Whittington Health NHS

Rosalind Murphy
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board
7 May 2014

Title:	Report on The Care Quality Commission's Inspection of Whittington Health January 2014		
Agenda item:	**14/085**	**Paper**	**4**
Action requested:	Board information and discussion		
Executive Summary:	The Care Quality Commission (CQC) visited the Trust in January 2014 to review the emergency department (ED), medical and surgical wards, outpatients, endoscopy, and Day Treatment Centre. This was an unannounced inspection the outcome of which is available on the CQC public website. The following outcomes were inspected: 4 - Care and welfare of people who use the service 7 - Safeguarding people who use the service from abuse 10 - Safety and suitability of premises 13 - Staffing 14 - Supporting workers 17 - Complaints We failed on outcome four during this inspection due to issues noted in ED and older people's services. All other outcomes were passed. CQC requested actions plans addressing issues raised in outcome four and several other outcomes. These were submitted at the end of March 2014.		
Summary of recommendations:	For board approval of actions in progress.		
Fit with WH strategy:	Strategic Goal three: 'Efficient and effective care'		
Reference to related / other documents:			
Date paper completed:	17th April 2014		

Author name and title:		**Rosalind Murphy Regulatory Compliance Manager**		**Director name and title:**		**Jill Foster Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**No**	**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	**No**

CQC Inspection January 2014

1. Introduction

On 8th January 2014, CQC representatives arrived at the Trust to perform an unannounced inspection and review the following outcomes:

4 - Care and welfare of people who use the service
7 - Safeguarding people who use the service from abuse
10 - Safety and suitability of premises
13 - Staffing
14 - Supporting workers
17 - Complaints

The inspectors visited ED, Coyle, Bridges, Mercers and Meyrick wards the Day Treatment Centre (DTC), Endoscopy, and Outpatients Clinics. At the end of the day, the inspectors provided verbal feedback and requested several items of supplementary data to be submitted i.e.

- Ambulance transfer times in ED
- Triage times in ED
- Specific detail on the delayed transfer of seven patients the day of the visit
- Bed Escalation Policy
- ED activity snapshots
- ED incidents
- Transport lounge waiting times
- Cleaning schedules
- Sickness rates for medical secretaries and medical records
- Adult safeguarding work plan
- Referral-to-treatment times for Day Treatment Centre

The inspectors re-visited on 17th January to clarify some of the ED data and obtain more information from the outpatient's department. Our final report was received on 6th March 2014 (see Appendices)

2. January 2014 inspection findings

2.1 – Standards met

The Trust passed the inspection with regard to outcomes 7, 10, 13, 14 and 17. However, several comments were made within the report that we need to address:

Outcome 7 : The inspectors found that on the whole, staff were aware of the procedures for raising an alert. It was noted that, despite having attended training, staff reported that they were not necessarily confident in using mental capacity or deprivation of liberty assessments.

Outcome 10 : Most areas were noted to be clean and well equipped but the report commented on storage issues throughout ED, cramped conditions and some use of public areas for patient observation and mixed sex toilets/bathrooms that could lead to privacy issues. They noted the intent to refurbish Isis in 2014. The Day Treatment Centre (DTC) was reported as having some confidentiality issues due to having patient bays rather than single room accommodation. Some of the toilets in outpatients appeared not to have been cleaned on the day of the visit.

Outcome 13 : The Trust's efforts to increase staff numbers were noted; most patients they spoke to felt that staff spent enough time with them. The ED consultant vacancy was highlighted. Some staff in outpatients commented on a shortage of Health Care Assistants (HCAs). These posts have been filled but the staff had not started at the time of the visit.

Outcome 14 : staff reported that they felt supported and that managers were visible. The inspectors noted good team working and access to training. In DTC some staff reported low morale, but this was improving. Staff affected by the recent changes to administrative roles told the inspectors that did not feel supported through the process and that communication was poor. Some admin teams reported high sickness rates and low morale and that there were a lot of changes made to roles which were challenging.

2.2 Standards not met.

The Trust did not pass Outcome four due to ED waiting times and some care delivery issues on Meyrick ward.

They found that we met the ED four hourly target in five of the last six months. However, we were below target for both the transfer times from the ambulance service to the department and the subsequent triage time by ED staff. On the day of the visit, there were still patients from the night before in the department waiting for a bed on the ward.

The inspectors that visited Meyrick Ward observed several patients that did not have a call bell in reach; call bells that were disconnected from the wall, placed on a locker, lying on the floor or behind the patient's bed. The staff were not asked to explain these findings at the time of the visit.

The inspectors also noted poorly completed fluid charts, risk assessments and Do Not Resuscitate forms. Although meals were served to patients hot, the staff did not inform the patient of when they would be back to help them eat. Several staff were seen to be going in and out of a bay that had patients with MRSA (this bay also houses the sluice room). Patients reported being bored and that they did not know there was a day room with a television available.

The Trust was advised to note the length of time some patients wait for their procedure in DTC and that problems with IT in the Trust result in ineffective monitoring of waiting times. Outpatient clinic waiting times were found to vary, with some patients reporting that they had to wait around two hours. Delays deteriorated for patients with appointments later in the day.

3. Actions and Assurance

Action plans (see Appendices) from the various services were submitted to the CQC on 26th March addressing the failings in outcome four and the points raised in other outcomes.

Services are now working to implement their actions plans and leads from each service are required to provide evidenced assurance to the nursing directorate via a series of governance meetings. The first of these is due to be held in the next couple of weeks and will continue until all actions are complete.

Appendices submitted as separate documents.

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RKE
Our reference	INS1-974537155
Location name	Whittington Hospital NHS Trust
Provider name	The Whittington Hospital NHS Trust

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	**How the regulation was not being met:**

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. A new ward manager post has been advertised and a temporary person in situ pending this appointment. Once in post this person will continue the work that has commenced in creating a cohesive effective team of staff.
2. Historic staff issues relating to poor performance are already being addressed by the Matron for Theatres and DTC pending the appointment of a new DTC manager.
3. Funding has been agreed for a Practice Development Nurse to work with the whole operating department. This will support the provision of education and supervision for DTC staff.
4. Medical and nursing staff working in DTC will avoid, where possible, discussing confidential issues with patients whilst in communal areas. This will minimise the lack of privacy afforded by layout (Theatre and DTC managers). Plain English will be used.
5. There is a review of office space and usage underway with a view to creating a consultation room in which private conversations can be conducted (Matron, Theatres/DTC)
6. PALs contact details will be displayed in DTC (DTC admin staff)

7. Scheduling procedures are being reviewed across theatres and DTC in order to improve the patient experience and reduce waiting times (Matron, Theatres/DTC)
8. Staggered arrival times have commenced for some theatre lists, this will be increased following the above review.
9. Patients will be provided with clear instructions re fasting times.
10. The process for booking temporary staff has been reviewed and altered to allow unfilled shifts to be referred to agency providers sooner thus improving staffing levels including times when the shift is declared at short notice. (Bank Co-ordinator/ward managers)
11. Ward nursing numbers are currently being reviewed with a view to increasing overall establishment. The increase will enable more flexibility during the shift to support attendance at training and allow ward managers to have more supervisory and administrative time. (Director of Nursing and Patient Experience)

Who is responsible for the action?	See actions

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1. New manager will be appointed
2. Poor performance will addressed and remedied
3. Practice development nurse will be appointed
4. Private conversations will not take place behind curtains if possible and patients will no longer express confusion due to excessive use of medical terminology.
5. A consultation room will be available for private conversations
6. PALs details will be visible for patients within the department
7. Patients will be given an arrival time that is appropriate for their place on the theatre list and provided with clear instructions re fasting times.
10. Sufficient staff numbers will be available each day according to activity
11. Establishment numbers will increase.

Who is responsible?	See actions

What resources (if any) are needed to implement the change(s) and are these resources available?

Financial approval pending for the increase in nursing establishment.
Ward manager and practice development nurse will need time to implement the changes necessary.
Admin time required to support the review of scheduling and changes to pre written patient letters and information

Date actions will be completed:	1 and 3 End of Quarter 1 2 commenced, end date variable according to need of individual 4. commenced 5. End of May 2014 6. April 2014 7 and 9. Commenced for some lists. Very large review of process underway, new process expected by end Q3. 10.Commenced 11End of Q1

How will people who use the service(s) be affected by you not meeting this regulation until this date?
1. Patients using DTC may feel their privacy is compromised if personal conversations have to take place in a communal areas behind curtains prior to consultation room being available 2. Staff may feel unsettled until the new manager/ practice development nurse are in post and the necessary changes are implemented.

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	25.03.14

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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Re enforce the process for obtaining pressure relieving mattresses and for highlighting any delays in receiving equipment with ward staff. (Tissue viability nurse and ward managers)
2. Delays in providing mattress outside of the terms of the contract will be addressed with the company.
3. The process for booking temporary staff has been reviewed and altered to allow unfilled shifts to be referred to agency providers sooner thus improving staffing levels including times when the shift is declared at short notice. (Bank Co-ordinator/ward managers)
4. Ward nursing numbers are currently being reviewed with a view to increasing overall establishment. The increase will enable more flexibility during the shift to support attendance at training and allow ward managers to have more supervisory and administrative time. (Director of Nursing and Patient Experience)
5. Ward managers to liaise with one another to obtain written or electronic staff training records if staff are required to move wards. (Ward managers and ESR managers)
6. Patient Experience staff to commence weekly walkabout to check all screens are working.

7. Screen saver in use on all computers reminding staff to obtain patient feedback and how to report any issues with devices (Patient Experience Manager)
8. Housekeeping services to be informed if Outpatients toilets are not cleaned as per rota (7times per day)

Who is responsible for the action?	See actions

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1&2 .Monitor datix records for evidence of late receipt of pressure relieving mattress
3. Monitor shift patterns and bank office records for numbers of unfilled shifts
4. Establishment numbers will increase.
5. Staff records transfer with staff members; access to ESR records transfer with staff members
6. Patient feedback screens that are not working will be reported and repaired promptly.
8.Existing rota of cleaning is adhered to.

Who is responsible?	See actions

What resources (if any) are needed to implement the change(s) and are these resources available?

Financial approval pending for the increase in nursing establishment.
Ward manager time required to obtain staff records, re enforce process required re pressure relieving mattresses; bank/agency bookings.

Date actions will be completed:	1 and 2. Commenced 3.Commenced 4. End of May 2014 5. April 2014 6. End of April 2014. 8. Commenced

How will people who use the service(s) be affected by you not meeting this regulation until this date?

1. On the rare occasion that there is no pressure relieving mattress in the on-site store and the provider company does not have suitable replacement in the vicinity a patient may have to wait up to 6 hrs. for a replacement over the weekend. (Six hours is the max wait agreed in the contract, wards rarely report a delay of this magnitude. If a delay occurs the Trust contract managers can discuss and review provision with the company to minimise reoccurrence).
4. Ward staff may continue to find it difficult to leave the ward for training whilst the current establishment is in force

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	25.03.14

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	How the regulation was not being met:

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Create and Implement a standard operation procedure for responding to complaints to clarify the procedure
   - a key lead for each division to review and allocate complaints
   - the requirement for lead investigators to contact complainants within 24 hours to introduce themselves, discuss the complaint and ensure any immediate resolution possible is completed
   - divisions to thoroughly quality assure responses before they are submitted to the PALS and Complaints Team
   - action plans to be submitted to PALS and Complaints Team within 2 weeks of the response being completed.
2. Create a standard operating procedure for the PALS and Complaints team on the use of Datix. This is to ensure data entry is consistent and of sufficient quality to enable robust and timely reporting to the divisions and trust board.
3. Restructure the Complaints and PALs teams to provide greater use of skills, clarify roles and improve response times
4. Recruit to any new posts created within the new structure.

5. Commence a regular training programme to cover local resolution, investigating complaints and writing responses.
6. Produce a guidance document for staff to cover local resolution, investigating complaints and writing responses.
7. Undertake a gap analysis to ensure all recommendations are considered and actions agreed as appropriate following the Designing Good Together: Transforming Hospital Complaint Handling and Clywd-Hart reports. This will go to the Executive Committee and Patient Experience Committee for agreement and monitoring.
8. Implement weekly monitoring meetings with Divisions and Chief Operation Officer
9. Change office opening hours from 9-5 to 9-4 to allow dedicated time for administration duties
10. Create partially generic response templates for issues that more common whilst the restricting process in progress
11. Division will submit action plans for complaints that are upheld or partially upheld.

Who is responsible for the action?	Head of Patient Experience

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

Quarterly reports to be submitted to the Quality Committee and Trust Operational Board to monitor progress. Response times and progress with action plans will be reported.
Action plans will be regularly submitted by Divisions
Weekly monitoring of complaints will increase response times and implementation of actions

Who is responsible?	Head of Patient Experience

What resources (if any) are needed to implement the change(s) and are these resources available?

Business case for recruitment of new staff will need to be agreed.
Existing Complaints and PALs Team staff will produce all procedural documents and create databases/action trackers; administration time will need to be allocated for this.

Date actions will be completed:	1 – 3, 5, 6, 7, End of March 2014 4, 5 End of Quarter 1 14/15 11 End of April 2014 8, 9, 10 Complete

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Existing outstanding complaints are being addressed as a matter of urgency so that those awaiting response are provided with one as soon as possible.

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	24.03.14

Report on actions you plan to take to meet CQC essential standards

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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. All staff to be informed of the requirement to meet ambulance transfer times to support improvement in patient care and in achieving national target.
2. Performance data to be included on noticeboard to inform staff of progress.
3. Ambulance handovers (10) will be audited weekly; feedback provided to staff and date published on noticeboard to inform staff of progress.
4. ED message of the week to focus on handovers to re enforce changes in practice and the need to meet required standards.
5. Role cards to be produced to clarify individual responsibilities
6. Going Home Bundle Project to be implemented to improve the discharge process for patients by early identification of patient needs and expected discharge dates.
7. The Ambulatory Care Centre is due to open w/c 31st March 2014. A large number of patients will use this facility rather than ED therefore reducing the occupancy of the main ED unit and Isis Ward.
8. The main ED and Isis Ward will be cleared of unnecessary items and more space will be

available once the patient flow changes.

9. Medical staffing establishment is being reviewed in light of the new commissioning standards. Recruitment to vacancies is on-going in the department.
10. The Trust is reviewing its initial assessment process in ED with a view to developing a front of house triage team consisting of a doctor, nurse and health care assistant. This will improve triage times and patient experience. In the meantime staff will focus on handover process as in action 4.
11. ED will bid for funding to renovate the main ED reception area to support the improvements in the initial assessment process.

Who is responsible for the action?	ED service manager and shift leaders. The implantation of actions will be overseen by the Head of Acute Care

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1. All staff to be reminded of ambulance handover requirements by email and by shift leader
2. Performance will be published on the performance noticeboard weekly
3. 10 handovers will be audited each week and the results published
4. Message of the week provided
5. Role cards will be produced
6. Going Home Bundles project to be implemented

8.Excess equipment will be removed or placed in storage facilities. Walkways and public areas will be less cluttered.
9. Review of medical staffing will be completed and an action plan produced.
10. A review of initial assessment process and action plans for change will be produced.
11. A bid will be submitted for funds to undertake renovation works.

Who is responsible?	ED Service Manager and shift leaders. The implantation of actions will be overseen by the Head of Acute Care

What resources (if any) are needed to implement the change(s) and are these resources available?

Funding will be required to increase Consultant staff numbers if recommended by the review.
Funding will be required as part of Capital Projects for building works to be undertaken in main ED reception area.
ED service manager and shift leaders time will be required to promote the handover and Going Home Project work. This will be accommodated within normal working hours.
Service manager and Head of Acute Care time will be required to lead on service reviews. This will be accommodated within normal working hours.

Date actions will be completed:	1.Completed 2. Completed 3. In progress 4. Complete 5.Complete 6. Project commenced 7.March 2014 8.May 2014

	9. May 2014 10. End of Q2 11. Dependent on Action 10 approx end of Q2.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Patients may experience > 20 minute triage times until the new ambulatory care is in operation and pending review of the initial assessment processes. Locum medical staff may be required pending recruitment to vacant posts.

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	25.03.14

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	How the regulation was not being met:
	On Meyrick Ward and in Outpatients care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. The provider was failing to meet Regulation 9 (1)(b)(i)(ii)(iii).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Continue the education of the clinical teams to ensure staff are aware of the assessment process and escalation procedure in relation to i.e. deteriorating patient, dementia, MCA/DoLs to satisfy regulatory compliance. (Practice Educator, Safeguarding Lead, Ward Manager)
2. Ensure a clear preceptorship programme is in place for new staff nurses to ensure staff have support and development to be safe practitioners within the specialty. (Ward Manager).
3. Review patient selection for Meyrick ward to ensure 'Right Patient, Right Bed' including the location of infected patients admitted to the ward to avoid cross infection and promote harm free care. (Lead Site Manager, Infection Control nurse and Ward Manager).
4. Ensure appropriate infection control measures taken with regards to cohorted patients to avoid cross infection of other patients. (Ward Manager and ICAM Infection Control nurse).
5. Review how information is communicated to patients on admission and improve where needed (e.g. television hire, ward routine, visiting times, patient/relative involvement). (Ward Manager, Matron).

6. Ensure all patients who are assessed as being able to use a call bell have easy access to the call bell and that this is included in routine patient checks to enable staff to be alerted to the needs of the patient. (Ward Manager).
7. Patients receive prompt attention when calling out or using the call bell to improve patient experience and patient safety and to reduce noise levels for other patients. (Ward Manager).
8. Ensure that systems in place that are thought to be robust e.g. patient feeding are carried out in the Ward Managers absence to ensure a good patient experience 24/7, seven days a week (Ward Manager, Matron).
9. Improve the standard of patient assessment and evaluation which is demonstrable through good quality documentation that meets NMC standards (Ward Manager, Practice Educator, Matron).
10. Nursing handover process will communicate good information, check the accurate completion of all nursing documentation, improve patient/relative engagement, create an environment whereby staff learn and where practice and plans are questioned (Ward Manager, Matron).
11. Staff identity is improved by all staff wearing name badges, the nurse in charge is clearly identifiable by signage at reception, staff photos and designation is displayed to enable patients/visitors to identify who they are talking to or being cared for by. (Ward Manager).
12. Improve the day room so that it is a more comfortable and safe environment for patients (Ward Manager, Matron, Estates and Facilities).
13. Roles and responsibilities of all the nursing team on Meyrick are defined and reviewed as part of the appraisal process. This should include the role of the coordinator in overseeing the delivery of care to all patients on the ward, safe delegation of tasks to juniors and unqualified staff (Ward Manager, Matron).
14. Staff are recruited who have an understanding and passion for caring for elderly people and who will be able to undertake the demanding nature of this type of nursing. Therefore improvements in recruitment through value based selection processes and the right make up of selection panel. (Ward Manager, Matron, Recruitment Manager).
15. Reduce lead in time for appointment of staff once recruited to ensure temporary staffed are not relied upon to fill vacancies on a regular basis. (Recruitment Manager).
16. A review of the establishment (staffing numbers and skill mix) to reflect the acuity and dependency of patients on the ward (Deputy Head of Nursing).
17. Practice Education Staff support to improve the skills set of nurses to enable staff to see the standard of care expected and to improve the clinical skills and knowledge required for caring for elderly patients. (Deputy Head of Nursing/ Head of Nursing).
18. Support the Ward Manager to provide clear management direction to her staff in a professional manner using the organisations policies to guide her. (Matron).
19. A review of the way in which ‘Specials’ are currently recruited on a shift by shift basis to improve the calibre of staff who provide an essential and challenging role to our most vulnerable patients (Deputy Head of Nursing).
20. Engage the MDT in ward issues that are centred on patients, safety and a culture of improvement (Ward Manager, Matron, Consultants).
21. Establish how best relatives/carers can be involved in decision making (e.g. being present for ward rounds) to improve the quality and understanding of decisions made (Ward Manager, Consultant).
22. Engagement of patients and families to participate in discharge planning as part of the Going Home Bundle (Ward Manager, Matron).
23. All staff to receive Pressure Ulcer prevention training and ensure awareness of pressure ulcer prevention takes a high priority for maintaining standards of care on the ward (Practice Educator and Tissue Viability nurse).

24. Explore ways of improving the support for ward staff (nursing) to reduce the level of stress, increase staff morale and improve the retention of nursing staff. I.e. clinical supervision, Swartz rounds (Ward Manager, Matron, Practice Educator).

Who is responsible for the action?	Responsible person(s) identified per action. Head of Nursing to provide support and oversee their implementation.

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1. Routine audits which are currently part of the on-going 'visible leadership' programme – Senior Nursing Team responsible for on-going delivery depending upon the topic.
2. Review all the metrics (e.g. C.Diff/MRSA, pressure ulcer, falls,) currently available to spot trends. (Matron, Ward Manager)
3. Redefined role of the Matron to focus on quality and safety. (Head of Nursing, Deputy Head of Nursing)
4. Ad hoc walkabouts and conversations with staff and patients (Matron, IPC team, Deputy Head of Nursing, Head of Nursing)
5. Exec walkabouts/ Patient Safety Walkabouts by Trust Executives.
6. Monitoring of 'Right Patient, Right Bed' on a daily basis (Matron, Ward Manager in conjunction with Site Team).
7. Request from recruitment department a weekly 'New starters' list with timelines (Head of Nursing).
8. Review incidents reported on the Datix system (Head of Nursing, ICAM Quality and Risk Manager).
9. Monitor appraisal process to ensure it is being carried out
10. Monitor provision and attendance at clinical and other forms of supervision
11. Staff meeting minutes
12. MDT meeting minutes
13. Monitor staff numbers completing preceptorship

Who is responsible?	Head of Nursing

What resources (if any) are needed to implement the change(s) and are these resources available?

1. Currently there is a nurse investment paper with the Trust Board to improve the ward establishment.
2. Recruitment processes are currently under review by the Trust and changes will be made to improve the process where needed
3. Daily (and up to five times daily) capacity/bed meetings take place which is the forum for discussions around correct placement of patients although Infection Control and not always present.
4. Increased Practice Educator support for the Division. The current provision is under review by the assistant Director of Workforce and Education.
5. A programme of work is being defined to improve day rooms (Chief Operating Officer and Estates).

Date actions will be completed:	Most actions will be on-going as they are embedded to become routine practice (1,2,3,4,5,6,78,9,10,11,13,17,18,20,22,23 Other actions involving review are

	expected to be completed by end of April 2014 (12,14,15,16,19,21,23) All actions will necessarily have a trial period before becoming mainstreamed so will evolve over time.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Ward based improvements have already been put in place to mitigate risks for patients (Actions 1-11). Actions are enhancements to improve the service that are now underway. There is not thought to be any risk to patients at present unless some nursing shifts or shifts where specials are required are not filled. This is being mitigated by easier booking of temporary staff as the process has recently changed to allow shifts to be put out to agencies earlier. This is having a positive effect on wards staffing.

Completed by: (please print name(s) in full)	ANGELA ADAMS
Position(s):	Head of Nursing (ICAM)
Date:	14 March 2014

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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Out patients

1 Make sure that clinic templates are reviewed in advance to ensure they are not overbooked and a reasonable amount of patients are booked for the clinic time available. This should be agreed with the Consultant in charge.
2 Undertake capacity and demand modelling to make sure that there are sufficient clinics in place to accommodate demand. (n.b. this action has been held up due issues with electronic patient record (EPR) that the TDA are aware of).
3 Any delays with the clinics will be communicated to the patients involved, apologies given and an indication of the waiting time, so that the patient can access refreshments etc. in the interim if they wish.
4 Make sure that staff who are operating and working in the clinic arrive in a timely manner so the clinics start on time
5 Monitor waiting times in each clinic daily to ensure the above actions are undertaken.

Who is responsible for the action?	General Managers for each out-patient area are responsible for their own speciality clinics

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

- Actions will be monitored via an out-patient balanced scorecard to include:
  - Patient complaints regarding waiting times
  - Review the Friends and Family test or other feedback mechanisms regarding the delivery of the clinic and waiting times
  - Each speciality that has undertaken capacity and demand work for its out-patient clinics
  - Monitoring of clinic start times and finish times (including arrival of clinicians)
  - Monitoring of waiting times in each clinic

Who is responsible?	General Manager for the Access Centre

What resources (if any) are needed to implement the change(s) and are these resources available?

- Staff member with information analysis skills to develop the Balanced scorecard for out-patients
- Staff member to interrogate EPR system and obtain capacity and demand and performance information once the system allows.
- Project management resources are available as Out-patients is a key area for transformation in 2014/15. These areas of performance are integral to the project.

Date actions will be completed:	Actions 1, 3 & 4 by end of March 2014. Action 2 by the end of April 2014 if EPR issues are resolved by then, Action 5 by end of May 2014.

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Action 1. The capacity and demand issues experienced by patients will be mitigated by the regular review of clinic bookings and rescheduling of appointments if necessary by the speciality teams. This will ensure clinics are not overbooked creating long waiting times for patients.

Action 5. Monitoring can be done by visual checks of the clinic bookings and walkabouts by service and general managers situated on site. This will be formalised once we have the balanced scorecard.

Completed by: (please print name(s) in full)	FIONA ISACSSON
Position(s):	Director of Operations Surgery, Cancer and Diagnostics
Date:	14th March 2014.

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RKE
Our reference	INS1-974537155
Location name	Whittington Hospital NHS Trust
Provider name	The Whittington Hospital NHS Trust

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:
	On Meyrick Ward and in Outpatients care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. The provider was failing to meet Regulation 9 (1)(b)(i)(ii)(iii).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Single point of contact for all safeguarding alerts to create central knowledge and reference point. (Safeguarding Lead)
2. Develop a database to record all safeguarding activity, track investigations and actions to ensure there is an accurate and accessible information trail of all safeguarding activity (Safeguarding Lead and Local Authority Leads)
3. Develop a database of all Deprivation of Liberty applications and outcomes to ensure there is an accurate and accessible information trail of all safeguarding activity(Safeguarding Lead)
4. Create Dashboards to provide clear feedback of safeguarding and deprivation of liberty activity per Division (Safeguarding Lead)
5. Utilise Datix to cross reference information and centrally record information (Datix Manager/Safeguarding Lead)
6. Review and update training provision for all staff (Safeguarding Lead)
7. Standardise Mental Capacity Act Assessment form and upload on to IT systems.

(Safeguarding Lead)

8. Increase presence of Safeguarding Lead on the wards to improve awareness of correct procedures for assessing mental capacity and deprivation of liberty (Safeguarding Lead)

Who is responsible for the action?	Adult Safeguarding Lead Local Authority Leads Datix Manager

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

The databases and dashboards will be created and accessible via the Safeguarding Lead. Reports on activity and progress will be provided to the Quality Committee 3 times per year. Reports will be provided quarterly to the adult Risk Committees

Who is responsible?	Adult Safeguarding Lead

What resources (if any) are needed to implement the change(s) and are these resources available?

There is a full time safeguarding lead employed in the Trust who will lead on all actions. Local Authorities have agreed on relevant information sharing via data managers

Date actions will be completed:	1 – 8 End of March 2014

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	24.03.14

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RKE
Our reference	INS1-974537155
Location name	Whittington Hospital NHS Trust
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Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Building works have been approved to reconfigure office areas in Jenner Building and Health records to accommodate administration and Health Records staff (Estates and Facilities)
2. Staff training for new roles will commence in anticipation of building work completion (Line managers)
3. Staff will be informed of buildings approval, the plan to commence training and have the opportunity to ask questions (Line managers and HR Lead)
4. HR staff and managers are available to respond to staff questions re the process (Line managers and HR Lead for Surgery Cancer and Diagnostics)
5. Staff will be provided with Standard Operation Procedures and Access Policies in preparation for their new roles (Line managers)

Who is responsible for the action?	See individual actions.

	Operations Lead for Surgery Cancer and Diagnostics will oversee the completion of actions.

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1. Building works will be complete and staff will be allocated desk space.
2. Staff will have received training and be equipped to undertake their new roles.
3. Staff will be aware of the plans for re location of desk space and training for new roles.
5. Staff will have received the documents and had the opportunity to read them.

Who is responsible?	Line managers. Operations Lead for Surgery Cancer and Diagnostics will oversee the completion of actions.

What resources (if any) are needed to implement the change(s) and are these resources available?

1. Finance for building works has been agreed.
2. Staff will need to be released from current duties to attend training. This will be accommodated using existing staff levels plus bank staff where necessary.
3. HR and line manager time to communicate plans to staff and answer queries

Date actions will be completed:	1. Six weeks from start date. No start date agreed yet as funding only confirmed last week. Approx End of May 2014. 2. Date to be confirmed in line with building works. Approx End of May 2014 3. April 2014

How will people who use the service(s) be affected by you not meeting this regulation until this date?

1. Staff may feel unsettled until the works are completed and they are in their permanent offices. We do not anticipate any effect on patient care.

Completed by: (please print name(s) in full)	Rosalind Murphy
Position(s):	Regulatory Compliance Manager
Date:	25.03.14

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Whittington Hospital NHS Trust

Trust Offices, Magdala Avenue, London, N19 5NF

Tel: 02072883939

Date of Inspections: 17 January 2014
08 January 2014

Date of Publication: March 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	The Whittington Hospital NHS Trust
Overview of the service	Whittington Hospital NHS Trust is an acute local general teaching hospital situated in Archway, in the north of Islington. It provides inpatient and outpatient services to the communities of North Islington and West Haringey, a population of approximately 250,000 people.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 January 2014 and 17 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During the two days of our inspection we visited a range of departments in the hospital. We visited the Accident and Emergency Department (A&E); Isis, Mercers, Meyrick, Bridges and Coyle wards; the Day Treatment Centre; endoscopy diagnostic services; and a range of outpatient services, including the breast clinic, urology clinic, ear nose and throat clinic, upper gastroenterology clinic and bariatric clinic. We also visited the medical records department, medical secretaries and appointments booking team. We spoke with many hospital staff performing a wide range of different roles.

Most of the patients we spoke with told us that they were happy with the care and treatment provided by the trust, felt their dignity was respected and that staff were friendly, polite and knowledgeable. Examples of comments we received include "the staff are good" and I "cannot complain at all, they [the staff] try and keep all the patients well looked after."

We found that many services were delivered very well and patients received a high standard of care. On the days we visited, the Accident and Emergency Department was extremely busy and patients needing to be admitted were experiencing very long waits for inpatient beds. However, we found that the trust was putting in measures to manage these delays.

We found two areas where improvements were required. Some patients were waiting a long time in outpatients. This had happened repeatedly for some people and they had not been given clear information about the delays. We also found several aspects of the care on Meyrick Ward that needed improving to ensure patient safety and welfare was maintained.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. However, whilst safeguarding processes are in place, further work is needed to embed and use information from these systems. In addition, whilst training was being undertaken in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and processes are in place, staff are not yet confidently applying this learning and consistently adopting these processes across the trust.

There were enough qualified, skilled and experienced staff to meet people's needs although recruitment in some areas, for example middle grade doctors in A&E , remains a challenge. People were cared for by staff who mostly felt well supported, although monitoring the health and morale of staff affected by the trust's Transforming Patient Experience programme needs improvement.

There was an effective complaints system available. Comments and complaints from patients were responded to appropriately. However, the trust was failing to meet its own targets in terms of responding to complaints within set timescales. The trust was aware of this issue and was recruiting extra staff to address it.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

On Meyrick Ward and in Outpatients, care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Accident and Emergency Department

In 2012-13 the Accident and Emergency Department (A&E) had approximately 90,000 patient attendances.

There is a Government target that 95% of patients attending A&E must be seen, treated, admitted or discharged in under four hours. In general the trust was meeting this target, and in five of the last six months of 2013 this target had been met. It was not met in September.

We looked at the data for the time taken to triage patients after they arrived in the department. The trust aims to triage 95% of patients within 20 minutes of arriving in the department. In the last three months of 2013 only 78% of patients were triaged within 20 minutes. This delay may result in patients experiencing delays in receiving the care they require.

There is also a target that patients are handed over from ambulance staff to hospital staff in under 15 minutes. In October and December 2013 the trust's data recorded that they had managed to meet the target in fewer than 40% of cases. We were told this was partly due to the computer system not being used correctly, which meant times recorded were not accurate. However, handover times were regularly over 15 minutes. This meant that patients were at risk of having their treatment delayed.

When we visited A&E on 8 January staff told us it was extremely busy. This was partly due to patients having to be treated in the department due to beds being unavailable elsewhere in the hospital. The previous night seven patients had spent the night in the

department waiting for a vacant bed on a ward. Of these, five patients were subsequently admitted and two discharged after a period of over 12 hours in A&E. Following the inspection the trust informed us that on the following day there were 16 breaches where patients spent over 4 hours in A&E. Although we were told specialist clinicians had assessed and started treating the patients this was not an appropriate environment to receive care. In addition, A&E was unable to assess and treat patients as intended as cubicles were occupied by those who needed to be treated elsewhere.

When we visited A&E on 17 January we were told that the department continued to work under pressure. To address this we were told that bed management meetings took place up to four times a day to ensure patient transfers and discharges were coordinated. We were also told that a temporary patient discharge lounge had been opened to facilitate discharges in response to winter bed pressures.

Inpatient wards

We inspected Meyrick Ward which cares for up to 25 older people in three bays. In general, patients looked well cared for and their privacy was maintained. We observed that all the patients were wearing nightclothes. When we spoke with patients they told us they had not been asked what they wanted to wear but were satisfied with the choice. We observed that staff working on the ward were polite and saw examples of good communication between staff and patients.

Of 15 patients observed only six patients had their call bell in reach. Those that were out of reach were hanging on hooks behind beds, on the floor, or, in one case, placed in the patient's drawer. We did not clarify exactly why each patient did not have their call bell but recognised that some patients wanting to use the bell may not have been able to reach it. We observed one patient calling out for help for 40 minutes and no staff offered assistance during this time. This patient did not have a call bell accessible to them and appeared distressed. When we asked a member of staff about this patient they told us that the patient "always called out." Staff from the trust told us that some patients who were unable to use their call bells had beds close to the nurses' station so they could be observed and assistance provided as needed.

The patient documentation on Meyrick Ward was poorly maintained. This meant that patients were at risk of receiving poor care. When we spoke with staff they told us that they had little time to complete notes as they were busy delivering care. We saw that fluid charts were inaccurate and many had not been completed. Other charts we saw were also only partially completed throughout the day. Whilst we were told that the ward had made improvements in how it managed pressure ulcers as had been reflected in their audits, a patient, who was at risk of developing pressure ulcers, had no risk assessment completed despite having been on the ward for 20 hours. We saw that care rounds were not documented for six hours in one patient's notes and for eight hours for another. Do Not Resuscitate forms had not been completed accurately for some patients. We saw examples that did not record any consultation with the person or their family members. This meant there was a risk someone may be resuscitated contrary to their wishes.

We observed lunch on the ward. Staff did not seem to be aware that meals were about to start, which meant patients were not prepared and tables were not cleared. Meals were well presented and most were served hot. Staff were telling people what the food was as they served them and there was a system in place to alert staff to a patient who required assistance. However, we saw meals being left on patients tables whilst staff went off to

help to give meals out throughout the ward. Staff did not explain to patients that a member of staff would be back to help.

We were concerned about the management of infection control on Meyrick Ward. One bay had been assigned for patients with MRSA. Staff had to enter this bay to reach the sluice, although this did not bring them into direct contact with the beds. We noted that infection control precautions in regards to hand-washing and changing of aprons were not routinely adhered to, although staff were reminding each other of them. Patients were not offered the opportunity to wash their hands prior to their meals and no hand wipes were offered.

Some patients told us that they were bored as there was little social interaction with the staff at busy times. We did not see patients watching television although these were available for hire. There was a day room available, although on the day we visited this was only used for meetings. Patients we spoke with were not aware it was there and had never used it. When we spoke with staff they staff explained it was used as a quiet room, for multidisciplinary meetings, therapy and activities.

We inspected Bridges Ward, which had been opened up as part of the trust's strategy for managing winter pressures and increased medical patient admissions. At the time of the inspection the ward could accommodate 17 patients. We observed that staff did not seem rushed and they were friendly and polite. Patients were also relaxed and we saw they all had drinks and call bells within their reach. Patients told us that "most of the staff are friendly" and that "the care is very good." They also said "if I want cup of tea they come" and that "they explain what is happening."

Most of the patients on the ward were older patients and many of them had dementia or were confused. Staff told us that because of the complex health needs of the patients treated on the ward, they worked in close partnership with the social work team, physiotherapists, occupational therapists and other professionals involved in patients care. We noted that there were good examples of multidisciplinary working with regular input from dieticians and tissue viability nurses. Staff told us that the diagnostic department were very good and that the radiology "were incredible" as they were sharing outcomes of medical examinations promptly. We were also told that occasionally patients faced delays in hospital discharge linked to difficulties in coordinating community care.

We were told that all staff had undertaken basic life support training and were able to deal with emergencies. We saw that there was a plan on how to act in the event of fire. There was adequate equipment available, such as hoists, to support patients with mobility difficulties.

On the day of the inspection we also visited Mercers Ward, which is an acute medical ward. We noted that a number of patients who were at risk of developing a pressure ulcer were on the ward. Staff told us that waiting times for a pressure relieving mattress increased outside the hours of 8am and 5pm. A maximum of a six hours wait was reported during weekends. During our visit we observed that one mattress had been ordered by a member of staff and it was received shortly afterwards.

The final ward we visited was Coyle ward. On this ward we found good care being planned and delivered and when we spoke with staff they were knowledgeable about their patients. Staff also told us that they felt well supported and worked well as a team.

Day Treatment Centre

Patients at the Day Treatment Centre (DTC) told us that they were happy with the care and treatment provided. One person said "overall it is good, it is a new Whittington". We noted that patients there were provided with accurate information concerning their care and treatment. Staff told us that doctors explained details of the procedure during the initial consultation and the choices available. We saw that patients' notes included a record of this conversation, including a discussion of the risks associated with the procedure. We saw there were admission packs available for day patients. Staff told us that they tried to keep their explanations simple and that they took time to allow patients to ask questions. One of the patients told us that "staff use a lot of medical terminology" and that "it would be useful if they could use more plain language".

Some of the patients told us that they were required to wait for a long time at the hospital before their day surgery took place. We noted that all patients were asked to arrive at the DTC at 7am but some of the surgery did not take place until several hours later and in a few cases not until the afternoon. This meant that patients would be waiting a long time without having had anything to eat or drink since the previous day. One person said "I came at 7:30am, now it is 10:45am. I saw a doctor at 8am and since then nobody came to talk to me". Staff told us they were aware of this issue and were exploring the introduction of a staggered arrival time for patients and being able to allow patients to have a drink where appropriate. The provider might find it useful to note that some patients attending the DTC were experiencing waits of several hours and had not been told when their surgery was taking place or if they could have a drink while they were waiting.

Endoscopy services

We visited the endoscopy services and spoke with staff. We observed that on the day of the inspection the service was working very smoothly for patients attending appointments. The manager confirmed that additional sessions have been provided at the weekend to ensure patients are no longer experiencing an extended waiting time for these tests.

Staff told us that if any additional medical tests were needed this could be completed on the same day and the results were provided promptly. This was confirmed by patients who told us that "everything was quick" when asked about their diagnostic and screening procedures.

We asked a number of staff during and after the inspection for the latest figures on how the trust was performing in relation to national referral to treatment targets. This information monitors how the trust is doing in terms of treating patients in a timely manner for different health issues. They told us that the introduction of the new IT system was preventing the production of this information and that they were working to get this addressed. However, this meant that at the time of the inspection the trust could not monitor its performance.

Outpatient services

Patients attending the outpatient clinics and their carers gave us very positive feedback about the approach of staff working in these areas. Comments included "the doctors and nurses have good interpersonal skills" and that staff "explain your treatment in layman's language".

Patients felt consultants and nurses in the outpatients' clinics spent a sufficient amount of time with them and most felt informed about their care and treatment. They experienced

no difficulties in obtaining follow-up appointments and they told us they felt communication with other professionals involved in their care, such as their referring GP, was good. If patients required a blood test this was done on site. There was a ticketing system in phlebotomy and we noted patients were seen promptly.

Whilst we found good practice in some clinics, this was not consistent and some patients were waiting long periods of time and not receiving clear communication on the delays. We could see, and patients told us, that they had to wait variable times to be seen in outpatients. Some patients told us that waiting times were "reasonable" and that staff would apologise for any delays. Other patients told us the wait to be seen was usually two hours and that the later in the day the appointment was, the longer the wait would usually be. They did however say that when waiting times were longer than two hours staff would often come out of clinics and tell people.

We noted that there was good information provided to patients in the breast clinic. Most appointments to the breast clinic were three stage appointments which took a long time and required some waiting in between the stages. The nurse told us that previously this had not been fully explained to patients in their appointment letters. In response to patients' comments the clinic had changed their correspondence to clarify the appointment routine. They had also introduced "a bleeper system" where patients were given a pager and could leave the waiting area if they wished.

A new computer system had been introduced at the trust in November 2013. Staff told us they were still learning to use the new system and this was affecting the patient experience. We were told by staff that at times queues were very long at the reception desk and simple tasks took longer to complete than on the previous system. Staff felt they had received enough training and support in using the system. We were also told that when the new system was being introduced there were signs throughout the department explaining to patients that they may experience delays.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Staff working at the hospital were mostly aware of the procedure they should follow if they suspected abuse was taking place and how to report it appropriately. Staff told us about the training they received and how this was refreshed annually. Some staff members were able to tell us about safeguarding alerts they had made and the outcomes for the patients concerned. Staff we spoke to on Meyrick Ward said they had received the training but were not always clear on the procedures they would follow. When we asked staff who they should contact if they had concerns they were not always clear on who this should be. However, they were clear on the need to raise concerns.

Over the past 12 months we had been notified of safeguarding incidents, both by the trust and by the local authorities working in partnership with the hospital. The provider may find it useful to note that they were not always able to provide us with accurate information about the outcomes of these alerts in a timely manner. This meant that patients were at risk as there was no system in place for identifying safeguarding themes and ensuring these are addressed appropriately. The trust had included this issue on their risk register and had discussed it at the Patients Safety Committee in November 2013. In addition, they had appointed a new lead in safeguarding. We were told that the trust now collated all information regarding incidents referred under safeguarding protocols.

We spoke with staff to ask them about the training they had received on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us that this subject was covered during their safeguarding training. However, staff members told us they did not feel it was sufficient and did not feel confident in applying it. We found examples of where staff were confused about the use of a checklist form that was intended to identify potential deprivations or restrictions of liberty and trigger the referral process. Some staff we spoke with thought that once this form was completed the DoLS was approved. This was incorrect. On Meyrick Ward we saw one patient wearing mittens to prevent them from removing their enteral feeding tube, which restricted their liberty. Staff were unable to say if a capacity assessment and best interest process had been followed. When we looked in the patient's records we found that a meeting had taken place with relatives as part of a ward round but had not been recognised as being part of a best

interest decision making process Senior managers told us they were very aware of the need for further work in this area and that this was part of the safeguarding leads role. The provider may find it useful to note that whilst MCA training and DoLS processes are in place staff are not yet confidently applying this learning across the trust.

The trust informed us that they were working towards raising the profile of the MCA and DoLS on acute wards. The trust was also in the process of developing a database to record all DoLS applications, which would allow them to be tracked centrally by March 2014.

In addition, they were in the process of reviewing the content of safeguarding training to recognise a broader range of abuse including female genital mutilation, and other forms of 'honour based abuse'.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained, although there were some areas where improvements were required.

When we visited the accident and emergency department we noted it was bright and clean. Patients were treated in an individual cubicle or side room, which allowed their privacy to be maintained. The department was accessible to people who use wheelchairs and wall fittings and doors provided visual contrast. The provider may find it useful to note that there were inadequate storage facilities in the department. For example, bed linen, both clean and dirty, and beds were stored in the main ambulance arrival corridor. This could present a potential infection control risk. Staff told us that they had lost some storage space due to the refurbishment of the building that was underway in order to enlarge the ambulatory care unit.

We also visited Isis Ward, which is a Clinical Decision Unit and part of the Accident and Emergency Department, where patients are admitted if they require medical observation. This ward has eight beds and two armchairs that are used by patients. We were told by staff that it had recently been organised in single sex bays. However, the bathrooms and toilets, which had been recently redecorated, were shared by patients of both sexes. The provider may find it useful to note that there was very little space in the ward given the number of patients. In addition, the two patient observation chairs, which were placed in an area that acted as a corridor, did not offer the patients much privacy. Lighting was poor and some window blinds were not attached fully. Paint work was chipped throughout the ward. There was inadequate storage, which meant corridors or bathrooms were being used for this purpose. For example, we saw dirty mops and buckets being stored in a bathroom. Staff from the trust told us that the ward is due to undergo refurbishment in April 2014.

Staff at the Meyrick Ward told us that they had monthly health and safety inspections to ensure the physical environment of the ward was suitable. They also said that they could ask for urgent repairs and they felt the ward and equipment was well maintained. On Bridges Ward which was only opened on a temporary basis, staff and patients told us that

the environment was appropriate with enough space and sufficient bathrooms and hand-washing facilities. Some individual bedrooms were available. There was sufficient equipment including hoists and the ward was clean at all times. The provider may find it useful to note that the ward was not well signposted and it is hard for visitors to find the ward.

The other wards we visited were well organised, well equipped and clean. Staff of the Day Treatment Centre (DTC) told us that they felt premises were fit for purpose and there were no problems with maintenance. Patients told us that "the toilets were clean." We noted that some of the bays lacked privacy and that conversations between patients and clinicians could be overheard. Staff told us that this was a problem and people could hear private conversations taking place at the time of admissions. The corridor of the DTC was used as a 'through way' by staff from other departments. We noted that three domestic staff were employed to ensure individual bays were kept clean. This meant that patients were cared for in a safe, clean and well maintained environment.

When we visited the outpatients' clinics we noted there were comfortable armchairs for patients to sit on. Patients could also watch television or browse through some of the leaflets displayed on the wall. The clinics were mostly in a good decorative order. One patient told us "the comfort of the clinic makes waiting easier". The provider may find it useful to note that the toilets in clinics 4 (a) and (b) had not been cleaned on the morning of our visit and the record on the wall showing when cleaning staff had attended had not been signed since 3.25pm the previous day. We spoke with staff who told us that cleaning was often done overnight and that they fed back to the cleaner if clinical areas had not been cleaned properly. They felt that the cleaning could be improved and were concerned that clinics were not cleaned during the day.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. The trust is looking at ways to make hard to fill posts more attractive to enhance the recruitment process.

Reasons for our judgement

We noted that since our last inspection the trust had made progress in their work to recruit additional nurses and health care assistants. Most patients who we spoke with told us they felt they had spent a sufficient amount of time with staff. Although a few patients told us they felt the nursing staff were very busy, most told us that they thought there were enough staff.

When we visited the Accident and Emergency Department we were told that, after a recent recruitment process, all the nursing posts were now filled. At the time of the inspection the department had six consultants in post. This is fewer than the ten consultants recommended by the Royal College for Emergency Medicine's guidance based on the activity levels of the department. When we spoke with staff in the department they told us they felt that the consultants were providing good cover and supervision, but there were vacancies for other middle grade medical staff. We were told that these vacant posts were being covered by locum (temporary) staff. In November 2013 there were 273 shifts covered by locum medics. However, locum staff may not always be familiar with the procedures in the department and may not provide the continuity of permanent staff. We were told that the department was in the process of looking at different ways to recruit to these posts including reviewing how the training is provided to make the posts more attractive.

On Bridges Ward, which had been set up to help with winter bed pressures, the ward manager told us that there were ten core members of staff who had been released from their permanent wards. There were also regular bank nurses and bank health care assistants and some additional bank or agency staff booked as required. When we visited, there were sufficient numbers of staff available to meet patients' needs. Doctors we spoke with told us that they felt supported in their work on the ward.

Mercers Ward had 16 patients, with eight of these patients being supported in side rooms. We noted that staffing numbers were sufficient to meet patients' needs and staff were visible supporting patients on the ward. As part of the recent transformation project, additional hours had been provisionally agreed by the trust to provide additional night

cover. There was visible consultant support and we observed a team discussion about all patients which demonstrated a good team work approach.

Patients of the Day Treatment Centre (DTC) told us that staff were friendly and polite and that they did not seem to be rushed. One person told us that "staff were available to talk." Another told us that "the nurses always check on you." On the day of inspection eight nurses were working in the morning and three nurses during the afternoon. A member of staff told us that staff numbers varied depending on the attendance list and how busy individual clinics were. When required the DTC would use bank or agency staff. We were told that when using agency staff they would work with an experienced member of the team. Some staff members told us that recently they had struggled with booking additional staff as the DTC dealt with increased number of attendances.

Staff of the outpatients' clinics told us that there were sufficient numbers of consultants and registrars in clinics with one nurse allocated for each clinic. However, some staff we spoke with told us that there were still not enough health care assistants working at the clinics and this was presenting difficulties, especially in terms of chaperoning female patients where needed. When we spoke with managers, they told us that four new healthcare assistants had been recruited.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We asked patients for their views on the staff at the hospital. In general, the feedback we received was positive. Comments we received included the following:
"[I have] found the staff friendly and jolly".
"[Staff are] lovely, kind and polite."
"Support [from staff] was given when I asked."

In general, staff told us they felt well supported in their roles. Staff also told us that senior managers were also visible and approachable. For example, one member of staff told us "senior managers are on the ward regularly"; whilst another told us "if there is a problem I can inform the directors" and added "you can actually have your say". Staff on Mercers Ward told us they felt able to raise concerns and that if they felt these were unresolved they could escalate it to the Director of Nursing. Staff were generally aware of the whistleblowing procedures within the trust and told us that they would use it if they had any concerns.

We saw that there were systems in place for assessing staff skills and competencies. For example, in the Accident and Emergency Department a competency assessment was being used to assess staff skills in undertaking triage. The trust has a clinical skills programme. Clear areas for further education had been identified including, amongst others, training in tissue viability, intravenous phlebotomy, catheterisation, bowel management and in mentorship.

When staff begin working at the trust they undertake an induction process. This includes a corporate induction and e-learning modules. When we visited Meyrick Ward we were told that, following this, staff members would gain experience on the ward before they go on to complete other training. On Mercers Ward staff members told us their induction to the ward had been very good and they felt well supported. They had been orientated and could ask the nurse in charge questions. They told us specialist training, such as on the management of falls, had been provided.

On Meyrick Ward all staff we spoke with told us they had completed their mandatory training which included safeguarding and infection control. Staff were sometimes able to

access more specialist training. For example, two nurses were due to attend 'dementia champions training' as there was no dementia champion on the ward. However, the provider may find it useful to note that staff on Meyrick Ward were not always able to attend the training they felt was relevant to their job. We were told that on occasions they were not able to be released from the ward for a short three hours training session as this would impact on the care delivery.

When we visited Bridges Ward the staff had no access to current staff training records, as this was held by the staffs permanent wards and managers. The ward manager had asked staff what training they had received and in addition to the mandatory training most staff had relevant training such as caring for people with dementia.

We observed examples of good teamwork. On Coyle Ward staff told us that they felt there was good multi-disciplinary communication and working between therapists, health care assistants, nurses and doctors. We were told that team meetings were held monthly and were well attended. A 'How are we doing board' was completed and updated regularly. Staff felt this was a good as it celebrated good practice, as well as being transparent with key issues that they had failed to deliver on. Staff told us that they had recently been appraised and that they felt valued. We noted that staff also had a good knowledge of patients and their individualised such as caring for people with dementia.

Nurses at the outpatients' clinics told us they were very well supported by the lead nurse, who often identified training courses they could attend. All nurses were given half a day each month known as an 'audit day' for meetings, training and professional development. Staff meetings were happening, although we noted that these were not always regular. However, the staff we spoke with told us that the local management and the team were approachable and supportive. We saw that a dementia awareness course was available to staff and there were several other training opportunities for staff to attend throughout the coming weeks. Staff we spoke with in outpatients felt informed about changes within the trust.

Staff in the Day Treatment Centre told us they found the local management receptive to comments and suggestions and they had good working relationship in general. Staff told us they felt supported with professional development and had access to training which included infection control, phlebotomy or specialist training related to their role. All the staff we spoke with told us that they had been appraised within the past 12 months. Some staff told us they felt the team "lacks spirit" and that staff morale was low, although it was noted that "things were improving". Staff also told us they felt they could receive more and improved support and supervision.

The trust has been undertaking a 'Transforming Patient Experience' (TPE) programme, which has the aim of improving patient administration processes. This is leading to a number of changes in how the trust accesses administrative and clerical support. We spoke with a number of staff affected by these changes, including people working at the medical records department, medical secretaries, and the appointments and admission team (access team). A number of staff we spoke with told us morale amongst staff was poor as a result of these changes. Some told us they thought they had not received proper support and communication from the senior management and the human resource team through the process. One member of staff told us "we were left in a horrible limbo; it is like a form of a torture." Another person complained that there was only minimal communication "I don't feel there is anybody I can talk to [regarding the future of their job]" and that they "have recently stopped asking."

Staff working at the medical records department had been recently asked to prepare patients' notes for some of the outpatient's clinics. This was a new area of work for them in addition to their regular task of pulling and chasing records. We were told by staff that it was hard to manage this additional work but records were still available in time for clinics.

The access team had also been affected by the changes introduced as part of the TPE programme. At the time of our inspection there were ten permanent staff working for the team and they were supported by eight bank staff. The manager told us that they had experienced a high turnover among the bank staff, which meant that they were required to constantly train new people. We were also told that staff morale was low and that sickness levels were high. After the inspection we asked how the trust to send us the latest sickness levels so we could see how they were monitoring staff sickness in these teams affected by the changes. The provider might find it useful to note that this information was not available in a timely manner and so we were not able to confirm if staff sickness was being monitored by the trust to ensure staff received the support they needed.

We met and spoke with four of the medical secretaries. There had been a number of changes to their roles following the introduction of a system where dictated letters were typed through an external service. It was clear that they were all finding the changes to their roles a challenge. They were feeling overworked, but did not feel that patients were affected. If staff were not working some additional secretarial input had been arranged to ensure there were no delays in sending out letters. Patients wanting to speak to the secretary could leave a message and a service manager checked these so they were responded to as needed. The trust acknowledged there had been a number of recent changes, but felt patients were not affected by the changes.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Work has started to ensure complaints are responded to in a timely manner.

Reasons for our judgement

People were given support by the provider to make a comment or complaint where they needed assistance. The trust website contains information on how to make a complaint, including who to contact if you were not satisfied with the trust's response. Information is also provided on advocacy services, which are independent services available to support people through the process, and access to interpreting and translation services. When we visited the hospital we saw information was available in most areas on how to contact the Patient Advice and Liaison Service (PALS). This team offers help, support, information and advice to patients and their relatives should they have a concern. This includes advising people on how to make formal complaints.

When we visited the hospital people told us they felt confident they would be able to raise concerns should they have them. When we spoke with patients in the outpatients clinic, they told us that they "did not have to make a complaint", but should they wish to they would speak to the person in charge. There was a poster displayed in the waiting area informing patients who to contact if they were dissatisfied with services. This included a picture of the clinic's manager, their telephone number and e-mail address. There was also a poster explaining how to contact PALS and make a formal complaint. Staff told us they had received lots of feedback from patients and this was both positive and suggesting improvements. They told us that if they received concerns from a patient they would first speak to the person to see if they could resolve any concerns, and if they couldn't they would refer them to PALS.

When we spoke with staff on Bridges Ward and Meyrick Ward they told us that if anyone had a concern they would refer them to the ward manager or PALS. We saw that information posters and leaflets were available to explain to people the process for how to complain. However, the provider may find it useful to note that when we visited the Day Treatment Centre no written information on how to contact the PALS team was accessible to patients.

The trust was collecting patient feedback in a range of ways. When we visited the outpatient clinics we noted that there were touch screens in clinics for people to leave feedback. However, one of the two screens we saw on the day was not working. In addition, patient feedback was being collected by the PALS team and at a local level. For

example, on Bridges ward, staff told us that patients were encouraged to share their experience and their feedback was gathered by the ward's clerk. The trust was also collecting information as part of the national friends and family test. This is a single question survey asking patients whether they would recommend the service they had received to friends and family. The trust was monitoring the performance of wards and departments in this test. The trust scored marginally below the London average in October and November 2013. One area of concern was that there had been a low response rate from the people who attended the Accident and Emergency Department. When we visited the department we were told the trust was trying to increase the response rate. One way in which this was being attempted was through providing a range of boxes with pictures to reflect the person's happiness with the service, which people could place cards in to reflect their view.

The provider took account of complaints and comments to improve the service. There was evidence that when complaints and comments were made that the information from these was monitored and used. We asked for and received a summary of complaints people had made and the provider's response. This showed that when a complaint was received themes were identified and these were responded to. In the areas we visited, staff were able to give us examples of recent complaints and the learning that had been identified. The trust was also monitoring and responding to most of the comments patients left on the NHS Choices website. Patients who left negative comments were encouraged to contact PALS

The trust was not responding to all complaints promptly. It has a target that 80% of formal complaints will be responded to within 25 days. We noted that the trust was regularly failing to meet this target. In November 2013 only 26% of complaints raised with the trust were responded to within the set timescale. When we asked staff why this was, they told us it partially due to staff shortages. At the time of the inspection there were five staff working at the department and the trust was in the process of recruiting two extra members of staff.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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 activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: On Meyrick Ward and in Outpatients care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. The provider was failing to meet Regulation 9 (1)(b)(i)(ii)(iii).

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

The provider's report should be sent to us by 19 March 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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