Inspection Report

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

Royal Sussex County Hospital

Royal Sussex County Hospital, Eastern Road, Brighton, BN2 5BE

Tel: 01273696955

Date of Inspections: 15 April 2013
11 April 2013
10 April 2013
09 April 2013

Date of Publication: May 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✔ Met this standard
Staffing	✔ Met this standard
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Brighton and Sussex University Hospitals NHS Trust
Overview of the service	Brighton and Sussex University Hospitals Trust is an acute teaching hospital trust working across two sites. The Royal Sussex County Hospital in Brighton, and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital. The trust provides district general hospital services to its local population. It provides more specialised tertiary services for patients across Sussex and the South East of England.
Type of service	Acute services with overnight beds
Regulated activities	Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 9 April 2013, 10 April 2013, 11 April 2013 and 15 April 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other regulators or the Department of Health. We talked with other regulators or the Department of Health.

What people told us and what we found

We carried out this review in response to concerns centred on the provision of emergency care. The trust had already been subject to external review which led to our decision to inspect the trust and also informed our inspection report. The trust had developed action plans to address the review's recommendations, but they were at an early stage of implementation.

Most patients we met said staff were dedicated and caring. However, the current inability to effectively discharge and manage the flow of patients through the hospital meant some patients were not treated with the privacy and dignity they should have been given. This was particularly the case in the emergency department, as pressure from elsewhere in the hospital impacted on them most acutely. In this and some other parts of the hospital, the pathways of care for patients were not working or organised effectively. This meant some patients were staying longer than clinically required.

The hospital was working well to play its part in cooperating with other providers of care. However, the trust was not doing enough to get sufficient support from the local health and social care community to alleviate pressures on the hospital. The trust had responded to staff shortages in some acute areas and had reviewed the way it effectively deployed staff to provide safe care. However, the governance of the hospital and leadership of services had not been effective in order to avoid or limit the current pressures.

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

What we have told the provider to do

We have asked the provider to send us a report by 12 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

Due to the pressure and overcrowding within the emergency department, and too many patients not being admitted onto hospital wards in an acceptable time, some patients' privacy and dignity were not respected.

This is a breach of regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Reasons for our judgement

Patients we met on the vascular ward during our visit to the hospital said they were happy with their care. They told us they were treated with privacy, dignity and respect by staff. Patient responses when we asked them about staff maintaining their privacy and dignity included how staff had been "terrific" and "I've no complaints whatsoever." One patient said: "I give them 15 out of 10 for everything."

Patients said staff told them their names and their role, and asked before carrying out any tasks. Staff closed curtains around beds when they wanted to talk in private or carry out examinations or tests. We saw staff spoke quietly and included patients in conversations about them. Curtains around beds had statements pinned to them to remind staff and visitors about maintaining patients' privacy.

Three patients in one of the bays in the digestive diseases ward told us they had been well cared for. They said staff were respectful, approachable and had time for them if they were anxious. One patient told us they had been waiting a long time for their procedure and they were not sure why. Staff told us the appointment system involved a group of patients coming into the hospital at the same time to allow for an efficient consultation with their doctor. We found this was not as well explained to some patients as it should have been. Doing this regularly would have helped patients understand why they were waiting longer than they had expected and may have reduced anxiety.

The hospital cared for older patients in the Barry building. We visited two wards where we

observed staff being patient and kind to people, a number of whom were frail and/or had dementia. Staff on Vallence ward had created a display of pictures and stories from 'The Good Old Days' in an area patients would walk through. Staff told us they found this had helped patients with dementia and reduced anxiety.

A member of staff told us they had received training and guidance from the hospital 'dignity champion'. They said they knew dignity was "a basic human right" and "something we do everyday as a priority." There was information in corridors and notice boards about caring for older people and how to support them practically to promote choice and independence. Staff told us it was important for patients to maintain as much control over their lives and their care as they could.

A relative of a patient we met on Vallence ward said there had not been a bed available to admit their elderly parent from the emergency department (ED) the previous night. However, the relative said: "the nurses were wonderful." They made sure the elderly patient was settled in a cubicle in the emergency department and provided with an inflatable mattress. Staff made the relative comfortable so they could stay with them and rest. We were told, under the circumstances: "staff were wonderful, and could not have done more."

Staff on Chichester ward told us they carried out 'comfort' rounds throughout the day. This was a process where nursing staff checked each patient directly to see if their fundamental and immediate needs were being addressed. This process focussed on patient comfort (pain and position); whether they had enough fluids; if they needed to use the toilet; if call bells were in reach; and the environment was safe.

During our visit, and from other information provided to us, we saw problems relating to privacy and dignity of patients who came to the ED, and with meeting their basic needs. The problems with privacy and dignity were not a result of poor care or a lack of compassion from staff in the ED. They were a result of overcrowding caused by the inability of the hospital to move patients efficiently out of the ED when they needed admission to a ward bed. Too many patients were not leaving the ED in an acceptable time and this resulted in new arrivals being held in corridors, entrance halls, rooms and wards not designed for long stays.

At the time of our visit, and for a number of months previously, the hospital had been dealing with pressures on patient services. One patient we met had spent three nights admitted onto the day surgery unit, which was not set-up for patients to stay overnight. The unit did have oxygen and suction provision, and bays were curtained. But when the patient we spoke with was admitted there were seven other patients on the unit. There was only a toilet with a small sink for the four male patients and another for the four female patients. There were no shower or other washing facilities. The patient said: "it was dreadful to not have a proper wash for three days." The patient also told us staff were not able to turn off or dim the lights at night, and it was difficult to sleep or rest.

In the ED we asked staff about meeting the basic needs of patients being held on corridors and in the area where they were being supervised by members of the local NHS ambulance trust. Staff told us patients who needed the toilet but were not able to walk at the time were taken to the 'plaster room' on their bed or in their chair to enable them to use a bedpan. The plaster room was cluttered and not clean, as well as not designed for this purpose. During our visit we found a patient in the plaster room who said they were "desperate for a bedpan." A doctor arrived and said they had been asked to catheterise

the patient, and was prepared to carry out this procedure in this room. The matron of the department informed the doctor this was not acceptable, and left to make other arrangements.

We acknowledge the new CEO, who started work on 1 April 2013, needs time to address these areas of concern and he has said he will do so urgently. Our evidence for this judgement included the trust already taking some urgent actions and considering how to make robust longer-term changes.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Some patients were not experiencing timely care, treatment or support delivered to meet their needs and ensure they were safe and their welfare protected. The hospital was not managing the flow through and discharge of patients to enable the emergency department to function safely and effectively.

This is a breach of regulation 9(1)(b)(i) and (ii), and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Reasons for our judgement

Most of the patients we met at the hospital said they felt the care they were receiving was good. One patient described his stay on the vascular ward and said: "it's been excellent. It's not been in line with what you've been led to believe from the press reports. I was somewhat concerned. But it's been a positive experience. Staff have been excellent, they really have. That includes the doctors, nurses and everyone. We are well looked after."

During our visit, and from other information provided to us, we were made aware of problems at the hospital relating to delayed patient discharge. One of the most significant effects of this was overcrowding within the emergency department (ED). Patients came into the ED at all times of the day and night. They were not then being effectively moved through to hospital wards to avoid a crisis in critical care developing from a shortage of treatment areas.

A patient we met in the ED said: "I'm doing OK. There's a lot of hanging around, but that's waiting for doctors to come mostly it seems." Another patient who was waiting in a holding area, and being monitored by a paramedic from the local NHS ambulance trust, said: "I think if I was to get critically ill they would have my back. They'd be straight out and be all over it." A patient we met who had stayed overnight in the acute medical unit (AMU: which was being used at the time as more of a general ward for female patients in ED) said they had been treated "very kindly." The relative of the patient said they had watched people around them who had been well treated. The patient said they would give the department staff "10 out of 10" for the care provided.

Staff in the ED we met told us patients were affected by being placed into inappropriate areas within the department. We were told of an elderly patient who had fallen and

fractured their hip as there was no falls prevention mattress available where they were placed. We also met a patient who had complex social and physical needs. This patient had been in the clinical decisions unit (CDU) in the ED (which was being used at the time as more of a general ward for male patients in ED) for 7 days. The patient said they needed help to gain strength to walk, but had not seen a therapist during that time.

We were also concerned about the length of time patients were staying in the hospital, as for some patients, this was too long. Where elderly patients, particularly those with dementia were concerned, for example, staying longer than clinically necessary in hospital has been shown to have a negative effect on their health and welfare. Research by the Alzheimer's Society shows longer stays in hospital can lead to a worsening of the effects of dementia and physical health; a greater likelihood of being discharged to a care home instead of the patient's own home; and a greater likelihood of antipsychotic medication being used. Nursing staff said they were concerned about the length of stay, and how patients were cared for during that time. Nurses told us patients' welfare and independence were being compromised by being in hospital too long without active therapy.

We were told some of the pathways of care for patients, particularly the frail elderly, did not involve the use of therapy staff until the patient was deemed medically fit for discharge. Nursing staff told us this meant, for some patients, they were getting little support to maintain or enhance their mobility during the period of medical care. Staff said the length of stay was therefore being extended for some patients due to a lack of assertive management of their care.

During our visit, we met a patient who had been admitted for care through the ED. The patient had initially been seen in the ED and after waiting for seven hours, had been told to return home at 1am as there was no bed available. This was despite being told by their doctor they needed to be monitored in hospital for any adverse reaction to an antibiotic they required. This patient was admitted to the hospital after returning to the ED later that same day. They then spent three nights in a ward not designated for the condition they were admitted for. They were admitted to the appropriate ward four nights after their initial visit to the hospital. Staff on the ward told us the length of stay for this patient had probably been extended as a result of the initial delays by several days. A consultant also confirmed this was likely to have been the case.

We acknowledge the new CEO, who started work on 1 April 2013, needs time to address these areas of concern and he has said he will do so urgently. Our evidence for this judgement included the trust already taking some urgent actions and considering how to make robust longer-term changes.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider was working on improved cooperation with others.

Reasons for our judgement

We had received information from other providers of health and social care in the local area about some patients being handed over into their care without adequate information about the patient. We were also told discharge documentation was not easy for other providers to follow, and key information was sometimes missing from the paperwork provided. Information was also not standardised across the trust or wards.

The hospital was aware of these concerns, and had taken action to improve the discharge of patients to other health and social care providers. We talked with the head nurse for discharge and partnerships, and their team, about improving the cooperation with other care providers. The hospital worked with a team of social workers, some of whom were based at the hospital site, and others integrated into the 'transfer of care' model.

We attended a meeting held each day between the hospital discharge staff and two of the social workers based on the site. There was also a telephone conference following this meeting with another social worker from a different local authority area. At both these meetings, patients in the hospital were discussed in detail and progress on their discharge to community settings was discussed. This included progress with local nursing and residential homes, and places secured in two local respite and rehabilitation centres. We saw good cooperation between the hospital and the integrated social worker team with both sides understanding the priorities for the other.

The head nurse for discharge shared with us the new documentation produced for patient discharge planning. It had been designed to limit the amount of information needed and to keep information together in one set of documentation. The documentation was being rolled out across the hospital with the intention of it being a standardised system for every patient being transferred into the care of other providers.

The hospital had also worked with the local NHS ambulance trust, South East Coast Ambulance Service NHS Foundation Trust (SECAmb), to alleviate the knock-on effects of pressure in the emergency department (ED) on the efficiency of the ambulance service. The trust had arranged for SECAmb to station an experienced member of their staff within

the entrance area of the ED as a temporary arrangement. This enabled ambulance staff to hand over their patients if necessary to this team member in the ambulance reception so they could return to standby duty or attend other calls.

We met and talked to two members of the ambulance team who were at the hospital waiting for despatch to their next call. They told us they expected the handover protocol to be a temporary arrangement while the hospital took steps to alleviate the pressures on the ED, but it had been appreciated by ambulance staff. They told us they occasionally had to wait longer than was ideal to hand over a patient when the ED was exceptionally busy, and had been diverted to other accident and emergency departments in other hospitals. But they said the situation had "got a great deal better."

The trust was aware there was more work to do with SECAmb to review arrangements and cooperation between the providers around diverting patients to other sites. The trust had also yet to provide sufficient clarity to ED staff around responsibilities and roles for ambulance personnel working at the hospital site.

The hospital is a major trauma centre which provided urgent care for people in and around Brighton. However, the provider may find it useful to note senior staff had not been working at a level of influence with the rest of the health and social care community to share learning and experience. The hospital had made significant progress and had much success in reducing avoidable falls and pressure damage to skin for frail patients or those with limited mobility. The trust had, however, not sought ways to promote this with, for example, the local nursing and residential homes. Doing so may have helped reduce hospital admissions from these mostly avoidable events.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Information provided to us from an external review of the trust indicated the hospital had staff shortages, particularly in the emergency department (ED). The external review of the ED had determined the trust needed to appoint an acute physician and therapists for weekends. There also needed to be increased nursing presence and adequate portering staff on duty.

The trust had responded to the review and developed an action plan to address these areas. Staff we met in the ED on our visit told us they had seen an improvement in staffing levels. This had included a response to sickness levels among the clinical staff by bringing in bank and agency staff. We were aware, however, sickness levels in this department were still running at a relatively high level. At the time of our visit, sickness in ED was at more than twice the national rate for sickness within the NHS in England. It was also twice the sickness rate for the whole trust over the 12 months to January 2013.

We were aware the hospital had internal problems caused by a previously inefficient system of discharging patients from wards back into the care community or their home. This had caused overcrowding and unacceptable outcomes for patients coming to the ED for care. To respond to this, the hospital had re-established the clinical site management team. The team consisted of experienced nursing staff and was managed by the head nurse for discharge and partnerships. There had therefore been recognition of how patient flow through the hospital and discharge required an established team to manage this service effectively. The team had been set up and was recruiting additional staff where necessary to enhance the efficiency of the team.

The hospital had recognised where it could use other professional staff to address its immediate problems. This had included recruiting a GP to work in the minor injuries area of the ED to deal with patients who did not need hospital care or admission. Also, the action plan for the trust included medium and long-term objectives. Long-term objectives included recruitment to therapy and acute physician posts; to recruit to other vacant clinical posts; and to normalise working across 7 days and not staff the department with a reduced coverage of skills and experience on weekends.

In order to have an overview of the whole hospital, the Director of Human Resources

provided us with statistics on staffing levels. These were the key performance indicators presented to the board each month. The data included the percentage of bank and agency staff used to cover staff vacancies or absences (predominantly in nursing roles). The trust had used mostly bank staff from its own internal staff retained for this purpose to cover gaps in staffing. The use of bank and agency staff had been relatively consistent in the 2012/13 financial year running at around 13%. Of this percentage, we calculated around only 3% of staff had been agency workers. The data showed the majority of staff shifts had been covered by permanent staff with temporary support when needed.

The vacancy rate at the trust was running at around 5%. Vacancies had fallen over the year from a high point of 7.6% in March 2012. The Director of Human Resources told us the actual vacancy rate was lower than presented. The hospital managed about two-thirds of the vacancies using bank staff, although this was not how the figures were presented.

The trust's chief nurse told us about a recent review of staffing levels and roles of nursing staff within the trust. An extensive review of trust practices, using information and guidance from the Royal College of Nursing, had recommended to the board the role of nursing leaders on the wards should be changed. Part of the recommendations was for ward leader nursing roles to be supernumerary. This would mean these roles would not be counted or rostered as part of the nursing cohort. These lead nurses would then be free to lead and manage patients and wards more effectively. This recommendation had been accepted by the board and, we were told, would be implemented by the trust.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Due to the failure to meet appraisal and training targets set for staff, and to support staff where that was most needed, the trust could not demonstrate patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

This is a breach of regulation 23(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

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

Reasons for our judgement

We met with the Director of Human Resources (HR) and four other members of this directorate. We discussed training, development and support for staff working for the trust. The directorate also shared key performance indicators around training and appraisal statistics for trust staff. These results were provided on a monthly basis to the trust board.

The data provided to the board about training and appraisals showed only 29% of trust staff had received an appraisal by February 2013 (i.e. 11 months into the 2012/13 financial year). In the previous year this figure was reported as only 35% for the whole year. A member of the senior nursing staff told us the results for ward appraisals were likely to be significantly better than what was being reported. However, the trust had not effectively collected this information to be able to provide more accurate data.

Staff confirmed there was not a consistent approach to appraisals. Some of the senior nursing staff we met had not had appraisals of their work, objectives and achievements for several years. One thought it was "at least three years" since they had last been appraised. They said this did not make them feel well supported and "they don't formally recognise when we're doing well either." Some other staff we met had received an appraisal. This included the four members of the HR department, although the Director of HR had not had an appraisal since joining the trust. One member of the managerial staff we met said they did not follow an appraisal programme for their staff, and did not support the objectives of this as they currently stood. Their staff had therefore also not had appraisals of their work, objectives and achievements for several years.

The majority of staff told us they felt they were being listened to at the trust. Key staff, such as those working in the emergency department; staff responsible for discharge

arrangements; and staff looking after clinical site management specifically told us this had improved recently for them and their views were being sought.

The trust had a programme of training for staff which covered mandatory subjects and professional development. We were given data to show what these courses were for all trust staff. The data we reviewed showed training for mandatory subjects to be completed or refreshed every year had been delivered to only 35% of staff. For courses to be delivered or refreshed every three years, the trust had achieved delivery to only 50% of staff. No training targets had been achieved for any of the mandatory subjects. We were told by the Director of HR the trust had not invested in professional development, education and learning in 2012/13. Only training provided by the Department of Health's Multi Professional Education and Training and funded through the Strategic Health Authority had been provided to staff in 2012/13.

The staff from the HR directorate told us of other ways the trust supported staff. This included numerous ways for staff to hear about what was happening in the hospital and trust. We saw a number of newsletters and events for staff to attend. The trust organised an annual conference for healthcare assistants. This was in response to healthcare assistants seeing nursing staff having an annual conference, and asking the trust to support them with their own conference. This event was in its third year. This year staff would be discussing, among other topics, dementia, palliative care, tissue viability and end of life care.

The trust had recognised and put in place supportive measures for staff who had been involved with caring for a patient when the outcome had been distressing for staff involved. There was also an intranet based forum facilitated by the trust for staff to raise issues and open a discussion among each other. Visits to this site had more than trebled in the last 12 months.

The trust had put in place measures to support staff, but we could not see how it knew these measures were the most appropriate way to support staff working under significant pressure. One senior member of staff working in the emergency department told us they were "shot to bits, burnt out and exhausted." Staff in this department were not receiving the support they needed to deal with pressure coming from elsewhere in the system.

We acknowledge the new CEO, who started work on 1 April 2013, needs time to address these areas of concern and he has said he will do so urgently. Our evidence for this judgement included the trust already taking some urgent actions and considering how to make robust longer-term changes.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The organisation had not responded effectively to emerging pressures within the hospital.

This is a breach of regulation 10 (1)(a)(b) and (2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Reasons for our judgement

We carried out this review in response to concerns about the provision of emergency care. The trust had already been subject to external review which led to our decision to inspect the trust and also informed our inspection report. The external review highlighted how the governance of the hospital and leadership of some parts of the trust had not been effective in order to avoid or limit the current pressures. The trust had developed action plans to address the review's recommendations, but they were at an early stage of implementation.

We met a number of members of the executive team and the board, including the new Chief Executive Officer who had just taken up his post. The trust Chair told us the Trust Board commissioned a formal external evaluation of its effectiveness in 2011, as part of the on-going review of the Board and Board Committees. We saw from board reports the board had been informed about the performance of the emergency department (ED) and the action plan had been presented and ratified.

We reviewed governance at the hospital based upon the specific concerns identified. Clinical staff told us the system was not working in some areas to promote effective discharge, and they felt this had not been addressed early enough. They said some care pathways were outdated and not as proactive as they should be to promote wellbeing. For example, clinical pathways used were considered by some staff to not be the latest best practice.

We saw the wider health economy and other decision makers were not entirely supportive of the hospital and this was certainly part of the problem. We were told some families were slow or reluctant to accept or agree to community care for their relative. This meant some older people were remaining in hospital when they were fit for discharge as they had

no community support when they left. For some patients this delay had been for several weeks. This was confirmed by social workers we met on our visit. We were told there was a shortage of rehabilitation, intermediate care or respite beds to meet demand in the community where people who no longer needed acute care could stay for a short time before going home. However, systems at the hospital were also having a negative impact on efficiency.

We found the trust executive team did not have enough information to enable it to see where it was not managing its own pressures. Discharge information was not provided in such a way as to enable the executive team to act upon areas it should be directly influencing. For example, while we were at a multi-disciplinary team discharge meeting, the team discovered three patients had not gone home the previous day as planned. This was because medicines to take out were not ready. It was not clear whether this was due to a lack of prescription or pharmacy support, so management were not able to manage this problem without more investigation. Also, managers who could influence this problem were not being made aware of these and other similar issues.

The discharge team did not have effective protocols to deal with some situations where discharge was delayed. For example, if a meeting was needed to decide how to proceed in a patient's best interests, the hospital faced delays if the family could not be contacted. There was no protocol to guide staff as to when to bring in an advocate.

Clinical staff told us they had concerns around staff accountability for how their actions affected others. They said some staff were "making decisions outside of the system" and this was having "a knock-on effect on others which they don't or won't see." We were told the trust felt fragmented to some staff and not all staff "pull in the same direction." This had also been highlighted by an external review into some of the specialty medicine as commissioned by the trust from the NHS Intensive Support Team.

We were concerned about reporting of incidents to the executive team and subsequently to the board. Some ways of working in the ED had become normalised due to the pressure on space. For example, a doctor we came across, intending to catheterise a patient in the plaster room, should have reported this inappropriate practice as an incident. Reporting this would have enabled hospital management to react to what should be an exceptional situation. However, this and other breaches of people's privacy and dignity we saw were not being reported.

During our visit we attended a bed planning meeting. At the end of the meeting we were unsure what objectives, if any, had been set for staff to proactively achieve. The discharge team and clinical site managers, who were responsible for the flow of patients through the hospital, were present at the meeting. Despite their experience and responsibilities, they were not able to contribute sufficiently to the discussion or decisions.

On a broader note: the trust and the hospital were achieving many good things in leadership, change management, and governance. During our visit we attended a briefing to senior staff. We saw the hospital was supporting and promoting junior doctors to be innovative in ways of working. This forum promoted professional development and gave junior doctors a voice in the organisation to promote change.

We were encouraged at meeting many members of staff who contributed to governance, patient safety, patient involvement, quality and innovation. We were told of other reviews and work streams, audits and risk assessments, which led to improvements in patient

care, safety and wellbeing. We saw, for example, work done to significantly reduce avoidable falls which had delivered excellent results. A programme to improve the organisation of patient blood tests had also been put in place and was delivering efficiencies and reducing frustration for patients and staff.

We acknowledge the new CEO, who started work on 1 April 2013, needs time to address these areas of concern and he has said he will do so urgently. Our evidence for this judgement included the trust already taking some urgent actions and considering how to make robust longer-term changes.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Some patients were not being treated with the privacy and dignity they should be afforded and were not admitted to wards in an appropriate time. Some patients had been admitted to wards which were not suitable for overnight stays and unable to wash properly. They had to share a single toilet facility. There was no privacy for patients who were being held in the emergency department corridors.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Due to a lack of effective planning to move patients through the hospital, the health and welfare of some patients was being adversely affected by the lack of available beds. The care pathways for some patients meant they were not being treated holistically during their stay. This was compromising the mobility and independence for some older frail patients.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers** **How the regulation was not being met:** There was no effective programme in place for supporting trust or hospital staff with training, appraisal, development and education. The trust was not able to demonstrate patients in its care were looked after by staff who were properly supported to deliver safe and effective care. Some staff working under significant pressure were not being effectively supported.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The hospital had not anticipated the pressures developing in the emergency department despite enhancing its current service, and the effect this had on other parts of the system. The trust had not robustly responded to the pressures when they began to emerge. Systems in place had not been able to identify, assess

This section is primarily information for the provider

Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	and manage risks to the health, safety and welfare of people using the service.

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

The provider's report should be sent to us by 12 June 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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