Blackpool Teaching Hospitals NHS Foundation Trust

Quality Report

Blackpool Teaching Hospitals NHS Foundation Trust
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Date of inspection visit: 15-16 January 2014
Date of publication: 04/02/2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Requires improvement
Are acute services at this trust caring?	Good
Are acute services at this trust responsive?	Requires improvement
Are acute services at this trust well-led?	Requires improvement

Summary of findings

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Summary of findings

Overall summary

Blackpool Teaching Hospitals NHS Foundation Trust is a medium-sized acute trust providing healthcare for the population of Blackpool, Fylde, Wyre and parts of Lancashire and south Cumbria. The indigenous population is around 440,000. However, there is a transient tourist population in excess of 10 million people each year, either on one-day visits or staying for longer periods of time.

The trust serves a population that has mixed health needs. Parts of the population are among the most deprived in England (Blackpool Local Authority is the 10th most deprived of 326 local authorities in England). The population's health is worse than expected in 23 of the 32 health indicators (for example: life expectancy, alcohol-related admissions, drug misuse, smoking related deaths and early deaths from cancer, stroke and heart disease). However, for the populations of Fylde and Wyre, they are better than expected: 9 of the 32 health indicators are better than the England average.

Within the Blackpool area, life expectancy is five years lower for men and three years lower for women compared to the national average.

In April 2012 the trust merged with community health services from NHS Blackpool and NHS North Lancashire as part of the Transforming Community Services programme. This has created a larger organisation with over 6,000 staff, in excess of 800 beds and an annual spend of approximately £360 million.

The trust provides a range of secondary care services usually found in all main hospitals along with tertiary cardiac surgery for the residents of Lancashire and south Cumbria (with an equivalent population of 1.6 million). The trust also provides some tertiary haemato-oncology services. Additionally, the trust manages the national artificial eye service on behalf of the whole country.

The trust operates from three sites:

- Blackpool Victoria, which is the main hospital site
- Clifton Hospital, which currently has four wards, mainly for elderly care and rehabilitation (with one outpatient clinic), and
- Fleetwood Hospital, which has outpatient clinics with some limited radiology on site.

The trust had a significantly higher than expected mortality rate from April 2012 to March 2013. As a result, the trust was included in Professor Sir Bruce Keogh's review of trusts in 2013. The report "Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England" is available on the NHS Choices website. The report found that the pace of change at the trust had been slow, with the trust leadership trying to do too many things at the same time. It said that governance arrangements should be more robust. It also said there was a disconnect between the leadership team and the frontline service. We saw that the trust has put significant effort into developing clinical pathways in a number of areas as part of its response to this report.

During this inspection, we inspected services in A&E, surgery, critical care, medicine, maternity and family planning, children's care, end of life care and outpatients.

We spoke to a large number (over 100) of patients in all areas, to the families and carers of some of these patients and to visitors to the hospital

We found that the people using the service were highly complimentary about the level of care they received from all of the staff they met.

Mortality

Mortality figures remained higher than expected for the trust, but these figures were falling (improving). The trust has undertaken some significant work on improving and clearly defining the clinical pathways (including steps to be taken at each stage and those staff responsible for doing it)to achieve this, and was monitoring patient care.

Staffing

Staff, were very committed and were making considerable efforts to provide good patient care. The quality of care in the children's care service was high. The trust had increased levels of medical and nursing staff and this was recognised by staff; allied health professionals, such as physiotherapists and occupational therapists, felt that their staffing had not increased in a way that reflected their contribution patient care.

All the staff we spoke with said they enjoyed their job, liked working for the organisation and valued their role.

Summary of findings

Complaints
The complaints process has improved. The newly-named Patient Relations Service has improved this process. However, we have spoken to many people using the service who do not know how to make a complaint, and so we conclude there is still much work to do here.

The trust's target was to respond to formal complaints within 25 days. This target was not always met. However, the divisional management team were working to address this and the number of complaints processed within 25 days had improved since April 2013. Following CQC's review of Outcome 17 in June 2013, the trust had reviewed its complaints process and the new arrangements were being implemented at the time of this CQC hospital inspection

We saw that Patient Relations Service leaflets were available, but these were not always visible in some of the areas we visited.

Leadership
The visibility of the executive team has increased significantly. We spoke to many people who had met (or knew of) many of the executive directors. However, visibility does not equate to engagement, and we did note that there still appears to be a disconnect in some areas between the board and the operational service, particularly among medical staff.

In a number of areas there were differences of opinion between the executive team and the clinical workforce. In part, this may be due to a more positive view of some challenges, but we were concerned that it may also be a symptom of this disconnect.

We were unable to identify a clear vision or strategy to support the new enhanced acute and community trust. We saw that there are considerable opportunities for the new trust to improve. However, this requires a clearly articulated vision.

Service developments
The trust has received external accreditation for its Bowel screening, Trauma unit, Radiology and Haematology (stem cell transplant) services.

The trust uses the palliative care amber care bundle (a process to support the quality of care of patients who are at risk of dying in the next one to two months but may still be receiving active treatment).

We saw examples of excellent integration between acute and community services. The staff we spoke to from the community all praised the method of integration, and they valued the welcome from other colleagues. Staff from both the community and the acute teams explained that the integration had improved their knowledge and understanding of the overall processes. We felt that the work put into the integration of the teams from acute and community had been highly effective and the trust should be proud of its work in this area.

Processes of care
There were challenges in patient flow. We saw that patients were staying for long periods, the trust was reliant on escalation beds and there was limited use additional medical staff. There were opportunities to significantly improve the pathway in this area. This would improve both the experience of the service for patients and could reduce the time they spend in hospital.

We noted that the accident and emergency service is largely meeting the national waiting time target of four hours. However, we did note that this success is down to an increased response within the last hour of the waiting time. This may mean that the systems in use are less efficient and some patients could wait longer than needed in the service.

We saw that cancelled operations had led to ineffective use of resources and challenges to patient flow. This meant that patients were not accessing the treatment and care they needed in a timely manner.

Medical records
There are challenges with medical records that may also interrupt patient flow and impact on safety. It was difficult to find information in the medical records. We noted that an electronic patient record solution is in development, but this may take some time and current challenges require an interim solution. For safe and effective clinical care, patients' medical records need to be easily accessible, legible and simple to follow.

Summary of findings

Safety

The trust had a significantly higher rate of primary postpartum haemorrhage (haemorrhage after childbirth) and this had led to some patients having a hysterectomy. Good practice guidelines on access to interventional radiology by the Royal College of Obstetricians and Gynaecologists (RCOG) were not followed and the trust has requested a review by the RCOG at the time of our inspection. This was a significant safety issue which the trust had not identified to us at the outset.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

Requires improvement

The trust has implemented some of the pathway work recommended by the Keogh review. The trust is improving its patient management through this. This is a good example of the trust tackling system-wide processes.

Within some areas we noted that the reporting of incidents and near misses was poor and required improvement. This may lead to valuable learning not being shared and improvements not made. We do note the trust is committed to safety.

Medical records were not always readily available and this led to delays in patients being seen. Medical records were very difficult to read and there were also records where it was difficult to follow the case history within them. Inability to read and access information will delay access to good care.

We noted areas where there were good examples of team working. However, we also recognised a shortage of medical staff in A&E and low staffing levels in some other areas. We noted that a lack of continuity of consultant cover impacted on arrangements and handover.

We observed a lack of hand washing in some areas and some dirty equipment. A sluice area in outpatients was also being used to see patients and also to offer treatment. Good hygiene practices are important to prevent the spread of infection.

Are services effective?

Requires improvement

The trust was using clinical pathways in a number of areas and is planning to introduce more pathways. The trust's mortality figures were improving and recent data demonstrated that the Summary Hospital-level Mortality Indicator (SHMI) (which is an indicator of whether there is a higher mortality rate at the trust than would be normally expected) had fallen from 125 in April 2012 to 110 by December 2013. The trust attributes this to the implementation of clinical pathways. Robust clinical pathways provide a strong basis for good quality care by ensuring that all staff know the actions to take at each stage.

The trust is using the Liverpool Care Pathway (LCP) as its care pathway for patients in the last days of their life. We noted that patients were consulted and aware of the processes used. The surgical service had recently implemented (November 2013) the five steps to safer surgery guidance to support safer perioperative care. We were unable to identify clear use of protocols within critical care.

Summary of findings

There was an audit of caesarean section infection rates, especially in obese patients. This was an ongoing audit, and showed that infection rates have fallen by 7%. There was a good midwife to birth ratio and an exemplary midwife to supervisor ratio.

We did note that there was a higher than expected rate of primary postpartum haemorrhage (PPH) at around twice the national expected figure and a much higher than expected rate of hysterectomy in these patients (five patients in six months). The trust has sought a clinical review by the Royal College of Obstetrics and Gynaecology.

There is an ongoing investigation by the Medical Director into diabetic care and an apparently high local amputation rate. We were not aware of progress and would encourage a rapid conclusion to this analysis. It is important that the trust is able to reassure patients on the service it provides. (Post visit note: Since the CQC visit in January this analysis has been concluded and there is no consultant who is an outlier in performance. The trust recently established a dedicated Diabetic Foot Clinic with multidisciplinary input and there is an ongoing re-organisation of vascular surgery services. It is too early to assess their effects on reducing amputation rates.)

We noted that there was a delay in getting access to medical records in outpatients. This led to delays in patients' appointments.

Are services caring?

Good

We spoke to numerous patients, almost all of whom were very happy or satisfied with their care The vast majority of the feedback was clear about the high standard of caring from the staff of the trust. This exemplifies the nature of the people we met during our visit; all of whom were dedicated, committed and caring. We particularly noted that at the time of our visit, a traveller family were staying on the trust's grounds, while the organisation was caring for their relative. This was clearly a very difficult time for the family. We spoke extensively to several family members who were full of praise for the HDU team and the trust as a whole. They identified it as the best care they had experienced.

We saw members of staff building good relationships with patients and their families. We saw staff explain procedures to patients before they started the procedure.

The Chaplaincy team was highly responsive and we were impressed with the end of life care team's approach. We saw an excellent bereavement support service that was available widely across the trust. This provides a strong holistic and pastoral support for patients during difficult times.

Summary of findings

Are services responsive to people's needs?

Requires improvement

The Chaplaincy and the End of Life care team responded well to patients' needs. However, the quality of communication in choice for patients receiving end of life care at a ward level was not always well understood. Staff need to be clear on offering choice to patients at the end of their life.

There were en-suite rooms within the children's inpatient area with very good play facilities. Following the results of stroke audit, the size of the clinical team had been increased. Also pressure mattresses were now available more quickly (in hours not days).

Some children's ENT patients are seen in an adult ENT area. This is not seen as best practice and children should be cared for in facilities set out to meet their needs.

The maternity and paediatrics service are now both in a new unit. We saw that this was well signposted. However the design of facilities in some other areas was poor. The design of the bathroom (for example) in the stroke unit made access difficult, and there were no specialist stroke shower chairs for those patients who needed physical support during washing. There are chairs available, but these do not offer the full support for stroke patients to encourage self-caring.

We observed that in outpatients, where patients are unwell they were fast-tracked in the appointment system. We did however note that waiting times can be quite long in outpatients.

In A&E, patients were kept on trolleys in corridors. Two patients were observed waiting on trolleys in the ambulance triage area. Patients should be managed in appropriately designed facilities to support best practice care.

We noted that in a number of areas where we spoke to patients and their families, many were not fully aware how they might make a complaint or comment to the trust, nor of the complaints service. As an example, six out of seven patients we spoke to in outpatients were unaware of how they would make their problems known to the trust. The trust is missing valuable opportunities to both respond to people who are unhappy with their care, but also to learn from this and improve the care they give in future.

However, we do note that the trust has invested in a central patient experience team and also a contract with an external patient survey provider. Every month, all discharged patients are surveyed two weeks after discharge (using questions from the national inpatient survey), as well as all outpatients and patients who used A&E.

Summary of findings

Are services well-led?

Requires improvement 

The trust has recently integrated the community services with the acute trust to create a larger joint service. We saw significant effort to support the integration, but we were unable to identify a clear vision and strategy for the newly merged organisation.

We heard many positive comments from the many focus groups about the culture of the organisation.

Staff who were previously part of the community services commented on the very positive efforts to integrate the new enhanced teams, both by their colleague and by the trust's management. Staff were able to articulate a sense of organisational belonging and a sense of joint purpose. We saw enthusiastic staff who were largely happy in their work.

The visibility of the executive has increased. The executive team do 'shifts' in the clinical areas that they 'buddy'. Staff were highly complimentary about the chief executive's visit to clinical areas on Christmas day. However, there is a difference between visibility and engagement. We saw a disconnect between the executive team of the trust and the staff. Many staff believe that the executive team are not fully aware of their key challenges and they believe their issues are not a focus of the board's discussions. This was reported from multiple service areas across many specialities, however, the greatest disconnect appeared to us to be among the medical staff. It is important that staff are confident that the trust board recognises and responds to issues in delivering care to patients. Failure to do this will lead to poor communication and low morale among staff.

We noted many areas under significant pressure and some services reported that this was a real challenge. Staff were positive about the contribution they were making, but worried that the pressure of the role was degrading their ability to respond. Although they has raised this, they were concerned this may not have been fully heard.

We heard of examples of innovation that may not yet have been recognised by the trust's leadership team. It was unclear how the trust would evaluate these opportunities.

Summary of findings

What people who use the trust's services say

We noted from the Friends and Family Test data, (a measure of how likely you are to recommend this service to your friends and family) that the trust has scored above the national average for three of the past four months for inpatient responses between July 2013 and October 2013. In October, 89.7% of all 722 respondents were likely or extremely likely to recommend a ward they had stayed on to their family and friends. In accident and emergency, the trust scored above the national average for all four months. In October, 93.6% of 190 respondents were likely or extremely likely to recommend the service to family and friends.

We spoke to many patients during our visit (over 70 people). Almost all praised the care from the trust.

We undertook a public listening event on the evening of 14 January 2014. We invited all members of the public to tell us their story. Healthwatch also supported us in promoting this event. Approximately 40 people attended, and our teams met the public in small groups or as individuals. We heard examples of good care people had received. However, we also heard examples of where care had fallen short of expectations.

The individual stories informed our inspectors' visits, and to preserve confidentiality will not be set out here, but in summary they included:

- Poor and hurried communication
- Poor transfer and handovers
- Long waits and delayed procedures
- Lack of understanding of clinical decisions/challenges to clinical decisions.

The Care Quality Commission undertook a detailed survey of the people from the Blackpool area who had recently used the services of Blackpool Teaching Hospitals NHS Foundation Trust. The survey was undertaken by RAISE who have significant experience with health and social care along with community and voluntary services.

They received 60 responses from people who had used the services of Blackpool Teaching Hospitals NHS Foundation Trust. Their survey focused on the key questions that the CQC inspection team also look at. They found that of the 60 responses; 59 people (97%) had used services within the last 12 months.

Against the five key questions that CQC looks at:

- 58% said they felt services were safe
- 56% said they felt services were effective
- 63% said they felt services were caring
- 60% said they felt services were responsive to their needs
- 53% said they felt services were well-led.

The survey showed that 63% of people knew how to make a complaint to the trust; 17 people had made a complaint in the past 12 months, and of those, nine people (53%) felt it had not been properly investigated. A further four people were not sure (don't know).

When asked to rate the services they had experienced, the people responding to the survey said:

- Outstanding 37%
- Good 10%
- Satisfactory 3%
- Requires improvement 50%.

Areas for improvement

Action the trust MUST take to improve

- The trust must improve its medical records. Both in terms of record keeping and timely access to notes. This must be ahead of a permanent electronic solution.
- The trust must progress an understanding (and action if necessary) of the high rates of primary postpartum haemorrhage and subsequent high rates of hysterectomy.
- The trust must ensure that appropriate and timely pre-operative assessment is undertaken by an orthogeriatric specialist.

Summary of findings

- The trust must improve its incident reporting service. All staff must be aware of their responsibilities to report both incidents and near misses.
- The trust must ensure staffing levels in all clinical areas are appropriate for the level of care provided.

Action the trust SHOULD take to improve

- The trust should further improve the awareness of the complaints and comments processes and encourage patients to use them.
- The trust should stop using sluice areas as surrogate clinic rooms.
- The trust should review the waiting area for patients on trolleys in A&E to ensure that these are appropriate for their care.
- The trust should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing activity and the responses to demand for services.
- The trust should develop a strategy for the new acute and community service and ensure this is widely articulated.
- The trust should review sickness rates in some areas where these are higher than expected.
- The trust should review activity levels in the diabetic foot clinic to avoid overcrowding.
- The trust should progress and resolve concerns over endocrinology and diabetes data that suggests higher levels of amputation than other areas.
- The trust's efforts in visibility of the leadership team have been successful. The trust should apply the same effort to engagement with the clinical workforce.
- The trust should review signposting of methods of communication from the new car park for those patients who require assistance in getting from the car park to the hospital.
- The trust should have a clear process for evaluating good ideas and service development opportunities.
- The trust should be able to reconcile nationally submitted data with that held locally.

Action the trust COULD take to improve

- The trust could review the opportunities of observation for vulnerable adolescents on the new children's unit.

Good practice

- Patient care in the trust is recognised as good by the patients we spoke to and the staff were praised by many who use the service.
- The trust has a highly committed workforce; there is a strong team culture within the trust.
- The trust-wide chaplaincy and end of life care service is recognised as highly responsive and valued by those who use it.
- The new facilities for the children and maternity service were recognised as a good development.

Blackpool Teaching Hospitals NHS Foundation Trust

Detailed findings

Hospitals we looked at:
Blackpool Victoria Hospital, Clifton Hospital, Fleetwood Hospital

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission (CQC)

Team Leader: Tim Cooper, Head of Hospital Inspections Care Quality Commission.

The team had 36 members including CQC inspectors, Experts by Experience, lay representatives and medical and nursing clinical specialists.

Background to Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust is a medium-sized acute trust providing healthcare for the population of Blackpool, Fylde, Wyre and parts of Lancashire and south Cumbria. The indigenous population is around 440,000. However, there is a transient tourist population in excess of 10 million people each year, either on one-day visits or staying for longer periods of time.

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Detailed findings

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Why we carried out this inspection

Blackpool Teaching Hospitals NHS Foundation Trust was originally inspected by Professor Sir Bruce Keogh and his team during June 2013. This was part of a selected review process informed by higher than expected mortality rates. The data for the Keogh review informed the planning for this visit.

The Secretary of State for Health has asked that all trusts in the original Keogh inspection were included early in the new CQC process.

We inspected this trust as part of our new in-depth hospital inspection programme. We chose this trust because it represented the variation in hospital care according to our new Intelligent Monitoring Model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

How we carried out this inspection

In planning for this visit we identified information from local and national data sources. Some of these are widely in the public domain. We developed 111 pages of detailed data analysis, which informed the thinking of the inspection team. The trust had the opportunity to review this data for factual accuracy, and corrections were made to the data pack from their input.

We sought information in advance of the visit from national and professional bodies (for example the Royal Colleges and central NHS organisations). We also sought views locally from commissioners and local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our thinking. We therefore held a well-publicised listening event on 14 January 2014. This was held before the inspection began and helped inform the thinking of the inspection team. Over 40 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We received information and supporting data from staff and stakeholders, both before and during the visit.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive to people's needs?
- Is the service well-led?

The inspection team at inspected the following core services:

- Accident and emergency
- Medical & Frail Elderly
- Surgical & Theatres
- Critical care

Detailed findings

- Maternity & Family Planning
- Children's care
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 16 January 2014. During our visit we talked with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event for the trust where patients and members of the public were given an opportunity to share their views and experiences of all the trust locations. We carried out three unannounced visits 24 and 28 January 2014.

Requires improvement

Are services safe?

Summary of findings

The trust has implemented some of the pathway work recommended by the Keogh review. The trust is improving its patient management through this. This is a good example of the trust tackling system wide processes.

Within some areas we noted that the reporting of incidents and near misses was poor and required improvement. This may lead to valuable learning not being shared and improvements not made.

Medical records were not always readily available and this led to delays in patients being seen. Medical records were very difficult to read and there were also records where it was difficult to follow the case history within them. Inability to read and access information will delay access to good care.

We noted areas where there were good examples of team working. However, we also recognised a shortage of medical staff in A&E and low staffing levels in some other areas. We noted that a lack of continuity of consultant cover impacted on arrangements and handover.

We observed a lack of hand washing in some areas and some dirty equipment. A sluice area in outpatients was also being used to see patients and also to offer treatment. Good hygiene practices are important to prevent the spread of infection.

Our findings

Safety and performance

In the past year, the trust has reported no never events (mistakes that are so serious they should never happen).

Learning and improvement

The trust has a group set up to learn from and share incidents. Serious Untoward Incident investigations are led by an Executive Director and signed off by the Chief Executive Officer. Learning is shared throughout the organisation by a newsletter. The Medical and Nurse Directors meet each Friday with the Associate Director of Governance to review safety themes and trends arising from weekly incidents and complaints.

Some staff do not report near misses, and some staff rely on others to report incidents. It is unlikely therefore that this group is effective as they will not be reviewing the full range of incidents and near missed in the trust. This means that valuable learning is lost to the organisation.

Systems, processes and practices

We noted areas of good practice within the trust on safety. For example, we noted some significant progress by the trust in its pathway work, and the wider engagement of many clinical disciplines in achieving this. Pathways have been developed and are being used in practice in some areas. Other pathways are in final stages of development. Audit data show that they are being used.

We also saw that staff in many areas were following the protocols and pathways developed, although in a small number of areas we saw opportunity for improvement.

Monitoring safety and responding to risk

Within some medical areas, bands 2-4 staff pass incident reporting upwards to more senior band 5 staff. We were concerned both that the band 5 staff may not have the time to report these fully, but also that this creates a lack of ownership of incidents and clinical risk. We felt this had significant potential to lead to under-reporting of incidents and near misses.

Medical records were not always readily available and this led to delays in patients being seen. We were aware of one patient who had been cancelled six times, other patients had also their appointments cancelled. Case notes and records must be available and not create delays for patients.

We observed three sets of notes within a medical area where our inspectors were unable to decipher the hand writing and understand the care plan. When challenged, the staff we asked were also unable to read the writing. We also saw a lot of records in which it was difficult to follow the case history within them. Poorly written or illegible writing can lead to a risk of error and lack of understanding in care plans.

There were good examples of team working and areas where a highly effective and responsive staffing model had been developed. We noted good staffing levels in outpatient services. We saw that medical services used a staffing tool (SCMT) to support their staffing levels, however we noted despite this staffing levels appeared low in some areas.

Requires improvement

Are services safe?

There is a shortage of medical staff in A&E. Additionally, nurse staffing levels appeared low in the surgical assessment unit. The sickness absence in surgical areas is higher than the trust average. Maternity teams had both a good skills mix and a good mix of experience in their teams. We did however note that with the maternity team managing their own staffing internally, some of their staff were called in at very short notice to cover shifts; this may be soon after the completion of a shift. The mix of normal and long day (12.5 hours) contracts makes managing these shifts difficult. The lack of staff at times had a negative impact on the ability to manage the process of induction of labour. On 16 January, staffing levels were low in the maternity unit, and two members of staff expressed their concern to us about these levels.

In ICU/HDU there were eight bays, but our inspectors noted that this was staffed for six bays.

We noted that staffing levels in these areas should remain the same both day and night. However, we observed that in the daytime, the area was staffed with 14 staff and at night this was with nine staff. Overall low staffing levels in critical care were noted. We also observed that skills mix appeared 'bottom heavy'. Limited or zero refreshment breaks were reported to us in this area. This is a concern especially given the staffing models described above.

We noted that a lack of continuity of consultant cover impacted on arrangements and handover.

We observed a lack of hand washing in A&E and also in outpatients. We also saw that in A&E some of the commodes were dirty. Areas within maternity, surgery and medicine were seen to be clean and tidy.

We noted positive examples of hygiene and infection control within critical care. We noted that the eight cases of MRSA previously reported were a clerical error, and this should have been zero cases reported.

The environment in the maternity unit was of a high standard. Ward 12 had improved facilities which had improved both the safety of care and the patient experience.

A sluice area in outpatients was being used to see patients and also to offer treatment. The inspection team were worried that this was both inappropriate use of facilities, but may also compromise patients' dignity.

Anticipation and planning

The trust does not have a full understanding of all incidents and near misses that occur in the trust. Many patients do not know how to make a complaint or comment on the service. The trust is therefore unable to plan services without access to the full information. However, in addition to learning from complaints, the trust has invested in a central patient experience team and also a contract with an external patient survey provider. Every month all discharged patients are surveyed two weeks after discharge (using questions from the national inpatient survey), as well as all outpatients and people who used A&E.

Requires improvement

Are services effective?

(for example, treatment is effective)

Summary of findings

The trust was using clinical pathways in a number of areas and is planning to introduce more pathways. The trust's mortality figures were improving and recent data from the trust demonstrated that the Summary Hospital-level Mortality Indicator (SHMI) (which is an indicator of whether there is a higher mortality rate at the trust than would be normally expected) had fallen from 125 in April 2012 to 110 by December 2013. The trust attributes this to the implementation of clinical pathways. Robust clinical pathways provide a strong basis for good quality care by ensuring that all staff know the actions to take at each stage.

The trust is using the Liverpool Care Pathway (LCP) as its care pathway for patients in the last days of their life. We noted that patients were consulted and were aware of the processes used. The surgical service had just implemented (within the past two weeks) the five steps to safer surgery guidance to support safer perioperative care. We were unable to identify clear use of protocols within critical care.

There was an audit of caesarean section infection rates, especially in obese patients. This was an ongoing audit, and showed that infection rates have fallen by 7%. There was a good midwife to birth ratio and an exemplary midwife to supervisor ratio.

We did note that there was a higher than expected rate of primary postpartum haemorrhage (PPH) at around twice the national expected figure and a much higher than expected rate of hysterectomy in these patients (five patients in six months). The trust has sought a clinical review by the Royal College of Obstetrics and Gynaecology.

There is an ongoing investigation by the Medical Director into diabetic care and an apparently high local amputation rate. We were not aware of progress and would encourage a rapid conclusion to this analysis. It is important that the trust is able to reassure patients on the service it provides.

We noted that there was a delay in getting access to medical records in outpatients. This led to delays in patients' appointments.

Our findings

Evidence-based guidance

The trust is using clinical pathways in a number of areas and is planning to introduce more pathways. We also note that mortality data measured through Summary Hospital-level Mortality Indicator (SHMI) (a measure of the number of actual deaths in the trust against the number of deaths that would be expected to occur) was falling. Very recent data presented to us by the trust, which is not yet available nationally suggests this trend is continuing. Data from the trust show it has now fallen from around 125 in April 2012 to 110 by December 2013. The trust attributes much of this drop to the implementation of clinical pathways. Staff within the trust were aware of the clinical pathways already in place and were using them.

The trust is using the Liverpool Care Pathway (LCP) as its care pathway for patients in the last days of their life. We noted that patients were consulted and were aware of the processes used. Staff had received training in Advanced Paediatric Life Support (APL).

The surgical service had just implemented (within the past two weeks) the five steps to safer surgery guidance to support safer perioperative care. We were unable to identify clear use of protocols within critical care. We do note the trust is committed to safety.

One patient and two families we spoke to within the end of life care service had all consented to being on an end of life care pathway. We also saw good incident reporting in outpatients

We observed poor diabetic care management in one patient, where staff were unaware of the patient's condition and his medication requirements.

Monitoring and improvement of outcomes

There had been an audit of caesarean section infection rates, especially in obese patients. This was an ongoing audit, and infection rates has had fallen by 7%. Data from the neonatal saving lives audit were available in case notes.

We did note that there was a higher than expected rate of primary postpartum haemorrhage (PPH) at around twice the national expected figure and a much higher than

Requires improvement

Are services effective?

(for example, treatment is effective)

expected rate of hysterectomy in these patients (five patients in six months). The trust has sought advice of the Royal College of Obstetrics and Gynaecology. The trust is investigating the PPH rate.

There is an ongoing investigation by the Medical Director into diabetic care and an apparently high local amputation rate. Against a backdrop of high local amputation rates for patients with diabetes, CQC were concerned to hear from local staff that the diabetic foot clinic is overcrowded and staff felt this was compromising patient care. We were also aware that concerns had been raised in this area and that the Medical Director was analysing data to identify trends. We would encourage a rapid conclusion to this analysis. Understanding this issue will allow the trust to provide appropriate assurance to patients using he service.

Sufficient capacity

There was a delay in getting access to medical records in outpatients. This led to delays in patients' appointments.

Data showed that within the surgical service, nursing sickness levels were currently running at approximately 10%. The trust was planning and managing this, but recognised the impact on capacity. [Post inspection note: data suggests this was a short term issue and the January data suggests 4.96% overall]. In A&E services, we observed good patient flow and pathways in place to support this. Within critical care we observed that new ventilators were now available across the whole service supporting effective service delivery.

We noted that there was a good midwife to birth ratio and an exemplary midwife to supervisor ratio.

Multidisciplinary working and support

We were informed by the A&E team of the positive and responsive nature of the Paediatrics team to requests from the A&E service. This demonstrated a strong team work culture. We saw good skills mix and use of staff in some areas (for example in outpatients). Maternity teams sought to cover all shifts with their own staff to ensure consistency and avoid the need for agency staff.

In A&E services, staff had received training in paediatric care. We were unable to identify multidisciplinary ward rounds that included members of the critical care team.

Good

Are services caring?

Summary of findings

We spoke to numerous patients, almost all of whom were very happy or satisfied with their care The vast majority of the feedback was clear about the high standard of caring from the staff of the trust. This exemplifies the nature of the people we met during our visit; all of whom were dedicated, committed and caring. We particularly noted that at the time of our visit, a traveller family were staying on the trust's grounds, while the organisation was caring for their relative. This was clearly a very difficult time for the family. We spoke extensively to several family members who were full of praise for the HDU team and the trust as a whole. They identified it as the best care they had experienced.

We saw members of staff building good relationships with patients and their families. We saw staff explain procedures to patients before they started the procedure.

The Chaplaincy team was highly responsive and we were impressed with the end of life care team's approach. We saw an excellent bereavement support service that was available widely across the trust. This provides a strong holistic and pastoral support for patients during difficult times.

Our findings

Involvement in care

We spoke to numerous patients, almost all of whom were very happy or satisfied with their care. We spoke to over 20 patients in A&E, eight patients in AMU, over 20 patients within the medical areas, three families in neonatal and six families in maternity services, and many other patients in other areas. We also telephoned some patients who we were not able to speak to within the service. The vast majority of the feedback was clear about the high standard of caring from the staff of the trust. This exemplifies the nature of the people we met during our visit; all of whom were dedicated, committed and caring.

We particularly noted that at the time of our visit, a traveller family were staying on the trust's grounds, whilst the organisation was caring for their relative. This was clearly a very difficult time for the family. We spoke extensively to several family members who were full of praise for the HDU team and the trust as a whole. They identified it as the best care they had experienced.

We noted that for those patients on the Liverpool Care Pathway, this was well communicated within the hospital notes. All patients we spoke to had consented to be on an end of life care pathway.

Trust and respect

We saw members of staff building good relationships with patients and their families. We saw staff explain procedures to patients before the procedure was begun. The trust had made significant attempts to build a good relationship with the family of a members of the travelling community during their stay. This strong relationship led to a good outcome of care for both the patient and the family.

Compassion, dignity and empathy:

The trust was ensuring that it maintained patients' privacy and dignity. We saw that male and female segregation was maintained in all areas we observed. We observed good levels of communication between individual members of staff and the patients they were caring for. This undoubtedly impacts on the high levels of positive patient feedback.

We did observe that a sluice area in the outpatients service was being used to both weigh patients and also to provide some care. This room was also used as a sluice area. A screen on wheels was used to develop some privacy, but in our opinion this was inappropriate and did not allow patients' privacy and dignity to be maintained.

Emotional support

We saw good End of Life care demonstrated in many areas of the trust. The Chaplaincy team was highly responsive and we were impressed with the end of life care team's approach. We saw an excellent bereavement support service that was available widely across the trust. We noted that a dedicated patient experience officer was present within the trust.

We did observe a potential for lack of continuity of care within maternity services. We noted that there may be a different consultant day, and we identified that this was a ‘notional nomination’. As such, patients' experience of care had the potential to be fragmented.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The Chaplaincy and the End of Life care team responded well to patients' needs. The quality of communication in choice for End of Life care patients at a wards level was not always well understood. Staff need to be clear on offering choice to patients at the end of their life care.

There were en-suite rooms within the children's inpatient area with very good play facilities. Following the results of stroke audit, the size of the clinical team had been increased. Also pressure mattresses were now available more quickly (in hours not days).

Some children's ENT patients are seen in an adult ENT area. This is not seen as best practice and children should be cared for in facilities set out to meet their needs.

The maternity and paediatrics service are now both in a new unit. We saw that this was well signposted. However, the design of facilities in some other areas was poor. The design of the bathroom (for example) in the stroke unit made access difficult, and whilst there were shower chairs, there were no specialist stroke shower chairs for those patients who needed physical support during washing.

We observed that in outpatients, where patients are unwell, they were fast-tracked in the appointment system. We did however note that waiting times can be quite long in outpatients.

In A&E, patients were kept on trolleys in corridors. Two patients were observed waiting on trolleys in the ambulance triage area. Patients should be managed in appropriately designed facilities to support best practice care.

We noted that in a number of areas where we spoke to patients and their families, many were not fully aware how they might make a complaint or comment to the trust, nor of the complaints service. As an example, six out of seven patients we spoke to in outpatients were unaware of how they would make their problems known to the trust. The trust is missing valuable opportunities to both respond to people unhappy with their care, but also to learn from this and improve the care they give in future.

We did note however that the trust has invested in a central patient experience team and also a contract with an external patient survey provider. Every month all discharged patients are surveyed two weeks after discharge (using questions from the national inpatient survey), as well as all outpatients and people who had used A&E.

Our findings

Meeting people's needs

The Chaplaincy and the End of Life care team responded well to patients' needs. We were however concerned at the quality of communication in choice for End of Life care patients at a wards level. We did hear that it was common practice for patients to complain locally (or comment negatively) to the palliative care team about end of life care at ward level. It is important that patients have choice and good communication at all parts of their treatment and care.

Rooms within the Paediatric area had very good play facilities. The trust is recruiting to specialist midwifery posts. We were aware that the maternity team have received two awards (in the areas of cardiac care and endocrinology) for their service.

We were aware that following the results of stroke audit, the size of the clinical team had been increased.

Pressure mattresses were now available more quickly (in hours not days). This means patients have quicker access to the equipment that supports their care.

Access to services

Some children's ENT patients are seen in an adult ENT area. This is not seen as best practice and children should be cared for in an environment that meets their needs..

The maternity and paediatrics service is now in a new unit. We saw that this was well signposted. We saw however that the design of facilities in some areas of the trust was poor.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The design of the bathroom (for example) in the stroke unit made access difficult, and there were no specialist stroke shower chairs for those patients who needed physical support during washing.

We observed that in outpatients, where patients are unwell, they were fast-tracked in the appointment system. We did however note that waiting times can be quite long in outpatients.

We saw that the trust had built a new car park to alleviate access problems on the hospital site. This is a good example of meeting access needs of the wider population. We were informed by one patients that he could not locate a phone or communication system from the upper level of the new car park; this patient had mobility problems and needed to call for assistance. We note that the trust have installed phones and communication in the car park, but that this was not easily identified by this individual who felt vulnerable and unable to attract attention.

There is a service level agreement between outpatients and paediatrics to allow the OP team to call for assistance in individual cases of clinical need.

We saw that in A&E, patients were kept on trolleys in corridors. Two patients were observed waiting on trolleys in the ambulance triage area. We were told this had been escalated to the executive team. We were informed that the service is staffed to be able to manage these trolley areas, and we are therefore of the opinion that this is a regular occurrence for the service. Patients should be cared for in areas that are designed for this purpose and support their needs.

Vulnerable patients and capacity

We saw ordering (and where necessary reordering) of surgical lists based on age and clinical need for paediatric, children and teenagers. This is good practice and is to be commended for responding to individual need.

We were aware that adolescent self-harm is a significant issue locally. Whilst we recognise the excellent facilities in the children's unit, we note that the potential for isolation from the main nurses station does not support close observation of this vulnerable group. People at risk of self-harm should be cared for in an environment where they can be more easily observed. We are subsequently informed by the trust that each young person is risk assessed and the plan of care agreed, this may include one to one (or two) nursing to keep the young person safe

We noted that there were midwifery leads in smoking cessation, obesity and mental health. We noted that in some patients; the outpatient staff followed through on patient procedures to ensure these were booked and in place.

We noted that there is a Mental Capacity Act coordinator for the trust. This is good practice for this vulnerable group.

Leaving hospital

There is a good follow-up of patients post discharge from critical care services. There is an enhanced discharge team in A&E to support patients leaving the service. These actions support patients in the early days of discharge and reduces the need for readmission to the hospital. We also noted that the A&E team are able to meet the 4 hour waiting times standard on many occasions.

Learning from experiences, concerns and complaints

In a number of areas where we spoke to patients and their families, many were not fully aware how they might make a complaint or comment to the trust, nor of the complaints service. As an example, six out of seven patients we spoke to in outpatients were unaware of how they would make their problems known to the trust. The trust is missing a valuable opportunity both to respond to complaints but also information to help improve and develop their care services.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust has recently integrated the community services with the acute trust to create a larger joint service. We saw significant effort to support the integration, but we were unable to identify a clear vision and strategy for the newly merged organisation.

We heard many positive comments from the many focus groups about the culture of the organisation.

Staff who were previously part of the community services commented on the very positive efforts to integrate the new enhanced teams, both by their colleague and by the trusts management. Staff were able to articulate a sense of organisational belonging and a sense of joint purpose. We saw enthusiastic staff who were largely happy in their work.

The visibility of the executive has increased. The executive team do 'shifts' in the clinical areas that they 'buddy'. Staff were highly complimentary about the chief executive's visit to clinical areas on Christmas day. There is a difference between visibility and engagement. We saw a disconnect between the executive team of the trust and the staff. Many staff believe that the executive team are not fully aware of their key challenges and they believe their issues are not a focus of the board's discussions. This was reported from multiple service areas across many specialities, however, the greatest disconnect appeared to us to be amongst the medical staff. It is important that staff are confident that the trust board recognises and responds to issues in delivering care to patients. Failure to do this will lead to poor communication and low morale among staff.

We noted many areas under significant pressure and some services reported that this was a real challenge. Staff were positive about the contribution they were making, but worried that the pressure of the role was degrading their ability to respond. Although they has raised this, they were concerned this may not have been fully heard.

We heard of examples of innovation that may not yet have been recognised by the trust's leadership team. It was unclear how the trust would evaluate these opportunities.

Our findings

Vision, strategy and risks

The trust's vision is "to provide the highest quality, integrated and sustainable health and care services, where patients can access the timely, personalised and safe care they need, within the most appropriate environment".

The trust has recently integrated the community services with the acute trust to create a larger joint service. We saw significant effort to support the integration, but we were unable to identify a clear vision and strategy for the new organisation's greater combined strength.

We were unable to identify where or how the trust's risk register is visible in all areas or whether it is understood within each service. Some services were clearer than others on whether their concerns were recognised by the trust. The risk register is an important recognition of all the issue that the trust faces and the actions that the trust is taking to address them.

Quality, performance and problems

There were a number of areas where the information at a local level did not agree with that submitted by the trust. Examples of this include the intensive care (ICNARC) audit data, data on venous thromboembolism (VTE) and A&E data. Data submitted nationally must be consistent with that held locally.

We noted in our earlier analysis the levels clinical coding and the where these are incorrectly recorded for payment by results which informs internal payment and accounting methodology. (It must be noted here that this is not clinical recording in patients' notes and has no direct bearing on diagnosis or outcomes.) The rates of incorrect clinical coding for the trust are much higher than the national rates. We deem this to be a risk for the trust for activity analysis, income and sustainability. We spoke to the lead for this area who informed us of a change in procedure to address this issue (largely through clearer identification in case notes of decision points and relevant diagnosis). We were told that this is improved and a submission is about to be made with new data. The trust is urged to monitor this carefully to assure the board that the position is improved and sustained.

Data from the 2012 NHS staff survey suggest a largely positive experience except for job related training and pressure to attend work when feeling unwell. In response

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

to the former, we were able to find little current evidence to support this, and all comments we received were positive, and staff told us they had received training or development opportunities. With regard to the latter, we did see evidence in both maternity and outpatients of internal systems to manage staff cover during leave and sickness. Some staff did feel that this resulted in them feeling pressurised to cover shifts.

Leadership and culture

We heard many positive comments from the multiple staff focus groups about the culture of the organisation. Staff were asked to imagine that they no longer worked for the trust but had a job elsewhere, we then asked if they would like to return to the trust. Overwhelmingly the response from many groups was that they would.

Staff who were previously part of the community services commented on the very positive efforts to integrate the new enhanced teams, both by their colleague and by the trust's management. Staff were able to articulate a sense of organisational belonging and a sense of joint purpose.

We saw enthusiastic staff who were largely happy in their work.

Individually we heard comments from one service praising the leadership of another. An example of this is A&E, where other services were positive about their view of its leadership; another is the nursing leadership in outpatients. We note that the friends and family test for Ward 12 had been amongst the lowest in the trust. We note however that the trust has put some significant effort into the environment of this service; and the strength of leadership on ward 12 was commended to us. One of our inspectors also observed strong leadership on Ward 26, where he noted positive actions in end of life care.

However, there appears to be a growing disconnect between the executive team of the trust and the staff. We are aware that visibility of the executive has increased, and that a buddy system is in place. We also recognise that the executive team do 'shifts' in the clinical areas that they buddy. Staff were highly complimentary about the chief executive's visit to clinical areas on Christmas day. However, there is a difference between visibility and engagement. We saw that the efforts to achieve visibility have been very successful. However, we are of the opinion that many staff believe that the executive team are not aware of their key challenges and that their issues are not a focus of the board's discussions. This was reported from multiple service areas across many specialities, however, the greatest disconnect appeared to us to be among the medical staff.

It is important that staff are confident that the trust board recognises and responds to issues in delivering care to patients. Failure to do this will lead to poor communication and low morale among staff.

Staff had regular appraisals, and many we spoke to had also had mid-year reviews. Many people were able to point to training and development that had arisen from their appraisals.

In many clinical areas (especially medicine), the band 7 staff are supernumerary. A business case for investment into the stroke service is being positively received by the trust.

We note that the trust has higher than national average rates of sickness in its medical and midwifery workforce. However overall sickness is below the regional and national averages.

Learning, improvement, innovation and sustainability

Many areas are under significant pressure and some services reported that this was a real challenge. We heard that some services responsible for booking patient appointments and managing pathways were particularly under pressure. We noted that they were positive about the contribution they were making, but worried that the pressure of the role was degrading their ability to respond. Whilst they has raised this, they were concerned this may not have been fully heard. The trust should be clear that all areas providing services either directly or indirectly to patients have the required resources to deliver the task to an acceptable standard.

We heard of examples of innovation that may not yet have been recognised by the trust's leadership team. We were told of a potential for increased radiographer reporting that was underdeveloped (this is nationally recognised good practice). This would reduce impact on radiologists, and improve recruitment and retention; radiographers were keen to progress this. We also heard of an innovative approach from the speech and language therapy team to supporting patients in their home using computers and IT programmes. This is at the end of a pilot project and earlier

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

work has already won awards. We understand there may a positive cost benefit the trust in both areas; however we are not sure that an evaluation of either of these opportunities has been made.

We were also informed of a donation of i-Pads to the speech and language team for use with patient which require an 'app' to be installed. We were told that the trust couldn't afford this 'app' and that the i-Pads are now unused.

The trust should be able to demonstrate that it is able to evaluate ideas from all teams and services. Following the evaluation, appropriate feedback should be given.

In surgery there is support for training of six advanced practitioners. We also observed an integrated paediatric and community outreach team. We noted in maternity that the governance lead attends the weekly team meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Records. People who use services and others were not protected against the risks associated with poor record keeping, access to records and inability to read instructions and annotations. Records must be legible, clearly ordered so important information is easy to find and accessible for all clinical requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Records. People who use services and others were not protected against the risks associated with poor record keeping, access to records and inability to read instructions and annotations. Records must be legible, clearly ordered so important information is easy to find and accessible for all clinical requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected from risk by through poor incident reporting systems and failure to report near misses. Valuable learning for assessment of risk and improvement future care has been lost.

This section is primarily information for the provider

Compliance actions

All staff should be responsible for incident reporting and staff should report both near misses as well as actual incidents.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing. People are at risk through the failure to provide sufficient numbers of suitably qualified, skilled and experienced persons in some clinical areas. The provider must regularly review staffing and skills mix in all its clinical and non-clinical areas. An agreed staffing level should be set, and maintained.

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