Review of compliance

Oxford Radcliffe Hospitals NHS Trust Horton General Hospital	
Region:	South East
Location address:	Horton Hospital Oxford Road Banbury Oxfordshire OX16 9AL
Type of service:	Acute Hospital
Publication date:	September 2011
Overview of the service:	The Horton General Hospital is a general hospital in Banbury. It serves the population in the north of Oxfordshire and surrounding areas. It has over 220 inpatient beds and over 20 day-case beds and provides a wide range of services. These include an emergency department (with a clinical decision unit), general surgery, acute general medicine, trauma and orthopaedics, maternity and gynaecology, paediatrics, a critical care unit, coronary care and cancer resource centre.

	Other clinical services include physiotherapy, occupational therapy, dietetics, radiology and pathology.

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

What we found overall

We found that the Horton General Hospital was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we suggested that some improvements were made.

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

Why we carried out this review

We carried out this review to check whether the Horton General Hospital had made improvements since our last review of compliance for this location in September 2010. We checked for improvements in relation to:

- Care and welfare of people who use services
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision

How we carried out this review

As part of this review we used a range of information and evidence. This included reviewing information we hold about the trust and reviewing information provided by the trust which was specific to the Horton General Hospital. We also carried out an unannounced visit to the hospital on 12 July 2011. During the visit, we observed how people were being cared for, talked to patients and their relatives and talked to staff on three wards at the hospital.

What people told us

During our visit on 12 July 2011, patients at the Horton General Hospital were very positive about their experiences of care and treatment.

Patients felt involved in making decisions about their care and treatment and stated that staff kept them informed about the care they could expect to receive. They also told us that staff responded promptly when called and that staff took time to help and support them.

What we found about the standards we reviewed and how well the Horton General Hospital was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

Patients praised staff and said that they were happy with the care they received. We found that the trust had improved waiting times for patients across a number of key areas. The trust demonstrated that it had worked in partnership with the wider health and social care sector to address delays in patients being discharged to other care settings. Some improvement had been made to the number of delayed discharges, though joint targets remained unmet. Radiology reporting times have been met for externally requested reports. Some issues remained with the inappropriate placement of patients on wards where staff were not trained to meet their needs, including those with dementia. The trust had plans in place to address this. In stroke care, we found that the hospital had made improvement with most targets, though some remained unmet. There was improvement in staffs' understanding of how national and other clinical guidance is disseminated and implemented, although this was not consistent across all wards.

- Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust provided evidence that it had worked to improve the management of staffing across the trust. Staffing levels had recently been reviewed and safe levels set for each ward and department at the Horton Hospital. Staffing numbers were monitored on a daily basis and monitoring reports were provided monthly to key committees and to the board. There was evidence that staffing levels had improved, and that most shifts were staffed to optimal or minimum levels. Ward staff, however, commented that patient dependency and skill mix needed to be taken further into consideration. Evidence was provided that a recruitment process was in place to increase the number of nursing staff.

- Overall, we found that the Horton General Hospital was meeting this essential standard.

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

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust provided evidence that there had been a significant improvement in staff attendance at statutory, mandatory and essential training. There were some programmes where further attendance at mandatory training was required, including training on safeguarding vulnerable adults. The number of staff who had received an annual appraisal had also improved, particularly with medical staff. Clinical supervision was in place although limited evidence was provided to demonstrate it was implemented and effective.

- Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust had made significant progress in implementing a new committee and reporting structure at strategic and senior clinical levels of management. The trust had comprehensive governance information and data available to identify areas of concern. We found evidence that reporting processes on patient safety, quality, and risk have become more comprehensive across the divisions. This information provided improved assurance for the quality and trust board committees. There was good evidence provided in some areas that action plans were resulting in improvements for patients including around radiology reporting. However, there was some evidence that not all issues were systematically addressed at divisional level. There was also limited evidence from minutes that learning of effective approaches was shared across the divisions. In addition, levels of venous thromboembolism assessments in some divisions required improvement.

- Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Action we have asked the service to take

We have asked the provider to send us a report within 21 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
The patients we spoke to praised the care provided by staff. They told us that staff explained their treatment to them and kept them informed of any changes. Patients said that they were involved in decisions about their care. They said that there was good communication between nurses and doctors. Patients felt that staff treated them with respect and made an effort to ensure their privacy and dignity. They told us, where applicable, that they had adequate pain relief. They also said that staff came promptly when they called them.

Other evidence
Our last review of compliance of this hospital identified that it was not meeting this essential standard. The concerns from our last compliance review were:
- Long patient waiting times for treatments following referral.
- High numbers of patients waiting to be transferred from hospital to other care placements.
- Radiology department not routinely meeting the target times.
- Best practice in stroke care was not always implemented.
- Bed management was poor across a number of wards.
- Relevant NICE guidelines were not always implemented or monitored.

During our visit in July 2011, we spoke to staff and conducted observations of the provision of care to people in order to identify improvements from our last review. Staff were able to describe how they involved people in their care. They could also

tell us what they did in order to ensure they respected people's privacy and dignity. This included closing curtains during personal or intimate care, addressing people by their preferred names, and acknowledging individual preferences. Staff were seen speaking respectfully to patients, taking time to answering their questions, and asking them their preferences on specific issues.

Staff told us that they used care plans as the basis for their care and treatment of patients. These were informed by risk assessments which were specific to each patient. Staff on all wards told us that there was adequate or good communication between nurses and doctors.

Waiting times

Although there had been an inconsistent performance against a number of targets over the past six months, the general picture is one of improvement. In quarter one for 2011/12, 95.6% of patients were seen in accident and emergency within 4 hours. The trust is ranked 105 out of 150 acute trusts within England for their performance. Whereas the 18 week target for treatment is no longer monitored by the Department of Health, the trust still report on this. In June 2011, 90% of all patients who required admission were treated within 18 weeks (against a target of 90%). Data provided by the trust showed a steady improvement since January 2011. However, there were some specialities where this target was not being met, including neurosurgery, vascular surgery and urology.

In the minutes of the trust board meeting from April 2011, senior executives commended the trust for these improvements and stated that the challenge lay in maintaining this level of care. The trust provided evidence to show that it had conducted analytical work to understand what was required in order to sustain achieving these targets.

Delayed transfers of care

There had been a long standing issue for the trust and the wider Oxfordshire health and social care sector with delays in the transfer of patients from hospital to other, more appropriate, care settings. An Oxfordshire wide partnership programme was established in September 2010 to improve delays in transfers of care and the patient pathway more broadly. A senior member on the programme board stated that the trust had been central to and engaged in this process. The trust demonstrated that they have worked to understand and address the problem. Solutions have focused on altering GP referral behaviour and making wider systems changes. The trust have worked to improve bed management and implemented an initiative called 'home by lunchtime' to improve the discharge (and therefore admissions) process. NHS Oxfordshire recently committed new funds to an early discharge programme to enable those patients who are able to move home to do so, with the necessary support. There was evidence of recent improvement with 7.8% of acute beds across the trust being occupied by a patient requiring discharge in May to 6% in June 2011 (against a target of 3.5% of acute beds). Further work is required within the trust and across the wider health and social care sector to fully address this issue.

Radiology waiting times

In September 2010, inconsistencies were identified in the way radiology reporting was managed across the trust. The time taken to assess scans, (that were externally requested), and report back varied between hospital sites. In this review, we found that significant improvements had been made at the Horton Hospital. The target is that 95% of reports should be completed within 5 working days. In April 2011, this was achieved for reports on routine film. In June 2011, it was met for all other scanning reports including plain film, computerised tomography scanning reports (known as a CT scan) and magnetic resonance imaging scanning reports (known as a MRI scan).

Stroke care

We found that all areas of stroke care had improved since last years review. However, not all patients who had a stroke were receiving some procedures and treatments within the required timeframe. In June 2011, the trust was ensuring that stroke patients spent most of their stay on a specialised ward. All patients were being scanned within 24 hours in arrival at hospital (when judged clinically appropriate) and almost all had multidisciplinary goals set within five days. However, only half of stroke patients had direct admission to the stroke unit within 4 hours of their hospital arrival. In addition, 73% of patients had received an assessment by the multi-disciplinary team within 72 hours of admission (against a target of 90%).

Bed management

In this review, we found some issues with bed management on two of the three wards we visited. On one large 30 bedded unit, we found that people required treatment for a wide range of medical conditions. The ward was intended for patients with a specific set of medical conditions but staff told us that only around 30% of the patients on the ward suffered from those particular conditions. Medical staff stated that there were consultant specialists available where required. However, nursing staff said that they sometimes found it difficult to care for patients because they lacked the clinical knowledge and experience for all the conditions they were expected to treat on the ward. The Commission will require the trust to keep us informed of their actions on these issues so we can monitor improvements.

On two of the three wards we visited, we found concerns regarding high numbers of people with dementia. The staff we spoke to told us they did not have training in meeting the specific needs of people with dementia. This raised issues about whether patients were receiving care that was appropriate to their specific and complex needs. The trust had recently been involved in a national dementia audit. The action plan incorporated actions to improve the screening of patients, training of staff and access to specialist multidisciplinary teams. NHS Oxfordshire had recently provided funding to increase the amount of specialist support for patients with dementia at the Horton Hospital. The Commission will require the trust to keep us informed of their actions on these issues so we can monitor improvements.

NICE guidance

Awareness and implementation of guidance from the National Institute for Health and Clinical Excellence (referred to as NICE guidance) was variable. Staff on two of the wards had a good knowledge of NICE guidance and were able to describe how they implemented recent guidance. Some staff were aware of NICE guidance which was being implemented on their ward but were not sure how the outcomes for

patients would be monitored. Some staff we spoke to were not sure how NICE guidelines were implemented at the hospital or on their ward.

Our judgement
There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

Patients praised staff and said that they were happy with the care they received. We found that the trust had improved waiting times for patients across a number of key areas. The trust demonstrated that it had worked in partnership with the wider health and social care sector to address delays in patients being discharged to other care settings. Some improvement had been made to the number of delayed discharges, though joint targets remained unmet. Radiology reporting times have been met for externally requested reports. Some issues remained with the inappropriate placement of patients on wards where staff were not trained to meet their needs, including those with dementia. The trust had plans in place to address this. In stroke care, we found that the hospital had made improvement with most targets, though some remained unmet. There was improvement in staffs' understanding of how national and other clinical guidance is disseminated and implemented, although this was not consistent across all wards.

Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
During our visit to the Horton Hospital in July 2011, patients told us they felt well cared for by staff. They felt staff gave them the time they needed to make decisions and to ask questions. People on all the wards we visited told us that staff seemed busy, but not overwhelmed. Staff on all three wards appeared to be busy but not overly rushed. We observed them assisting people and answering queries. When people rang the call bell, we saw that staff responded promptly and addressed their needs.

Other evidence
Our last review of compliance of this hospital identified that it was not meeting this essential standard. The concerns from our last compliance review were:

- There were insufficient numbers and types of staff on duty at all times.
- Lack of available substantive staff due to vacancy, maternity leave and sickness.
- High use of agency and bank staff in some areas in order to support wards.

The trust provided evidence of the work it had conducted over the past six months to set, monitor and improve nursing staffing levels. In March 2011, divisional leads were asked to conduct a detailed review of ward and department staffing establishments, examining shift by shift resource allocation, and the staff skill mix. Patients' care needs were considered, as well as the professional opinion of ward sisters and matrons. Staffing levels for each ward and department were established

based on this work.

Staffing levels for nurses have been benchmarked against an Audit Commission database across all of the trust's wards and departments. This is based on the average number of registered and unregistered nurses required for a specific type of ward. Evidence was provided to show that on the three wards we visited at the Horton General Hospital, the number and skill mix of staff was the same or better when compared to the Audit Commission database. The trust was also in the process of reviewing staffing levels against two other university NHS trusts.

We found that the trust had monitoring processes in place to review if wards were meeting the established levels of staff. A new approach was implemented in July 2011. Meetings were held twice a day with deputy chief nurse, matrons and divisional nurses to review staffing levels shift by shift. Requests for additional staff for each of the three major hospitals were considered. An electronic rostering management procedure (dated June 2011) had been developed. This outlined the approval procedure for staff requesting additional, staff as well as how annual leave, study leave and sickness were managed.

The trust outlined how safe levels of staffing were more broadly monitored. A risk matrix had been developed that identified optimum staffing levels (green), minimum staffing levels (amber) and at risk staffing levels (red) for each ward/department and each shift. Staffing information was collated against this matrix and reported monthly at clinical unit, directorate and divisional meetings. Evidence was also provided of reports presented to the trust clinical governance committee and the board meetings. In the report for June 2011, nursing and midwifery staffing across all of the trust was deemed to be adequate to provide safe levels of care.[1] There were a number of wards at the Horton General Hospital highlighted in the quality matrix reports where permanent staffing was below 70% for some shifts in April 2011. The trust rated these wards amber and stated that safe staffing levels were achieved through the use of temporary staff.

During our visit in July 2011, staff on two of the wards we visited expressed concerns about staffing levels. Staff on one ward told us they had 96% of the staff they needed to accommodate the 25 beds for which the ward was designed. We were told, due to pressures to open more beds, that there were often 30 beds on the ward. Staff stated that when extra beds were opened, that additional staff were not always available. We reviewed a monitoring table which showed that in July 2011, six late shifts were not fully staffed. The trust provided staffing data over May, June and July for the wards we visited at the Horton Hospital. Over these months, 3.9% of shifts had staffing numbers below safe levels. Staff told us they had made a number of attempts to close the additional beds in the last two years, but they had not been successful. Senior staff on the ward had also conducted risk assessments as they were concerned about the risks posed to patient care. This ward had a high proportion of patients with complex needs, including dementia.

[1] This means that there were no more than 3 shifts a month where staffing levels were below the required minimum.

On another ward we visited staff raised concerns about the skill mix of staff. While there were sufficient numbers, they felt that there was sometimes a high proportion of less experienced, although qualified, nurses. They stated that this put a strain on staff teams and gave an inaccurate picture of the staff resources available to provide necessary care to patients. Senior staff members did say that they could put in requests for additional staffing from NHS Professional and that these requests were usually honoured. On this ward 1.36 % of shifts were below minimum (safe) staffing levels over May, June and July.

Staff we spoke to said that they were rarely asked to work over their contracted hours. They were, however, asked to work longer shifts or to work shifts they were not scheduled to work. Staff on two of the wards told us they relied heavily on bank and agency staff. Figures showed that there were a high proportion of bank and agency requested, particular across one ward we visited.

The trust provided evidence that it is actively recruiting staff to cover vacancies. In July there were a total of 215 (working time equivalent) vacancies for registered and unregistered nurses. The trust stated that it had made 69 confirmed offers to staff to start within six to eight weeks. A further 129 conditional positions had been offered. Since September last year the use of bank staff has remained the same. The use of agency staff has shown some improvement.

In our previous review in 2010, issues were also identified with the levels of midwifery and obstetricians on the maternity units at the Horton Hospital and John Radcliffe Hospital. This review found that the trust had no midwifery vacancies on these units. Staff we spoke to said that they usually had sufficient staff on duty but that the nature of midwifery care meant that they had no control over when the delivery suite would be busy. When the labour ward was busy, staff were moved from the wards. Staff commented that this sometimes left the post-natal wards short staffed. One midwife stated that they were often very busy and at times they couldn’t attend training or team meetings. Staff on the maternity day assessment unit said they were adequately staffed and well supported.

Our judgement

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust provided evidence that it had worked to improve the management of staffing across the trust. Staffing levels had recently been reviewed and safe levels set for each ward and department at the Horton Hospital. Staffing numbers were monitored on a daily basis and monitoring reports were provided monthly to key committees and to the board. There was evidence that staffing levels had improved, and that most shifts were staffed to optimal or minimum levels. Ward staff, however, commented that patient dependency and skill mix needed to be taken further into consideration. Evidence was provided that a recruitment process was in place to increase the number of nursing staff.

Overall, we found that the Horton General Hospital was meeting this essential

standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We did not speak to people about requirements relating to this essential standard.

Other evidence
Our last review of compliance of this hospital identified that it was not meeting this essential standard. The concerns from our last compliance review were:
- Low attendance at mandatory and essential training across a range of areas, including adult and children safeguarding training and health and safety management training.
- Not all staff received an annual performance appraisal.
- Variable supervision of staff in clinical roles which was described as ad-hoc for some staff.

The trust provided data for the number of staff who had attended statutory, mandatory and essential (SME) training. The trust had come to the end of a three year plan in April 2011. This aimed to achieve 80% compliance with all 41 SME training programmes. Of these, 18 were statutory and mandatory courses and 23 were essential courses. In April 2011, 23 of these courses had met or exceeded compliance targets, 9 were recorded as having compliance between 60% and 80%, and 9 were below 60%.

The trust commented that that they had worked hard from April to July 2011 to

increase the number of staff trained across the five mandatory training courses that were below 60%. Data was provided to show that in July 2011, over 80% of staff had attended these five courses. This included fire safety yearly update training, safeguarding adults level 1 'alerter' training, moving and handling training, general health and safety training which included slip, trips and falls and infection control for non clinical staff. In addition, all of the mandatory training courses that were identified as having low attendance in September 2010, had achieved over 80% attendance. This included safeguarding for children training, health and safety management and infection control training for clinical staff. We found that there was further work to do to ensure all relevant staff attended adults safeguarding training. In June 2011, 70% of staff had received this training, although over 80% had attended protection of vulnerable adults foundation stage training.

The trust's health and safety committee had the role of monitoring SME attendance. However, the reports provided offered a summary account and were not specific enough to identify attendance by staff groups or clinical services. The trust stated that they were in the process of implementing a new system for monitoring training attendance.

Staff we spoke to at the Horton Hospital told us that they attended mandatory training and that some of this was through an e-learning programme (learning via electronic media such as the internet). Some staff told us that the e-learning training was useful but that they were not always given dedicated time to work through the training. They said they had to fit the training while carrying out their other duties or undertake it in their own time.

Appraisals

During our visit, all the staff we spoke had received an annual performance appraisal. The trust provided data that showed that in June 2011, 72% of non-medical staff across the trust had received an appraisal. The minutes of the public board meeting in April 2011 outlined that there had been a strong focus on improving the number of appraisals conducted for medical consultants. The trust had also worked to improve the reporting process for these appraisals. Evidence was provided to show that in April 2011, 81% of medical staff had received an annual appraisal, a significant improvement from last years figure.

Supervision

The trust explained that a preceptorship programme[2] was in place across the trust for enabling unregistered staff to become qualified. Staff we spoke to at the Horton Hospital told us they had regular supervision and performance monitoring discussions with their managers, but that these were not formalised.

The trust stated that medical staff have clinical and educational supervisors. Newly recruited medical staff were required to have mentoring arrangements in place

[2] Preceptorship is defined as a period of practical experience and training for a student, especially of medicine or nursing, that is supervised by an expert or specialist in a particular field.

before they could begin work at the trust. The trust outlined that there had been a review of mentoring arrangements and procedures for other staff groups including allied health care professionals, nurses and midwifes. Supervision processes were also reviewed as part of the annual appraisal process.

Our judgement

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust provided evidence that there had been a significant improvement in staff attendance at statutory, mandatory and essential training. There were some programmes where further attendance at mandatory training was required, including training on safeguarding vulnerable adults. The number of staff who had received an annual appraisal had also improved, particularly with medical staff. Clinical supervision was in place, although limited evidence was provided to demonstrate it was implemented and effective.

Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak to people about requirements relating to this essential standard.

Other evidence
Our last review of compliance of this hospital identified that it was not meeting this essential standard. The concerns from our last compliance review were:

- Reporting arrangements and the quality of information produced to monitor the quality and safety of patient care across the organisation were not effective.
- Lack of a systematic process in place to ensure actions required to improve services were implemented, followed-up and their impact monitored.

In the past nine months, the trust has restructured both its management and committee structure. The trust board approved a revised sub-committee structure in October 2010 and the new committee structure was implemented on 1 January 2011. The board had four subcommittees: the board in committee, the quality committee (to replace the governance committee), the audit committee and the remuneration and appointments committee.

In February 2011, revised terms of reference were approved for the trust

management executive. There were eight new sub-committees which included the clinical governance committee which met monthly. The clinical governance committee had comprehensive membership consisting of senior clinical and managerial staff from clinical divisions and other corporate areas. The quality committee (which reports to the board) had quarterly meetings and minutes from the clinical governance committee were tabled on the agenda.

The trust provided evidence of improvements made to reporting processes for clinical governance. Managers of the trust's six clinical divisions were required from March 2011 to provide monthly reports using a specific template. The template had key areas to be populated relating to patient safety, quality and risk. These were presented as a 'dashboard' so that key areas of risk were easily identified. The reports also included details of staffing levels, clinical outcomes and patient experience. Examples of two divisional reports were provided. Minutes of the clinical governance meetings from April to July 2011 showed discussion of the reports by division. There was some evidence of progress being discussed across a range of issues including monitoring of assessments for venous thromboembolism (VTE) and single sex accommodation breaches. However, these discussions focused mainly on reporting results with limited (minuted) discussion of actions taken or evidence that learning was being shared across the divisions.

Quality reports were collated and tabled at both the quality committee and the board. The individual divisional reports were also provided. The minutes of the board meetings showed discussion of the quality reports, including feedback on how the reporting process could be further improved. Other reports on the quality of patient care have been tabled at board meetings over the past six months including the infection control annual report, action plans for improving care and ombudsman's reports. Detailed complaints reports were also provided at the quality committee and board meetings. These documents detailed the analysis of complaints and actions taken in response to complaints including recommendations for learning. Complaints were monitored at divisional level.

Further evidence of progress in improving governance and risk management systems was provided. In July 2010, an independent review of paediatric cardiac care was commissioned by the Strategic Health Authority (SHA) following four deaths after paediatric surgery in a short space of time. The review identified that a number of areas required improvements across the trust, including systems for risk management, clinical governance systems and the management of new clinical staff. The trust developed an action plan following the review. In April 2011, the trust submitted a report that stated that all actions had been completed with three exceptions. Based on a review of documents and discussions with senior management, the SHA panel agreed that progress had been made against the recommendations. They recommended that further monitoring and assurance testing be carried out within the normal NHS processes and that 'this would constitute a proportionate response'.

In this review, we found that the trust had risk management processes in place to identify and address clinical and non-clinical risks. Serious incidents requiring investigation (SIRI's) were collated at divisional level and reported to the clinical

governance committee, the quality committee and the board. Staff told us they were encouraged to report incidents and accidents so that they could help improve services for people. They felt confident they could report incidents without censure. Staff were able to demonstrate how they would report an accident or incident. We were told that staff were contacted by the trust's risk management team when serious incidents were investigated. However, some staff were unable to tell us how general risks were recorded or reported.

The trust provided its clinical audit programme which demonstrated involvement in national and mandatory audits and detailed the local clinical audits that were to be conducted. The trust had a clinical audit team in place and had recently established a clinical audit committee (due to meet for the first time in September 2011). An audit report (draft) provided by the trust outlined a methodology for the conduct of audits and an example was provided of a documentation audit which was systematic and robust. Recommendations were included in the findings and organisational learning was highlighted.

In 2010/11, the trust had been involved in 44 national clinical audits and five national confidential enquiries it was eligible to be involved in. During our visit, all the staff we spoke to were aware of audits which had been conducted on their wards. Examples were given of their involvement in hand hygiene, food hygiene, cleaning, MRSA skin contamination, food and privacy and dignity audits. Staff told us audit results were discussed at ward and team meetings. We were told that staff could participate in audits and that staff who wanted to lead on a particular audit were often supported to do so. Monitoring of audits was included in the divisional quality reports.

Through its audit process, the trust identified a concern with the number of patients not receiving an assessment for venous thromboembolism (VTE). The department of health required VTE assessments to be reported nationally from June 2010. In May and June 2011, the trust's clinical governance meeting minutes reported that VTE assessment rates needed to improve for most of the six divisions within the trust. This included the emergency medicine, therapies and ambulatory and the neurosciences, trauma and specialist surgery division. The minutes reported some improvement, but further work was reported to be required.

Our judgement

There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed.

The trust had made significant progress in implementing a new committee and reporting structure at strategic and senior clinical levels of management. The trust had comprehensive governance information and data available to identify areas of concern. We found evidence that reporting processes on patient safety, quality, and risk have become more comprehensive across the divisions. This information provided improved assurance for the quality and trust board committees. There was good evidence provided in some areas that action plans were resulting in improvements for patients including around radiology reporting. However, there was some evidence that not all issues were systematically addressed at divisional level.

There was also limited evidence from minutes that learning of effective approaches was shared across the divisions. In addition, levels of venous thromboembolism assessments in some divisions required improvement.

Overall, we found that the Horton General Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Action
we have asked the provider to take

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.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury. Assessment or medical treatment of persons detained under the Mental Health Act 1983. Surgical procedures. Diagnostic or screening procedures. Maternity and midwifery services. Termination of pregnancies. Family Planning.	**9**	4
	Why we have concerns: There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed. Patients praised staff and said that they were happy with the care they received. We found that the trust had improved waiting times for patients across a number of key areas. The trust demonstrated that it had worked in partnership with the wider health and social care sector to address delays in patients being discharged to other care settings. Some improvement had been made to the number of delayed discharges, though joint targets remained unmet. Radiology reporting times have been met for externally requested reports. Some issues remained with the inappropriate placement of patients on wards where staff were not trained to meet their needs, including those with dementia. The trust had plans in place to address this. In stroke care, we found that the hospital had made improvement with most targets, though some remained unmet. There was improvement in staffs' understanding of how national and other clinical guidance is disseminated and implemented, although this was not consistent across all wards.	
Treatment of disease,	**23**	14

disorder or injury. Assessment or medical treatment of persons detained under the Mental Health Act 1983. Surgical procedures. Diagnostic or screening procedures. Maternity and midwifery services. Termination of pregnancies. Family Planning.	**Why we have concerns:** There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed. The trust provided evidence that there had been a significant improvement in staff attendance at statutory, mandatory and essential training. There were some programmes where further attendance at mandatory training was required, including training on safeguarding vulnerable adults. The number of staff who had received an annual appraisal had also improved, particularly with medical staff. Clinical supervision was in place although limited evidence was provided to demonstrate it was implemented and effective.	
Treatment of disease, disorder or injury. Assessment or medical treatment of persons detained under the Mental Health Act 1983. Surgical procedures. Diagnostic or screening procedures. Maternity and midwifery services. Termination of pregnancies. Family Planning.	**10**	16
	Why we have concerns: There was evidence that most, but not all, of the concerns raised in our last review of compliance were addressed. The trust had made significant progress in implementing a new committee and reporting structure at strategic and senior clinical levels of management. The trust had comprehensive governance information and data available to identify areas of concern. We found evidence that reporting processes on patient safety, quality, and risk have become more comprehensive across the divisions. This information provided improved assurance for the quality and trust board committees. There was good evidence provided in some areas that action plans were resulting in improvements for patients including around radiology reporting. However, there was some evidence that not all issues were systematically addressed at divisional level. There was also limited evidence from minutes that learning of effective approaches was shared across the divisions. In addition, levels of venous thromboembolism assessments in some divisions required improvement.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent within 21 days of this report being received.

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

Document purpose	Review of compliance report
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