The Hillingdon Hospitals NHS Foundation Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of our comprehensive inspection programme of all NHS acute providers and we inspected both of the trust's locations of Hillingdon and Mount Vernon Hospitals.

Overall, this trust was rated as requires improvement with an inadequate rating for providing safe care and a good rating for caring. We rated it requires improvement for providing effective care, being responsive to patients' needs and being well-led.

Our key findings were as follows:

- There were many concerns identified which present risks to patient safety.
- The trust was not complying with infection prevention and control standards.
- Staff records regarding training showed poor performance in key areas such as infection prevention and control, safeguarding and moving and handling.
- The trust is failing to effectively assess and monitor the quality of care it provides.
- The trust was delivering the key national performance indicators, such as ED waiting times with 95.2% of patients attending being treated, transferred or discharged across the A&E (87%) at Hillingdon Hospital and the Minor Injuries Unit (99%) at Mount Vernon Hospital.
- The trust had a very committed workforce, but there was a significant shortage of nursing staff which was compounded by additional wards being open.
- The trust performed better than expected in the number of patients acquiring clostridium difficile, however, they performed worse than expected for patients acquiring MRSA bacteraemia.
- There were many areas where the trust was aware of the challenges and risks and had logged these risks on local and corporate risk registers, however, there were often no plans or measures for implementation for when the risks were going to be addressed or when changes had been made, including:
  - The risk that child protection issues could be missed due to a failure to follow agreed processes had been identified, but not addressed;
  - The risk of admitting children with high dependencies to wards that aren't appropriately staffed to meet their needs, has been on a risk register for over a year without being appropriately managed; and
  - There were risks identified with the management of the storage of anaesthetic drugs where changes had been implemented, but were not sufficient to manage the risks.

We saw several areas of good practice including:

- The nurse practitioners in the Minor Injuries Unit made direct referrals to specialities both internally and externally to the hospital; this included tertiary referrals to specialists such as plastic surgery.
- The effective management of 18 week referral to treatment times for patients.
- The specialist care for children with diabetes, specifically the outreach work into schools.
- A maternity triage care bundle to promote consistency of care provided for women.
- Announced and unannounced "skills drills" training to rehearse obstetric emergencies.
- Good access to physiotherapy and occupational therapy and good multidisciplinary team working for surgical patients at Mount Vernon Hospital.
- Good multidisciplinary team working to support one stop outpatient clinics.
- Trainee doctors commented very positively on the support and mentorship they received while working at the trust.
- The critical care unit had physiotherapy presence seven days a week, and undertook ward rounds each day, as well as being available on call.
- The trust had a proactive specialist nurse for organ donation.

However, there were also areas of poor practice where the trust needs to make improvements:

The trust MUST

- Make sure it complies with infection prevention and control standards and that it monitors cleanliness against national standards.

Summary of findings

- Assure itself that the ventilation of all theatres meets required standards.
- Address the risks associated with the numerous staffing establishment shortages across the trust.
- Make sure that staff are appropriately trained in safeguarding both adults and children, and that the trust regularly monitors and assesses the completion of actions agreed at weekly 'safety net' meetings.
- Make sure that all staff understand their responsibilities in relation to the trust's systems and processes that exist to safeguard children.
- Make sure staff are trained and understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Make sure that the use of keypads on wards does not unlawfully restrict patients' liberty.
- Make sure that all staff receive the full suite of mandatory training that is required to minimise risks to patient safety.
- Make sure agency staff receive an appropriate local induction on to wards.
- Make sure that there are adequate numbers of paediatric staff trained in Advanced Paediatric Life Support as per the Royal College of Nursing's recommended standard.
- Make sure of the effective operation of systems to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of patients.
- Make sure that local leaders are held accountable if they do not routinely and accurately complete required audits.
- Make sure that trust premises are secure and that maternity and children's areas and wards cannot be accessed by the public without staff knowledge and appropriate challenge when necessary.
- Make sure patients are protected against the risks associated with the unsafe use and management of medicines.
- Make sure patients and visitors are protected against the risks associated with unsafe or unsuitable premises.
- Make sure that there equipment is properly maintained and suitable for its purpose and that out of single use equipment is disposed of appropriately.
- Make sure that equipment is available in sufficient quantities in order to ensure the safety of patients and to meet their assessed needs.
- Make sure that records are accurately and appropriately maintained, are kept securely and can be located promptly when required.
- Make sure that early warning system documentation is appropriately maintained and that all staff react appropriately to triggers and prompts.
- Complete venous thromboembolism assessments as appropriate.
- Log the date of receipt of a complaint as the date the trust are first made aware of the complaint.

The trust should:

- Review the process for admitting patients to wards from the accident and emergency to make sure the process is effectively managed and that unnecessary delays in transferring patients are not occurring.
- Ensure there is a fixed rota for consultant cover out-of-hours for the critical care unit.
- Consider providing support from a Practice Nurse Educator for critical care nursing staff.
- Consider contributing to ICNARC data collection.
- Confirm the trust's permanent bed capacity and an accurate base staffing establishment figure the trust projects it needs to deliver safe and effective care for this number of beds.
- Engage with local end of life care leadership to establish the trust's strategy for the service.
- Make sure that appropriate translation services are available and are being utilised to meet patient need.
- Review the resourcing of medical secretaries to make sure they can meet patient need and the trust's own targets for sending GP letters.
- Consider implementing the Friends and Family Test for all wards at the trust.
- Consider whether patient outcomes could be improved through dedicated consultant cover and / or consultant oversight for the Minor Injuries Unit.
- Consider auditing pre-operative starvation to make sure patients are not starved for significantly longer than required.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to The Hillingdon Hospitals NHS Foundation Trust

The trust provided services from both Hillingdon Hospital and Mount Vernon Hospital.

The current Hillingdon Hospital opened its doors in 1967 and was awarded foundation status in April 2011

In 2012/13 the trust had a turnover of £190 million and employed over 2,500 staff.

The trust provides care to the residents of the London Borough of Hillingdon, and increasingly to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire, giving us a total catchment population of over 350,000 people

Hillingdon is a diverse suburban borough, with a large young population and an increasing proportion of older people. 25% of the population is under 18 years of age, while the proportion aged over 85 is set to rise by 22% by 2020. The proportion of the population from an ethnic background has risen to 28% of the total, and is projected to rise to 37% in 2020.

Hillingdon is the nearest district general hospital to London's Heathrow Airport, the busiest airport in Europe in terms of passenger numbers.

Our inspection team

Our inspection team was led by:

Chair: Mark Pugh, Executive Medical Director, Isle of Wight NHS Trust

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission (CQC)

Inspection Manager: Damian Cooper, CQC

CQC inspectors were joined on the inspection team by a variety of specialists including a student nurse and junior doctor, consultants in emergency medicine, obstetrics, intensive care medicine and paediatrics, experts by experience, an associate medical director, a consultant nurse for older people, a consultant midwife, clinical nurse specialists, a physiotherapist, a pharmacist and estates and facilities advisers.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The announced inspection visit took place between the 1 and 3 October 2014, with subsequent unannounced inspection visits on 15 and 16 October.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 30 September 2014, when people shared their views and experiences of

Hillingdon and Mount Vernon Hospitals. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

During our inspection we held focus groups with a range of hospital staff, including support workers, nurses,

Summary of findings

doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, outpatients, maternity and the trust's emergency department and minor injuries unit. We also held a focus group with the trust's Council of Governors. We observed how people were being cared for, talked with carers and/ family members and reviewed patients' personal care or treatment records

We would like to thank all staff, patients, carers and stakeholders for sharing their views and experiences of the quality of care and treatment at Hillingdon and Mount Vernon Hospitals.

What people who use the trust's services say

Friends and Family Test (FFT)

In 2013/14 the trust had a participation rate for 18% for its A&E patients, 40% for its inpatients and 27% for maternity patients.

In October 2014, 91% of respondents (17% response rate) recommended the trust's A&E as a place to receive treatment against an England average of 87%.

In October 2014, 91% of respondents (42% response rate) recommended the trust's inpatient services as a place to receive treatment against an England average of 94%.

In October 2014, the trust scored significantly below the England average for the number of women who recommended their antenatal and postnatal services, but scored the same as the national average for women who recommended giving birth at the trust.

Patient-led assessments of the Care Environment (PLACE) 2014

- The trust performed below the England average (96.1%) for cleanliness at 90.8%
- The trust performed slightly above the England average (88.4%) for privacy, dignity and wellbeing at 88.8% which was almost a 10% increase from their 2013 score
- The trust performed significantly below the England average (88.3%) for facilities at 81.52%
- The trust performed slightly above the England average (86.7%) for food at 87.79%

Accident and emergency survey 2014

In the Care Quality Commission 2014 Accident and emergency survey, the trust performed the same as other trusts in England for all eight of the questions asked.

NHS choices

The trust is rated at 3.5 stars out of a potential 5 on NHS Choices based on 124 patient ratings. From the ratings made in 2014 up until 19 November 2014, approximately 70% of reviewers gave the trust 4 stars or more.

Listening event

Patients at our listening event came to share with us a mixture of both positive and negative experiences.

The main themes from the experiences people shared were that they thought that there was good communication with nurses and doctors across the trust and good care in maternity and when using children's services, but despite several experiences of good communication, there was also a theme that people experienced longer waiting times than expected in A&E with often no explanation or reason for the wait. We also received negative comments about the lack of facilities in the trust's A&E.

Several people shared with us that their experience was that the trust staff were friendly, caring and compassionate.

Facts and data about this trust

- Beds – **480** of which 416 are general and acute beds, 48 maternity beds and 9 intensive care beds
- Inpatient admissions 2013/14 - **48,904**

Summary of findings

- Outpatient attendances 2013/14 - **292,615**
- A&E and MIU attendances 2013/14 - **91,154** the privately managed Urgent Care Centre (established in October 2013) saw just over 47,000 patients from January to July 2014
- Births 2013./14 - **4,067**
- Annual turnover - **204 million (2013/14)**
- Surplus (deficit) – **0.744 million**

Safe

- **Never events in past year** – There were three never events reported between April 2013 and June 2014. Two never events were reported between April 2013 to May 2014, both were retained swabs. In June 2014 a never event was reported which related to the sub-optimal care of a deteriorating patient in the A&E department.
- **Serious incidents (SIs)** - 44 serious incidents were reported between April 2013 and May 2014. Over 25% of those related to ambulance delay, other serious incidents reported included six unexpected admissions to the Neonatal Intensive Care Unit, six grade 3 pressure ulcers, three maternal unplanned admissions to the Intensive Therapy Unit and three were sub-optimal care of a deteriorating patient**.**
- **National Reporting and Learning System (NRLS)** reported from April 2013 to May 2014
- Deaths - **27**
- Severe - **39**
- Moderate - **300**
- Low - **1,934**
- No harm - **3,595**
- **Total - 5,895**

Effective

- In 2014 the trust was one of twelve in the country to have seen an improvement (a move to a higher banding) in performance at weekends on either weekend emergency HSMR, weekend readmission rates or weekend repair of broken hips.
- Both HSMR and SHMI mortality rates for the trust were within expected levels.

Caring

2013 Adult Inpatient Survey

- The trust scored consistently in line with other trusts in average for the questions asked in the survey carried-out by the Care Quality Commission between September 2013 and January 2014
- It performed no better than the national average performance for any of the areas and performed below the average performance nationally for giving enough privacy when examining patients in A&E and the cleanliness of rooms or wards

Summary of findings

2013/14 Cancer Patient Experience Survey

- The trust had a similar response rate to the England average at 61% compared to 64%.
- The survey shows that the trust was in the bottom 20% for 22 of the 68 questions asked and in the top 20% for 11 questions.
- The questions where the trust scored worse compared to the 2013 survey related to information and the communication between doctors and nurses and / or the patient and family members.
- The trust scored better on five questions, including questions related to providing patients with details of support groups and patients having seen cancer research information within the hospital.

Responsive

- The overall bed occupancy for the trust was 90%.
- The trust cancelled 203 operations on the day of the operation for non-clinical reasons in 2013/14.
- The trust was achieving the A&E target of seeing, treating and discharging or admitting 95% of patients within 4 hours of attendance at the A&E department.
- The trust was also achieving the referral to treatment target that 98% patients will be seen and treated within 18 weeks of referral.

Well led

NHS Staff Survey 2013

- The staff response rate for the trust was just under the national average (49%) at 45%
- For 30 indicators assessed, the trust performed the same as or better than the national average for 17 of the indicators and worse than the national average for 13.
- 83% of staff (compared to 79% nationally) felt satisfied with the quality of work and patient care they were able to deliver
- Appraisal rates and the quality of appraisals improved from 2012 whereas the percentage of staff who received health and safety and equality and diversity training was lower than in 2012
- Staff reported working more extra hours since the last survey, however, staff felt they worked more effectively as a team with the trust achieving a score in line with the national average
- There was an increase in staff motivation and overall staff engagement since 2012 with the trust scoring above the national for both scores at 3.95 and 3.77 respectively
- Staff job satisfaction was in line with the national average
- The number of staff who would recommend the trust as a place to work or receive treatment had increased since 2012 and scored above the national average of 3.67 at 3.70.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Inadequate** 

Incidents

The trust had not learned lessons from incidents. The trust had a number of serious incidents which involved deteriorating patients and our findings were that early warning documentation was not routinely completed and that triggers and prompts were not always followed-up as appropriate.

Several Incidents were reported in April 2014 that equipment was not always being maintained, or was not available when staff required it. We observed that equipment was not always being maintained.

Staff told us that they knew how to report incidents.

The trust had two never events which were retained swabs and had since implemented and monitored compliance with the WHO check list in theatre, however, this was not being complied with in radiology and no audits were taking place.

Infection prevention and control

When we inspected Hillingdon Hospital in October 2013 we found that the trust was non-compliant with regulation 12 of the Health and Social Care Act 2008. Regulation 12 governs cleanliness and infection control. When we inspected the hospital we found that the trust continued to breach this regulation.

We found that the trust did not follow the guidelines of the National Specification for Cleanliness (NSC) in the NHS. This was despite the monthly cleaning report stating “the cleaning monitoring system operates around the National Specification for Cleanliness in the NHS”.

The trusts target scores for the very high risk areas and high risk areas were lower than that of the NSC. Their target score for the significant risk and low risk categories were higher than that of the NSC.

The trust’s risk category classification does not follow that of the NSC. The frequency of audits does not match the NSC. We found no evidence of the trust applying the NSC methodology in either the strategic cleaning plan or the operational cleaning plan.

Date of Audit report: July 2014

- Amount of audits across both Hillingdon and Mount Vernon Hospitals undertaken in month: 102
- Hillingdon Hospitals Foundation NHS Trust reported failures: 5
- Amount of failures if the NSC % target had been used: 25

Date of Audit report: August 2014

Amount of audits across both Hillingdon and Mount Vernon Hospitals undertaken in month

- Amount of audits across both Hillingdon and Mount Vernon Hospitals undertaken in month: 96
- Hillingdon Hospitals Foundation NHS Trust reported failures: 4
- Amount of failures if the NSC % target had been used: 17

We checked 62 monthly audits and none were completed as they should have been. Over two thirds of audits that did not achieve 100% compliance had no corrective actions recorded. No audits had been signed-off to confirm that corrective actions had been checked.

There was insufficient evidence to assure us that a safe, clean, compliant environment for surgical procedures was provided at the hospital. A direct expansion (DX) air conditioning unit was used in theatre 2 to cool the air supplied to the room. The use of unit in this environment is not recommended, due to risks associated with the cleanliness of recirculated air. Theatres 1 and 7 were of 'ultra clean' classification. These theatres contained highly efficient filtration and a laminar flow of air over the operating table.

The trust carried-out a review of the theatre's ventilation systems and the associated plant room shortly after our inspection, and took appropriate steps to mitigate the risks to patients. The trust has also been providing the Commission with weekly updates on progress against an improvement plan to address the concerns we highlighted.

Local audits were not always completed and some local audits found that the ward practices and environment were 100% complaint. We found that areas were not clean and that good practice was not consistently adhered across the hospital.

In some areas we found that staff training on infection prevention and control was at 50% against a trust target of 80% of staff having received this training.

For the year to date to September, the trust had reported four cases of clostridium difficile against a target of 12 for the year. Against a target of zero tolerance, the trust had reported one patient with MRSA bacteraemia.

Summary of findings

Environment

When we inspected Hillingdon Hospital in October 2013 we found that the trust was non-compliant with regulation 15 of the Health and Social Care Act 2008. Regulation 15 governs the safety and suitability of premises.

When we inspected this time, we found that the trust continued to breach this regulation.

The age of the building and the challenges of the estate were evident throughout our inspection and the concerns found on main wards and in theatres are detailed in the two individual hospital reports that accompany this provider report. The challenges had also been highlighted to us by the Chief Executive of the trust prior to our inspection.

The Estate had suffered under investment due to proposals regarding the future of the site. This had left the hospital vulnerable to infrastructure failures due to ageing systems. The maintenance activities have been in principle largely reactive.

However, when we asked trust services about maintenance requests they were very positive and believed they received a good service from the Estates team.

The trust has recently employed a new Director of Strategic Estate Development and Asset Management who has identified risks due to the predominantly reactive maintenance regimes. The Director of Estates has developed a proposal to restructure the Estates team, reinforcing the management, and focusing on preventative maintenance regimes. A draft business case has been prepared and sets out a clear programme of improvement.

The trust's Legionella policy expired in April 2014 and therefore the trust did not have a current policy. While there was some evidence of appropriate management of water quality, there was insufficient evidence to demonstrate that the trust had made sure that there was suitable management of water safety in compliance with the approved code of practice.

Equipment

We found numerous concerns with equipment that presented a risk to patient safety. We identified equipment without a valid up to date portable appliance test, infrequent checks, lack of auditing and testing of equipment. We also identified out of date supplies of medical and surgical equipment and resuscitation trolleys not being checked as appropriate and inaccessible in some areas.

Summary of findings

There were shortages of equipment on the children's wards, for high-dependency patients, as well as shortage of routine items. Shortage of materials was high on the list of concerns of staff in the paediatric staff survey. The outpatient clinics did not have their own child-appropriate resuscitation equipment.

Medicines

Non-compliance with legislation and trust medicines policy was on the divisional risk register for surgery. Routine checks of medicine and auditing of medicine storage, security and records were not in place to ensure that associated risks were mitigated.

The trust had not completed the NHS protect medicines security self-assessment tool and medicines storage did not comply with the standards set out in the revised Duthie report, "the safe and secure handling of medicines ".

Key performance indicators for the pharmacy department for September 2014 showed the average waiting time for a prescription when a patient was being discharged was 67 minutes against a target of 120 minutes. The average waiting time for an outpatient prescription was 24 minutes, which was within the target range.

Records

The hospital used a monthly clinical effectiveness checker for adult inpatients, to monitor record keeping on the wards. This was not consistently or effectively used as we found many anomalies with the completion of records including missing signatures, sections of records not completed as required and prompts to act or complete other records not followed.

We also found unsecured records that were not stored confidentially, and temporary records that hadn't been merged with permanent records for several weeks.

Consent and the Mental Capacity Act

We identified significant concerns in relation to the training and application of the Mental Capacity Act (MCA) in the trust, as well as the Deprivation of Liberty Safeguards. There were insufficient numbers of staff that had completed the training. We raised this as an immediate concern with the trust as we noted a direct impact for patients who had been given a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).

We raised concerns with the trust's senior managers about the documentation and the lack of a demonstrable understanding of the MCA. In response to these concerns the trust added an additional sentence to the DNACPR form stating "If the patient lacks

capacity the mental capacity form must be completed and placed in the patient's medical notes." However, on our unannounced inspection we found that the new system was not being implemented on wards.

Despite the trust having carried-out an annual audit of the completion of the DNACPR documentation since 2009, recent data provided by the trust showed that they were not achieving 100% compliance in nine of the 10 target areas. The trust's resuscitation committee noted the results "were not that great" particularly around documenting reasons for decisions, and communication / discussion with the person or relatives when patients lacked capacity. There was also a reduced compliance with consultants completing or verifying the decision and completing the form.

The MCA audit (staff understanding) was carried out two yearly. The most recent result reported in April 2014 and presented to the June 2014 Quality and Risk Committee showed 55% of staff were aware of their responsibilities under the act. This was reported as an increase of 18% on the 2012 audit result of 37%.

A number of incidents had been reported of patients absconding. In response to these incidents the trust had introduced keypads on all of its medical wards. We found that there was no consideration of how this impacted on patients' liberty, there were no signs to inform patients on how they could obtain the access code for the keypads and there was no authorisation under deprivation of liberty safeguards for patients who were deemed to lack capacity.

Safeguarding

The statutory post of named nurse for safeguarding was vacant and would not be filled until January 2015. The three-month gap was being covered through additional consultant oversight, but this did not include the training role of the named nurse. Two doctors shared the named doctor role for safeguarding. These were unusual arrangements, as there should be both a named nurse and a named doctor in a trust. There were no link nurses for safeguarding on any of the wards or in the emergency department.

67.47% of staff had completed level one safeguarding children training, 56.48% had completed level two safeguarding children training and 48.37% of identified staff had completed level three safeguarding children training. 70.47% of staff had completed safeguarding adults training.

The training dashboard for the specialist palliative care team indicated they were not required to complete training in safeguarding children at any level. Although the team are not

providing palliative care support to children, they are providing care and support to patients with children and therefore would be deemed as staff requiring training as per the intercollegiate guidance.

Clinical staff reviewed the notes of potential safeguarding cases at weekly A&E 'safety net' meetings. We looked at the minutes of the safeguarding meetings from 28 July, 4 August, 11 August, 18 August, 1 September, 8 September and 22 September. Handwritten notes of these were recorded in a book. The notes from each meeting were written in different formats and records were inconsistently completed. The person nominated to complete a specific action was not always named in the minutes. Some actions were annotated with a tick to suggest that the action had been completed or next to an identified action we saw the letters NFAR which stood for no further action required.

Evidence of the necessary action having been taken was sporadic. A few actions had signatures against them, but many had no signatures and were left blank. All the meeting notes, except the 8 September, had cases that did not appear to have been followed up, with as many as five cases for each in two sets of notes. The safeguarding consultant told us that they "usually" asked if people had followed up on the previous weeks' actions but this was not recorded.

The A&E and Medicine risk register showed a medium risk that some vulnerable young people were not being identified in the ED. Two incidents were categorised as 'child protection concerns missed' and were reported in February and June 2014 respectively.

In these instances, the relevant authorities were not consulted or notified (including a failure to notify the health visitor liaison nurse) as appropriate and a safeguarding checklist was not completed as required. In one instance the child's paediatric notes were not referred to. The trust has subsequently identified that the child who presented in June 2014, was a looked after child with a named social worker and that if the necessary checks had been carried-out, this would have been identified when they attended A&E.

Staffing

When we inspected Hillingdon Hospital in October 2013 we found that the trust was non-compliant with regulation 22 of the Health and Social Care Act 2008.

When we inspected this time, we found that the trust continued to breach this regulation.

Summary of findings

There were nurse staffing issues in the A&E department. The department had recently increased the number of permanent A&E consultants based in the department from four to eight by making four long-term locum posts substantive.

We found one ward with one qualified nurse covering 20 patients at one time, before first one, then another nurse later joined them after being requested from other wards. We also found one ward being covered only by two bank / agency nurses and no permanent staff.

The trust was constantly moving staff between wards to try to ensure they always had a permanent member of staff on each ward, but this meant most wards were below their establishment, or at least that they had a number of agency staff. Some ward staff were covering two wards without all the extra staff they needed for the additional ward, and they had been covering two wards on most shifts for over a year.

Most wards we visited both during day and night had less staff than their establishment, despite full bed occupancy, and staff reporting that patient acuity was high, and that the establishment was not high enough for current patient dependency and acuity. One ward had at least 27 and up to 29 of its patients at level 1b in the last week (stable but acutely unwell patients), and had only four nurses covering during the day and only two at night.

We found that there was no fixed rota for consultant cover, out of hours, for critical care patients.

Are services at this trust effective?

Requires improvement

We observed effective multi-disciplinary working for critical care patients and good multi-disciplinary working in other divisions, with the outpatients department having extended clinic times to weekend and evening clinics. Diagnostic services also ran at weekends to support the clinics.

There were some key roles though that weren't resourced, to provide adequate support such as the vacant role of named nurse for safeguarding and a part-time liaison health visitor.

Out of hours there was no provision for an on-site radiologist and only one in three weekends on the critical care unit were covered by a specialist consultant in intensive care.

The emergency department used National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine guidelines to determine the treatment they provided.

Summary of findings

We found that maternity services had processes in place to promote evidenced-based care and to audit compliance with guidelines. For medical care, guidance was not universally applied across the division.

The critical care unit collected data to determine performance with recognised indicators. However, the unit did not contribute data to the Intensive Care National Audit & Research Centre (ICNARC) and was one of the 5% of adult general critical care units in England, Wales and Northern Ireland who did not participate. Key policies were based on recognised specialist guidelines. The NEWS escalation policy was based on the National Institute for Health and Care Excellence (NICE) guidance for acutely-ill patients (CG50) and the Resuscitation Council (UK) guidance.

The trust was not a heart attack centre so did not deal with the acutely unwell cardiology patients in the first instance. Their results in the relevant audit was variable as they scored 100% on the Myocardial Ischaemia National Audit Project (MINAP) for patients receiving secondary medicines. However, they were worse than average for non-ST segment elevation myocardial infarctions (NSTEMIs) being seen by a cardiologist, referrals for an angiograph and angiograph post-discharge.

The trust was not a first receiver of stroke patients, so most patients they treated were at least 72 hours after their initial stroke. The Sentinel Stroke National Audit Programme (SSNAP) audit showed they received the best possible rating in ten measures, including thrombolysis, and average in 13. However, they received a poor rating overall, due to poor Multi-disciplinary team (MDT) working and discharge processes.

Overall, the hospital's readmission rate for all elective treatments (124) was worse than the average of 101. For non-elective treatments it was better (93) than the average of 100.

PROM (Patient Reported Outcome Measures) is a programme of evaluation of surgical outcomes based on questionnaires completed by patients before and after their surgery. The number of patients who reported that their condition had improved (49%), or worsened (17%), were similar to the England averages of 51% and 18% respectively.

The hospital had consistently met the referral to treatment targets (RTT) in 2013/14 and performed better than an average English hospital. The percentage of people waiting less than 31 days from

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diagnosis to first definitive treatment and the instances in which the hospital met their 18 week RTT targets was also better than the average for admitted treatments, non-admitted treatments and for patients waiting for treatment.

Approximately 97% of trauma and orthopaedics, urology, ophthalmology, oral surgery and general surgery patients had received treatment within 18 weeks in 2013/14 for admitted adjusted pathways.

The trust participated in the National Care of the Dying Audit Hospitals (NCDAH). The report published in May 2014 showed the Trust scored on a par with the England average in three out of seven of the organisational national targets and slightly better than the England average for one national target.

The trust could not assure itself of the competencies of its staff as training rates were low.

Are services at this trust caring?

Good

We noted that staff were kind and had a caring and compassionate manner.

We spoke with numerous patients and their families who had received treatment at the hospital. Most of the people we spoke with told us they felt that care and treatment was given in a kind and respectful way.

Patients and relatives were very happy with the care provided on the critical care unit. Staff were described as “very caring” and “highly professional”. Patients and relatives said they were given the information they wanted to have, and that staff handled bad news or difficult messages with compassion and understanding.

A patient in the trust’s A&E told us “I have been using a wheelchair for a couple of years now. I come here a lot. Despite the long waits, I always find staff treat me with respect. They have always been good to me.”

Another person told us they had visited the department with their elderly father from a care home. They said of the staff, “they treated the both of us with dignity and respect and I think they do a good job.”

Patients and their families shared mixed experiences of how they were actively involved in their treatment and care. Parents commented positively on the knowledge of the staff treating their children and how they included them, however, some patients told

us that they were not given enough information regarding what would happen once they had been booked into A&E, and did not know anything until they were called, which sometimes could be hours later.

We observed very friendly staff that were sensitive to patients' needs. We observed staff giving good explanations of what was happening and including relatives where possible. This extended to porters, who were friendly, cheerful and reassuring.

Are services at this trust responsive?

The trust was not complaint with the National Service Framework for Children as the dedicated waiting room within the A&E department could not accommodate the numbers of children presenting. The constraints on the A&E environment also meant that patients who were ill were waiting in chairs, as there were not enough cubicles, and patients were seen in areas not fit for consultation.

The trust did not have a digital hearing loop for patients with hearing impairments in A&E.

The trust was achieving the national target of treating and discharging or admitting 95% of patients within 4 hours of attendance across the emergency department.

On average, the trust saw 96% of patients within 18 weeks on the referral to treatment pathway – the NHS operating standard is 92%.

The trust had a system to identify patients who had learning disabilities in order that they could be prioritised. The trust also had a system for identifying frequent attenders, their needs were recognised and a plan of care was in place to support this patient group.

Patients shared with us that they felt translation services were poor in the trust. A mother reported never having been offered a translator despite English not being her first language, and her son having complex needs. She had to attend the hospital on a number of occasions.

The trust had a significant capacity issue and had contingency / escalation wards to support the number of admissions. Despite the extra beds being open the occupancy rate remained high and patients were being cared for on "outlier" wards and not in specialist areas. The trust was not monitoring and reporting the numbers of times patients moved wards and we were told of high numbers of patients being moved in the night for non-clinical reasons.

Summary of findings

The trust did not have a fully staffed theatre available 24 hours a day to perform immediate interventions within minutes of a decision to operate being made.

The trust had mixed outcomes on the length of stay for specific specialities and had cancellation rates of 4.6% for the year to date against a target of less than 5%.

The trust had an exceptional ward environment designed to support the care of patients with dementia, unfortunately patients were admitted to the empty bed rather than based on the appropriateness of the ward environment and the staff.

The critical care unit had inadequate facilities for relatives as the trust was limited by the environment to be able to respond adequately to patients and relative's needs.

The maternity unit despite recent refurbishment remained challenged and women described crowding in the waiting room a lack of privacy when being assessed, and we were also told of women labouring in the assessment area. The trust have aimed to provide choice to the woman and introduced a dedicated home birthing team at the end of 2013, however Midwives told us that they did not have the capacity to provide a home birthing service to all those that want it.

Discharge letters were not being consistently sent to GPs within the agreed time frames and this was particularly an issue in children's services. The outpatients department was not providing letters to the patients GPs to advise them of the outcome of the consultation within the agreed time frames, some letters were taking two months to be typed and sent to the GP.

The trust was however, consistently meeting the two week target, which meant that all patients referred to this hospital with suspected cancer were all seen in outpatients within two weeks from referral.

Children were taken to theatre before they needed to be there and we observed a child waiting an additional 30 minutes in the anaesthetic room.

End of life care at the hospital was not always responsive to patients. The environment did not provide enough facilities to have private conversations and patients who were dying often did not have access to a side room. 92% of patients referred to the specialist palliative care team were seen within 24 hours, although this was

not seven days a week. The processes after a patient had died were not compassionate towards the relatives as they were required to visit multiple areas of the hospital to collect belongings and the death certificate.

The trust had taken action to reduce the number of patients who did not attend their outpatients' appointment and this had reduced from 10% to 8.2%. The trust was auditing patient delays in outpatients,

and this showed some considerable waits for patients to see the Doctor. The outpatients department showed evidence of listening to patients' complaints and taking action as a direct result.

The trust had a leaflet advising patients and their families on how to complain but this was only available in English. Some staff were not aware of the formal process. We heard accounts that individuals felt that complaints were not being listened to and many of the complaints were about poor communication and the attitude of the staff.

The trust does not always start the clock ticking for its response time for complaints when it receives a complaint from the complainant. The complaints lead at the trust told us that if they weren't sure what a complainant was seeking as a resolution or what the complaint was about, they would write back to the complainant to ask them to clarify the issues and ask for further information, and not instigate an investigation at this time. This means that when the clock starts ticking is dictated by when the complainant corresponds again with the trust. If this is a number of weeks, then the complaint response deadline may have already passed before the complaint is logged for investigation and response. Also, if the complainant doesn't correspond again, any identifiable issues within the complaint letter may never be addressed by the trust.

The NHS complaints process gives trusts the discretion to agree investigation and response timetables with complainants that can be built in to this process, but it asks that the clock start ticking from the date the complaint is received and is recognised as a complaint. If it is unclear whether the correspondence is a complaint, then the trust would be expected to err on the side of caution and log the correspondence as a complaint. The trust also has the option at this stage and is encouraged by the process to invite the complainant to a meeting to gain a better understanding of their concerns, to seek to learn from and resolve their complaint satisfactorily. The trust does not routinely invite complainants to meetings upon receipt of their complaint letter if the letter doesn't coherently communicate the issues and any required redress.

Summary of findings

This year to date, the trust has responded to 89% (trust target is 90%) of complaints within its target response time (last published in September 2014) of 30 days from receipt. However, a proportion of these complaints won't have been logged for investigation and response on the date they were received.

We saw limited of examples of where the trust had engaged with users to develop services.

Are services at this trust well-led?

Requires improvement

Vision and strategy

'Shaping a Healthier Future' is a programme to improve NHS services for the two million people who live in North West London. The trust was actively engaged in this reconfiguration project.

The trust was also engaged in and committed to the in the Quality and Safety Programme: Acute Emergency and Maternity Services, London Quality Standards.

Locally in departments however, some services had no discernible strategy such as critical care and children's services and where local leaders shared their thoughts on service strategy, such as for the End of Life Care service, this strategy had not been actively formalised by the trust.

The Chair and trust executives told us of the CARES values of the trust: Communication, Attitude, Responsibility, Equity and Safety. Some staff also told us about the trust's CARES values:, which they recognised were a framework for all staff to adopt.

The CARES values were also used as part of the appraisal process, and the trust was recognised positively in the national staff survey in relation to the number of staff who had received an appraisal.

While on inspection we experienced mixed views on the CARES values and some staff told us they were working day to day, with no vision for the future.

Some staff had undertaken training on embedding the values and all staff were expected to attend customer care training as part of this strategy. We were told that staff identified as having weak communication skills had been identified to attend the customer care training first.

Summary of findings

Governance, risk management and quality measurement

We identified risks to patient safety that would be significantly reduced through the effective operation of systems. Local leaders were not held to account for not completing local audits and the trust did not make sure that all local leaders took ownership of local risks.

On medical care wards, there was a dashboard that included data on the average length of stay, bed occupancy, readmissions rates, safety thermometer, infection control, staff sickness, turnover and training, patient surveys, incidents and mortality rates. However, some wards are not submitting all the information to this dashboard, which means that overall performance cannot be monitored.

In critical care, audits of certain aspects of safety within the unit are not carried out and there was no audit calendar. There is no audit carried-out routinely to determine if equipment checks had been regularly undertaken. As a result, refrigerator checks were missed and some of the paediatric equipment was past the expiry date which was not discovered. Another example was no audit of cleaning routines, so the dust in some harder to reach areas was not found. No achievements from any audits or performance indicator data were visible on the unit.

We met a very committed Board who appeared to be open and transparent. They were reliant on either limited, inaccurate or in some cases an absence of data to provide them with the required assurance, to be confident that safe care was being provided to patients.

We met with the Council of Governors who told us they felt their role was encouraged and that they were engaged since the appointment of the interim chair at the trust. They were enthused that they could make a difference in holding the trust to account. However, while they recognised the issues with the trust's estate, when we asked them what they considered to be the significant challenges for the trust, very few of the issues we identified during our inspection were shared.

Among other concerns, we have highlighted that infection control audit scores are misleading, cleanliness audits are not being carried out to national standards, complaints are not routinely being logged upon receipt, items are on risk registers for sometimes a year at a time without mitigation, the trust could not assure us or itself that theatres were appropriately ventilated, there had been a 7% spike in non-elective admissions since Easter 2014 which had continued, meaning that winter pressure wards were now known as surge

wards as they were open all year round without the appropriate staffing to meet patient need, and incidents highlighting missed child protection issues had been reported but systems and processes were not changed to address these concerns.

Our findings and our conversations with the Board representatives and the Council of Governors show that they are not currently providing the appropriate level of challenge and scrutiny of trust leadership.

Leadership of trust

When we inspected the trust in October 2013 we found that the trust was non-compliant with three of the regulations we monitor compliance with. When we returned to the trust this time, we found that the trust were continuing to breach all three of those regulations and were non-compliant with a further four regulations. This meant that the trust had not made sure that it had acted appropriately and that it had adequate systems and processes in place to assure itself of compliance.On-site during our inspection, when we raised our concerns with the senior team they responded

immediately. We identified very experienced executives in this team who were aware of the multiple challenges the trust faced, however, they had not been at the trust a significant time and were clearly only able to priorities immediate issues and were not taking an holistic view of trust performance.

There is a need to strengthen communication within the executive team, as it was not clear while on inspection if the additional wards were for the medium term or they were to be made substantive. This meant that the staff on these wards were unclear about their future, and as patients were being cared for on generic wards with a temporary workforce this meant that specialist care was not being provided.

The trust was not rigorous in monitoring the quality of care being delivered on the wards as we identified a number of areas that were not routinely submitting this data therefore the Board could not be assured.

Safety thermometer data was not visible in the clinical areas for the public and the professionals to be aware of the areas performance.

Culture within the trust

Throughout the inspection we noted friendly, welcoming staff. Many of the staff we spoke with were able to discuss the trust's CARES initiative confidently. Within the outpatients department there was an obvious sense of pride from staff about their department, and they were keen to tell us about things that they were doing to improve the patient experience.

Summary of findings

Junior doctors told us they felt well supported by their consultants and middle-grade doctors. Junior nurses also told us they felt supported. Staff in training told us they would return to this trust to work due to the support they had received and the positive culture.

Senior staff were aware that staff morale was not good and that staffing and workload issues were having an adverse effect on staff. This information had also been highlighted in the NHS Staff Survey 2013, where workload pressures were identified as being 'worse than expected' when compared to other trusts

Results of the NHS Friends and Family Test organised for staff from April 2014 to June 2014 indicated that 68% of staff would recommend the hospital as a place to work. 77% of them would recommend care at the hospital. The result is slightly better than the England average (62% and 76%). Staff we spoke with told us they would be treated at the hospital.

However, some ward leaders were knowingly not routinely completing audits and submitting returns as required, and a culture of local leaders feeling accountable for these audits was not evident.

Public and staff engagement

We saw limited examples of engagement with patients and their families while on inspection.

There was no engagement with users of the A&E service, the views of children and their families were not actively sought in children's services and there was very limited engagement with patients and their families on the critical care unit and the maternity unit.

Nurses within children's services felt engaged with their patients and wanted to provide a good service to children and their families, but felt overwhelmed by the workload. They felt they were not able to contribute to service improvement, and told us change was communicated to them through email.

The outpatients department was actively engaging with service users and ran a quarterly patient satisfaction survey that patients were encouraged to complete.

The trust serves a very diverse population but despite this we did not see the variation and commitment to public engagement that we expected to see. As a foundation trust, the trust has a Council of Governors. They highlighted the challenges in increasing the membership, but they did not raise any significant issues

that may impact on patient safety or that the trust had been found to be non-compliant when the Commission last inspected.

Summary of findings

We were told the hospital aimed to involve patients and members of the public in the development and planning of services and decision-making through the patient and public involvement forum, which met bi-monthly. Members of the forum also assisted in drafting trust materials, such as new leaflets and provided feedback on other documents, such as annual reports. Patients were also invited to attend a public trust board meeting and council of governors' meetings.

Some of the staff we spoke with felt they had a voice and their opinions were valued, some did not. Staff we spoke with were proud of their work and this was reflected in the staff survey.

Innovation, improvement and sustainability

Staff generally believed there had been some gradual improvements made in recent years, but capacity and resources was an ongoing challenge which compromised the sustainability of the way they were working.

Individual clinicians shared plans for the development of specific specialist services, for example, aiming to deliver level 2 services for children with cancer. However, the infrastructure was not in place and nursing staff shared how they were 'fire-fighting' and had no time to plan for the future services.

Individual specialities, such as the diabetic service and the allergy clinics had developed some innovative ideas. The diabetes service offered support 24 hours a day and had introduced clinics in schools where there were a number of pupils with diabetes.

At the time of inspection there were additional wards open in the hospital and there were significant nurse staffing issues across the wards and in the adult and children's A&E departments. Maternity had significant recruitment challenges, midwives had been appointed but were not yet in post, the community midwifery service was experiencing significant challenges., innovation

Overview of ratings

Our ratings for Hillingdon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity & gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Mount Vernon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for The Hillingdon Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.
2. The rating of requires improvement overall for accident & emergency at Hillingdon Hospital is a deviation from our principles of aggregation. This is because effective is not rated.
3. We have issued the trust with a warning notice for a breach of regulation 10 of the Health and Social Care Act Regulated Activities Regulations 2010. Regulation 10 governs 'assessing and monitoring the quality of service provision' which relates to the well-led domain. This enforcement action is a deviation from our published guidance which sets out that we would, usually, only issue a warning notice for a breach of regulation 10 if a well-led rating for any core service was rated inadequate.

Outstanding practice and areas for improvement

Outstanding practice

- The nurse practitioners in the Minor Injuries Unit made direct referrals to specialities both internally and externally to the hospital; this included tertiary referrals to specialists such as plastic surgery.
- The effective management of 18 week referral to treatment times for patients.
- The specialist care for children with diabetes, specifically the outreach work into schools.
- A maternity triage care bundle to promote consistency of care provided for women.
- Announced and unannounced "skills drills" training to rehearse obstetric emergencies.
- Good access to physiotherapy and occupational therapy and good multidisciplinary team working for surgical patients at Mount Vernon Hospital.
- Good multidisciplinary team working to support one stop outpatient clinics.
- Trainee doctors commented very positively on the support and mentorship they received while working at the trust.
- The critical care unit had physiotherapy presence seven days a week, and undertook ward rounds each day, as well as being available on call.
- The trust had a proactive specialist nurse for organ donation.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Make sure it complies with infection prevention and control standards and that it monitors cleanliness against national standards.
- Assure itself that the ventilation of all theatres meets required standards.
- Address the risks associated with the numerous staffing establishment shortages across the trust.
- Make sure that staff are appropriately trained in safeguarding both adults and children, and that the trust regularly monitors and assesses the completion of actions agreed at weekly 'safety net' meetings.
- Make sure that all staff understand their responsibilities in relation to the trust's systems and processes that exist to safeguard children.
- Make sure staff are trained and understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Make sure that the use of keypads on wards does not unlawfully restrict patients' liberty.
- Make sure that all staff receive the full suite of mandatory training that is required to minimise risks to patient safety.
- Make sure agency staff receive an appropriate local induction on to wards.
- Make sure that there are adequate numbers of paediatric staff trained in Advanced Paediatric Life Support as per the Royal College of Nursing's recommended standard.
- Make sure of the effective operation of systems to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of patients.
- Make sure that local leaders are held accountable if they do not routinely and accurately complete required audits.
- Make sure that trust premises are secure and that maternity and children's areas and wards cannot be accessed by the public without staff knowledge and appropriate challenge when necessary.
- Make sure patients are protected against the risks associated with the unsafe use and management of medicines.
- Make sure patients and visitors are protected against the risks associated with unsafe or unsuitable premises.
- Make sure that there equipment is properly maintained and suitable for its purpose and that out of single use equipment is disposed of appropriately.
- Make sure that equipment is available in sufficient quantities in order to ensure the safety of patients and to meet their assessed needs.

Outstanding practice and areas for improvement

- Make sure that records are accurately and appropriately maintained, are kept securely and can be located promptly when required.
- Make sure that early warning system documentation is appropriately maintained and that all staff react appropriately to triggers and prompts.
- Complete venous thromboembolism assessments as appropriate.
- Log the date of receipt of a complaint as the date the trust are first made aware of the complaint.

Action the trust should take to improve

- Review the process for admitting patients to wards from the accident and emergency to make sure the process is effectively managed and that unnecessary delays in transferring patients are not occurring.
- Ensure there is a fixed rota for consultant cover out-of-hours for the critical care unit.
- Consider providing support from a Practice Nurse Educator for critical care nursing staff.
- Consider contributing to ICNARC data collection.
- Confirm the trust's permanent bed capacity and an accurate base staffing establishment figure the trust projects it needs to deliver safe and effective care for this number of beds.
- Engage with local end of life care leadership to establish the trust's strategy for the service.
- Make sure that appropriate translation services are available and are being utilised to meet patient need.
- Review the resourcing of medical secretaries to make sure they can meet patient need and the trust's own targets for sending GP letters.
- Consider implementing the Friends and Family Test for all wards at the trust.
- Consider whether patient outcomes could be improved through dedicated consultant cover and / or consultant oversight for the Minor Injuries Unit.
- Consider auditing pre-operative starvation to make sure patients are not starved for significantly longer than required.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises (1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of — (a)suitable design and layout; (b)appropriate measures in relation to the security of the premises; and (c)adequate maintenance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is —

This section is primarily information for the provider

Compliance actions

(a) properly maintained and suitable for its purpose; and

(b)used correctly.

(2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of — (a)an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and (b)such other records as are appropriate in relation to — (i)persons employed for the purposes of carrying on the regulated activity, and (ii)the management of the regulated activity. (2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are— (a)kept securely and can be located promptly when required; (b)retained for an appropriate period of time; and (c)securely destroyed when it is appropriate to do so.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take

This section is primarily information for the provider

Compliance actions

appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to — (b)identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (2) For the purposes of paragraph (1), the registered person must— (d)establish mechanisms for ensuring that— (i)decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and (ii)P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and (e)regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

(1) The registered person must, so far as reasonably practicable, ensure that —

(a)service users;

(b)persons employed for the purpose of the carrying on of the regulated activity; and

(c)others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity,

are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2).

(2) The means referred to in paragraph (1) are —

(a)the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection;

(c)the maintenance of appropriate standards of cleanliness and hygiene in relation to—

(i)premises occupied for the purpose of carrying on the regulated activity,

(ii)equipment and reusable medical devices used for the purpose of carrying on the regulated activity, and

(iii)materials to be used in the treatment of service users where such materials are at risk of being contaminated with a health care associated infection.