# Review of compliance

## Barts Health NHS Trust
### Whipps Cross University Hospital

<table>
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<tr>
<th>Region:</th>
<th>London</th>
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<tr>
<td>Location address:</td>
<td>Whipps Cross Road&lt;br&gt;Leytonstone&lt;br&gt;London&lt;br&gt;E11 1NR</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<td>Date of Publication:</td>
<td>July 2012</td>
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## Overview of the service:

Whipps Cross University Hospital is situated on the outskirts of Leytonstone in the London Borough of Waltham Forest, serving a local population of more than 350,000 from Waltham Forest, Redbridge, Epping Forest and East London.

Beech Ward, the focus of this report, is an elderly care ward set among a group of similar wards located in the main
| hospital building. |
Summary of our findings for the essential standards of quality and safety

Our current overall judgement

Whipps Cross University Hospital was meeting all the essential standards of quality and safety inspected.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 07 - Safeguarding people who use services from abuse
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 1 May 2012.

What people told us

We visted Beech Ward, an elderly care ward, following allegations of abuse that had been disclosed to the hospital through their whistleblowing procedure. The hospital reported to us that it had taken measures and actions to ensure that people were protected from the risk of further harm and that the allegations were being properly investigated.

This visit took place to ensure that people were being protected from harm and to look at the trust's immediate response to the disclosure.

People who use the service told us that the care and treatment they had received had been good and people were complimentary about the service they had received from nurses. We were told that nurses responded to buzzers in a timely manner and that people's needs were being met. One person told us that communication could be better with the medical staff who had not spoken to the family about their relative's health issues.

What we found about the standards we reviewed and how well Whipps Cross University Hospital was meeting them

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider had responded appropriately to the allegation of abuse.
Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The provider was supporting staff appropriately in response to the allegation of abuse.

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

The provider had taken appropriate measures to check on the quality and safety of the ward in response to the allegation of abuse.

Other information

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety.
Outcome 07: Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We visited Beech Ward and spoke to patients and members of their families. We asked them about their treatment and care, the quality of nursing and whether they had any concerns.

We were told that the care and treatment they had received had been good and people were complimentary about the service they had received from nurses. We were told that nurses responded to buzzers in a timely manner and that people's needs were being met. One person told us that communication could be better with the medical staff who had not spoken to the family about their relative's health issues.

"I'm not sure there's anything wrong with it. Its all fine and I mean that. If I had any fault I'd tell you. I've not found any fault at all. I praise the people who run it".

"Treated with great respect by everybody. Couldn't fault it. When you're ninety it's nice not to be treated as an old nuisance. I feel rather vulnerable generally so it's nice".

"I can't find anything to fault it. Majority of nurses and sisters are very kind and very helpful. I was also here a few years ago. This time I've got nothing bad to say about them. I call them and they come and if they don't I understand. I rang twice this morning. The sister said she would get someone to me as soon as possible because they were all busy. It's never been too late".

"It's good and friendly. There's lots of staff around to help out. We need a better.
channel of communication with the medical team really. We haven't been given a prognosis or diagnosis. We haven't spoken to them about our issues yet and it's been over a week. We don't know what the next steps are. I think the nurses are good though”.

Other evidence
We visited Beech Ward and spoke with ward staff and senior managers to check that people were being safeguarded against further risk of abuse. We also checked that actions the hospital had told us they had taken to protect people were appropriate and in place. We were presented with documentary evidence to support the actions that had been described to us and spoke to members of staff who had taken on new responsibilities following the allegations of abuse.

We reviewed minutes of the safeguarding adults’ strategy meeting. The hospital was fully engaged with the local safeguarding process. Strategy meeting minutes demonstrated participation at a senior level and agreement to follow up on actions had been formally agreed to at this forum.

A senior management team at the hospital (director of human resources, managing director, director of nursing and medical director) managed the allegations as a formal internal incident, meeting initially 3 times daily to log progress, issues and any actions taken; the meetings then became daily after the first 2 weeks. This was demonstrated by documentation. We were told by the senior hospital managers that the senior management team briefed the trust's executive team weekly as a minimum and that additional telephone conversations were also held.

It was confirmed that staff involved in the alleged abuse had been suspended from all duties by the trust, reported to the police and subsequently arrested and bailed. Actions taken had ensured that the staff concerned would not work in a care setting while the investigation continued.

We saw documentary evidence stating that Beech Ward had been closed to new admissions. We visited the ward and found empty beds. We spoke to the matron on the ward who further confirmed this action. Planning was in place to be able to meet the needs of patients in the event of the ward needing to be closed. We subsequently learned that the ward had been closed and all patients moved to other elderly wards.

We were told that all patients had been spoken to individually by the matrons who asked people if they had any concerns or any comments to make about their care. Patients confirmed that they had been spoken to. We were told by a senior nurse that they had spoken to the alleged victims and their families. Where patients lacked capacity, a senior nurse at the hospital had spoken to family members.

Senior management had spoken to all Beech ward medical, nursing and therapy staff making them aware of the investigations and interviews. The hospital had prepared a list of all staff who had worked on the ward and all patients who had been admitted to Beech ward over the last four weeks for the police as requested. We found other examples of the hospital's full co operation with the police investigation and that the investigation would run alongside the trust's own serious incident investigation. The hospital had worked with the police to set up a joint interview process that included consideration of vulnerable patients.
Our judgement
The provider had responded appropriately to the allegation of abuse.
Outcome 14: Supporting staff

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people about this outcome.

Other evidence
We visited Beech Ward to check that the hospital had responded appropriately to allegations of abuse. We spoke with ward staff and senior managers to ensure that actions that had been described to us in response to the allegations of abuse and in relation to supporting staff had been put in to place. We were presented with documentary evidence and spoke to members of staff who had taken on new responsibility following the recent safeguarding disclosure.

We spoke to the head of nursing education at the hospital, who was on the ward at the time of our visit. We were told that in response to the safeguarding disclosure her role involved a renewed focus on the professional development of staff in elderly care and specifically on Beech ward that included working alongside the ward staff and carrying out practical nursing tasks. A structure for this was to be agreed with the matron in charge of the ward.

We spoke to the matron who was on the ward at the time of our visit. We were told that she was based on the ward every weekday supervising and assisting in practical nursing tasks.

We reviewed the staffing rota for Beech Ward over a four week period, covering the week since the disclosure and the next three weeks. It demonstrated that the ward was staffed to its stated compliment and skill mix. In response to the safeguarding disclosure the hospital told us that charge nurses would now be doing nightshifts. The
rota confirmed that charge nurses had been added to the night duty rota. Extra nurses had been added to the ward rota in order to cover this demand and that a senior charge nurse was now acting up in to the ward manager role since the ward manager’s removal to other duties. We were also provided with evidence that clinical site managers had been visiting the ward unannounced and at regular intervals during the night shift, following the incident's disclosure. The rota also showed that day time senior cover was being provided by a matron, head of nursing education, nurse consultant and associate director of nursing who were all working shifts and sessions on the ward.

We spoke to the nurse consultant for dementia care who was asked to carry out shifts on the ward. The rota demonstrated that he was based on the ward for three mornings a week. We were told by the nurse consultant for dementia care that his role would involve joining in nursing tasks to observe normal routine practice and the nursing culture over a period of time and play a role in developing nursing practice where required.

We also spoke to the associate director of nursing who told us that part of her role in response to the disclosure was to look at the education and training remit within safeguarding training. We were told that part of the training needs analysis involved a renewed focus on staff responsibility to recognise and report abuse. A feature of this incident was possible staff complicity and the culture of disclosing abuse needed to be addressed. This work would start with Beech and move to other elderly care wards. We were told that maintaining delivery of care to a good standard was a priority. A rota had been developed so there was senior support to enable this which included charge nurses and sisters undertaking night duty rotation.

Our judgement
The provider was supporting staff appropriately in response to the allegation of abuse.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

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<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**
We did not speak to people about this outcome.  

**Other evidence**
We visited the hospital and spoke with ward staff and senior managers to ensure that checks on quality and safety that had been introduced in response to the allegations of abuse were appropriate and in place. We were presented with documentary evidence to support what had been described to us.

All ongoing actions and improvements were channelled through a dedicated task and finish group that met weekly and was chaired by the assistant director of nursing. Fortnightly updates were reported up to the hospital's senior management team and the trust's executive team.

A rota of senior nurses including the corporate nursing team had been organised to undertake unannounced out of hours inspections using a dedicated proforma. All of the ward inspection reports were reported back to the Executive Nursing and Midwifery Committee for action and improvement where necessary. We saw the assessment sheet that had been devised for these visits and the rota of senior staff who were conducting these visits. We also spoke to senior staff who had carried these out.

We found evidence that the hospital were planning an external review of elderly care, to be carried out by a suitably experienced and qualified expert in elderly care.
We also learned that the hospital is planning a development initiative to work on improvements in elderly care, to be led by a specialist from an expert body currently on secondment at the hospital. This had not started yet.

Our judgement
The provider had taken appropriate measures to check on the quality and safety of the ward in response to the allegation of abuse.
What is a review of compliance?

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

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

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<td>Author</td>
<td>Care Quality Commission</td>
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