# Dignity and nutrition for older people

## Review of compliance

**Countess of Chester Hospital NHS Foundation Trust**  
**Countess of Chester Hospital**

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<th>Region:</th>
<th>North West</th>
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<tr>
<td>Location address:</td>
<td>Countess of Chester Health Park Liverpool Road Chester CH2 1UL</td>
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<tr>
<td>Type of service:</td>
<td>Acute Services</td>
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<tr>
<td>Publication date:</td>
<td>May 2011</td>
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<td>Overview of the service:</td>
<td>The Countess of Chester Hospital NHS Foundation Trust is a 600 bed General Hospital located on the outskirts of Chester. It provides a range of medical services to more than 425,000 patients per year from an area covering Western Cheshire, Ellesmere Port, Neston and North Wales.</td>
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Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that the Countess of Chester Hospital NHS Foundation Trust was meeting both of the essential standards of quality and safety we reviewed.

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

Why we carried out this review

This review was part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information we held about this provider, carried out a visit to the Medical Assessment Unit and Tower Ward, and observed how people were being cared for. We talked with eight people who use services, talked with seven staff, checked the provider’s records, and looked at records of seven people who use services.

The inspection teams were led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.
What people told us

All of the patients we talked to said their needs were met. Most of the patients said that the staff were very helpful and responded to call bells promptly. All said that they were given information and encouraged to take part in drawing up their plan of care and felt confident that if they didn’t understand anything they could ask for further explanation. One patient said “the staff are very good at explaining things, they speak in your language”. Another said “the information is given at my level”.

Patients said that the staff always asked permission before carrying out any examinations or care and also regularly asked if they had any concerns. They said staff asked them how they wanted to be addressed, were respectful and always maintained their privacy. All said they had never been embarrassed or felt uncomfortable while care was being carried out.

Patients told us that they enjoyed the meals, the food was good and they were given enough to eat, although two people on the longer stay ward said they would like more variety in the menus. They said that they were given help to eat if they needed it and they had never missed a meal. Patients confirmed that there always snacks and drinks available.

What we found about the standards we reviewed and how well the Countess of Chester Hospital NHS Foundation Trust was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Overall, we found that the Countess of Chester Hospital NHS Foundation Trust was meeting this essential standard.

Outcome 5: Food and drink should meet people’s individual dietary needs

- Overall, we found that the Countess of Chester Hospital NHS Foundation Trust was meeting this essential standard.
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 1: 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 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

All of the patients we talked to said their needs were met. They said that the staff were very helpful and responded to call bells promptly, although one said “they can be a bit delayed if they're very busy”. Another patient said “most of the staff are very kind, but sometimes you get an odd one who may be abrupt”. They said that the staff always ask permission before carrying out any examinations or care and also regularly ask if they have any concerns.

The patients we talked to said that staff had explained to them about their medical condition and that they were encouraged to take part in drawing up a plan of care and also encouraged to ask questions if they didn’t understand anything. One patient said staff were very good at explaining things, “they speak in your language”. Another patient said that he was given the information and keeps a notebook to record any questions he has. He said that staff give him full answers to his queries and he also said “the information is given at my level”.

Patients said staff asked them how they wanted to be addressed, were respectful
and always maintained their privacy. All except one said they were called by their preferred name. All said they had never been embarrassed or felt uncomfortable while care was being carried out.

We observed the staff caring for the patients. We saw that staff explained procedures to patients and asked their permission before they carried them out. Staff drew curtains round patients before carrying out examinations or personal care, and clipped a sign to the curtain saying ‘care in progress, please do not enter’. When staff were talking with patients, they spoke quietly to maintain privacy. We noted that when one of the consultants spoke to patients, he always asked had they understood and did they want to ask any questions.

We noted that staff smiled and made eye contact with patients and were sensitive to their needs. Call bells were within reach and staff answered them promptly. One patient was upset and a nurse drew the curtains round her and sat with her for a while. Another patient was quite confused, but staff spoke quietly to her and spent time explaining what they were doing and encouraging her. Another patient was hot and asked for a fan. This was provided and the member of staff who brought it asked where the patient wanted it positioned and what speed they wanted it. One patient was provided with a higher chair to make it easier for him to stand up from the chair.

However, another patient asked a member of staff if his chair could be moved to the other side of the bed to make it easier for him to get out of bed. The staff member said she would ‘have to ask’ but didn’t come back. Another male patient was left bare-chested by a technician after an electrocardiograph (ECG) and was struggling to put his pyjama top on on his own.

It was clear that patients’ relatives were consulted and involved in patient care. A pharmacist was talking to a patient about her inhaler and asked could she ring the patient’s son and ask him to bring it in. The patient agreed and when the pharmacist had made the phone call he came back to tell the patient about the conversation. A nurse came to another patient to tell them that their relative had rung and also told them about the content of the conversation.

Other evidence
The Trust’s Quality Account said that care and treatment of the older person and improving communication to patients were priority areas. It also showed that in 2010 a Delivering Same Sex Accommodation (DSSA) peer review had been carried out and the Trust had achieved virtual compliance.

The Patient Environment Action Team (PEAT) assessment outcome for Privacy and Dignity was ‘Good’ in 2010.

The Trust also commissioned Age Concern Cheshire to undertake an audit of dignity, which was carried out in March/April 2010. The outcome was that the Trust had a ‘Growing Dignity Profile Status’, which meant it was actively working to raise the profile of dignity in care. Since the audit the Trust has set up a Dignity Steering Group, which monitors the action plan produced following the audit. So far, the Trust has increased the number of active dignity champions, produced literature for patients about their rights and responsibilities, included patient quotes in the quarterly reports and provided more pairs of pyjamas to wards. Other actions are ongoing and due to be reviewed at the end of this month.

The Trust told us they have a single equality scheme and promote the FREDA
principles (fairness / respect /equality /dignity and accountability) outlined in human rights legislation. They say they have procedures in place to support staff in ensuring that the requirements of the Mental Capacity Act and Deprivation of Liberty legislation are met sensitively and where an independent advocate is required this is made available.

We interviewed seven members of staff. When asked how they involved patients in decisions about their care, they all said that they would explain about the care planned and ask for permission to carry out the care. The ward managers and a doctor said if the patient did not have mental capacity, they would consult with the family.

We asked staff how they maintained people’s privacy and all talked about single sex accommodation and the use of curtains and signs. The managers said that visitors are not allowed in the ward during ward rounds and a private room is available for consultation. A housekeeper also identified that each patient had a phone by their bed so they could make and receive calls with more privacy. The Medical Assessment Unit is a mixed ward, but bays and bathrooms were designated either male or female. The ward manager said that any breach of single sex accommodation only happens in an emergency and must be reported to the hospital board. She said that the last breach on her ward was seven months ago and it was for less than two hours.

Staff said they had received training in understanding and implementing the concepts of privacy, dignity, independence and human rights. All felt that patients’ privacy and dignity were well maintained. Staff said that if they observed another member of staff being disrespectful to a patient they would report it to the ward manager and the managers said this would be treated very seriously and disciplinary action would be taken.

The nursing records were held electronically. Patients’ preferences were recorded in relation to how they wished to be addressed, their religious requirements and dietary needs. Two patients had had an assessment of mental capacity and one, who was determined as not having capacity, was awaiting a multi-disciplinary best interests meeting. (The assessment had only been done the day before).

Medical notes on the Medical Assessment Unit were not stored securely, being left in a trolley in each bay.

The Trust said that each patient has a care plan which is individually tailored to their needs following a holistic assessment and multi disciplinary team meetings are held to enable expert advice and planning in conjunction with patients. The Trust said it is committed to the provision of therapy services tailored to meet individual needs with a strong focus on enablement, for example cover is provided seven days a week on orthopaedic wards, also outreach into the community to enable early discharge.

The staff we interviewed said that they promote independence by asking patients what they were able to do before they were in hospital and encouraging them to maintain those skills. They said that referrals to therapists are made if necessary and that there was a physiotherapist based on the ward. A student nurse said that she knew how to meet patients’ needs because she was able to read the admission assessments and the care plans and she was also told what patients’ needs were at the safety briefing at the start of a shift. The ward managers said that they speak to all the patients every day to make sure they are satisfied that their needs are being met and they said that they also carry out regular care audits involving patients. All the staff said that, on the whole, they felt they had enough time to meet patients’
needs, and if they didn’t they would ask for more staff.

The Trust aims to give patients and their support network full information from which they can make informed choices and decisions about their care plan and treatment. They have in 2010-11 introduced advanced care planning for patients who are known to be approaching the end of their active treatment in two specialties. They are advancing this further in 2011-12. Reasonable adjustments are made for patients regarding all aspects of the Single Equality Scheme and the Trust has a communication book with multiple aids for communication and also can provide access to face to face and telephone interpreter services.

Staff confirmed that they discuss treatment and care options with patients. One gave an example of how one patient had requested that his wife attend to his personal care and this had been accommodated. The ward managers said that they attend ward rounds and make sure that doctors give full explanations of treatment options and afterwards they check that patients have understood. They said that patients are provided with written information about the ward and the facilities available in the hospital, which includes information on how to raise concerns or complaints. A junior doctor told us that she always explains to patients the treatment options that are available and checks their understanding. She said she backs this up with printed information from the NHS website and ensures that nurses are aware of what the patient has been told so they can answer any queries.

The Trust told us that there are monthly leadership walk rounds by the executive team which involve discussions with staff and at least three patients on each ward regarding their care and experience. They said that patient stories are received by the Board and there is patient representation on all equality and diversity subgroups. They carry out monthly postal patient experience surveys of people who have recently been discharged. Any positive comments and compliments are passed onto the relevant ward and incorporated into Board reports. Particular references around sub standard care and treatment are dealt with, with an action plan to ensure that lessons are learned and shared. These are discussed at whole hospital ward managers meeting and supported via the matrons at supervision meetings to ensure that action plans are completed within agreed timescales. Any hospital wide trends are managed via centralised training programmes. Comments cards are received in large numbers by anybody using Trust services or visiting. All are actioned and reported back to the public via quarterly summary reports on public facing notice boards. The Trust holds a variety of internal and external events and road shows to gain public and patients’ views regarding patient experience and views regarding development of services. They have a proactive Board of Governors who are highly engaged in this work and are represented on many internal forums.

The manager of the Medical Assessment Unit said that she carries out audits of patient care, 10 per month, and asks the patients for their feedback as part of the audit.

Our judgement
Patients are treated with respect and are involved in making decisions about their care, treatment and support.
Outcome 5: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

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<td>What people who use the service experienced and told us</td>
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<td>The patients told us that the food was good and they got enough. Most said they enjoyed the meals, although one patient said the food wasn’t always hot enough and two of the patients on the longer stay ward said the choice was limited. Patients confirmed that there were always snacks and drinks available. One patient told us that he was away from the ward once during lunchtime, but a meal was provided for him when he returned. Patients who were not mobile said they were not offered the opportunity to wash their hands before or after a meal.</td>
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<td>We observed lunch being served on the Medical Assessment Unit. This was overseen by a staff nurse in each bay. Staff assisted people to get into a comfortable position for eating and gave assistance where required. A student nurse was helping a patient who could not feed themselves. She told the patient what was on the plate and took her time feeding the patient and encouraging her to eat. One patient needed a special diet, which had not come on the trolley from the kitchen. A member of staff went to the kitchen straight away to get the meal. One patient became breathless while eating and was asked would they like some medication to help with their breathing before they tried to finish their lunch. The patient said yes and the meal was kept warm for them until they were able to eat it.</td>
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<td>We saw that people were offered choices at lunchtime. One patient said he’d rather...</td>
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have some toast and this was provided. The meals looked appetising and we saw that almost all the patients finished their meal. They were not interrupted by hospital staff whilst eating. We noticed that patients were given drinks in cardboard cups in holders, unless they needed a feeding cup. We felt that people should be offered the choice of a proper cup.

**Other evidence**

The Trust told us that patients are nutritionally risk screened on admission and weekly thereafter using the Malnutrition Universal Screening Tool (MUST), following which the appropriate care plan is implemented which may include monitoring of intake and/or referral to dietetics. The care plan may also include the use of snacks and nutritional supplements (ordered by dietetics) or in some cases a move to enteral feeding. At the safety briefing daily at ward level nutritional requirements for individual patients are discussed including feeding assistance required. Health care support workers, staff nurses on preceptorship and junior doctors all receive dietetic education within their programmes. This includes a dignified approach to feeding for nursing and healthcare staff.

There is a volunteer service which includes members of staff from non clinical departments and members of the public who assist wards in the meal service ranging from cutting up food and opening packages to actual feeding. All volunteers undergo training to prepare them for this role. Equipment is sourced on an individual needs basis however this is under review currently to see if any further improvements can be made.

Staff told us that on admission patients or their relatives are asked about their usual diet, what their preferences are and whether they require any assistance. This information was recorded in the nursing records. They said that they then observe patients at mealtimes to determine if they need assistance or have any swallowing difficulties. The ward managers said that all patients have a nutritional assessment using MUST within 36 hours of admission, which includes obtaining the patient’s weight, and referrals are made to dietetics or a speech and language therapist (SALT) for a swallowing assessment if required. They said MUST assessments are reviewed every three to seven days. A staff nurse told us that if a referral is made the patient is usually seen the next working day. A health care support worker told us that she received training on how to assist people with eating on her induction and has since done more in-depth training in nutrition as part of a National Vocational Qualification (NVQ).

All staff said they are briefed at the start of a shift about who needs assistance and all felt they had enough time to assist patients to eat and drink. The ward managers said that if they felt there weren’t enough staff to assist with meals they could access trained volunteers. The manager of Tower Ward said that they often have quite a lot of patients that need help and she makes sure that all staff are engaged at mealtimes and also involves families and volunteers. If she felt that there weren’t enough people to assist, she said she would speak to her manager who would enrol assistance from other wards who were less busy at the time.

The manager said that access to specialist advice was very good, and a dietitian was on the ward most days. On the day we visited an enteral feeding nurse specialist was on the ward advising on care of two of the patients. The ward housekeeper told us that she had had training in nutrition, which included training on
the importance of positioning, taking your time and providing the right equipment. She said it also covered risk of choking and the importance of using thickening agents if prescribed. She told us that patients’ needs and preferences were written on the menu board in the ward kitchen.

The nursing records showed that patients had a MUST assessment on admission which was reviewed every week. They showed that one patient had been referred to the dietitian and SALT because he wasn’t eating well. Another patient was recorded as being on a diabetic diet and having a poor oral intake. He was receiving subcutaneous fluids and it was recorded that they needed to discuss with his family the option of enteral feeding.

The Trust assessed themselves as compliant in the area of nutritional screening and monitoring apart from the implementation of protected mealtimes. They submitted an action plan to us for the introduction of a full rollout of protected mealtimes at least once a day by June 2011, where patients will not be interrupted by ward rounds or investigations. They said that any patients with complex nutritional needs would be referred to the care of the Nutritional Support Team which comprises a doctor, a dietician, a speech and language therapist, a nutritional nurse specialist and where appropriate a pharmacist and biochemist. Swallowing difficulties are assessed and managed by a clear policy and in some cases a higher level of nursing expertise has been introduced to assist this process, for example in stroke care.

Staff said that they monitor patients’ food and fluid intake by recording it on charts at the end of the bed. We saw that this was done after each meal or drink. They also said that patients were weighed every three to seven days. They said that if a patient misses a meal for any reason staff can go to the kitchen and get another meal or there are sandwiches kept in the fridge on the ward.

The Patient Environment Action Team (PEAT) assessment outcome for food and food services was ‘Excellent’ in 2010.

Cheshire West and Chester LINk carried out an Enter and View visit in February 2011 focusing on food. They felt the hospital was ‘working to a very good standard’. The Trust told us that food is cooked on site everyday and is fresh, using local suppliers where possible. Meals are provided to meet cultural and religious beliefs, although these are not always cooked fresh on site. The catering department meet individual patients’ requests where the usual menu is not meeting a need. Snacks and additional meals are also available on request. They said that maternity and the assessment units have 24 hour access to ready meals, but between 2am and 6am all other areas only have ward snacks available.

The hospital menu has a two week cycle as the trust has an average length of stay of up to three days in planned care and up to seven days in urgent care. The menu choices include a higher calorie choice for those at risk of malnutrition, a soft and pureed choice for those with swallowing difficulties and a healthier choice for those with long term conditions. The menu is built to support individual patient choices, however in circumstances where the menu may not meet a patient need the catering department has the ability to provide individual meals and will meet with patients at ward level to discuss their requirements. Patients are able to select a portion size individual to their requirement.

The patient’s bedside information folder describes the content of the menu using
visual aids, such as red hearts for healthier choices, timings of meals, portion sizes and how to select your meal and request any special requirements.

Staff said they ask patients on admission if they have any particular dietary preferences. The ward managers said that the ward housekeeper or a health care support worker goes round in the morning with the lunch menu asking patients what they would like for lunch, and again in the afternoon for tea. Staff told us that special diets are catered for and that they felt the hospital catering was good and that the food was hot when it arrived. A health care support worker told us that snacks are available on the ward, such as sandwiches, toast, cereal, yogurt and cheese and biscuits and other food can be obtained from the kitchen up until 8pm. The ward managers said that Halal and Kosher meals are available and that during Ramadan they inform the kitchen if they have any Muslim patients so that the kitchen can provide the meals after sundown.

A housekeeper told us that the main meal is served at lunchtime and includes a choice of three hot meals, salad or sandwiches. In the evening there is only one hot choice, salad or sandwiches, but she said the kitchen will make other simple hot meals on request, such as an omelette. She said that she thought that it would be a good idea to provide biscuits on the ward because patients often asked for them, but they didn’t keep any on the ward. All staff spoken with said they thought the food was good and the patients seemed to like it.

**Our judgement**
Patients’ nutritional needs are assessed and they are supported to have adequate food and drink of their choice. The food provided is of a good quality.
What is a review of compliance?

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

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

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

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

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

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

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

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

**Dignity and nutrition reviews of compliance**

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.
## Information for the reader

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

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