

Dignity and nutrition inspection programme

National overview



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Overview, by Dame Jo Williams



Dame Jo Williams

In December 2010, the Secretary of State for Health asked CQC to look at standards of dignity and nutrition in NHS hospitals. A series of highly concerning reports from bodies like the Patients Association and Age UK had drawn attention, yet again, to the poor care experienced by some older people in hospitals. The Parliamentary and Health Service Ombudsman's report in February 2011 added to the debate by highlighting shocking cases of poor care.

In response to the Secretary of State's request, CQC planned and delivered a series of 100 unannounced inspections of acute NHS hospitals in England between March and June 2011, looking at standards of dignity and nutrition on wards caring for elderly people. Each individual hospital report has already been published and this national report summarises what we found.

This was our first themed programme of inspections using our new 'outcome-based' model of regulation. This means we spent the majority of our time observing how care was delivered on wards, talking to patients and their families, and interviewing staff.

The programme was a genuinely collaborative effort, working with practising nurses and 'experts by experience' (people with direct experience of care services) in our inspection teams. An external advisory group offered us strong challenges throughout the process and helped make sure the inspection reports have had an impact. They added a lot to this piece of work and we have learned a great deal about how we can improve the way we regulate as a result of their input.

I was heartened by the amount of good and excellent care we saw. Many of the hospitals we visited showed a genuine commitment to delivering person-centred care, with registered nurses, doctors, other care professionals and health care staff pulling together to treat the people they cared for with compassion and respect.

As Chair of CQC, I was pleased to see that three-quarters of trusts told us they had made changes to the way they looked at dignity and nutrition as a result of this inspection programme. An impressive 78% agreed our judgements were fair, despite many of the judgments being negative – and only six per cent disagreed.

There is, however, a great deal in the reports to give cause for alarm. Around half of the hospitals we visited gave our inspection teams cause for concern. Twenty hospitals were not delivering care that met the standards the law says people should expect.

themselves delivering care that falls below essential standards because they are overstretched.

Staff must have the right support if they are to deliver truly compassionate care that is clinically effective. In the current economic climate this is easy to say and far harder to deliver, but as the regulator our role is to cast an independent eye over care and reflect on what we see. There are levels of under-resourcing that make poor care more likely, and those who run our hospitals must play their part in ensuring that budgets are used wisely to support front line care staff.

We entrust our loved ones to the care of the NHS – our parents, brothers and sisters, family members, and friends – and hope that they will be treated as we would treat them.

Many people benefit from truly wonderful care from nurses, doctors and other people in multidisciplinary teams who are a credit to the NHS.

Sadly, a significant number of people are nowhere near so fortunate. The findings of this report suggest that many hospitals are struggling or failing to meet the basic needs of older people.

With this in mind, it is concerning that many of these conclusions are not startling or new. We have had these debates before; there is no mystery around how best to care for older people, and no dearth of toolkits or action plans to help hospitals do what they should. Members of our advisory group for this project – the Royal College of Nursing, BAPEN, Kissing it Better and others – have excellent resources available. The question for leaders in the NHS and policy makers is why so many hospitals still fail to do it.

This report must result in action. CQC will play its part by holding hospitals to account for poor care when we find it. Our survey of trusts suggests many are already responding. Our inspection teams are actively following up where we had concerns to check whether planned improvements have been made. But the system as a whole – those who are responsible for making sure care meets essential standards, and those who commission that care – must respond if we are not to find ourselves here, yet again, a few years down the line.

Dame Jo Williams
Chair, Care Quality Commission

Summary

In December 2010, the Secretary of State for Health Andrew Lansley MP asked CQC to carry out an inspection programme to look at dignity and nutrition in NHS hospitals.

We carried out unannounced inspections at 100 NHS acute hospitals in England between March and June 2011, using teams made up of CQC inspectors, a practising and experienced nurse, and an 'expert by experience' – someone with experience of caring or receiving care, trained and supported by Age UK.

The programme was supported by an 'external advisory group' made up of organisations representing patients, care providers, professionals and campaign groups. Full details are in section five.

We chose the hospitals using our own risk data, information from members of the programme advisory group, and some hospitals named in the Parliamentary and Health Service Ombudsman's '*Care and compassion?*' report (February 2011), as well as several random selections.

We checked two 'outcomes' during each inspection: Outcome 1, which is 'respecting and involving people who use services,' and Outcome 5, 'meeting nutritional needs'. Appendix A has details of how we check standards and more information about these outcomes is available on our website: www.cqc.org.uk.

Of the 100 hospitals inspected, we found overall that:

- 45 hospitals met both standards (they were 'fully compliant').
- 35 met both standards but needed to improve in one or both (they were 'fully compliant, with improvements suggested').
- 20 hospitals did not meet one or both standards (they were 'non-compliant, with improvements required').

We had forecast that 10-20 % of hospitals could be non-compliant (20% were), and that a further 30-40% would show evidence of concerns (35% did), based on findings from our first set of inspections. Overall, 55% of hospitals were either non-compliant or gave cause for concern, against a forecast of 40-60%.

In some cases, we found that care was poor on one ward of a hospital, rather than across both of the wards we looked at. In those cases, our policy was to base our overall decision on the poorest performance found (taking into consideration the proportionality and reasonableness of the decision).

Outcome 1: Respecting and involving people who use services

Of the 100 checks we made against Outcome 1:

- 60 hospitals were fully compliant.
- 28 were compliant but needed to make improvements.
- 12 were not compliant and had to take action to become compliant.
- None were a cause of major concern.

Where we did find problems, key themes were that:

- Patients' privacy and dignity were not respected – for example curtains were not properly closed when personal care was given to people in bed.
- Call bells were put out of patients' reach, or they were not responded to in a reasonable time.
- Staff spoke to patients in a condescending or dismissive way.
- Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.

Outcome 5: Meeting nutritional needs

Of the 100 checks we made against Outcome 5:

- 51 hospitals were fully compliant.
- 32 were compliant but needed to make improvements.
- 15 were not compliant and had to take action to become compliant.
- Two were a cause of major concern and had to take urgent action.

Where we did find problems, key themes were that:

- Patients were not given the help they needed to eat, meaning they struggled to eat or were physically unable to eat meals.
- Patients were interrupted during meals and had to leave their food unfinished.
- The needs of patients were not always assessed properly, which meant they didn't always get the care they needed – for example, specialist diets.
- Records of food and drink were not kept accurately, so progress was not monitored.
- Many patients were not able to clean their hands before meals.

Publication and follow-up

We published our inspection reports on all 100 hospitals on our website, along with details of what action hospitals needed to take where they were either delivering poor care, or were at risk of delivering poor care if they did not make improvements.

It took just over six months from the Secretary of State's initial request to conclude the inspection programme. Follow-up actions are now in place and we have already carried out follow-up inspections at some hospitals.

Hospitals where we had major or moderate concerns

We assessed the following hospitals as a 'major' or 'moderate' concern. All other hospitals that we visited as part of the programme are included reporting Appendix B, along with details of which hospitals were not compliant with which outcomes.

Major concern

- Alexandra Hospital, Worcestershire Acute Hospitals NHS Trust
- Sandwell General Hospital, Sandwell and West Birmingham Hospitals NHS Trust

Moderate concern

- Barnsley Hospital, Barnsley Hospital NHS Foundation Trust
- Bedford Hospital, Bedford Hospital NHS Trust
- Colchester General Hospital, Colchester Hospital University NHS Foundation Trust
- Conquest Hospital, East Sussex Hospitals NHS Trust
- Darent Valley Hospital, Dartford and Gravesham NHS Trust
- Eastbourne General Hospital, East Sussex Hospitals NHS Trust
- Great Western Hospital, Great Western Hospitals NHS Foundation Trust
- Ipswich Hospital, Ipswich Hospital NHS Trust
- James Paget Hospital, James Paget University Hospitals NHS Foundation Trust
- John Radcliffe Hospital, Oxford Radcliffe Hospitals NHS Trust
- Norfolk and Norwich University Hospital, Norfolk and Norwich University Hospitals NHS Foundation Trust
- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust
- Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust
- Royal Free Hampstead Hospital, Royal Free Hampstead NHS Trust
- South Tyneside District Hospital, South Tyneside NHS Foundation Trust

- Stepping Hill Hospital, Stockport NHS Foundation Trust
- University Hospitals Bristol site, University Hospitals Bristol NHS Foundation Trust
- Whiston Hospital, St Helen's and Knowsley NHS Trust

How we carried out the inspections

A CQC inspector led each inspection, often assisted by a second CQC inspector. They were supported by a practising nurse and an Age UK 'expert by experience'. More than 100 CQC inspectors, 50 nurses and 40 experts by experience were trained and took part in the inspections.

In the inspections, we used observation tools, spent time on hospital wards (including observing a meal time) and talked to patients, relatives, carers and a variety of staff. We checked two 'outcomes' in each inspection (see appendix A for an explanation of outcome-based regulation).

We carried out each inspection on a single day (from Monday to Friday) and covered two wards where older people were cared for in each hospital. All inspections were unannounced. We typically arrived at a hospital at 9am and stayed until 4pm, making sure that we observed one meal – usually lunch time – in its entirety. This focus on lunchtime meant we were able to make better comparisons between hospitals.

During the inspections, our emphasis was on observing the quality of care given to older people. This included whether patients were helped to eat and drink if they needed it, and whether they were treated with respect.

We used existing CQC methods and systems as well as specially adapted interview and observation tools to gain a greater understanding of ward activities relating to the two outcomes.

We recorded our observations of the general environment and provision of care, including the process of giving meals to patients. We also checked patients' records to look at how or whether care planning took account of their wishes, preferences and choices, and how these were documented and monitored.

Our findings and key areas of concern

We identified several repeated areas of concern against Outcomes 1 and 5 in the hospitals where we saw non-compliance. In this section, we explain how common these problems were in relation to each outcome in turn, and gives some examples from our published reports. We also set out some basic analysis of what we saw, and highlight areas of consistent practice in those hospitals that did meet the essential standards of quality and safety. Reports for every hospital are available on our website: www.cqc.org.uk.

Appendix A explains in more detail what we mean when we talk about compliance and non-compliance, and minor, moderate and major concerns.

Outcome 1: Respecting and involving people who use services

Sixty hospitals were fully compliant with this standard. Another 28 were compliant but we issued them with 'improvement actions' to make sure they remained compliant. That left 12 hospitals that didn't meet the standard, all of which we identified as moderate concerns. None of the 100 hospitals was rated as a major concern under Outcome 1.

The key themes we saw in non-compliant hospitals were:

- Patients' privacy and dignity were not respected – for example curtains were not properly closed when personal care was given to people in bed.
- Call bells were put out of patients' reach, or they were not responded to in a reasonable time.
- Staff spoke to patients in a condescending or dismissive way.
- Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.

Findings by theme

Did staff behave in a way that respected patients' dignity?

Three-quarters of the 12 hospitals that were failing to meet CQC's standard had serious problems in this area in at least one of the wards visited.

"The patient constantly called out for help and rattled the bedrail as staff passed by... We noted that 25 minutes passed before this patient received attention. When we spoke with the patient we observed that their fingernails were ragged and dirty."

"People were not taken to a toilet away from their bed space, commodes were used for much of the time and the process could be heard throughout"

the bed areas. Commodes were also taken to patients' bed space at meal times."

Were call bells within reach, audible and responded to properly?

Nine of the 12 hospitals had failings here in at least one of the wards inspected.

"On both wards visited we saw call bell devices left in their holders, on the floor, hanging off the bed, or generally not accessible to the person. One person told us that to attract a nurse's attention he hit his water jug on the bedside table or shouted."

Did patients have their privacy respected?

Seven of the 12 hospitals that failed to meet Outcome 1 had problems in this area in at least one ward.

"We saw a staff member taking a female patient to the toilet. The patient's clothing was above their knees and exposed their underwear. The staff member assisted them to the toilet in full view of other patients on the ward, only closing the door when they left the toilet room."

Were staff appropriately trained?

Half of the 12 hospitals were found to be failing in this outcome area (it was not assessed at one of the 12). Failings were found to be consistent throughout all wards visited at each hospital.

"None of the staff we spoke to were able to recall having specific training in how to ensure people's privacy and dignity was supported."

"Staff told us they had very little training on dysphasia, rehabilitation, privacy, dignity or dementia."

Were patients involved in decisions about their care, including being asked their views and preferences?

Five of the 12 hospitals had failings here, although there was variation within these five and only one hospital had consistent failings in all wards visited.

"One patient said she had received very little communication, whilst another said that the doctors tended to talk about you and not to you."

"We spoke to patients who knew that staff had some information about them, but who had not been involved in the planning of their care. People said that they had not been asked about religion or their needs or preferences. There was little evidence of patients having contributed to their records, for example, by having a care plan which included their views."

Were there enough staff on the ward?

We assessed this standard at half of the 12 trusts that fell below the bar, and of those we looked at five were failing in this area.

"When we spoke to one member of staff about how they managed to meet the needs of people on the ward, they said that they did not have enough time to care for patients. They said that when they are rushed they cannot always meet people's needs and some things have to be delayed as a result."

"All the ward staff we spoke to on the stroke unit said they felt the unit was understaffed and the current levels were not appropriate to meet the needs of the patients."

Comment and analysis on Outcome 1

Poor practice

For the three areas where we found the most common failings – dignity, use of call bells and privacy – there was a large degree of variation in practice.

In terms of dignity and privacy, not one of the hospitals found to be failing was failing consistently on both the wards we visited. In all cases where we did see failings, there were also instances of care being delivered that met the essential standards. For call bells, for example, four of the nine failing hospitals had consistent problems across both wards – but for the other five we saw significant variations in practice.

This suggests that hospitals that were failing to meet this standard had failed to set expectations across and within wards, or had failed to hold staff to account consistently for performance.

There were widespread inconsistencies in practice around call bells, with patients reporting a real variety in responses within wards and hospitals. This is a simple issue that matters a lot to patients, based on the comments and feedback we heard.

In addition to looking at non-compliance, we also identified common minor concerns in hospitals that were meeting the essential standards. These were cases where hospitals were delivering care that meets the standards the law says people should expect, but where our inspection teams saw some matters that were of concern.

Staffing levels were another concern mentioned in hospitals that were meeting this standard, but where we still recommended improvements. The key theme was around the lack of time staff had to spend with patients to attend to their individual care needs. Reference was often made to certain times of day or night when staffing was inadequate.

We had a small number of concerns about providing information to patients and their families. The most common comment was that people had received little or no information about what to expect from care delivered in the wards they were on.

Good practice

We saw common themes in terms of good practice in hospitals that were meeting CQC's standard for dignity (60 of the 100 hospitals met this standard).

We found a high degree of consistency in terms of staff behaving in a way that respected patients' dignity, with patients often describing staff as positive, sensitive and respectful.

Many examples of good practice around privacy were also cited (with reports of seeing good practice across both wards a recurring factor). The most common positive evidence included staff taking care to protect patients' privacy by closing curtains when care was being delivered, and using an appropriate speaking volume when discussing people's care.

Of the 60 hospitals that met Outcome 1, we found strong consistency in involving patients in decisions about their care (although we noted that full documentation of care plans was often lacking in places where the quality of care patients experienced was good). We saw a similar high level of good practice around explaining treatment options.

This suggests that staff (and management) in hospitals that met this standard understood the importance of privacy, and took the time to both involve patients in their care and explain what it meant for them.

Across all 100 hospitals, the availability of single sex facilities was consistently good, with single sex accommodation and facilities available in all 87 locations where we made a specific assessment of it. While overall wards were generally mixed, patients were usually accommodated in single sex bays or side rooms, with single sex bathroom facilities available.

A second area of widespread good practice was people feeling that their care needs were being met – we found only two of 90 locations failing here. This was based largely on patients' feedback, rather than detailed analysis of care plans and individual packages of care needs.

Outcome 5: Meeting nutritional needs

We found that 17 of the 100 hospitals were failing to deliver care that met this essential standard. Two of these were of major concern, with the other 15 subjects of moderate concern.

The key themes we saw in hospitals that did not meet the standard were:

- Patients were not given the help they needed to eat, meaning they struggled to eat or were physically unable to eat meals.
- Patients were interrupted during meals and had to leave their food unfinished.
- The needs of patients were not always assessed properly, which meant they didn't always get the care they needed – for example, specialist diets.
- Records of food and drink were not kept accurately, so progress was not monitored.
- Many patients were not able to clean their hands before meals.

Findings by theme

Were records of food and drink intake accurate?

We checked this at 13 of the 17 hospitals and found 12 of these had significant failings. The majority of cases had problems in both wards.

"We found staff recorded what had been offered to a person; not what they had actually eaten."

Were patients offered the chance to clean their hands?

This was checked at 15 of this group of hospitals and 13 were found to have failings. Problems were across both wards in 10 of these cases.

"Nobody was routinely offered hand washing before or after their meals and hand gel was not within easy reach."

Were procedures for identifying patients at risk followed and was appropriate action taken?

We checked this at 16 of the 17 hospitals that were failing to meet this outcome, and 13 were found to have problems. We found problems on both wards in five of these 13.

"When we asked about the red tray system there was a mixed response. Some senior nursing staff told us that the red tray system was in use but the junior nursing staff on the ward did not know what the red tray system was. They told us that they had never used it."

Did staff have time to support patients?

This was checked at 15 of the 17 hospitals and 11 were found to have failings here. In six of these cases, the wards either appeared understaffed or staff told our inspectors that they were.

"Staff were trying to help patients sit up and serve lunch, whilst a medication round was being carried out at the same time."

"On the second ward although we did observe staff supporting patients to eat and this was done in a caring way, there were not enough staff to support all the patients who needed assistance. Staff told us that this was not an unusual situation. One said: 'Sometimes I am the only staff member to feed on the ward. How can I feed all these people? Sometimes by the time I get to the last bay either the food is cold, or it has been taken away.'"

Were patients who needed support given it?

All 17 hospitals that were failing against this outcome were assessed against this area and 13 were found to have significant problems. In all but two cases, this was not consistent across both wards.

"One person's meal was delivered and a member of staff promptly helped them to eat it. However, another person in the same bay had their meal delivered at the same time. The person did not have any assistance and the food was left on their table for over half an hour before they were assisted to eat."

Was support provided adequately?

We checked this in 17 hospitals and found 12 to have significant failings. There was some overlap between this and the question above. In most cases, there were inconsistencies either within the same ward or between wards.

"Two members of staff who were assisting people with their meal at the time were having a conversation between themselves."

Comment and analysis on Outcome 5

Consistency and inconsistency across wards were a significant factor in this area.

Poor practice

In terms of offering people the chance to clean their hands, failings were usually seen across both wards. But in almost every other area we looked at, problems were not present across both wards, or even varied widely within wards. This suggests that there was a widespread lack of consistent practice around this outcome area in hospitals that were failing to meet CQC's standard.

Key factors that we saw included people not being given the support they needed to eat or being interrupted during meals. We also saw that people's needs were not always assessed properly and that records were not accurately kept. In some cases, staff talked across patients rather than to them.

Several factors may have contributed to what we saw, both in terms of resources and organisational culture.

A lack of time to deliver care (due to short staffing, persistent high demand or excessive bureaucracy) can prevent staff from making sure that people's needs are assessed and they are given the right support to eat.

Poor practice may also result if there is a culture in a hospital that does not place an emphasis on treating people with dignity and respect. This might explain why needs assessments do not seem to be a priority in some hospitals, and the habit of talking across (rather than to) patients by staff.

Good practice

In those hospitals that we judged were meeting the standard, we saw common good practice with making sure appropriate support was provided to patients. In those cases, patients were helped to sit comfortably to eat their meal, staff cut up food where necessary and sat with patients while they ate, and mealtimes were unrushed with staff reassuring and encouraging people.

The availability of meals for people who had missed set mealtimes was consistently strong in hospitals that met Outcome 5, and snacks and drinks were available outside of mealtimes.

In those hospitals that met this standard, we saw good practice around identifying patients at risk, with a significant number using coloured (usually red) trays or jugs to identify people at risk.

The highest level of compliance we saw across all hospitals was in terms of food quality. We checked this at 77 hospitals of the 100, and 73 were found to be meeting this standard. In 66 cases, food was reported to be good across the board, with seven cases where opinion was mixed but acceptable.

The choice of food was also widely reported to be good, with two-thirds of all hospitals offering a choice of food as standard practice. In places where this was not so good, common themes included people not always getting the meal they had chosen if they were the last to be served, people not being able to change their mind, and a lack of pureed or alternative types of food being available.

It should be noted that this assessment of food quality is based on patient feedback – not on any detailed assessment of how appropriate it was for the person given their care needs.

We also saw good availability of dietitians and other specialists across most sites (either on-site, or off-site but accessible), with only a handful of cases where patients did not have timely access to specialists.

CQC follow up actions so far

We published inspection reports on each of the 100 hospital inspections between May and July. We shared these reports with the hospitals in advance of publication, and each inspector gave immediate feedback to the hospital on the day of its inspection.

There were 56 hospitals where improvement or compliance actions were included in the CQC inspection report.

We dealt with each case in the context of the hospital, so there were no standard actions put in place. Details of the actions that individual hospitals had to take are set out in the reports published on our website. We will update these actions regularly as and when we carry out follow-up inspections, so they are not recorded here.

We contacted strategic health authorities, primary care trusts, local media and MPs about every case where we saw non-compliance.

We have so far carried out targeted follow-up visits to eight of 12 trusts that had compliance actions on Outcome 1 (respecting and involving people). In addition we visited two locations in one trust where follow-up was needed as part of a separate review, and this included Outcome 1. We have followed up with six of 17 trusts that had compliance actions on Outcome 5 (nutrition).

In September 2011, we served a warning notice on James Paget University Hospitals NHS Foundation Trust as a result of its failure to protect patients from the risks of inadequate nutrition and hydration. This was a follow-up to our April dignity and nutrition inspection, and the first warning notice to result from the programme.

Following the April inspection, the trust had provided an action plan outlining what improvements it would make. However, when our inspectors returned to the trust on 1 September to carry out a second unannounced inspection, they saw incidences of patients not being given appropriate support to eat and drink, and that people in need of intravenous fluids did not have infusions. The trust could face prosecution or suspension of services for failure to become compliant.

Decisions on when and how to follow up on improvement and compliance actions is based on the levels of risk (in terms of potential impacts on patients) associated with our judgments. Further follow-up action is planned at every hospital where improvement or compliance actions were put in place.

Feedback on our inspection methods and joint working

A CQC inspector led each inspection, often assisted by a second CQC inspector. They were supported by a practising nurse and an Age UK 'expert by experience'. More than 100 CQC inspectors, 50 nurses and 40 experts by experience were trained and took part in the inspections.

In this section, we look at the feedback we had from hospitals during the programme and at the way we worked with experts by experience, practising nurses and our external advisory group.

How hospitals responded to our inspections

We sent out a short survey to the 96 trusts (four trusts had inspections at two hospitals) that were inspected as part of this programme. Of these, 74 responded.

The results from those who replied were positive:

- Nine out of 10 agreed that the process was clearly explained and questions were dealt with effectively during the visit.
- More than 70% agreed or strongly agreed that feedback on the day was helpful, and that the mixed team (CQC inspector, nurse and expert by experience) improved the quality of the inspection.
- In terms of our judgments, 78% agreed or strongly agreed that our decisions were a fair reflection of performance, with only 6% of those who responded disagreeing.
- Three-quarters of trusts agreed they had made changes to the way they approach dignity and nutrition as a result of the inspection programme. Six per cent disagreed.

1. The inspector clearly explained the process when they arrived and was able to answer your questions about the visit

88% agreed, 2% disagreed

	Number	%
Strongly agree	34	46
Agree	31	42
Neither agree nor disagree	7	9
Disagree	1	1
Strongly disagree	1	1

2. The feedback given on the day of the inspection was helpful

73% agreed, 15% disagreed

	Number	%
Strongly agree	19	26
Agree	35	47
Neither agree nor disagree	9	12
Disagree	9	12
Strongly disagree	2	3

3. The skill mix of the inspection team (CQC inspector, practising nurse, expert by experience) improved the quality of the inspection team in terms of the scrutiny of care

71% agreed, 8% disagreed

	Number	%
Strongly agree	12	16
Agree	41	55
Neither agree nor disagree	15	20
Disagree	6	8
Strongly disagree	0	0

4. Overall, the inspection outcomes were a fair judgement of the trust's performance in relation to Outcome 1 and Outcome 5

78% agreed, 6% disagreed

	Number	%
Strongly agree	23	31
Agree	35	47
Neither agree nor disagree	11	15
Disagree	4	5
Strongly disagree	1	1

5. Our trust made changes to the way it approached dignity and nutrition as a result of the inspection programme

74% agreed, 6% disagreed

	Number	%
Strongly agree	17	23
Agree	38	51
Neither agree nor disagree	14	19
Disagree	4	5
Strongly disagree	1	1

Using nurses on our inspection teams – what we learned

Our inspectors said that the majority of nurses had an excellent or good impact on the inspection process. Nurses themselves gave us positive feedback from taking part and some remarked that it 'demystified' the CQC inspection process. Others said they incorporated learning from our programme into their everyday practice reviews in their own hospitals.

We faced several challenges in setting up nurse participation. We had initially thought we could use recently retired nurses or those on career breaks – but we needed to ensure that every one who took part had had up-to-date appraisals, CRB checks and current inclusion on the Nursing and Midwifery Council's register. This limited us to those nurses in current practice.

We had to manage conflicts of interest. It was essential that nurses were not asked to report on their own trusts, which meant we needed to plan carefully to make sure there was no suggestion that the nurses' independence was compromised. The tight timescales for the programme, and the need to be reasonable in terms of the distances people travelled, made this a challenge.

Another challenge – and rather a welcome one, in some respects – was demand, which in some areas meant we had 10 times more applicants than we required.

Finally, we had to manage cost. Recruiting, training and deploying the nurses (and experts by experience, see below) was a resource-intensive process. While we appreciated that carrying out inspections at evenings or on weekends might have given us different data, we had to bear in mind the overall cost of the programme and this was a factor in our decisions.

Using 'experts by experience' on our inspection teams – what we learned

CQC works with 'experts by experience' – people of all ages, with experience of giving or receiving care, and from diverse cultural backgrounds – to improve the way it regulates.

Experts by experience take part in an inspection and talk to the people who use the care service. Sometimes they hold telephone interviews for people who use home care agencies, one-to-one meetings with people in supported living and groups sessions over lunch for people in care homes. If they are visiting a service, they will also look at the environment; see how everyone gets on together and what the atmosphere feels like.

For this inspection programme, we engaged experts from the existing contractual arrangements we had with Age UK. Few had experience of hospital visits, having predominantly visited care homes. Several experts took part in more than one inspection.

Age UK's programme manager played a valuable role, coordinating briefing sessions, helping with the inspection programme and updating experts on progress.

Age UK carried out an evaluation of their contribution. Some highlights are:

- Age UK's experts by experience have been positive about the approach taken by CQC in conducting the dignity and nutrition inspections. They all appreciate that CQC has actively involved people that use services in this important inspection programme.
- Experts have fed back overwhelmingly that patients were happy to talk to them and many were very keen to tell their stories. A number mentioned how professional they felt their teams were and that they were impressed by their inspector's knowledge and skills.
- Experts recommend doing further work that takes into account the needs of people with dementia.
- It would help to involve a small group of experts in the development of the tools earlier in the process for future inspections.

Anecdotally, we were told that the mixed teams were a real benefit to CQC because of the range of perspectives that they brought to the inspection process and because they could engage with patients and staff in a different way. A nurse and expert by experience attended a meeting of our advisory group and we heard that staff in hospitals tended to be more open about the challenges they faced with 'fellow nurses'; likewise, patients were more open with 'experts by experience' because they could empathise with them and were not seen as 'part of the establishment'. The CQC inspector brought a welcome independent balance to the team, and was able to speak to both patients and staff to help triangulate feedback.

We are developing this approach further through a range of initiatives to make more use of specialist expertise and to work more closely with people who use services in our inspections.

Working with our external advisory group

The dignity and nutrition inspection programme was CQC's first project to use a new approach to working with stakeholders, by setting up a 'task and finish' advisory group to help us improve the way we delivered the work. The group met six times during the duration of the programme and met for the last time in September to comment on the draft of this report.

Due to the expectation that CQC would deliver this programme in a short space of time, the group had limited influence over the original design of the programme and inspections. They were, however, able to help shape its progress. Other current advisory groups have been set up at an earlier stage to make sure that stakeholders are able to have more influence over overall shape and methodology.

The following organisations were part of CQC's external advisory group for the programme. This summary report should not be taken as a representation of their views, although they all played a vital part in shaping it.

- Age UK
- Action on Elder Abuse
- BAPEN (British Association for Parenteral and Enteral Nutrition)
- Dignity in Care Network, supported by the Department of Health
- Equality and Human Rights Commission
- Kissing it Better
- LINKs representatives – Anita Higham (Oxfordshire) and Ivy Elsey (East Sussex)
- National Patient Safety Agency
- Nursing and Midwifery Council
- NHS Confederation
- Patients Association
- Relatives and Residents Association
- Royal College of Nursing
- Royal College of Physicians
- Social Care Institute for Excellence

The group was chaired by CQC. The approach throughout was for CQC to be as transparent as possible with group members – for example, early results of all inspections were shared with the group in confidence to allow them to prepare a response. Every group member respected this arrangement throughout.

The group's views on how CQC carried out the programme were extremely valuable. We made changes to the way we targeted hospital sites and wards, approached the inspections, wrote our compliance reports and gave feedback as a result of their input.

Several of their suggestions about our core model feature in a consultation (launched in September 2011) to make improvements to the way we regulate.

Appendix A: How CQC checks if care is safe

Hospitals must meet 'essential standards of quality and safety'

CQC's role is to check whether care meets standards that the government says people should expect. These standards are based on the Health and Social Care Act 2008 and secondary legislation.

We do this by registering 'care providers' (hospitals, care homes, dentists, and so on), which allows them to provide certain types of care in accordance with the law. The provider (a hospital, for the purposes of this report) accepts responsibility for making sure that the care they deliver meets the 'essential standards of quality and safety' that the law says people should expect.

We then check whether these standards are being met, usually through unannounced inspections. We do this by listening to what people say about care and looking at what data tells us to identify possible risks. If we see signs of risk, we check to see what lies behind them. We make most of these checks through unannounced inspections. Many of our inspections happen as a result of information we receive from members of the public, or care staff.

If we find that a hospital is not meeting the standards we expect, we take action to make them put it right. We seek improvements against clear timescales or take enforcement action. If the care provider does not do what we ask and we believe people are at unacceptable risk of poor care, there are a range of actions we can take, including cancelling their registration as a last resort. This means they are no longer allowed to offer care.

The law does not require CQC to make judgements about whether care is good, bad or excellent. We look to see whether care meets the standards the law says it must (care is 'compliant' with standards) or not (care is 'non-compliant' and therefore breaking the law).

CQC does not make recommendations about improvements, or offer a commentary on the causes of poor care beyond stating what our inspectors have seen and found. When we find non-compliant care, a hospital has to take steps to make sure they become compliant. But we do not tell them how to do this, and do not make suggestions about how hospitals can deliver care that is better than compliant.

It is not CQC's job to guarantee that hospitals are providing safe care. It is the responsibility of the hospital and the people who work there to make sure they are not breaking the law.

Are hospitals meeting the standards people should expect?

When a hospital meets the standards the law says people should expect, we say the hospital is 'compliant'. When a hospital is failing to meet those standards, it is 'not compliant'. There are a number of decisions we can make as a result of our inspections and in this review we used four:

Compliant – this means the hospital is meeting the standards and no action is needed to improve.

Compliant, minor concern – this means the hospital is meeting the standards we expect but needs to take action to make sure they keep meeting the standard. In this case, we set the hospital an 'improvement action' to try to prevent them falling below the bar. We will check later to see if they have done this.

Non-compliant, moderate concern – this means the hospital is not meeting the standards we expect and although people are generally safe there some are unacceptable risks to their health and wellbeing. In this case, CQC puts a 'compliance action' in place for the hospital. They must carry out the action we tell them by a set date or face further action.

Non-compliant, major concern – this means the hospital is not meeting the standards we expect, and people are not protected from unsafe or inappropriate care. In this case, we also use a 'compliance action' but may use one of our most serious powers – which can include suspending or even closing services – to protect people from harm.

When a hospital is non-compliant, it does not mean everyone who uses that hospital will experience poor care. It means there is an increased risk of people receiving poor care. Given the size and complex nature of the care delivered in hospitals, you will always find examples of good care in non-compliant hospitals, and occasional poor care in compliant hospitals. CQC's judgements try to capture the overall quality of care at hospital-wide level. We try to tackle problems that make the risk of poor care in any given case more likely.

Appendix B: Hospitals inspected in this programme

Numbers 1 and 5 in brackets refer to the outcomes where hospitals were not compliant (1 is 'respecting and involving people who use services', and 5 is 'meeting nutritional needs').

Hospitals where we had a major concern

- Alexandra Hospital, Worcestershire Acute Hospitals NHS Trust (major concern 5, moderate 1)
- Sandwell General Hospital, Sandwell and West Birmingham Hospitals NHS Trust (major concern 5, moderate 1)

Hospitals where we had a moderate concern

- Barnsley Hospital, Barnsley Hospital NHS Foundation Trust (5)
- Bedford Hospital, Bedford Hospital NHS Trust (5)
- Colchester General Hospital, Colchester Hospital University NHS Foundation Trust (1 and 5)
- Conquest Hospital, East Sussex Hospitals NHS Trust (1 and 5)
- Darent Valley Hospital, Dartford and Gravesham NHS Trust (1 and 5)
- Eastbourne General Hospital, East Sussex Hospitals NHS Trust (1 and 5)
- Great Western Hospital, Great Western Hospitals NHS Foundation Trust (1)
- Ipswich Hospital, Ipswich Hospital NHS Trust (1 and 5)
- James Paget Hospital, James Paget University Hospitals NHS Foundation Trust (1 and 5)
- John Radcliffe Hospital, Oxford Radcliffe Hospitals NHS Trust (5)
- Norfolk and Norwich University Hospital, Norfolk and Norwich University Hospitals NHS Foundation Trust (5)
- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust (1)
- Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust (5)
- Royal Free Hampstead Hospital, Royal Free Hampstead NHS Trust (1 and 5)
- South Tyneside District Hospital, South Tyneside NHS Foundation Trust (1)
- Stepping Hill Hospital, Stockport NHS Foundation Trust (5)
- University Hospitals Bristol site, University Hospitals Bristol NHS Foundation Trust (5)
- Whiston Hospital, St Helen's and Knowsley NHS Trust (5)

Hospitals where we had minor or no concerns

- Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

- Aintree Hospital, Aintree University Hospitals NHS Foundation Trust
- Airedale General Hospital, Airedale NHS Foundation Trust
- Bradford Royal Infirmary, Bradford Teaching Hospitals NHS Foundation Trust
- Cannock Hospital, Mid Staffordshire NHS Foundation Trust
- Chapel Allerton Hospital, Leeds Teaching Hospitals NHS Trust
- Clatterbridge Centre for Oncology, Clatterbridge Centre for Oncology NHS Foundation Trust
- Clatterbridge Hospital, Wirral University Teaching Hospital NHS Foundation Trust
- Countess of Chester Hospital, Countess of Chester Hospital NHS Foundation Trust
- Croydon University Hospital, Croydon University Hospitals NHS Trust
- Cumberland Infirmary, North Cumbria University Hospitals NHS Trust
- Derriford Hospital, Plymouth Hospitals NHS Trust
- Doncaster Hospital, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Dorset County Hospital, Dorset County Hospital NHS Foundation Trust
- Ealing Hospital, Ealing Hospital NHS Trust
- East Surrey Hospital, Surrey and Sussex Healthcare NHS Trust
- George Eliot Hospital, George Eliot Hospital NHS Trust
- Good Hope Hospital, Heart Of England Foundation Trust
- Grantham and District Hospital, United Lincolnshire Hospitals NHS Trust
- Halton Hospital, Warrington And Halton NHS Trust
- Hereford County Hospital, Hereford Hospitals NHS Trust
- Homerton University Hospital, Homerton University Hospital NHS Foundation Trust
- Huddersfield Royal Infirmary, Calderdale and Huddersfield NHS Foundation Trust
- Kettering General Hospital, Kettering General Hospital NHS Foundation Trust
- King George Hospital, Barking, Havering and Redbridge University Hospitals NHS Trust
- Kingston Hospital, Kingston Hospital NHS Trust
- Leighton Hospital, Mid Cheshire Hospitals NHS Foundation Trust
- London Road Community Hospital, Derby Hospitals NHS Foundation Trust
- Manor Hospital, Walsall Hospitals NHS Trust
- Musgrove Park Hospital, Taunton and Somerset NHS Foundation Trust
- Newark Hospital, Sherwood Forest Hospitals NHS Foundation Trust
- New Cross Hospital, Royal Wolverhampton Hospitals NHS Trust
- Northern General Hospital, Sheffield Teaching Hospitals NHS Foundation Trust
- North Hampshire NHS Trust Treatment Centre, Basingstoke and North Hampshire NHS Foundation Trust
- North Manchester General Hospital, Pennine Acute Hospitals NHS Trust
- North Middlesex Hospital, North Middlesex University Hospital NHS Trust
- Northwick Park Hospital, North West London Hospitals NHS Trust
- Nuffield Orthopaedic Centre, Nuffield Orthopaedic Centre NHS Trust

- Ormskirk and District General Hospital, Southport and Ormskirk Hospital NHS Trust
- Peterborough City Hospital, Peterborough and Stamford Hospitals NHS Foundation Trust
- Princess Alexandra Hospital, Princess Alexandra NHS Trust
- Princess Royal University Hospital, South London Healthcare NHS Trust
- Queen Alexandra Hospital, Portsmouth Hospitals NHS Trust
- Queen Elizabeth the Queen Mother Hospital, Margate, East Kent Hospitals University NHS Foundation Trust
- Queen Elizabeth II Hospital, East and North Hertfordshire NHS Trust
- Queen's Hospital, Burton Hospitals NHS Foundation Trust
- Queen Victoria Hospital, Queen Victoria Hospital NHS Foundation Trust
- Royal Blackburn Hospital, East Lancashire Hospital NHS Trust
- Royal Bolton Hospital, Royal Bolton Hospitals NHS Trust
- Royal Bournemouth General Hospital, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Royal Devon and Exeter Hospital, Royal Devon and Exeter NHS Foundation Trust
- Royal Liverpool University Hospital, Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Royal Orthopaedic Hospital, Royal Orthopaedic Hospital NHS Foundation Trust
- Royal Shrewsbury Hospital, Shrewsbury and Telford Hospital NHS Trust
- Royal Surrey County Hospital, Royal Surrey County NHS Foundation Trust
- Salford Hospital, Salford Royal NHS Foundation Trust
- Scunthorpe General Hospital, North Lincolnshire and Goole NHS Foundation Trust
- Southlands Hospital, Western Sussex Hospitals NHS Trust
- Southmead Hospital, North Bristol NHS Trust
- St George's Hospital, St George's Healthcare NHS Trust
- St Mary's Hospital, Imperial College Healthcare NHS Trust
- Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust
- St Thomas' Hospital, Guy's and St Thomas' NHS Foundation Trust
- Torbay Hospital, South Devon NHS Trust
- Trafford General Hospital, Trafford Healthcare NHS Trust
- University College Hospital and Elizabeth Garrett Anderson Wing, University College London Hospitals NHS Foundation Trust
- University Hospital Coventry and Warwickshire, University Hospital Coventry and Warwickshire NHS Trust
- University Hospital Lewisham, Lewisham Healthcare NHS Trust
- University Hospital of Liverpool, North Tees and Hartlepool NHS Foundation Trust
- University Hospitals Bristol main site, University Hospitals Birmingham Foundation Trust
- Warwick Hospital, South Warwickshire NHS Foundation Trust
- West Cumberland Hospital, North Cumbria University Hospitals NHS Trust
- Wexham Park Hospital, Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Walkergate Hospital, Newcastle Upon Tyne Hospitals NHS Foundation Trust

- West Middlesex University Hospital, West Middlesex University Hospital NHS Trust
- Whipps Cross University Hospital, Whipps Cross University Hospital NHS Trust
- The Whittington Hospital, Whittington Hospital NHS Trust
- Wythenshawe Hospital, University Hospital of South Manchester NHS Foundation Trust
- York Hospitals NHS Trust HQ, York Hospitals NHS Foundation Trust

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