td>Outcome 17</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the 1983 Act.</td>
<td>How the regulation is not being met</td>
<td>The outcome for people that should be achieved</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>The trust’s complaints system is not effective because staff involved in complaints are not fully trained in their roles and investigations are not completed in a timely manner to allow the trust to take action to address the issues.</td>
<td>People who use the service are assured that their comments and complaints are listened to and acted on effectively.</td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td>Maternity and midwifery services</td>
<td></td>
</tr>
</tbody>
</table>
Maternity and midwifery services

The provider must send CQC a report that says what action they are going to take to achieve 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 this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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