University College London Hospitals NHS Foundation Trust

University College Hospital & Elizabeth Garrett Anderson Wing

Quality Report

235 Euston Road
London
NW1 2BU
Tel: 020 3456 7890
Website: www.uclh.nhs.uk

Date of inspection visit: 12-14 and 20-21 November 2013
Date of publication: 14/01/2014

This report describes our judgement of the quality of care at this hospital. 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.

Contents

Summary of this inspection

Page

Overall summary 3
The five questions we ask about hospitals and what we found 5
What we found about each of the main services in the hospital 7
What people who use the trust's services say 12
Areas for improvement 12
Good practice 13

Detailed findings from this inspection

Our inspection team 14
Why we carried out this inspection 14
How we carried out this inspection 14

Summary of findings

Findings by main service 16

Areas in need of improvement 56

Action we have told the provider to take 58

Summary of findings

Overall summary

University College London Hospital is an acute hospital run by the University College Hospitals NHS Foundation Trust. It is located in central London and provides acute and specialist services to the local populations of the London Boroughs of Camden, Islington, Barnet, Haringey and Westminster as well as patients from further afield. It has a total of 650 beds and serves a population of 1.3 million people. The hospital includes the Elizabeth Garrett Anderson (EGA) Maternity Wing, and Macmillan Cancer Centre.

The trust also provides specialist services at the Hospital for Tropical Diseases, the Royal National Throat, Nose and Ear Hospital, the National Hospital for Neurology and Neurosurgery, the Royal London Hospital for Integrated Medicine, the Heart Hospital and the Eastman Dental Hospital. It was one of the first to gain foundation trust status.

Our focus on this inspection was on University College London Hospital as part of our acute hospital inspection programme. We did not inspect the specialist services.

We chose to inspect University College London Hospital as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital varying from those considered to be high risk of poor care to those where the risk of poor care was judged to be lower. University College Hospital was considered to be a low risk provider. It has been visited by CQC five times since it was registered in October 2010 and has always been assessed as meeting the standards of care set out in legislation.

Our inspection team included CQC managers, inspectors and analysts as well as doctors, nurses, allied health professionals, a pharmacist, senior midwife, patient representatives and people who have used services (Experts by Experience) as well as senior NHS managers. The team spent three days visiting the hospital and conducted further unannounced visits six and seven days afterwards. We held a public listening event in Camden and heard directly from 30 people about their experiences of care.

Our analysis of data from CQC's 'Intelligent Monitoring' system before the visit indicated that the trust was operating safely and effectively across all services. The trust's mortality rates were as expected or better than expected for a trust of its type and size.

We found that, generally, services were safe, effective, caring, responsive to patients' needs and well-led. When we inspected we saw many examples of good care. We were impressed by the dedication of the doctors and nurses we saw and the level of support that they were given as well as the mutual respect shown within teams, leading to high levels of care. We were also impressed with the emphasis placed at all levels from the trust's board and governors down to ward level on putting the needs of patients first.

The vast majority of patients we spoke to at University College Hospital were very positive about the care they received. Many members of staff told us that they felt well supported by senior clinical staff who responded quickly to requests for help. Staff told us they were proud to work at the trust and proud of the level of care they were able to deliver.

It has a stable and experienced board and the trust's Governors act very much as patient champions, providing challenge. There is a clear governance structure based in clinical divisions but with a corporate overlay and this has resulted in high levels of care being developed and maintained.

We wish to emphasise here some of the many good aspects of care we saw being delivered at this hospital,including:

- The commitment of staff in A&E to delivering good care
- In Medical Care, examples of excellent caring staff, well supported, with good care and positive interaction with patients.
- In Surgery examples of excellent care, support for patients' needs and a strong consultant presence.
- In Intensive/Critical care, examples of caring efficient staff showing good multi-disciplinary working with good clinical outcomes.

Summary of findings

- Maternity services that overall were safe, caring, effective, responsive and well –led.
- In Children's care a strong collaborative style of working for the benefit of children, young people and their families.

We did however note areas of the hospital where staff were delivering care under pressure and where the environment was less good:

- In A&E we found that staff, to their credit, were delivering safe care but in very difficult circumstances. The physical environment was inadequate. Due to shortage of space, facilities and equipment and patients' privacy and dignity was severely compromised. We also found that the emphasis on receiving large numbers of patients through A&E instead of direct to an appropriate receiving clinical area was making the situation worse.In failing to address these issues we found trust leadership in A&E needed to be strengthened and improved. We believe the trust should take action to alleviate those pressures.
- We found a risk of unsafe surgery as the World Health Organisation (WHO) surgical safety checklist was not always fully completed.
- On medical wards, we were concerned about written nursing assessments, care plans and care delivery records being insufficiently completed. Although we saw no evidence of unsafe care being delivered, insufficient recording meant there was an increased risk of inappropriate or unsafe care or treatment.
- The management of outpatient clinic was not adequate resulting in overcrowding and patients being left without seating in busy periods.
- During our visit we became aware that the trust may not be recording its cases of hospital acquired infection in accordance with national guidelines. We raised this with the trust at our inspection. It is currently in discussion with Public Health England on this issue.
- The trust was not ensuring that the paperwork for patients who had been assessed as not requiring resuscitation was always fully completed.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from preventable falls. Records were maintained to a good standard in most areas.

However we found deficiencies in recording of assessments in medical care. We found that the physical environment and patient throughput in A&E presented the staff there with considerable pressure. We have questioned the trust's method of recording cases of C. difficile infections.

Patients were not always protected against the risk of unsafe surgery because the WHO Surgical checklist was not always fully completed.

Are services effective?

Services were effective and focused on the needs of the patients. The trust's latest Hospital Episode Statistics showed better or much better than expected performance in 10 of the 20 diagnostic groups. Key targets were being met or exceeded, but in outpatients some of the targets within the 18 week waiting for treatment indicators were not being met.

Are services caring?

The overwhelming majority of people told us about their positive experiences of care. The trust scores highly in patient survey results including cancer care, but excluding issues around communication and information in relation to cancer. Overall, patients said they were satisfied with how they had been treated and those doctors, nurses and other staff were caring and professional. We observed many instances of good and in some cases outstanding care. Staff respected patients' dignity and privacy.

Are services responsive to people's needs?

Services were generally responsive to patients' needs and they were kept well informed. Overall patients were treated promptly. Complaints and concerns were handled appropriately. However, we found that the environment in A&E prevented all patients' needs being met. There were positive comments from patients who had been on A&E, but these were tempered by the environment.

Summary of findings

Are services well-led?

The trust was generally well-led. We saw high levels of efficiency at all levels. The Board of Governors acted as patient champions and exerted a positive influence. Ward leadership ensured highly motivated staff performing well.

However, we had concerns that the trust needed to re-examine and bring forward its priorities in relation to re-developing A&E, and children's A&E. Operational and strategic leadership in emergency needs to be strengthened and improved.

The trust also needs to improve its monitoring and timely achievement of improvements in response to actions and learning from serious incidents.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The physical environment of A&E was inadequate and not responsive to the needs of patients, and we had concerns that the current environment and layout could compromise patient safety and requires considerable improvement. The staff in the A&E were caring with patients and supportive of each other, and as a team, through their attitude and practice, they mitigated the impact of the inadequacy of the A&E on patient care. However, at times of intense pressure, we had concerns that staff were disempowered from being able to care for patients appropriately.

We also had concerns about the effectiveness and leadership of the A&E, and the trust's response to known risks and failures. This includes allowing the pressure on the A&E to increase through routing referred medical and surgical patients through the department.

In the context of the trust, what we found and what staff told us it was felt that the A&E service was not a priority. It is clear that not all staff were aware of the focus of the board in this area.

Medical care (including older people's care)

The acute medical wards we visited provided people with safe care. However, people's written nursing assessments, care plans and care delivery records were consistently inadequate, which meant there was an increased risk of inappropriate care or treatment.

We found the majority of systems and processes in place made sure that people received effective care, including a good level of information sharing among professionals.

We found the quality of care provided was excellent, and people we spoke with were extremely complimentary about the compassionate care and treatment they received. However, patients' notes were on occasions held in areas that were not secure or supervised to ensure patient confidentiality.

The acute medical wards were responsive to people's needs, including operating appropriate systems for triaging, and procedures were in place in the event of medical emergencies.

We found wards were well-led by competent and approachable senior staff. There was evidence at ward level of learning from incidents to ensure current and future safe practice. However, we saw less evidence of trust-wide learning from trends of incidents at ward level.

Summary of findings

Senior staff had recognised the need the need to improve nursing records but we found improvements had not been implemented.

Surgery

Surgical patients and their visitors told us staff were caring and they felt their needs had been met. Overall they were very satisfied with the care and treatment they received. This was reflected in the positive patient satisfaction survey results that the surgical division continuously achieved.

Patients' needs were met and clinical management guidelines were used. There was a strong consultant presence in the surgical division and all staff worked together to provide the best outcome for patients.

On the wards we found staff were responsive to patients' needs and kept them involved in their care and treatment. However, we found that the recovery area for patients did not have the capacity to care for and treat the high volume of patients.

Services appeared safe. However there was a risk of unsafe surgery as the WHO surgical safety checklist was not always completed. Staffing arrangements enabled safe practice and agency staff were rarely used.

There was leadership at all levels of the division and staff felt well supported to carry out their roles. A clinical governance framework was in operation to monitor the quality of the service; however, we found that when areas of improvement were identified, action was not promptly taken.

Intensive/critical care

There were enough specialist staff to meet people's needs and ensure they had appropriate 24-hour care and treatment. People received care and treatment according to national guidelines and admissions were prompt and appropriate. The critical care service performs better than most other similar units across the country with a lower than expected mortality rate. Quality and safety was the focus for the service which was reviewed daily as well as formally through the hospital's clinical governance and performance monitoring frameworks.

Patients and relatives reported a caring, supportive environment with information sharing and input from families and patients so that care was holistic. Patient feedback reflected this with 92% saying they would recommend to family and friends.

Patients' welfare was continuously monitored and reviewed. There were links with external services, such as The Intensive Care National Audit, to enable the service to benchmark its services.

Summary of findings

There were processes for audit and the service was involved in clinical research. We saw that there was good communication between the critical care unit (CCU), the rest of the hospital and other hospitals.

The critical care service was well-led. One staff member told us "I like it here, I respect and admire colleagues". Staff reported good training and support.

The CCU did not have an on-site 24-hour cleaning service and this could lead to delays out of hours. Some moveable equipment was stored on a corridor with no process of stock control and re-cleaning before use.

Maternity and family planning

We found overall the maternity services were safe, caring, effective, responsive and well-led.

Staff were caring, attentive and professional in their roles. The women felt confident with the care provided. The wards were clean and safe and had good security measures in place to protect women and their babies. Most of the women that we spoke to told us they had positive experiences with the maternity care and felt confidence in the staff that cared for them.

Maternity services were being planned to meet the increasing demand by extending the number of beds and recruiting more staff.

There was insufficient evidence that all staff learned from incidents and complaints. There was a maternal death in the last year and it was unclear that the lessons learned from the incident had been shared.

Midwives were well supported. The ratio of supervisors of midwives to midwives was 1:16.

Services for children & young people

There were sufficient skilled staff to meet patients' needs and there was prompt recruitment to vacant posts. Neonatal services were working to develop the skills and knowledge of their nursing team in order to retain staff and enhance their service in the face of a national shortage of experienced neonatal nurses. Children's services had systems in place to effectively monitor and improve patient safety.

There was good communication for the benefit of children and young people between different parts of the trust's children's services, and also with other hospitals and services that some patients used.

Summary of findings

All the staff displayed a warm and caring attitude towards the patients and their families, as well as to each other. Staff spoke with children and young people using age-appropriate language and we saw how they tried to engage with the children while they were treating or monitoring them.

Children and young people with complex needs received individualised care and treatment .The strong link between audit findings and education meant that training could be provided if issues were identified.

Without exception, staff members spoke well of management within the Paediatrics Division. Charge nurses and ward sisters provided effective leadership and the senior management within children's services was supportive. However, we found less evidence that the children and young people's agenda was given priority within the trust as a whole.

The services delivered to children did not include A&E. The A&E section focuses on this issue.

End of life care

We found that the trust was improving support for people at the end of their lives.

The trust had recognised the need to increase the staffing levels in its palliative care team and was taking action to do this.

The trust was no longer using the Liverpool Care Pathway. It had been recently replaced by an interim "Excellent care in the last days of life – Individualised care plan."

We found that staff were caring and responsive to patients' needs. There was a good working relationship between the different support services that were available. We received positive feedback from relatives of patients.

However, the trust was not ensuring that the paperwork for patients who had been assessed as not requiring resuscitation (do not attempt resuscitation or DNAR) was always fully completed. We found examples where there was no evidence recorded of discussions with the person or their family members and there was no consultant signature to indicate they had reviewed the order.

We found that the trust was seeking to develop and improve its End of Life service. It had an End of Life Board to provide senior leadership in developing the service at the trust. A five-year strategy for End of Life is currently at draft stage.

Summary of findings

Outpatients

The physical environment in the main central outpatient department was not adequate. During busy periods clinics were at times overcrowded and patients were without seating.

The trust's overall targets for patient waiting times from referral to treatment had improved and staff across all levels of the trust had been responsive to improving performance. However, the administrative processes across the entire outpatient services were not streamlined and were therefore working variably across the different patient pathways. In addition the trust had breached four of the cancer waiting time targets in July 2013 for both admitted and non-admitted pathways.

Patients we spoke with and patient satisfaction survey results rated the overall care they received as good. However ratings were lower when asked about the respect and dignity they sometimes received in the main central outpatient department and when asked about waiting times past their booked appointment times across all the outpatient services. In addition some patients said they had experienced difficulties in accessing appointments. Staff informed us that there was very limited access to psychology services across the outpatient services.

There were arrangements to enable safe practice across the outpatient services. There were arrangements for staff to respond appropriately to foreseeable medical emergencies. The provider also has clear arrangements in place for infection control, the management of medicines, the reporting of incidents and escalating safeguarding concerns.

The trust supported professional development for its staff. Staff received mandatory training and annual appraisals.

Summary of findings

What people who use the trust's services say

Inpatient Performance: In August 2013, 892 people completed the Friends and Family Test for the trust. 96.4% of patients asked were "extremely likely" or "likely" to recommend the trust's inpatient departments to friends or family. Of 932 people, 88.1 would say the same for Accident and Emergency.

In the 2012/13 Cancer Patient Experience Survey (designed to monitor progress on cancer care) the trust was rated in the bottom 20% of all trusts nationally for 30 out of 64 questions. The trust scored better than average in questions relating to clinical care but worse than average in questions relating to communication, information, pain control and support.

The trust's ratings on the Patient Opinion Feedback survey ranged from 2.5 out of 5 for parking to 4 and over out of 5 for medical and nursing care and showing respect to patients.

The trust has scored an average 4 out of 5 overall in the NHS Choices Review covering cleanliness, staff co-operation, dignity and respect, involvement in decisions and provision of same sex accommodation.

The Patient Environment Action Team (PEAT) annual assessment (July 2012) of inpatient healthcare sites in England rated the trust "Good" for Privacy and Dignity; "Excellent" for Food, and "Good" for Environment.

Areas for improvement

Action the trust MUST take to improve

- Review the current A & E and children's A & E provision and assess what planned improvements can be brought forward or interim measures can be employed to mitigate risks to patient safety.
- Improve the quality, completeness of people's care assessments, care plans and care delivery records on the acute medical wards to ensure that people do not receive inappropriate or unsafe care.
- Improve the care and security storage of patient records on acute medical units.
- In Intensive/Critical care improve access to 24 hour cleaning support in the critical care unit and improve space for the storage of equipment.
- In surgery, improve patient flow by alleviating pressure on beds and reviewing bed capacity in operating theatre recovery area.
- Ensure full completion in all cases of the WHO surgical checklist to help prevent "Never Events".
- The trust must ensure that the paperwork for patients who have been assessed as not requiring resuscitation is always fully completed.

Action the trust COULD take to improve

- Provide information for non-urgent patients presenting at A&E about other services available to them and review repeat patient visits to identify opportunities to educate where appropriate. Site the information screen in A&E reception where the majority of seated patients can view it.
- Consider whether staffing levels support the need to chaperone and whether staff could act as champions for vulnerable groups visiting A&E.
- Improve the provision in all areas in the trust of written information to patients whose first language is not English. Improve patient information to visually and hearing impaired patients in A & E.
- Consider the possibility of utilising voluntary groups or other means to provide food and drink to patients in A&E.
- Improve patient flow through the AMU onto general wards to relieve pressure on the unscheduled care pathway.
- Wards should be provided with information about any trends in datix incident data to ensure any required improvements can be implemented.
- The assessment medical unit (AMU) could have physiotherapy or occupational therapy support over the weekend to support discharge at these times.
- The AMU could have a dedicated acute medical consultant to help the future development of the unit.
- Ensure the rollout of dementia awareness training for care staff on all wards.

Summary of findings

- Ensure environmental improvements are made to the elderly care wards and the AMU to improve the hospital experience for people with dementia.

Good practice

Our inspection team highlighted the following areas of good practice:

Accident and emergency

- The commitment of staff to good care despite environmental challenges.

Medical care

- Excellent caring staff, including positive caring interactions with patients. Staff provided people with regular information and promoted their involvement in their care. They maintained people's privacy and dignity and promoted their independence.
- Senior ward staff were given the opportunity to complete leadership training which meant wards were managed by competent and approachable staff.
- Some senior managers were visible on wards and participated in delivering care which meant they understood how wards worked so they knew first-hand about staff and patient experiences. Strong clinical leadership was clearly visible on wards.
- Effective training in the care of patients with Dementia was being compassionately put into use on the AMU by care assistants

Surgery

- Areas of good practice were as follows: Patients and their relatives found staff to be caring, supportive and felt that their needs had been met. We observed people being treated with dignity and respect.
- There was a strong consultant' presence at all stages of patients' surgical pathway ensuring decisions on care and treatment were made by the appropriate qualified healthcare professional.

Intensive/critical care

- Areas of good practice included good examples of caring, efficient staff showing good multi-disciplinary working; good patient mortality rates and clinical outcomes; daily ward input from microbiologist and psychological support for patients and staff

Children's care

- Clinical Nurse Specialists and other staff linked effectively with community services for children and young people with complex needs to try to ensure services were as seamless as possible. 'Patient passports' had been developed to aid communication.
- There were arrangements in place for young people receiving ambulatory care to get immediate access to an in-patient bed in the event of a sudden deterioration of their condition.
- There was a strong commitment to a collaborative style of working in the Paediatric Division for the benefit of children, young people and their families. For example, the Neonatal Unit held daily Capacity and Safety meetings which involved a wide range of staff.
- The outpatients' clinics for children and young people had procedures in place to check reasons for non-attendance. This safeguarded children who might have missed appointments due to abuse or neglect.
- The competence of new clinical staff was checked before they were allowed to work unsupervised.

University College Hospital & Elizabeth Garrett Anderson Wing

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; and Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Consultant Physician, Medicine and Elderly Care, Hampshire Hospitals FT; Programme Director NHS Leadership Academy.

Team Leader: Robert Throw, Care Quality Commission

The team included CQC managers, inspectors, analysts, doctors, nurses, midwife, pharmacist, paramedic, patient Experts by Experience, patient representatives and senior NHS managers.

Why we carried out this inspection

We chose University College London NHS Foundation Trust as one of the Chief Inspector of Hospital's first wave of new inspections because we were keen to visit a range of different types of hospital, from those considered to be low risk to those who were the risk of poor care is likely to be higher. University College London NHS Foundation Trust was considered to be a low risk trust.

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 inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)

Detailed findings

- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

The lines of enquiry for this inspection were informed by our Intelligent Monitoring data.

As part of the inspection process we contacted a number of key stakeholders and reviewed the information they gave us. We received information from people who use the services, Healthwatch, Monitor, Camden and Islington Clinical Commissioning Groups.

We held six focus groups with qualified nurses and allied health professionals; junior doctors; student nurses and nursing assistants; consultants; medical directors; non-executive directors and interviewed a range of staff including the Chairman, Chief Executive, Lead Governor, Chief Nurse, Director of Quality and Safety, Corporate Medical Director, and we held drop in surgeries for members of staff to come and talk to us.

We carried out an announced inspection visit on 12, 13 and 14 November 2013. As part of the inspection we looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients. We talked with people who use the services, their carers and family members. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We placed comment boxes around the trust and received comments from people who use the service and staff.

We held a listening event on the evening of 12 November 2013. People were able to talk to us about their experiences and share feedback on how they think the trust needs to improve.

We carried out unannounced inspections on 20 and 21 November 2013 when we followed up on areas of the trust we had inspected in the previous week.

The inspection team would like to thank all those who attended the focus groups, listening events, and drop in sessions for being open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from preventable falls. Records were maintained to a good standard in most areas.

However we found deficiencies in recording of assessments in medical care. We found that the physical environment and patient throughput in A&E presented the staff there with considerable pressure. We have questioned the trust's method of recording cases of C. difficile infections.

Patients were not always protected against the risk of unsafe surgery because the WHO Surgical checklist was not always completed. We have told the trust that they must act to improve in this area.

Our findings

The staff in A&E were delivering safe care in a department under pressure. We had concerns that the current environment, layout and patient flows could compromise patient safety and requires considerable improvement.

The acute medical wards we visited provided people with safe care. However, people's written nursing assessments, care plans and care delivery records were consistently inadequate which meant there was an increased risk of care or treatment being delivered which was inappropriate or unsafe.

Surgery appeared safe. However there was a risk of unsafe surgery as the WHO surgical safety checklist was not always completed. Staffing arrangements allowed safe practice and agency staff were rarely used.

People received critical care and treatment according to national guidelines and admissions were prompt and appropriate. Quality and safety was the focus for the service with reviews daily as well as formally through the hospital's clinical governance and performance monitoring frameworks.

We found overall the maternity services were safe.

Children's' services were safe. There were sufficient skilled staff to meet patients' needs.

We found that the trust was improving support for people at the end of their lives. The trust had recognised the need to increase the staffing levels in its palliative care team and was taking action to do this.

Overall trust targets for patient waiting times from referral to treatment had improved and staff across all levels of the trust had been responsive to improving performance. However the administrative processes across the entire outpatient services were not streamlined and were therefore working variably across the different patient pathways.

We were concerned at the trust's interpretation of national guidelines on the reporting of Clostridium Difficile (C.diff) infections in that they appear to retrospectively not report cases that have been confirmed as C.diff positive if those cases have subsequently been found to be not requiring treatment. The current national guidelines state that all samples submitted that are positive for C.diff. should be reported. We attempted to seek clarification from the trust on this point during the inspection. We note that the trust is in ongoing discussion with Public Health England on this issue.

Are services effective?

(for example, treatment is effective)

Summary of findings

Services were effective and focused on the needs of the patients. The trust's latest Hospital Episode Statistics showed better or much better than expected performance in 10 of the 20 diagnostic groups. Key targets were being met or exceeded, but in outpatients some of the targets within the 18 week waiting for treatment indicators were not being met.

Our findings

The staff in the A&E were caring with patients and supportive of each other, and as a team, through their attitude and practice, they mitigated the impact of the inadequacy of the A&E on patient care. However, at times of intense pressure, we had concerns that staff were prevented from being able to care for patients appropriately.

We found the majority of systems and processes in Medical Services made sure that people received effective care including a good level of information sharing among professionals.

In surgical services patients' needs were met and clinical management guidelines were used. There was a strong consultants presence in the surgical division and all staff worked together to provide the best outcome for patients.

The critical care service performs better than most other similar units across the country with a lower than expected mortality rate.

In maternity the patients felt confident with the care being provided. The wards were clean and safe and had good security measures in place to protect women and their babies.

On the Children's care wards there were sufficient skilled staff to meet patients' needs and there was prompt recruitment to vacant posts. Neonatal services were working to develop the skills and knowledge of their nursing team in order to retain staff and enhance their service in the face of a national shortage of experienced neonatal nurses. Children's services had systems in place to effectively monitor and improve patient safety.

In its end of life care the trust had recognised the need to increase the staffing levels in its palliative care team and was taking action to do this. The trust was no longer using the Liverpool Care Pathway. It had been recently replaced by an interim "Excellent care in the last days of life – Individualised care plan."

Overall trust targets for outpatient patient waiting times from referral to treatment had improved and staff across all levels of the trust had been responsive to improving performance. However the administrative processes across the entire outpatient services were not streamlined and were therefore working variably across the different patient pathways.

Are services caring?

Summary of findings

The overwhelming majority of people told us about their positive experiences of care. The trust scores highly in patient survey results including cancer care, but excluding issues around communication and information in relation to cancer. Overall, patients said they were satisfied with how they had been treated and those doctors, nurses and other staff were caring and professional. We observed many instances of good and in some cases outstanding care. Staff respected patients' dignity and privacy.

Our findings

The staff in the A&E were caring with patients and supportive of each other, and as a team. Through their attitude and practice, they mitigated the impact of the inadequacy of the A&E on patient care. In the children's A&E there was a play specialist which made a positive contribution to children's' experience

We found the quality of care provided on the medical wards was excellent, and people we spoke with were extremely complimentary about the compassionate care and treatment they received.

Overall patients spoke highly of the service they received on Surgical wards. They said they had been treated as individuals and were satisfied with their care and treatment. One patient told us "everyone talks to you, doctors don't talk over you, they talk with you."

In critical care, patients and relatives reported a caring, supportive environment with information sharing and input from families and patients so that care was holistic. Patient feedback reflected this with 92% saying they would recommend to family and friends.

In Maternity, staff were caring, attentive and professional in their roles. The women felt confident with the care being provided.

In Children's Services all the staff displayed a warm and caring attitude towards the patients and their families, as well as to each other. Staff spoke with children and young people using age appropriate language and we saw how they tried to engage with the children while they were treating or monitoring them.

We found that in end of life care staff were caring and responsive to patients' needs. There was a good working relationship between the different support services that were available. We received positive feedback from relatives of patients.

Patients we spoke with in outpatients and patient satisfaction survey results rated the overall care they received as good. However ratings were lower, when asked about the respect and dignity they sometimes received in the main central outpatient department.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Services were generally responsive to patients' needs and they were kept well informed. Overall patients were treated promptly. Complaints and concerns were handled appropriately. However, we found that the environment in A&E prevented all patients' needs being met. There were positive comments from patients who had been on A&E, but these were tempered by the environment.

Our findings

Staff in A&E were personally responsive to people's needs but were hampered by the physical constraints of the department and pressure of patient numbers directed through the department.

The acute medical wards were responsive to people's needs including operating appropriate systems for triaging, and procedures were in place in the event of medical emergencies.

On the surgical wards we found staff were responsive to patients' needs and kept them involved in their care and treatment. However we found that the recovery area for patients did not have the capacity to care for and treat the high volume of patients.

In Critical Care patients' welfare was continuously monitored and reviewed. There were links with external services, such as The Intensive Care National Audit, so that benchmarking could be undertaken. There were processes for audit and the service was involved in clinical research. We saw that there was good communication between the CCU, the rest of the hospital and other hospitals.

Maternity services were being planned to meet the increasing demand by extending the number of beds and recruiting more staff. However, there was no robust system in place for the wider clinical teams to learn from incidents and complaints.

Children and young people with complex needs received individualised care and treatment .The strong link between audit findings and education meant that training could be provided if issues were identified.

The trust was not ensuring that the paperwork for patients who had been assessed as not requiring resuscitation was always fully completed. We found examples where there was no evidence recorded of discussions with the person or their family members and there was no consultant signature to indicate they had reviewed the order.

Some out- patients said they had experienced difficulties in accessing appointments. Staff informed us that there was very limited access to psychology services across the outpatient services.

The trust had good systems in place for dealing with complaints, following good practice. There were 674 written complaints submitted to the trust in 2012-13, of which 446 (66.2%) were upheld. This was a 29.6% increase from the 520 complaints in 2011-12. However the number of complaints is not always an indicator of poor performance because a trust may actively encourage comments.

Every six months the Ministry of Justice publishes a summary of Rule 43 recommendations which have been made by the local coroner with the intention of preventing deaths and learning lessons from the cause of death. There are currently no concerns regarding the trust in the Coroner's Rule 43 Reports.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust was generally well-led. We saw high levels of efficiency at all levels. The Board of Governors acted as patient champions and exerted a positive influence. Ward leadership ensured highly motivated staff performing well.

However, we had concerns that the trust needed to re-examine and bring forward its priorities in relation to re-developing A&E, and children's A&E. Operational and strategic leadership in emergency care needs strengthening and improving.

The trust also needs to improve its monitoring and timely achievement of improvements in response to actions and learning from serious incidents.

Our findings

We found that there was a clear organisational structure at the trust. There was also a clear governance and risk management structure. Members of the Executive Board and Board of Governors undertake regular tours of wards. The Board discusses performance information and both the Chief Executive and Chair had a clear vision of the future strategy of the trust. Overall in our visits to wards we found a general level of efficiency, affirmation of support by senior staff to ward staff and focus on patient care that was indicative of good leadership.

Oversight of clinical governance is the responsibility of the Board Member Corporate Medical Director in partnership with the Director of Quality and Safety. The Deputy Director of Quality and Safety has oversight of Serious Incidents and Never Events trust wide. The three remaining Medical Directors are responsible for clinical governance within their own division. The Deputy Chief Executive has corporate responsibility for the trust Risk Register and Board Assurance Framework. All Medical Directors sat on the Quality and Safety Committee where all incidents at all levels were reported. We noted that this was a very large committee.

We tracked an incident involving a 12 hour trolley wait that occurred in May 2013.No Action Plan had been formed, no discussions with relevant areas – Paediatric and A&E staff - had as yet taken place. This was corroborated with A&E staff as when asked what the learning had been from the incident the general manager had stated they had no feedback as yet.

Two Serious Incidents (SI's) were then reviewed with a similar presentation and realisation. We checked and found that the Board and the Quality & Safety Committee had no system of assurance of actions and timely implementation of actions following a serious incident. We found this in the case of other incidents we tracked including a maternal death in June 2013 where actions marked immediate were still not complete. From our observations on the wards we also found that in some cases ward staff were not aware of discussions and outcomes at Board or Quality & Safety Committee of the levels of incidents and/or SI that had occurred in their service.

We saw that the trust had processes in place to appoint investigating officers but we did not see where there is a multi-disciplinary approach at the outset meeting. Where clinicians directly involved are included in initial discussions as well as agreement to what immediate actions are required there does not appear to be strong Non Executive involvement and no executive involvement in oversight of actions being delivered or recorded on the corporate system that was shared with CQC.

In the 2012 Staff Survey the trust had "Better than Expected" for 11 out of 28 indicators. The quality indicators monitored by CQC in terms of reporting culture, risks reported by other bodies such as Monitor, GMC national training survey, Staffing levels, staff survey and intelligence from other sources such as NHS Choices all indicated no evidence of risk in relation to the trust.

Overall sick absence rates for the trust were to be commended at 2.6% against a London NHS average of 3.52% and a National Average of 4.24%.

The trust participated in 45 out of 47 National Clinical Audits in 2012/13.

The trust performed better than expected in the General Medical Council Training Scheme Survey in Clinical Radiology, Haematology, Medical Oncology, Neonatal and Respiratory Medicine. It performed worse than expected in some areas of adequate experience, access to educational

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

resources, feedback and regional teaching. The trust was highlighted as better than expected in training in Audio Vestibular medicine, Clinical Neurophysiology, Infectious Diseases, Public Health Medicine and Rheumatology.

We had concerns about the effectiveness and leadership of the A&E, and the trust's response to known risks and failures. This included allowing the pressure on the A&E to increase through receiving referred medical and surgical patients through the A&E department. The trust had invited the Emergency Care Intensive Support Team (ECIST) to review services in July 2012. Out of 23 recommended actions for improvement, 11 were specifically for the A&E department. A number of the same issues, raised previously by ECIST, still remained.

We found medical care wards were well-led by competent and approachable senior staff. There was evidence at ward level of learning from incidents to ensure current and future safe practice. However, we saw less evidence of trust wide learning from trends of incidents at ward level.

There was leadership at all levels of the surgery division and staff felt well supported to carry out their roles. The clinical governance framework was in operation ensuring the quality of the service being provided was monitored.

The critical care service was well-led. One staff member told us "I like it here, I respect and admire colleagues". Staff reported good training and support.

Without exception, staff members spoke well of management within the Paediatrics Division. Charge nurses and ward sisters provided effective leadership .Senior management within children's services was supportive. However, we found less evidence that the children and young people's agenda was given priority within the trust as a whole.

We found that the trust was seeking to develop and improve its End of Life service. The trust had an End of Life Board to provide senior leadership in developing the service at the trust. A five year strategy for End of Life is currently at draft stage.

Leadership within outpatients was affected by different clinics belonging to different directorates. However, there were arrangements to enable safe practice across the outpatient services. There were arrangements for staff to respond appropriately to foreseeable medical emergencies. The provider also has clear arrangements in place for infection control, the management of medicines, the reporting of incidents and escalating safeguarding concerns.

Accident and emergency

Information about the service

The Accident and Emergency department (A&E) provides a 24-hour service, seven days a week. The department has facilities for triage, ambulatory care, minor and major injuries, children's A&E, resuscitation area and a clinical decision unit. It is led by a clinical director known as the clinical lead.

The department supports a hyper acute stroke unit (HASU) for North Central London and receives all acute stroke patients across that area. Patients that have a stroke have good clinical outcomes when compared nationally.

It is also a designated place of safety for patients with urgent mental health needs and receives patients from a wide catchment who are brought to the A&E under powers provided to the police under the Mental Health Act (1983).

We spoke with 35 patients during an inspection over three days and one evening. We also spoke with 26 members of the trust's staff, which comprised of the department's clinical lead, the department's general manager, the department's matron, three senior nurses, three receptionists, six junior doctors, six nurses, one student nurse, one health care assistant, one personal assistant and a member of the integrated discharge team. We looked at 13 sets of patient records.

The A&E was built in 2005 when approximately 65,000 patients visited the department annually. The department received 112,506 visitors in the year from April 2011 to March 2012, and in the six months prior to our inspection from April to October inclusive, 73,368 patients visited the A&E. In July 2012 it was reported that approximately 12.5% (15,000) of A&E attendees were children.

Summary of findings

The A&E environment is inadequate and compromises the safe delivery of care and treatment. Patients are frequently doubled up in cubicles designed to accommodate only one patient. Using seven majors cubicles for 14 patients means that monitoring and other essential equipment is only available to one of two patients at any one time. Shared cubicles increase the risk of cross contamination of infection.

Due to cramped conditions we found patients being treated in areas not originally designated for them. The children's resuscitation area was continually occupied by an adult presenting a risk to children's safety if they need to be rushed to this area. Resuscitation and majors patients are moved between areas depending on need, with majors (major illness or injury) patients being frequently cared for in the resuscitation area as majors cubicles are full.

There was a dedicated, committed and supportive staff team who were disempowered at times from caring for patients how they would like to because of the constraints of the department. However, patient feedback of their experience of A&E was overwhelmingly positive.

The trust's process of patient flows through the department created unnecessary pressure on the department and staff. Medical and surgical patients referred from elsewhere (for example GPs) were often routed through the A&E rather than being admitted to an appropriate ward, and all patients who presented at A&E reception with non-urgent symptoms were accepted by the department.

The department was not responsive to patient's needs and it did not effectively respond to the needs of vulnerable patients. Privacy, dignity and patient confidentiality are compromised by the A&E environment.

Nursing leads worked hard to support team members, but for the majority of our time in the department a recognisable leader was not visible. We asked staff in charge and received inconsistent answers, with many

Accident and emergency

not aware who the designated lead was at that time. The trust's leadership acknowledges considerable efforts are required to solve the many issues facing the ED,

The trust invited the Emergency Care Intensive Support Team (ECIST) to review services in July 2012. The ECIST report given to the trust in October 2012 identified 11 actions for the A & E department. The subsequent action plan identified completion in 4 areas and progress in some others. At the time of our inspection a number of the same issues raised by ECIST remained. The trust acknowledged no progress in gaining more space for the Emergency Department t (ED) and diverting patients expected from GPs to areas other than ED.

The trust had a development plan to increase capacity in A&E that was due for completion in approximately 2016. Given the ECIST report in July 2012, where the same concerns were identified, and current pressures and increasing demand on the service, we were concerned that this period is too long.

Are accident and emergency services safe?

The A&E environment was inadequate and compromised the safe delivery of care and treatment.

Equipment and facilities

A&E cubicles designed for one patient are being used to accommodate two patients in close proximity, divided only by temporary dividers. This was a risk to patient safety .The arrangement also severely compromised patient privacy and dignity and patient confidentiality. This issue was highlighted as a major risk on the trust's risk register in December 2012, and the risk had not been mitigated when we inspected. The crowded and cramped environment in the A&E majors area presents an increased risk in the event of a rapidly deteriorating patient in a difficult to access situation. The area for receiving patients conveyed from an ambulance was also very constrained offering no privacy, dignity or confidentiality.

In the seven majors cubicles regularly used by 14 patients, there was one monitor which meant that one person in the cubicle could be connected to that monitor. There was one buzzer in each cubicle which meant that one of the patients using the cubicle was not able to call for assistance. One patient out of two had access to oxygen and suction equipment at any one time. It was a risk that equipment was shared without always being cleaned in between each use, and we observed this with the use of blood pressure measuring equipment.

Ward hygiene

The department was kept clean and tidy. However, patient beds in the majors cubicles are side by side which presents a risk of cross contamination of infection between patients. Patients were not risk assessed for MRSA within the A&E department until they are admitted. The medical and surgical wards carried out these assessments. This meant that patients that may be high risk are mixing with other patients without any assessment taking place. We were told that the trust does not flag MRSA positive patients, and even those known to the hospital were not isolated to protect others. However, the A&E department would not be able to act on an assessment, as they have no effective isolation facilities.

Accident and emergency

Patient capacity

The resuscitation area was often full with acutely unwell patients. Many of the patients in the resuscitation area were majors patients and not resuscitation patients. We spoke to one nurse who stated that the resuscitation area was an extension of majors as they required the capacity. We witnessed on two occasions, patients having to be moved out to receive a patient requiring resuscitation.

Due to the demand, this meant that there was often an adult occupying a resuscitation bed designated for paediatric cases. We spent three hours one evening in the department and for all of that time, we observed that an adult was using the paediatric resuscitation area. We were told that the management plan for a child emergency in the paediatric department, some distance from the resuscitation room, would be to "rush them into resus". At the time we asked this question, the nurse was not aware that the paediatric resuscitation bed in the department was occupied by an adult. The consultant lead for paediatrics in A&E stated that "paediatric patients would never be cared for anywhere other than resus' or the paediatric department A&E area".

Are accident and emergency services effective?

(for example, treatment is effective)

We identified issues that render the department ineffective.

Performance and waiting times

Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in A&E. The trust's performance has frequently fallen below the 95% target over the last 12 months and had been getting worse since October according to NHS England data.

On the evening we attended A&E we were told that at 6:30pm that evening the department had 26 patients that had breached the four hour target for that day. We were also told that there were 11 patients in the department who were waiting for a bed that had been requested elsewhere in the hospital. However, out of those 11 patients only one of them had undergone an assessment leading to a formal decision to admit (DTA). This meant that the team in the department were asking for beds they were reasonably confident would be needed, but were not able to arrange a timely assessment and DTA. The question 'from the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward?' in the CQC Adult Inpatient Survey 2012 scored 7.53 out of 10 compared to 2011 score 8.38 (high score is better). This meant more patients felt they were waiting longer for a bed.

Staff were working to full capacity to care and treat all patients presenting at A&E. We observed over an hour period that all clinical areas were occupied. The matron told us this was not a busy period.

Patients' pathway

All patients that have been seen and sent into hospital by another clinician present to A&E and are regularly seen there and not directly by the accepting team on the relevant hospital ward. A new system of streaming patients to different areas has been introduced, in order to relieve pressure in A&E. This has been welcomed by staff as a positive move. However, staff told us that it is "unusual for patients to go directly to the specialty areas, such as AMU". We saw on our visit that this new system, recommended by ECIST in July 2012, had yet to be fully implemented. It is recognised by the College of Emergency Medicine that failing to define the core service of an A&E department will result in the department becoming the default safety-net for deficiencies elsewhere in the system.

We asked the trust for the number of patients over the last six months that had used the A&E and the percentage of those patients who were direct surgical or medical referrals. The information provided showed that between 14% and 15.5% of patients from April to September 2013 received by the department were medical or surgical referrals.

We were told by A&E staff that no patient who presented at A&E was referred elsewhere if they had non-urgent symptoms. There was no information in the A&E of other services that patients could contact instead of visiting the A&E, such as the NHS 111 telephone service available in Camden.

IT systems

A common complaint by the medical staff, juniors and consultants was that IT systems were ineffective and that they had difficulties navigating three separate systems day

Accident and emergency

to day. One member of staff said streamlining the system would be the biggest impact on providing effective patient care. It would free up staff time and allow for patients information to be more easily accessible.

Blood sampling

Junior medical staff expressed concern at the length of time blood samples took to return because sampling was not completed on site. This caused delays in decisions to admit or transfer or discharge patients. In such cases they stated that these decisions were always referred to a senior clinician or nurse. A senior nurse also stated that the turnaround times for blood diagnostics had a considerable impact on patient delays in A&E.

Are accident and emergency services caring?

Staff were caring.

Patients' feedback

We spoke with ten patients who were on an acute surgical ward, all of whom had experienced the A&E department before being admitted to the ward. The feedback from the patients we spoke with about the care and treatment received from staff was overwhelmingly positive although experiences reflected how busy the department seemed when they attended. In August 2013, 932 people completed the friends and family test (FFT) and 88.1 of patients were extremely likely or likely to recommend the A&E service to friends and family if they needed it. This was lower than the national figure.

Staff concerns

Out of 30 mixed members of staff; covering all grades and roles, five of whom were ambulance staff they all unanimously stated that the A&E department was "good" overall. However, the majority of the staff we spoke with also recognised the constraints of the environment they were working in, and shared the trusts acknowledgement that the environment was inadequate. There were concerns raised by staff about the difficulties the demands and pressures had on their ability to demonstrate caring, particularly with the nursing groups who said that they felt that this was "inadequate" at times.

Delays in care

We rarely observed patients with food or drink. During a busy period in the department we identified that one patient had been in the department for more than four hours without having anything to eat. We asked staff if food could be provided for this patient and it was provided. Another patient told us that they had been waiting for 6 hours. They said that for the first few hours the care they had received had been impeccable. However after a few hours they were moved to another area of the department and had to wait for two and a half hours for an antibiotic.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

The environment and facilities were not responsive to meet the needs of patients.

Patients with special needs

The matron told us that there were no measures in place to support patients with dementia in A&E. When we spoke with staff about how they would look after someone with such specific needs, the responses we received were caring but generalised. Two nurses we spoke with about dementia care were not familiar with the abbey pain score tool, a technique of assessing non-communicative patients, and in particular those with dementia. Staff stated that they were taking the needs of people with dementia into account in future work and considering guidance. At present though there was nothing in place, and similarly there was nothing to support the appropriate delivery of care for patients with learning disabilities.

Patient information

Throughout the inspection there was evidence of good established practice of informing patients about their treatment plan even when there was little known because of their recent arrival and limited interactions. One elderly patient on their own, said that they specifically requested to be brought to this department from further away because "it was a good hospital", they knew they were awaiting blood results and that they may require transferring to another part of the trust hospital site who specialised in heart problems. However, there were no updateable sign or methods of communication exist to relay waiting times to patients. There is a large information screen in the A&E reception. However, due to its positioning; only four of the 30 seats in reception can see the screen when patients are sat waiting.

Accident and emergency

Communicating with patients

Staff unanimously spoke of the ease of requesting language line. There were some advice leaflets for patients in A&E giving important advice to patients and parents, for example signs to look for following a head injury. Many of those on display were poor quality photocopies. None were available in languages other than English.

Privacy and dignity

Patient privacy, dignity and confidentiality were seriously compromised in the A&E. Conversations about care and treatment can be overheard by those sharing a cubicle. A nurse told us that "It was terrible when having to ask or question patients, or when doctors were carrying out procedures, knowing no matter what you did it could be heard". In October 2012, ECIST recommended that the capacity in the acute medical unit should be utilised to alleviate the pressures on the A&E department. The trust reviewed this and decided not to implement the recommendation.>

Are accident and emergency services well-led?

There were areas senior managers and the trust need to examine urgently in relation to patient flows and throughput, processes, reporting, training and the physical environment within which the A&E department is operating. It is currently not well-led to varying degrees in these areas.

In the context of UCLH. Staff recognised that A&E was not a priority and shared this with the inspection team.

Culture

In the day to day running of the A&E we found staff committed to providing good care and treatment. There was a well-formed, cohesive and committed nursing team, and nurses commented on the comradeship within the nursing team, and commended the A&E matron. Under pressure the nurse in charge takes the brief time available to offer support to staff and checks in to see that they are okay. However, during busy pressured periods, there lacked a sense of overall charge or command from any one person. The floor coordinator, nurse in charge, A&E nurse manager and matron were all at the centre desk, all working hard, but none of them stood out as taking charge over another. During quieter periods, it was apparent that the department was well coordinated.

It was evident from observations, talking with staff and reviewing the A&E expansion plans that staff felt that the service was not a priority, despite the issues identified. There was no evidence that action had been taken to make improvements more swiftly. Examples of this were the trust's failure to respond to the needs of vulnerable patients in A&E; lack of effective management of the pressure of patient numbers and to divert unnecessary pressure elsewhere; failure to remedy the shortfalls with IT systems; make the appropriate equipment available; provide adequate information in the A&E; or make food and drink available in the busiest periods. These were all actions that could be taken within the current A&E environment.

Dealing with serious incidents

Staff confirmed that issues and incidents were always shared and raised within the team. They felt confident to report things to a senior person. However, all staff said that they had not completed an incident report about the concerns that they had raised. The staff we spoke with were not able to provide a reason why they didn't complete an incident report. There had recently been breaches in meeting for the four hour wait target. The reasons for the breaches were unknown and had not been looked into at the time of our inspection.

Children's A&E

The trust recognised that the physical environment did not meet the requirements for children in the relevant national service framework.

At the trust's request following a serious incident, The Royal College of Paediatrics and Child Health (RCPCH) produced a service review report presented to the trust in November 2012. This made 10 recommendations relating to Paediatric A & E, including providing an expanded waiting area suitable for children and the relocation of the paediatric rapid referral clinic adjacent to the Emergency Department. Of the 10 recommendations in the report, from the trust's action plan, only a few were documented as complete and the status of the remainder was either unclear or out of the trust's own timeframe for completion. The recommendations relating to expanded waiting area and relocation of paediatric rapid referral clinic were among those documented as incomplete.

Use of an area adjacent to A&E had been included in an initial design of the building but was not in the final plan at the end of 2008. The trust board decided to use the area

adjacent to A&E as a clinical research facility and decided on a long term plan for A&E development to be delivered in October 2016. We were told that the area currently being used as a clinical research facility (CRF) had six observation bays that could have been readily used by A&E, and that the area itself was not being fully utilised by the CRF at the time of our inspection.

Staff induction and training

Locum and new staff received a local induction including making sure that locums who were new to the department, knew their surroundings, local procedures and useful information. Workbooks were used by nursing staff to understand various aspects of their role and responsibilities and to demonstrate competencies. These included a triage and orthopaedic workbook specific to the department and devised internally. Staff found these booklets useful and their content was comprehensive. Junior doctors we spoke with who were new to department felt that senior staff were approachable and supportive.

Before our inspection our intelligence highlighted a high number of incidents of aggression towards staff. During our inspection we were told about a recent incident where a member of staff had been subjected to aggressive behaviour by a patient. The consultant who told us about this incident felt that there wasn't adequate support for staff around these instances, including the option to debrief after such incidents. The trust has set a 90% benchmark for the majority of trust wide mandatory training to be delivered by March 2014. Training on how to respond to conflict, violence and aggression had been delivered to 60.3% of A&E staff and had been denoted as a red rating, meaning it was below expected levels at the time of our inspection.

Mandatory training delivered to the department compared unfavourably with other trust departments, with 14 out of 24 training modules given a red rating, denoting a lower than expected completion rate.

Medical care (including older people's care)

Information about the service

Medical services (including frail elderly) at University London College Hospital include nine inpatient wards providing general and specialist medical care to patients. These include two care of the elderly and clinical pharmacology wards; the hyper acute stoke unit (HASU); the assessment medical unit (AMU); the infectious diseases and respiratory wards; two oncology inpatient wards and the haematology inpatient ward.

We visited eight wards including two care of the elderly and clinical pharmacology wards; the hyper acute stoke unit (HASU); the assessment medical unit (AMU); the infectious diseases and respiratory wards; one oncology inpatient ward; and the haematology ward.

We spoke with a total of 22 patients and five visitors; reviewed 32 patients' nursing and / or medical records; and spoke with 37 staff from a wide range of disciplines. We also spoke with some people in the discharge lounge.

Prior to our inspection we received data and information about the trust which we used to determine our key lines of enquiry. This included information about staff shortages on the AMU; staff knowledge and implementation of the requirements of the Mental Capacity Act (2005); incidents of acquired pressure ulcers and recently increased infection rates.

Summary of findings

The acute medical wards provided people with safe care. People's needs had been adequately risk assessed. There was evidence of learning from incidents to ensure current and future safe practice.

However, the majority of written nursing assessments, care plans and care delivery records were insufficiently completed, which meant there was an increased risk of inappropriate or unsafe care or treatment. Recording of resuscitation status was often absent or incorrectly completed.

The majority of systems and processes in place made sure that people received effective care including a good level of information sharing among professionals. However, patient notes were left unattended in a public reception area out of hours.

We found the quality of care provided was excellent, and people we spoke with were extremely complimentary about the care and treatment they received. However, integration of Interserve staff into teams and their values was inconsistent.

The acute medical wards were responsive to people's needs, including operating appropriate systems for triaging, and procedures were in place in the event of medical emergencies.

We found wards were well-led by competent and approachable senior staff. However, although staff had recognised the need the need to improve nursing records we found improvements had not been implemented. There was evidence at ward level of learning from incidents to ensure current and future safe practice. However, we saw less evidence of trust-wide learning from trends of incidents at ward level.

Medical care (including older people's care)

Are medical care services safe?

Care and treatment was assessed and delivered in a way that was intended to ensure people's safety and welfare. However inadequacies in patient records were a risk to this.

Risk Assessment and Prevention

We found appropriate measures were in place to reduce any identified risks including regular staff monitoring of potential pressure areas and the frequency in which patients with limited mobility would require turning. Staff we spoke with were aware of the risks to people and the ways in which they could reduce the likelihood of harm occurring. Staff told us they knew about these risks through daily handover and allocation meetings and also from reviewing patient's risk assessments.

Patient Records

While the care being given was safe, we found consistently on the wards we visited that a significant number of patients nursing records were insufficiently completed. However, we found no evidence to conclude that this impacted on patient care. We reviewed 32 medical and or nursing records and found to some degree in all incomplete or missing information. For example, following an assessment of a person's needs, nurses had selected the appropriate generic care plan, but in most cases had not ticked or documented people's specific needs in relation to this area. Nursing staff had also not always adequately completed care delivered records such as food and fluid charts to ensure people received care that met their needs. This meant that although there was a good level of multi-disciplinary communication; and care was delivered by sufficiently trained and competent staff; there was, in some cases, an increased risk of inappropriate or unsafe care being delivered due to the inadequacies of people's records.

We came across unsecured patient records trolleys. They were not kept locked (although had facilities to be locked), and most trolleys were kept in corridors, not necessarily near to where doctors/nurses were based. This was a particular problem on the Infectious Diseases and Respiratory wards where most patients were cared for in side-rooms. Here their records were stored in pigeon-hole type arrangements, free for anyone walking along to access. A large number of case notes were also left unattended during the evening in the unstaffed reception area of the AMU.

Nutrition and Hydration

People's nutrition and hydration needs were assessed. People were referred to dieticians if their risk of malnutrition had been assessed as being high at the time of admission. The HASU screened people for their risk of swallowing difficulties to ensure they were supported in a way that was safe as soon as they were admitted to the ward. People had been referred to the speech and language therapy team (SALT) where they had swallowing difficulties, and that SALT recommendations had been followed.

Not all patients with stroke however were being treated in a specialist stroke area. We met a number of stroke patients being treated in general ward areas. One patient on AMU had been admitted with a stroke via A&E to AMU and still remained there 5 days later.

Safeguarding

Several wards we visited had visible safeguarding vulnerable adult's policies and procedures on display. Staff we spoke with on a number of wards told us they knew which types of concerns to report and how to do this. We found examples where staff had raised concerns and they had been escalated appropriately. These included concerns relating to ward admissions of patients with significant pressure ulcers or when these were acquired during in-patient stays. We found people who were vulnerable to abuse had this highlighted to relevant staff at the "hospital at night" handover meeting and daily triage meetings in the assessment medical unit (AMU).

Learning from incidents

On a number of wards we visited we found examples where staff had learnt from incidents and had subsequently implemented improvements. Staff on the elderly care wards we spoke with told us that following the last acquired positive MRSA on the ward to a person's cannula site, further catheter care training had been provided to staff and a new system for cannula scoring and care planning had been introduced.

Medical care (including older people's care)

Medical Equipment
Each of the wards had sufficient equipment to meet people's needs. We found equipment was regularly serviced and adequately maintained. Staff we spoke with had no concerns about the quality, availability or maintenance of equipment.

Medication Management
We checked the medication management arrangements on some medical wards we visited and found that the management of medicines was safe. Medicines were administered and recorded appropriately, and were stored securely. Patients had access to medicines they brought from home in bed-side lockers. The management of medicines was audited regularly on each ward and wards received support from the hospital pharmacy where it was needed. We found that where issues had been identified during medication audits, improvements had been implemented. On the infectious diseases and respiratory wards medicines omissions had been high early in 2013. As a result the matron told us that staff training and further support from the pharmacy had been implemented in order to improve this.

Staffing
People received safe care and treatment from sufficient numbers of suitably skilled, qualified and experienced staff. We spoke to senior nursing staff about staffing levels on each ward we visited and we checked some staff rotas. We found the numbers of nursing staff was sufficient in relation to the numbers of beds and the dependency of patients on each ward. Nurses were adequately supported by healthcare assistants who were allocated specific patients to care for each day.

Pressure Ulcers
We found people who were at risk of pressure ulcers received safe care including the frequent monitoring of pressure areas, appropriate equipment in place and frequent repositioning where required. Staff we spoke with told us they had access to the hospital's tissue viability team if they needed support or where input was required to oversee the care of people with significant pressure ulcers. We saw wards maintained adequate pressure area nursing records to ensure that people who were at high risk received the input they needed.

Are medical care services effective?

(for example, treatment is effective)

We found some effective systems and processes in place to ensure people received the care and treatment they needed.

Clinical management and national guidelines
Staff we spoke with on the stroke ward and HASU told us they had one of the fastest door to needle times nationally for people who required thrombolysis. The stroke audit data showed that around 13% of people admitted with a stroke were thrombolysised which was better than the national average of 11.8%. Patients were given thrombolysis quicker within 35 minutes compared to the national average of 60 minutes.

Patients had good clinical outcomes. In May 2013 the trust focused on patients who had a predicted mortality of less than 20% who died while being treated as in-patients specifically those with a cardiology or cardiac surgery sub-specialty. The cases were reviewed and there was no evidence that poor care caused or contributed to the deaths. The hospital has a low mortality rate compared to other trusts.

Acute Medical Unit (AMU)
People who required in-patient stays were medically assessed and triaged on the hospital's assessment medical unit (AMU). From here, patients were sent to wards where they could be most suitably cared for in accordance with their assessed medical need. We found several wards had outliers i.e. patients who would normally be treated on other wards if there were sufficient beds. However we found, where possible people on these wards were cared for by their appropriate medical and therapy team. We found daily multi-disciplinary meetings on wards considered the care and medical needs of outliers on other wards.

Patient Information
Effective systems were in place for information sharing between staff, and from staff to patients on all the wards we visited. People's care was coordinated through daily ward rounds involving a range of relevant professionals. Ward rounds meant people were kept informed about their care. Patients we spoke with were happy with the level of information they received. Medical multi-disciplinary team (MDT) meetings took place daily on the elderly care wards and the AMU.

Medical care (including older people's care)

Special Needs

To ensure all unstable medical patients in the hospital received the care they needed during the night, there was a daily "hospital at night" handover meeting at 9pm which included relevant medical staff and senior nurses. Identified patients were individually discussed, and their care for the coming night was planned including any observations, tests or interventions they might require in order to stabilise their condition. A further meeting at 2am was convened to review each of the patients and their progress, and to establish whether any further care or treatment should be planned or delivered. We found people who lived with dementia or those who lacked the capacity to make specific decisions had their capacity assessed and decisions made in their best interests.

Are medical care services caring?

Medical Care services were caring. This contrasted with the attitudes of some contract agency staff.

We spoke with 22 patients and five visitors across each of the acute medical wards we visited. The overwhelming majority of people we spoke with were happy with the care they received.

We saw that people consistently received care that was compassionate, respectful, and which promoted their privacy and dignity. People we spoke with confirmed that the care they received was excellent. One person told us "I can't fault the nurses; they can't do enough for me"; and a visitor we spoke with told us "the care here is very good. The nursing staff are so helpful and friendly; they are genuinely nice people". Another person told us "the nurses here are all lovely. When they assist me they always introduce themselves first". Finally, one person said "I have been overwhelmed by the love from all the staff. Everyone has been like angels sent from heaven". This person also told us they had been given a birthday card from the ward staff when their hospital stay coincided with their birthday.

Food and Drink

People were appropriately supported and their preferences respected during mealtimes. People had an extensive menu choice at each mealtime, and people who found it difficult to make a choice were supported by the use of pictures on the menu. People received food on colour coded trays so those who needed support could be prioritised. We found staff including volunteers supported people in a way that enabled them to eat at their own pace and in a caring environment.

Involving Patients in Care

People told us about how they had been involved in their care. We found people's preferences had been taken into account when they were admitted onto a medical ward, and we found staff knew people's preferences if, for example, they were unable to communicate their needs. People told us that staff sought their consent before providing intimate care for them, and staff we spoke with confirmed they always asked for people's consent. We found some examples where people had refused care or treatment and their wishes were respected. Where people lacked the capacity to make specific decisions or to consent to their care, we found people's relatives had been involved in order to ensure that people received care that was in their best interests and in accordance with their preferences

Cultural Needs

People's religious, cultural and spiritual needs were respected. We found, on every ward, access to an interpreter service for people who required this. We also found that the trust were able to make information available to people in other formats or languages where this was requested. People's religious and spiritual needs were considered when they were admitted to a ward to ensure the care they received met their specific needs. Staff we spoke with were aware of specific religious needs, for example, in the event of a person's death.

Privacy and dignity

The physical environment in most cases promoted people's privacy and dignity. We found most people were cared for in single-sex wards. For example, the elderly care wards were divided into male and female areas. Staff on several wards told us that only when demand for beds was particularly high for a specific gender might people receive care temporarily on a mixed ward. However, we found this was not the case on the majority of the wards we visited during our inspection.

Medical care (including older people's care)

Are medical care services responsive to people's needs?
(for example, to feedback?)

The acute medical wards were responsive to people's needs.

Delivering Patient specific care
We found the medical wards worked with local partners such as people's GP's and local authorities to ensure people received the care they needed. For example, the daily multi-disciplinary team (MDT) meeting we observed on the elderly care ward demonstrated that doctors regularly liaised with people's community GP's to ensure that when people were being considered for discharge, that people had the community based support they needed. We found staff also liaised regularly with local authorities' social work teams to ensure that people were assessed for any required social care that they were entitled to, to ensure they received appropriate on-going support following their discharge.

Medical Emergencies
There were systems in place to ensure that medical emergencies were appropriately responded to. The trust had a patient emergency response and resuscitation team who covered the hospital 24 hours a day, seven days a week in the event resuscitation was required on the wards. Ward based staff were aware of how to contact this team in the event of an emergency and we heard from staff that all cardiac arrests were reviewed to ensure any learning was implemented. All clinical staff received basic life support training to ensure people who required resuscitation received this when required.

Patient Discharge
People's discharge was appropriately coordinated. People we spoke with and their relatives told us they had been involved in their discharge planning. We found daily MDT meetings considered when people might be fit for discharge including any people outlying on other wards. The MDT meetings were attended by representatives from the integrated discharge team who ensured the meetings were discharge focused. MDT meetings also had representatives from ward based physiotherapy and occupational therapy teams who provided input on whether people were suitably rehabilitated in preparation for possible discharge. We found MDT meetings considered a range of people's needs to ensure their discharge was appropriate.

Complaints
Patients we spoke with told us they knew how to make a complaint or raise concerns if they needed to. People were supported to provide feedback about their experiences at the hospital, and wards publicised satisfaction rates monthly on quality assurance notice-boards. We found people were supported to feedback their experiences by staff who used a computer tablet. However, we found people's responses were not fully anonymous or totally independent as staff sometimes sat with people while they responded.

Are medical care services well-led?

Wards were well-led by senior nurses. However although the need to improve nursing records had been recognised little had been done to rectify this.

Ward Leadership
There was evidence of good leadership during meetings including daily multi-disciplinary (MDT) meetings, assessment medical unit (AMU) triage meetings and the 'hospital at night' handover meetings. The meetings we attended during our inspection were led by consultants, junior doctors and senior nurses.

Ward Staff
While we found that there was evidence of learning from incidents that had occurred at ward level, ward management staff we spoke with told us that any learning from incidents was led at a local level as opposed to being initiated by the trust. Staff told us they did not therefore have an oversight of any specific trends relating to the incidents they reported.

Problem solving
Although we found that overall wards were well managed, we had some concerns that issues we identified during our inspection were already known to the director of nursing, matrons and ward sisters, but the necessary improvements had not been implemented. For example, we asked senior nursing staff about the poor quality of people's nursing records, and we consistently found that matrons and ward sisters knew this area required improvement. However,

none had made significant efforts to improve the quality of care assessments, care plans or care delivery records as it had not impacted on patient care. We also spoke to the director of nursing who acknowledged the problems with record keeping, but was unable to tell us about ways in which the required improvements would be implemented.

Staff Appraisal

Staff we spoke with told us that they received an annual appraisal which enabled senior staff to appraise their performance, as well as providing an opportunity to discuss their own training and personal development needs. Staff we spoke with about the appraisal told us that conversations were based on the trusts core visions and values, and we found overall staff adhered to these in the work they carried out.

Surgery

Information about the service

Surgical specialties, gastrointestinal (GI) services, Women's Health and Paediatrics are responsible for delivering surgical services at University College Hospital. There are 250 beds for surgical patients.

There are 18 operating theatres including two operating theatres dedicated to treating day surgery patients.

Patients whose operations are planned visit the pre-assessment clinic up to six weeks before their surgery. On the day of surgery patients come to the surgical reception before going to theatre for their operation. After the operation patients are monitored in a recovery ward before being transferred to another ward.

Patients whose surgeries are unplanned (known as emergency) are seen in A&E, and then taken to theatres. They are monitored in recovery before going to a dedicated ward for emergency patients on the 6th floor of the hospital.

Day surgery patients are treated in a separate unit on the second floor. They are assessed, operated on and discharged within a day.

We spoke with 14 patients, 3 visitors and 27 staff including senior and junior medical staff, junior and senior nurses, pharmacists, domestic staff and administration and clerical staff. We visited the pre-operative assessment clinic, surgical reception, theatres, recovery, the elective short stay unit, the acute surgical assessment unit, day surgery and the trauma and orthopaedic ward. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed the performance of the service.

Summary of findings

Surgical patients and their visitors told us staff were caring and they felt their needs had been met. Overall they were very satisfied with the care and treatment they received. This was reflected in the positive patient satisfaction survey results that the surgical division continuously achieved.

Patients' needs were met and clinical management guidelines were used. There was a strong consultant presence in the surgical division and all staff worked together to provide the best outcome for patients.

On the wards we found staff were responsive to patients' needs and kept them involved in their care and treatment. However we found that the recovery area for patients did not have the capacity to care for and treat the high volume of patients.

Services appeared safe. However there was a risk of unsafe surgery as the WHO surgical safety checklist was not always completed. Staffing arrangements enabled safe practice and agency staff were rarely used.

There was leadership at all levels of the division and staff felt well supported to carry out their roles. A clinical governance framework was in operation to monitor the quality of the service however we found that when areas of improvement were identified, action was not promptly taken.

Surgery

Are surgery services safe?

Staffing levels and hygiene practices enabled a safe service. However the fundamental standard of ensuring patients were not put at risk of unsafe surgery was not always in place.

Managing risk

Senior staff we spoke with were aware of the risks in their area. The division held a risk register that was discussed at monthly clinical governance meetings. A recent risk that had been addressed after four years was a new clinical area set up on the acute surgical unit to ensure staff had a dedicated area to carry out clinical assessments safely and in private. An example of a risk to patients that was being managed was the functionality of the imaging system in theatres. The service (imaging) was unavailable for two short lived in March 2013, which led to cancellations. When the breakdown of the system occurred, staff referred to pre-assessment records for the most recent x-ray but this was no substitute to looking at a patient x-ray prior to surgery. The director of ICT was planning to review the system and seek alternative systems.

Patient Safety

Three Never Events (serious events that should never happen) occurred at the trust in the 12 months between October 2012 and September 2013. Two of the Never Events involved wrong site surgery. This meant two patients had undergone a different surgical procedure to the one they had consented to. The third was classified as a surgical error where a piece of equipment had not been removed. The trust previously reported five Never Events between October 2011 and September 2012. We were told that as a result of the Never Events a 'surgical pause' had been introduced during theatres. Surgeons paused and carried out final checks before putting knife to skin. The surgical pause was not documented. Most staff said they were aware of the Never Events and the surgical pause had been implemented to ensure Never Events did not occur.

Staff in theatres used the World Health Organisation (WHO) surgical safety checklist to ensure that people had consented to the procedure and that the necessary checks were completed before, during and after surgery. We reviewed five patients' medical records and found three WHO surgical safety checklists were fully completed and two were partially completed. In day surgery we checked four records and found they had been completed. The hospital audited the completion of the WHO surgical safety checklist four times a year. The latest audit results for July to September 2013 found that 65%, 79 out of 121 operations checklists were fully completed. 100% of checklists should be completed to ensure patient safety. This meant patients were put at increased risk of unsafe surgery. We have told the trust that they must act to improve in this area.

Medicines Management

We saw pharmacy staff attending to patients and discussing their medication needs. Patients told us they had discussed their medications and were aware of their purpose. On some wards before and after surgery pharmacy technicians were available to ensure patients received their required medicine promptly.

On one ward we found the fridge temperature was outside the safe range for storing medicines and two previous readings had been at the maximum thresholds for within the required range. We raised this with the matron and this was rectified during our visit. Fridge temperatures on other wards were recorded to be at the correct temperature for the safe storage of medications. We also found in one operating theatre, local anaesthetic infusion bags not stored separately due to lack of storage.

Care meets patients' needs

Some patients that require surgery could be at risk of developing deep vein thrombosis (DVT) due to their restricted or limited mobility. According to the division's scorecard, on average 89% of patients were risk assessed for Venous Thromboembolism (VTE) in the last six months. The division aimed for 90% of patients to be risk assessed.

Hospital infections and hygiene

Systems for ensuring cleanliness and the prevention of infections were in place and followed by staff and visitors. There were dedicated cleaning staff on the wards and in the theatres. The clinical areas we visited were visibly clean and we saw cleaning staff wearing gloves and aprons while cleaning equipment appropriately. Nursing assistants and cleaning staff explained the processes they followed to ensure the ward environment and equipment was clean. We checked a commode and found it was clean. Clean equipment that was ready for use was identified by a signed and dated green label.

Surgery

Staffing

All patients we spoke with felt the hospital was well staffed. They were able to speak with staff when they needed with minimal delays. Staffing arrangements enabled safe practice. During our visit we were told that a ward in another division was short staffed. The nurse in charge reviewed the needs of the patients and released a nurse to provide support to where it was more needed. On another ward we visited there was nursing staff shortages for short periods of time. The nurse in charge explained how the nurses would be utilised to ensure patients were cared for. For example with each nurse being responsible for an additional patient.

Are surgery services effective?
(for example, treatment is effective)

Clinical services were effective. However lack of capacity in the theatre recovery area affects patient throughput.

Clinical management and guidelines

The medical director was the lead for implementing best practice in accordance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). NCEPOD's purpose is to assist in maintaining and improving standards of surgical care for the benefit of the public by reviewing the management of patients and by undertaking confidential surveys and research. Consultants had protected time to participate in morbidity and mortality audit. This meant they examined ways in which recommendations made by NCEPOD were addressed.

'100 days to demonstrate excellence' was launched to consolidate the different initiatives in operation across the wards. Senior nurses shared initiatives and developed recommendations to roll out implementation of all initiatives on all wards. One recommendation that worked well was 'Intentional rounding' (also known as comfort rounds or round the clock care) that had been introduced. It meant all patients had their fundamental care needs proactively assessed every two hours. Patients told us that this was a minimum and nursing staff asked them regularly how they were or if they needed anything. Intentional rounding reduced the number of times patients needed to use their call bells for attention. During our visit the inspection team noted that wards were quiet and call balls rarely needed to be used.

Pressure Ulcers

The wards had processes in place for preventing pressure ulcers. For example providing pressure relieving equipment and ensuring patients were mobile as far as possible. On one ward it had been 406 days since the last hospital acquired pressure ulcer grade two or more.

Pressure ulcers (grades three and four) accounted for the majority (61%) of the Serious Incidents that occurred at the trust between October 2012 and September 2013. In the past there had been a higher incidence of pressure ulcers on the trauma and orthopaedic ward. The causes were investigated and it was recommended that skin bundle documentation was only needed to be in place for patients assessed as being at risk of developing pressure ulcers instead of all patients. This allowed nurses to focus on the patients who needed monitoring and reduced the amount of documentation. This had reduced the number of pressure ulcers for trauma and orthopaedic patients.

Consent

Patients we spoke with at different stages of their surgery told us staff had checked they were ready to proceed and were well informed to give consent. We checked the documentation for nine consent forms and found in all cases they were completed and signed by competent staff who were responsible for making the decisions about the care and treatment given.

Multidisciplinary input

One of the trust's values was teamwork. Patients told us they interacted with a range of staff including doctors, nurses, physiotherapists and domestic staff. We saw consultants leading ward rounds with junior doctors and clinical nurse specialists. The clinical nurse specialists provided continuity of care as they saw patients in follow up clinics after they were discharged from hospital.

Are surgery services caring?

Surgery services were caring.

Patient experience

Overall patients spoke highly of the service they received. They said they had been treated as individuals and were satisfied with their care and treatment. One patient told us "everyone talks to you…doctors don't talk over you, they talk with you."

Surgery

Patients reported that staff were very attentive during the day and night. They described the staff as "incredible" and "fantastic".

Patients and carers involved in their care and treatment

Patients and carers were involved in their care and treatment. We observed that staff made themselves understood and explained things in lay terms and checked that relatives had no queries unanswered. When planned patients were initially referred to the hospital it was identified if they required an interpreter. At pre-assessment this was rechecked. On the wards for emergency patients staff had access to 'language line' which is a telephone interpreting service.

Patient Dignity and Respect

At the pre-assessment clinic patients were assessed by a nurse in private. It was unclear when the rooms were in use but we saw staff knocking on doors before entering. When the surgeons call for patients at surgical reception, male patients were escorted usually by a male nurse into a dormitory area with curtains where they prepare for surgery. Female patients had separate bays and were usually escorted by female nurses. We observed patients being escorted to theatres. Staff treated them with kindness and ensured their dignity was protected.

Patients were cared for in single sex bays. There had been three reported breaches in mixed sex accommodation for surgical patients in the 12 months from September 2012.

Food and drink

The hospital had recently changed the food supplier as a result of patients reporting the food as unacceptable. Some patients were dissatisfied with the food, describing it as "dire" and "dreadful". However some patients, including an ex-chef told us the food was good and could not be better. On the wards we visited we saw an increase of patient satisfaction with the food on one ward from 35% to 55% and on another ward 68% to 88%. Staff recognised this was an area that required continual improvement.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Surgery services were responsive to patients' needs.

Responding to patients' needs

Patients reported getting swift care that met their needs. One example was a patient that required urgent attention with a chronic history of medical problems who was admitted through A&E during the night. They were seen very quickly, operated on and on the ward within four hours. The patient was very reassured he was being well looked after.

Theatres

The theatre lists were planned according to patients' clinical needs. For example at pre-assessment a patient raised that in the past they had experienced sickness and dehydration when waiting for surgery. Staff ensured the patient was first on the theatre list on the day of surgery and had a minimal wait. Patients with diabetes were put first on the list.

Out of hours care

Out of hours there was sufficient cover from medical staff on call. Recently a triage system of a nurse practitioner receiving the out of hours calls had been implemented. The nurse practitioner attended to the tasks they were competent to do, for example, taking bloods and cannula changes when a doctor was not required. The system ensured the most appropriate clinician treated the patient. Staff told us the system was working well and there had not been any delays in accessing a doctor when required.

Cancellations and postponements of elective operations

An elective operation had been cancelled on the day of our visit and we heard it was common for operations to be cancelled. We spoke with anaesthetists and they felt that operating three sessions a day did not meet the patients' needs. It meant that theatre lists often overran and led to cancellations. 1525 out of 172,961 operations were cancelled from April 2012 to year date. 117 of these were because of theatre lists overrunning.

Recovery

There was an inherent risk in the system due to the lack of the space in recovery areas. On average 50 to 60 patients were operated on in the main theatres each day. The patient flow was staggered. The recovery ward had 23 beds. The patient flow was managed and there were twice daily discussions on bed availability. However we were told that

there was pressure in the system due to the capacity of the recovery ward. The recovery area was too small for the volume of patients coming through theatres and it led to blockages in patient flow.

Concerns and complaints

Patients we spoke with were positive about the service provided and were not intending to make any complaints. They were aware of how to make a complaint or access Patient Advice and Liaison Services (PALS) from the information provided in their welcome pack. One patient said my consultant has "gone above and beyond in providing me care."

There was a very low rate of complaints. Staff told us they were informed about complaints relating to their area in team meetings. Numbers of compliments and complaints were displayed on the wards. On one ward a complaint was received in August 2013. Staff involved arranged to meet with the complainant to discuss and feedback to the ward some suggestions for improving communication.

Are surgery services well-led?

The surgery division was well-led.

Leadership

Staff we spoke with felt that the surgical directorate was well-led. We saw senior staff providing leadership and support to staff on the wards. Staff were proud to work for the hospitals and the surgical department. Staff were aware of how to raise concerns within the hospital and were aware of the trust's whistle-blowing policy. Leadership training was completed by senior nursing staff. Staff spoken with told us they felt their managers and teams supported them in their roles.

The Quality and Safety Committee was chaired by a board member, and ensured an overview and appropriate decisions were made by the senior level staff. The surgical division held their own governance meeting monthly that fed into the Quality and Safety Committee. Staff on the wards told us they received feedback on clinical governance topics.

Record keeping

We reviewed five medical care records and found they covered all aspects of the patients' care. Paper records were kept and some records were large with loose pages. However we saw that they were kept securely. In pre-assessment there were staff whose role was to ensure patients records were available and were ready to stay with the patient throughout their admission. Nursing records were kept separately at the end of the patient's bed and we saw nurses updating the records when care and treatment had been delivered.

Managing quality and performance

Each specialty within the surgical division held monthly clinical governance meetings that discussed incidents, patient safety, performance, complaints and workforce issues. Some specialties, for example urology held weekly meetings in addition. The specialty clinical governance meetings fed into the division's clinical governance meeting chaired by the clinical division manager.

Intensive/critical care

Information about the service

The critical care service at the trust incorporates the Critical Care Unit (CCU) providing general adult intensive care; high dependency care; the Post-Anaesthetic Care Unit (PACU); critical care outreach and the critical care follow up clinic.

There are 35 beds in the CCU arranged in bays of four to five patients with 11 single rooms. Staff provide care and treatment for adult patients with serious life-threatening illnesses or following surgery.

Around 57% of patients come to the CCU unplanned, for example through the Accident and Emergency department, with 2176 admitted patients in 2012. Some are transferred from other hospitals for the specialist care this hospital provides. The critical care outreach team assists in the management of critically ill adult patients across the hospital.

We talked to three patients, five relatives and 31 staff including nurses, doctors, consultants and managers over the course of our three day inspection. We observed care and treatment and looked at medical records in CCU. We visited the follow up clinic to see how patients were cared for post CCU. We received comments from our listening event and reviewed performance information about the service.

Summary of findings

There were enough specialist staff to meet people's needs and ensure they had appropriate 24-hour care and treatment. People received care and treatment according to national guidelines and admissions were prompt and appropriate. The critical care service performs better than most other similar units across the country with a lower than expected mortality rate. Quality and safety was the focus for the service with reviews daily as well as formally through the hospital's clinical governance and performance monitoring frameworks.

Patients and relatives reported a caring, supportive environment with information sharing and input from families and patients so that care was holistic. Patient feedback reflected this, with 92% saying they would recommend to family and friends.

Patients' welfare was continuously monitored and reviewed. There were links with external services, such as The Intensive Care National Audit, to enable the service to benchmark services. There were processes for audit and the service was involved in clinical research. We saw that there was good communication between the critical care unit (CCU), the rest of the hospital and other hospitals.

The critical care service was well-led. One staff member told us "I like it here, I respect and admire colleagues". Staff reported good training and support.

The CCU did not have an on-site 24 hour cleaning service and this could lead to delays out of hours. Some moveable equipment was stored on a corridor with no process of stock control and re-cleaning before use.

Intensive/critical care

Are intensive/critical services safe?

Intensive/critical care services were safe.

Patient safety

The service and leadership were focussed on safety and the individual needs of each patient. The CCU matron had developed a 'Message of the week' which was discussed for a few minutes with each shift handover daily. This was often about important safety messages. We saw examples for 17 June 2013 about insulin safety and 12 August 2013 about pressure ulcer prevention. We observed a staff 'quality and safety huddle' with 14 members of staff present. They were undertaken twice daily for day and night staff and reviewed falls, pressure ulcers, medication incidents, infection control, nurse staff levels, complaints and compliments and patient survey results.

Review of incidents including pressure ulcers

Staff reported incidents although this was led by nurses with less doctor input. We saw the CCU performance report for year to date up to September 2013. This showed no falls with harm in six months, no serious untoward incidents, 100% of antibiotic indications documented, and 100% compliance with guidance on use of antibiotics. The report included the number of pressure ulcers which was used as a marker for safe, good quality care. Each bay had a pressure ulcer champion and each patient an updated skin risk assessment. This was audited and required within six hours of admission to the unit. We noted during our visit that three patients had acquired grade 3 pressure ulcers in the unit in November 2012. These had all been investigated to see how and why they had occurred and review was being undertaken externally to check that best practice had been undertaken and seek any further ideas for these patients' conditions. Incidents, including infection control and pressure ulcers, were discussed and reviewed at the monthly CCU meetings and clinical governance meetings.

Hospital acquired infections and hygiene

Patients and families told us the CCU was clean and we saw staff wash their hands before touching patients. We observed staff wearing personal protective equipment such as gloves and aprons. There were hand washing facilities in each patient area. Visitors were encouraged to wash and gel their hands and staff were observed to be bare below the elbows in clinical areas.

Hand hygiene audits were undertaken monthly. In October 2013 there was 97% compliance with hand washing and compliance was 100% for high risk activity such as giving intravenous drugs. We checked the commodes on the unit and found they were clean, and date labelled when cleaned.

Cleaning

Patients were cared for in a clean unit. The CCU was visibly clean on the days of our inspection. There was daily cleaning until 16.30 each day. Staff relied on the on call cleaning team out of hours and this could be a problem if a patient area needed cleaning quickly after a patient's discharge and to allow swift admission of another patient. Nursing staff cleaned the bed and equipment between patients and daily as part of their infection control and prevention processes.

Medicines

We saw that patients were given their medications on time and this was recorded. This included pain relief medication. The stock medicines were stored in a locked room with the fridge temperature monitored to ensure it stayed within safe limits. There were locked medicine trolleys in each bay so that staff did not have to leave the area to collect medicines for their patients. A pharmacist attended a daily review of each patient and reviewed each patient's medications to ensure that they were suitable and within prescribing guidelines.

Safeguarding

All staff had undertaken safeguarding of vulnerable adults training with the senior nurses undertaking advanced training. There were good links with the hospital's vulnerable adults' team. We heard of examples where safeguarding concerns were raised about patients. These were referred appropriately to the relevant local authority safeguarding teams and investigated. Interpreters could be used to assist in discussions with patients to understand their needs better. On rare occasions young people aged under 18 years were treated in CCU. This was always as a planned admission and with supervision by their primary medical team and was for clinical reasons as CCU was judged to be the safest place for clinical treatment and care.

Staffing

There were enough appropriately trained nursing staff to meet the needs of patients and patients agreed that they were well looked after. The CCU provided one to one

nursing or one nurse to two patients. This was decided depending on the assessed needs of each patient. Each patient bay or the group of side rooms had a senior nurse in charge. Planning was undertaken 24 hours in advance so that if extra nurses were required these would be supplied by the hospital's bank of critical care trained nurses or suitably trained agency nurses. Extra support for nurses was provided by nursing assistants who were always supervised by trained nurses. These staff could provide assistance, for example when turning patients, so that patients did not have to wait for a second trained nurse.

Medical equipment

Each bed area had sufficient working equipment to safely meet the needs of patients. We spoke with a member of the medical physics team who have responsibility for the maintenance of medical equipment in CCU. They provided an efficient, responsive service. We saw that all equipment was identified with electrical safety and servicing up to date. Equipment that required staff training before use was identified so that staff without training would not use it. Where equipment required calibration this was identified, undertaken and recorded.

The environment

The environment was safe for patients, staff and visitors. Access was by monitored admission only.

Are intensive/critical services effective? (for example, treatment is effective)

Intensive/Critical Care services were effective.

Clinical management and guidelines

Patients received care and treatment according to national guidelines and this was monitored. There were criteria for the admission of patents so that those who required critical care received it. There was an audit programme which focussed on quality improvement. We saw the plan for 2013 which supported the team working to best practice guidelines and the development of better processes.

Research

The service's research ensured that the hospital was involved in the development of new treatments and improving clinical outcomes for patients. There was a lead clinician and lead nurses for research. We observed the caring and considerate way consent was sought from relatives for their agreement to research involving their family member.

Patient mortality

Clinical outcomes were very good with the Intensive Care National Audit and Research Centre Case Mix Programme reporting a standardised mortality of 0.77 for the CCU with a high throughput, low mortality and low readmissions compared with peer units. In 2012 Civil Eyes Research, a benchmarking organisation, showed the CCU, when compared with 21 other similar facilities, had the highest turnover of patients, had complex admissions, the shortest length of stay for high dependency patients and very high consultant productivity. Data from The Shelford Group which compared foundation trusts showed the CCU had the lowest elective and emergency lengths of stay for patients.

Critical care outreach team

Patients whose conditions were deteriorating were provided with prompt, effective care. The critical care outreach team supported staff with the care of any other adult patients in the hospital. The team was nurse led and provided a 24 hour service daily. All the nurses had worked in intensive care areas. There was support from a registrar from CCU when needed and we observed how this worked in practice. The team visited a patient who was unwell, examined them, took observations and then determined what the next actions should be in conjunction with their primary medical team.

Communication with others

We saw that there was good communication between the CCU and other hospitals, for example when the latter wanted to transfer a patient for specialist care. On the first day of our inspection a patient requiring transfer from a hospital in the south of England was moved to UCLH for their specialist services. Staff told us that no one has been refused a bed who needed one, although there we heard of occasional instances where hospital surgical teams omitted to inform the PACU that a bed would be required. This was then managed by the teams working together in the best medical interests of the patient. We also saw that within the hospital CCU staff responded effectively to the needs of their colleagues and their patients. When patients

were discharged to the wards a summary of their treatment and care needs was sent with them, as well as medication, so that there was no wait for information to delay continuing care.

Are intensive/critical services caring?

Intensive/Critical Care services were caring.

Patient and relatives' feedback

Relatives told us the care of their family member was very good with good communication with other areas of the hospital. Doctors and nurses had telephoned relatives at home to update and reassure them. One family told us they would "100% recommend the unit for their friends and family". Another family said staff were "informative, polite and very caring". They said they could not fault the treatment. There was a relatives' room and quiet room outside the unit where people could wait or discuss care of their family members with staff privately. Relatives told us they were well supported and had received care themselves. They were kept informed about what was happening to their family member and said they could ask as many questions as they needed to.

Patients' privacy and rights

We observed nurses, doctors and other health professionals caring for and treating patients in a kind and friendly way. Staff explained procedures and sought consent as well as providing reassurance. Patients were cared for in mixed sex bays which is within national guidelines for patients requiring critical care. Privacy was maintained by the use of curtains around each bed space or in the 11 single rooms. People were returned to their wards when they were well enough. If there was no bed available there was a process for reporting a breach of the Department of Health's guidance on mixed sex sleeping accommodation. We visited the hospital's operations centre where staff observed the real time bed situation and responded to demand for beds from the wards and CCU. The September 2013 year to date CCU performance report showed no mixed sex breaches for the last 12 months.

Food and drink

Nutrition and hydration was considered and provided for each patient, with daily support from a dietician. We saw that specialist feeds were supplied and could be made up with the individual requirements for a patient. This supported people who were unable to eat and drink while they were critically ill. Suitable meals were provided when people could start to eat and drink and people were helped with this. Staff recorded in detail the amounts of food and fluids taken.

Follow up clinic

The CCU follow up clinic invited patients who were on the unit for 3 days or more to attend a few months after discharge. This gave them, and relatives, an opportunity to discuss their experiences in CCU with a clinical nurse specialist, a psychologist and a clinician. This was a therapeutic support to patients as they recovered from a critical illness. Patients could be referred to their GP and/or a mental health team if required. Staff reported that about a third of patients accepted the invitation to attend. They could revisit the unit if they wished and were encouraged to suggest any ideas for improvements based on their own experiences. Recent audit showed a 100% satisfaction rate for this clinic.

Care of the dying patient

We heard that if patients were dying staff did all they could to keep them in the unit so that they were cared for by people who knew them and their relatives. We saw there was a system for daily review of do not attempt resuscitate requests. This would involve patient and relatives' input and required both doctor and nurse sign off. We heard that independent medical capacity advocates were used and could be accessed quickly where people had no relatives.

Are intensive/critical services responsive to people's needs?
(for example, to feedback?)

Intensive/Critical Care services were responsive to people's needs.

Patients' feedback

Patients' feedback was requested when they were well enough. An opportunity was also provided for reflection at the follow up clinic. Patient experience information, complaints and compliments were reviewed and discussed at the daily 'quality and safety huddles'.

Patients' welfare

We saw that patients' welfare was continuously monitored and reviewed. Patients did not stay any longer on the unit than was clinically necessary. Psychologists were available to see patients who required psychological help and this

included when they had been discharged back to the wards. Staff were trained to look for psychological symptoms such as low mood, anxiety or panic. Leaflets were available for people in CCU describing what they might experience and what to expect after discharge home following the intense and sometimes frightening experience of being critically ill. There was a link to community mental health teams and GPs for patients already mentally unwell prior to admission to CCU.

Organ donation

There was a link nurse for organ donation from the NHS Blood and Transplant service, working at the trust in the CCU but linked to the specialist nurses working across London. The hospital followed National Institute for Health and Care Excellence (NICE) and national guidance about organ donation with the patient and their relatives at the centre of discussions. All deaths were audited monthly and any missed referrals noted and learning from this actioned. Best practice about timely referral and understanding of the patient and relatives' wishes were followed. We heard that every effort was made to find people's relatives so that their views were known. There was a good referral rate with a consultant lead, nurse and doctor teaching and annual updates about the part staff could play in ensuring organ donation was managed effectively.

Complaints

There was a process for review and investigation of complaints in the unit. We saw these reviewed at the unit 'quality and safety huddles'. Learning was followed up. The September 2013 year to date performance report showed no complaints for the last six months. We saw that people and their relatives had written to the unit with thanks following their discharge.

Are intensive/critical services well-led?

Intensive/Critical Care services were well-led.

Leadership

The critical care service was well-led. One staff member told us "I like it here, I respect and admire colleagues". Another said "even under stress it's well run". Staff reported a responsive and supportive senior team. Every consultant had a lead area, for example for audit or research. The medical infrastructure allowed for professional support for staff on a daily basis and we saw this at the ward rounds and reviews of patient treatment. Other non-CCU staff reported a well-run department, which was progressive and responsive. We saw the daily running of the unit over three days with the nurse in charge and consultants working well together to promote safe, good quality care and treatment for all the patients in the unit as well as prospective and past patients.

Managing quality and performance

The service monitored the safety and quality of care and action was taken to address identified concerns. There were links with external services so that benchmarking could be undertaken. There was also a system for referral of individual cases for peer review, advice and support.

Records

We observed the recording of vital signs and care and treatment given in patients' electronic records at the bedside. We saw that staff could prescribe care interventions, such as turning two hourly, so that the system alerted them to the need to undertake the action and this then was recorded as done. This meant that care activity was not missed.

Support for staff

Staff reported good support. Nursing staff undertook a week trust induction with the second week as supernumerary on CCU. There was a local CCU six month course for staff who had not worked in a critical care environment before as well as an external university intensive care course where some unit staff were seconded. This involved a programme of lectures as well as working on the unit. Staff had received their mandatory training such as life support, infection control and safeguarding. The specialist CCU nurse educators were visible and available for staff. There was specialised training for other staff groups, for example the physiotherapist team received CCU specific training weekly. Student nurses who worked in the CCU as part of their training were well supported with identified mentors and a link lecturer form their university.

Maternity and family planning

Information about the service

University College London Hospital (UCLH) provides inpatient maternity services from the Elizabeth Garret Anderson (EGA) Wing. The building opened in 2008 and transferred its maternity and gynaecology services to new building. Maternity services are provided over three floors. The first floor has two antenatal clinics that consist of 14 consulting rooms and a number of ultrasound examination rooms. The second floor has a labour ward with 12 beds, two theatres and one birthing pool. The third floor has 45 beds for antenatal and postnatal services, a seven bedded birthing unit and two birthing pools.

The hospital currently offers maternity services for around 6,200 births a year.

We talked with 12 women and 15 members of staff including the Clinical Director for Women's Health, the Head of Midwifery (HoM), the Supervisor for Midwives (SoM), midwives, doctors, senior managers and support staff. We visited the antenatal clinic on the first floor and the antenatal and postnatal labour wards on the third floor. This inspection review did not include the neonatal unit or foetal medicine.

Summary of findings

We found the maternity services were safe, caring, effective, responsive and well-led.

Staff were caring, attentive and professional in their roles. The women felt confident with the care being provided. The wards were clean and safe and had good security measures in place to protect women and their babies. Most of the women that we spoke to told us they had positive experiences with the maternity care and felt confidence in the staff that cared for them.

Maternity services were being planned to meet the increasing demand by extending the number of beds and recruiting more staff.

There was insufficient evidence that all staff learned from incidents and complaints. There was a maternal death in the last year and it was unclear that the lessons learned from the incident had been shared.

Midwives were well supported. The ratio of supervisors of midwives to midwives was 1:16.

Maternity and family planning

Are maternity and family planning services safe?

We found the maternity services being provided were safe. However learning from incidents and information from risks could be improved.

Staffing

Care and treatment was provided by suitably trained and qualified staff. Arrangements were in place to ensure there were enough staff to provide safe care. The department had a minimum midwife-to-women ratio of one midwife to 30 women. Although the recommended ratio is one to 28 the department had less postnatal support to manage as 70 percent of the women were from outside the area also they had sufficient numbers of maternity care assistants in place to provide support.

The women we spoke with told us they felt there were enough staff around to care for them and help them with their needs. One woman said "Staff arrive fairly quickly when I press the call bell I don't wait long" Another said "There are enough staff around to help me when I need them. My baby needs changing often so someone always comes." We also saw one of the midwives interrupt her workflow to assist a patient to their bed who had left the bathroom feeling weak. We observed staff being attentive to the needs of the patients and they worked as a team to ensure patients and babies were comfortable and safe.

Access to wards and medical equipment

All the entrances to the wards were protected by intercom systems that were controlled by staff on duty at the reception desks. We observed further security keypads to areas that access the birthing pool that only staff had the entry codes for. This meant women and their babies were protected and kept safe.

Risk

There was a clear understanding demonstrated by staff of the corporate and specialty risks that had the potential to impact on service delivery going forward, for example the introduction of the Maternity tariff, with these being appropriately escalated and plans being developed to mitigate risks. The Head of Midwifery told us she attended meetings weekly led by a consultant to discuss the risks around maternity services and progress was updated regularly. It was clear from the discussions we had with some members of staff that this information was not being shared with the wider team.

Hygiene

There were domestic staff working on all floors providing cleaning services and we noted staff addressed them by their first name. This told us they were inclusive as part of the team for providing quality and safety to patients and staff. We were told cleaning services were provided 24 hours a day seven days a week and there were enough staff working on a rota system covering any absence as required.

Staff used the hand hygiene liquids for cleaning before entering wards and also advising people visiting to use them before entering the area. All staff wore uniforms and name badges so they could be clearly identified by patients and their relatives.

Are maternity and family planning services effective?
(for example, treatment is effective)

We found overall maternity services were being provided effectively.

Care and treatment

We looked at eight patient's records to review the quality of care being recorded and found them to be complete providing relevant information required for treatment and care. Training records showed staff had completed mandatory training and took part in "skills and drills" simulation and learning events. 95% of the staff had completed an appraisal in the last 12 months. This meant that care and treatment was provided by suitably trained and qualified staff.

Patient discharge

There was an effective discharge team in place that consisted of midwives, maternity care assistants and a doctor. This multi-disciplinary approach had been developed to reduce delays in the discharge process for woman and their families. Women were referred on to the community midwives team who arranged home visits to check the health of new mums and their babies. Community midwives worked well and had clear and consistent routes of access to the trust. They told us they

had good support from the maternity department and management. Their caseloads were manageable and they had access to translators if needed. They had access to trust policies and email to ensure they were aware of events and changes in practice. No concerns were raised about accessibility of equipment.

Are maternity and family planning services caring?

We found overall the maternity services were being provided by caring staff. However further improvements might occur if midwives had better knowledge of patients' conditions beforehand.

Attitude of staff

Most of the women that we spoke to told us they had positive experiences with the maternity care and felt confidence in the staff that cared for them. Some of the comments we received were "one of the midwifes who looked after me had excellent bedside manners and was very sensitive to me", "they bought me a cup of tea and toast without me even asking for it, that was really thoughtful", "I received more information than I expected, it really helped me with my labour" and "The staff are so caring and lovely I wouldn't go anywhere else and was lucky to be able to come here".

During our observations we noted that staff attended patients with a caring and sensitive approach. They spoke quietly to respect people's privacy and dignity and we noted that they always made sure the curtains were drawn and asked permission from the patient before entering. Women who were staying in the hospital told us they had no complaints about the food and drinks were available at any time. We saw there were good facilities for women and their relatives to make hot drinks/ snacks if they wanted to.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Maternity services were responsive to access to care and the needs of patients. We found the maternity services to be responsive to access to care and the demand for services.

Patients' feedback

The women we spoke to commented positively about the way staff responded to their needs. We talked to several patients that told us they were categorised as a 'high risk' pregnancy or labour. This was because they may have had complications during a previous pregnancy that related to conditions or they had complications during the recent labour. One woman told us "I have been asked to come for more appointments and scans so they can keep an eye on things" and another said "They have offered me more scans because I am classed as high risk, I have preeclampsia." We spoke to one mother on the postnatal ward who had given birth recently and told us she had a complicated birth but staff were very supportive during the whole labour.

Meeting patients' needs

The department responded well to the demand for emergency and elective C sections by extending theatre cover 24 hours seven days a week. There were doctors on call that were specialists in women's health and a consultant was available in person or on call. The minimum requirement for out of hours cover is 98 hours and this was sufficiently covered by the department. Many midwifery staff had specialist roles for example in foetal medicine, infant feeding and 2 midwifes were specialists in multiple births. This meant staff could support women better if their needs identified with a speciality.

Staff explained how they were responsive to people that did not communicate in English. They told us they could access interpreters whenever needed even if it was late in the night. They used a system called 'language line' where and interpreter would communicate via telephone with the patient to help them understand the information being provided to them.

Are maternity and family planning services well-led?

The maternity services were well-led.

Leadership

Staff spoke positively about senior managers and colleagues in the team and described the service as well-led. They demonstrated strong team work and support and appeared to be motivated and enthusiastic about their

roles. We observed them to be professional and confident in their duties of providing care. We noted that the majority of the junior doctors had specialist experience in women's health.

Supervisors of Midwives

Midwives had access to a supervisor of midwives (SoM) for advice and support. All staff understood there was a daily supervisor arrangement in place. The 'supervisor of midwives ratio' was noted to be one supervisor to 16 midwives, with not all midwives clear of who their personal supervisor was. While the most recent Local Supervising Authority (LSA) audit report was clear and comprehensive, the draft of the strategic plan for supervision could be strengthened to ensure there is a clear programme in place to work towards meeting the recommended LSA ratio of one supervisor to 15 midwives.

Support for staff

Staff that we spoke to told us they received appropriate support from senior managers to develop and maintain the necessary skills to provide safe and effective care. One of the junior doctors who we spoke to told us "I must say that the trust is good at identifying areas of weakness and reacts to improve this."

Services for children & young people

Information about the service

Services for children and young people are located in and around the main hospital site. There are two in-patient wards for children aged 12 years and under on the eleventh floor of the hospital's tower block and two in-patient wards for young people aged over 12 years and over on the twelfth floor. One of the wards on each floor focuses on cancer treatment. The other provides more general care and treatment. Beds for day surgery patients are also located on each floor.

The service has schoolroom facilities on both floors, one for younger children, the other for teenagers. A playroom is available on the eleventh floor and an activities room is located on the twelfth floor. The teachers, play specialists and activity co-ordinators will also work at children and young people's bedsides when this is more appropriate for individual patients.

We spoke to 36 members of staff working in children's services and 20 patients and parents or carers using children's services. We reviewed a range of records and other documents which were available in the wards and clinics and other information which we requested from the trust.

Summary of findings

Children's experience of the A&E department is covered in the A&E section of this report. There were sufficient skilled staff to meet patients' needs and there was prompt recruitment to vacant posts. Neonatal services were working to develop the skills and knowledge of their nursing team in order to retain staff and enhance their service in the face of a national shortage of experienced neonatal nurses. Children's services had systems in place to effectively monitor and improve patient safety.

There was good communication for the benefit of children and young people between different parts of the trust's children's services, and also with other hospitals and services that some patients used.

All the staff displayed a warm and caring attitude towards the patients and their families, as well as to each other. Staff spoke with children and young people using age appropriate language and we saw how they tried to engage with the children while they were treating or monitoring them.

Children and young people with complex needs received individualised care and treatment .The strong link between audit findings and education meant that training could be provided if issues were identified.

Without exception, staff members spoke well of management within the Paediatrics Division. Charge nurses and ward sisters provided effective leadership and that senior management within children's services was supportive. However, we found less evidence that the children and young people's agenda was given priority within the trust as a whole.

Services for children & young people

Are services for children & young people safe?

Children's care services were safe.

Staffing

Staffing levels were generally sufficient to meet the needs of patients but there were extra pressures recruiting sufficient experienced neonatal nurses and registered nurse night cover.

Ward managers told us that it was difficult to predict staffing requirements as admission rates were variable. Bed occupancy in 2012-13 had fluctuated between 43-69%. However, at times there were additional pressures. For example, some young people who self-harmed needed extra supervision. Ward managers said they were now able to bring in extra staff in response to short term needs.

Surgical procedures

We checked the records of three patients who had recently had surgery to see if the WHO surgical checklist had been fully completed. In one case the 'sign in' section was complete, but other sections were not. In another case all relevant sections had been completed but some signatures were missing. Two staff members told us that children under the age of one year who required a general anaesthetic for surgery were referred to a specialist children's hospital.

Infection prevention and control

We observed a high standard of hygiene in all parts of children's services. In particular in the neonatal unit parents had been instructed in good practice by a staff nurse. However, one cleaner we spoke to was unable to explain the different types of deep clean to us. Out-patient staff said that clinics occasionally suffered disruption as they had to wait for a deep clean if a patient turned up with an infectious disease. The ward managers we asked said that they were satisfied with the standard of cleaning. The cleaners on duty in the Teenage Cancer Unit told us that they felt part of the unit team.

Equipment

The neonatal unit was heavily reliant on technology, in common with other neonatal units. Nursing staff competency with each piece of equipment was tested before they used anything new to them. A ward manager told us that they had sufficient well maintained equipment for staff to carry out their roles on the ward, but some items, for example, infusion (IV) pumps, tended to move around the hospital. We saw that IV pumps were now stored securely and could only be removed with the full knowledge of staff on the ward.

Risk Management

We saw that an appropriate nutrition screening tool was in use, as well as a tool to assess and monitor pressure ulcer risks. These measures showed that children's services were alert to risks for hospital in-patients.

Medication

We noted that three recent medication errors had been recorded on one ward. These had been followed up and addressed very quickly. We tracked one medication error that had occurred on another ward that day and saw that it was a prescribing issue. We noted that there had been liaison with appropriate people, such as the pharmacist, immediately the concern had been identified. The incident had been reported using the datix system. We were told an investigation would take place and that learning points would be discussed at the regular medicines safety meeting. We looked at a recent Medicines Briefing which was used to pass on new information about medicines to staff and to reinforce good practice.

Safeguarding

All staff we spoke with were well informed about safeguarding. One nursing assistant told us that they had reported concerns about a child and these had been followed up by the hospital with the local authority. When we looked in another patient record we saw that there had been liaison with relevant professionals, such as the child's health visitor and a member of hospital staff had attended a safeguarding meeting.

We looked at training records for one ward and saw that all staff had completed level three child protection training or were working towards it. The trust employed an independent consultant social worker. One of the consultants told us that this person was very good at "untangling the issues [related to the child's home circumstances] and identifying whether or not safeguarding is needed".

Are services for children & young people effective?

Services for children & young people

(for example, treatment is effective)

Services are effective.

Communication

Tools had been developed to support communication about children and young people with complex needs as they used different parts of the NHS. We saw completed 'blue sheets'; which contained specific instructions about what to do if a particular child stopped breathing. They were designed for parents/carers to pass over to attending paramedics or in Accident and Emergency Departments.

Coordination of services

Two pathway coordinators were funded for young people using the Macmillan Centre. Their role was to ensure there were effective links between all the teams involved in treating the young person within UCLH and in their home community. They followed up to make sure all test results were received in time for clinics and meetings. The ward sister told us that 'it takes the responsibility off the families and medical staff when they are dealing with other things'.

Are services for children & young people caring?

Services were caring with staff displaying warm and caring attitudes.

Support for patients and their families or carers

We spoke to twenty patients or their family members during the course of our visit. They all reported that staff had been polite and friendly when dealing with them. One parent of an in-patient told us that staff were 'very helpful' and they were kept well informed about their child's condition. Another parent of an in-patient said they and their child had received 'absolutely brilliant care from all the nurses'. They added that 'nothing is too much trouble'. A parent in the neonatal unit described the staff team as 'a second family'.

Patient surveys

We were shown a young in-patients survey conducted in 2012 in which young people and their parent / carer had rated their experience. When benchmarked against the results from two other foundation trusts in London, the trust performed significantly better than the other participating hospitals in approximately a third of all areas surveyed and significantly worse in none.

Palliative care

We asked staff about palliative care on the Teenage Cancer Unit and heard that they liaised with the Palliative Care Team to ensure symptoms were controlled. Different pain scales were used to help identify the level of pain children and young people were experiencing. One of them could be used with children who were too young or unable to speak. Nursing staff told us how they tried to respect the wishes of the young person and to give them choices while taking the family situation into account. The ward manager in the Macmillan unit also stressed giving young people as much control as possible over their treatment. The ambulatory care model had been set up to help achieve this. It kept many teenagers in the community for much of their treatment.

Food and Drink

Staff reported that the food had improved since the trust changed its catering contract in the summer. However, the promised children's meals had not materialised by the time of our inspection. We saw that there were plenty of snacks available for patients, although one person told us that fresh fruit was rarely provided. A major supermarket chain kept a parents' kitchen stocked with free ready meals.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Complaints

Senior nursing staff told us that they rarely received formal complaints as they tried to resolve issues straight away at local level. The last formal complaint about children's services was received in July 2013. We saw that information about how to complain was widely available, including in 'Welcome' booklets.

Individualised care and treatment

Patient care and treatment plans were tailored to individual needs. The template that was used to plan the discharge of children who will be leaving the hospital with

oxygen was very comprehensive. It involved checking parent or carer competency at each stage so that they were confident of their ability to administer oxygen appropriately immediately on discharge.

Age appropriate environment

A wide variety of high quality toys and games was available throughout children's services. Young people were able to record their own CDs while receiving treatment at the Macmillan Centre. Whenever possible there were separate areas for younger children and teenagers. For example, there were two different waiting rooms in out-patients which meant that children of all ages could wait in an age appropriate space when attending the same clinic.

Gathering patients' views

In-patients or their parent/carer were invited to take part in the trust-wide Meridian Patient Survey on the day of discharge. Ward managers reported a low uptake and told us that they felt this was due to so many other things taking place at the time of discharge. One ward manager told us that they thought that more people would complete the survey if it was sent out two weeks later, once they had had time to reflect on their experience.

Children's' Out-patient clinics

Everyone we spoke to in the young people's waiting area mentioned that clinics sometimes ran late. We saw that administrative staff and nursing assistants tried to keep people up to date with running times. Delays were indicated on a white board, usually by the consultant's name. Two of the young people we spoke with did not know their consultant's name, therefore the whiteboard was meaningless to them. Most parents/carers came prepared to wait and believed it was acceptable. However, most young people were annoyed about it. Those who were most concerned by delays were those who had a further wait for patient transport.

Are services for children & young people well-led?

Services are well-led with staff reporting effective senior management support.

Management support

Ward managers (sisters and charge nurses) said they received good support from senior managers within the Paediatric Division. One told us, 'They are very helpful with recruitment, they understand the pressures'. Another said, 'They are very open and approachable'. One nurse described their ward sister as 'amazing' and others spoke highly of the support they received from all colleagues at ward level.

Monitoring quality and safety

On each in-patient ward a Quality and Safety Board was prominently displayed. We were told this initiative had come out of a Matron Development Programme. It gave an 'at a glance' overview of ward performance in certain key areas, such as medication incidents; staff vacancies; and registered nurse staffing ratios. It also included quotes from compliments and complaints, alongside any actions taken in response.

Support for new staff

Orientation programmes were in place for new starters and student nurses in line with the trust-wide induction policy. We observed staff being taken through their induction and we looked at the schedule for two recent new starters. A new bank nursing assistant in one of the out-patients clinics we spoke with told us that their competency had been checked before they had been left alone with any task. They said they had not been asked to do anything they had felt uncomfortable with or unprepared for. A supportive culture was described in the focus group for Registered Nurses, with a strong emphasis on education.

Mandatory training and appraisals

We asked three nursing staff about their mandatory training. They told us that they received reminders when they were due for refresher training and, if they did not attend, they were called in by their managers to explain their non-attendance. They said this made them keep up to date with training. We found that there was a high level of participation in annual nurse appraisals which included reference to the trust's core values.

Outpatients

Information about the service

The trust runs a wide range of outpatient services for children, young people and adults, with an estimated 800,000 outpatient attendances each year. This number is expected to grow.

The main central outpatient department located within the hospital runs a number of speciality clinics, for example orthopaedic and gastrointestinal clinics. Due to the increase of patients accessing the main outpatient department, several clinics were temporarily moved to the Rosenheim building. This is located within walking distance of the hospital. The main outpatient cancer department is situated in the Macmillan cancer centre, which is close to the hospital. There is an ambulatory cancer service within the cancer centre which provides certain cancer treatments to patients. If patients need to stay close to the hospital for treatment but do not require a hospital bed they are assessed and admitted to a local patient hotel nearby. We also visited a range of children and young people's outpatient clinics, for example the adolescent rheumatology clinic.

We spoke with patients, a range of staff at all levels of the trust, observed waiting areas of the clinics and interactions between staff and patients. We received feedback from our listening event, staff focus groups and patients contacted us to tell us about their experiences. We also reviewed performance information about the trust.

Summary of findings

In contrast to the newly opened (April 2012) and purpose-built MacMillan Cancer Centre, the premises and facilities in the central outpatient clinic were not adequate. During busy periods clinics were at times overcrowded and patients were left without seating.

The Department of Health introduced a target of 18 weeks for the maximum time it should take from a patient being referred by a doctor or GP to the start of their treatment. However these targets were not always being met. In addition the trust had breached four of the cancer waiting time targets in July 2013 for both admitted and non admitted pathways. Overall staff working in the outpatient clinics and across the divisions had taken action where required to make improvements to their own clinics where possible. However the management of the clinics fell across a number of directorates, which made implementing changes to the overall booking administration system a challenge.

We looked at the results of 55 responses to the patient satisfaction surveys for the general outpatient department for the month of October 2013. Overall respondents rated the care they received as good. However ratings were lower when asked about waiting times in the clinic and the respect and dignity they sometimes received in the clinic. Staff informed us that when negative results and free text comments were received, these were automatically passed to the relevant division to action and make changes where necessary.

There were arrangements to enable safe practice across the outpatient services. There were arrangements for staff to respond appropriately to foreseeable medical emergencies. The trust also has clear arrangements in place for infection control, the management of medicines, the reporting of incidents and escalating safeguarding concerns.

Outpatients

Are outpatients services safe?

Overall services were safe but the environment and overcrowding did not support patient safety.

Environment

The premises in the main central outpatient department were not adequate. During busy periods clinics were at times overcrowded and patients were left without seating. On one occasion there were patients waiting at the reception desk, due to the volume of patients exceeding the capacity in the seating area for the orthopaedic clinic. Throughout the three days of our inspection, due to a lack of seating, we observed patients with walking sticks, crutches, and with bandaged feet standing in the corridor. On the service level risk register we saw that the fracture clinic environment had been raised as a risk area back in March 2011 but had not been reviewed again until April 2013. The situation remained the same on review and was categorised as still being reviewed. The trust accepts that the plaster room was too small for emergency intervention and had inadequate ventilation. Control measures had been put in place, such as an electric fan to maximise the air-flow and unnecessary equipment had been removed to increase space usage. No review of the decision to move the room was recorded on the register.

Arrangements to enable safe practice

There were arrangements across the outpatient services for staff to respond appropriately to foreseeable medical emergencies. We followed up one patient incident in the ambulatory cancer service in November 2011. Appropriate actions were taken and as a result changes had been implemented. We saw there were clear emergency response protocols for staff to follow and they were able to describe this to us and changes had been made to the eligibility criteria for patient admissions to ambulatory cancer care. Additionally, the provider had clear arrangements in place for infection control, the management of medicines, the reporting of incidents and escalating safeguarding concerns.

Are outpatients services effective?
(for example, treatment is effective)

The trust was not always meeting national guidance and targets to ensure effective services and some administrative systems led to inefficiencies.

Managing quality and performance

The Department of Health introduced a target of 18 weeks for the maximum time it should take from a patient being referred by a doctor or GP to the start of their treatment. The trust had declared compliance with all three of the 18 week performance indicators. However we found that some of the targets within these indicators were not always being met. In the trust's performance report to the board of directors in August 2013, it was acknowledged one area where performance had decreased was with the 18 week referral to treatment (RTT), where the number of patients waiting for over 36 weeks had continued to increase. For July 2013 it was reported that 237 patients had been waiting for over 40 weeks. Additionally according to the report, four of the cancer waiting time targets had not been met.

Trust improvements

Since July 2013 the trust had responded to the missed 18 week targets which fell within the gastrointestinal speciality and performance improvements had been made to date. The responsible division had followed up on all the missed targets and each closed breach was reviewed by the assistant general manager to ensure its accuracy and to mitigate future breaches. However the surgery and cancer board had not reached the required 92% trust indicator for incomplete pathways at the time of this report.

Remaining issues

Measures had been put in place to mitigate the number of waiting time target breaches for outpatient appointments. However the administrative processes across the entire outpatient clinics were not streamlined and were therefore working variably across the different patient pathways. The potential to miss targets remained an issue. Several staff informed us the booking administration system caused confusion. For example if staff were booking patients for follow up appointments within target timeframes they could not always track whether the patient fell inside or outside of the target

time for treatment. We were told that once test results were ready, the onus was for the patient to book a follow up appointment to discuss their results. Patients would also not be aware of where they fell within the target timeframe.

Are outpatients services caring?

Outpatient services were caring.

Patient feedback and staffing attitudes

Patients we spoke with and patient satisfaction survey results rated the overall care they received as good. Patients told us they were generally kept informed of waiting times and reasons for any delays. Patients and relatives of patients we spoke with who had used the MacMillan Cancer Centre had rated the service and staff highly.

Some patients told us that staff were always caring and respectful and we observed positive interactions between staff and patients across the three day inspection. We saw staff were attentive to patient needs by asking how they were and where they needed to go.

Privacy and dignity

All patients were treated privately in consultation rooms. In the children's and young people's outpatients' department, if patients were distressed they could be taken to an empty clinic room or the family room for privacy. Patients were informed in their outpatient letter to notify staff if they required interpreter services and to bring a chaperone along to the appointment if they wished.

Are outpatients services responsive to people's needs?
(for example, to feedback?)

The service was not always responsive to patient needs. Waiting times were variable across clinics. During busy periods clinics were at times overcrowded and patients were left without seating. On one occasion there were patients waiting at the reception desk, due to the volume of patients exceeding the capacity in the seating area for the orthopaedic clinic. We saw a patient with diabetes attending a foot clinic having to stand as there was nowhere to sit and wait.

Waiting times

We received mixed feedback from patients' across the outpatient services. Some reported not having long to wait for appointments. Several patients informed us they had waited 30 and 45 minutes respectively past their booked appointment times on one occasion and we observed a patient express frustration to staff that they had been waiting past their appointment start time.

Booking appointments

Some patients said they had experienced difficulties in accessing appointments. For example one patient said they were unable to get an appointment in the Urology department due to no capacity. They were eventually re-referred back into the hospital through their GP.

Meeting people's needs

The self-check in kiosk was accessible to patients in a range of languages and for those who were visually impaired. There was a dedicated kiosk for people in a wheelchair. This system was not implemented across all the outpatient sites. There was mixed feedback about this system. Several patients expressed they were not happy with the self-check in kiosk system. They felt it was ''impersonal'' and ''confusing'' and both said they would prefer face to face contact with staff. There were receptionists in the main central outpatient department and the Macmillan cancer centre to assist patients with the kiosk when required.

Access to psychology services

Staff informed us that there was very limited access to psychology services across the outpatient services.

Are outpatients services well-led?

Outpatient clinics were not well-led due to diverse management arrangements.

Leadership

Outpatient clinics are managed across different divisions of the trust and this is a challenge to concerted leadership. In response to the decreased performance against several key metrics which included the waiting time targets, a task and finish group was established with senior representatives from each of the clinical boards to

focus on improving performance in these areas. An outpatient efficiency group had been established and tasked to review the scheduling of appointments, increase productivity and improve utilisation of clinics.

No review of the decision to move the plaster room within the fracture clinic was recorded on the service level risk register. Therefore we could not be assured that risks were responded to in a timely and appropriate manner.

The future of outpatients

A trust strategy document set our recommendations for outpatient services, including the implementation of technology to improve the outpatient process. For example self-check in kiosks and text reminders about appointments. However it was noted that these solutions had not yet been implemented across all of the clinics.

Staff training and development

There were formal system structures in place for staff to receive training and annual appraisals. For example we saw a log to show that staff had completed mandatory training in e-learning and we saw appraisals had been completed. Staff's performance, learning objectives and how they were meeting values were discussed in appraisals. Staff we spoke with also confirmed they had received training and what they discussed in appraisals.

Good practice and areas for improvement

Areas of good practice

Accident and emergency

- The commitment of staff to good care despite environmental challenges.

Medical care

- Excellent caring staff, including positive caring interactions with patients. Staff provided people with regular information and promoted their involvement in their care. They maintained people's privacy and dignity and promoted their independence.
- Senior ward staff were given the opportunity to complete leadership training which meant wards were managed by competent and approachable staff.
- Some senior managers were visible on wards and participated in delivering care which meant they understood how wards worked so they knew first-hand about staff and patient experiences. Strong clinical leadership was clearly visible on wards.
- Effective training in the care of patients with Dementia was being compassionately put into use on the AMU by care assistants

Surgery

- Areas of good practice were as follows: Patients and their relatives found staff to be caring, supportive and felt that their needs had been met. We observed people being treated with dignity and respect.
- There was a strong consultant' presence at all stages of patients' surgical pathway ensuring decisions on care and treatment were made by the appropriate qualified healthcare professional.

Intensive/critical care

- Areas of good practice included good examples of caring, efficient staff showing good multi-disciplinary working; good patient mortality rates and clinical outcomes; daily ward input from microbiologist and psychological support for patients and staff

Children's care

- Clinical Nurse Specialists and other staff linked effectively with community services for children and young people with complex needs to try to ensure services were as seamless as possible. 'Patient passports' had been developed to aid communication.
- There were arrangements in place for young people receiving ambulatory care to get immediate access to an in-patient bed in the event of a sudden deterioration of their condition.
- There was a strong commitment to a collaborative style of working in the Paediatric Division for the benefit of children, young people and their families. For example, the Neonatal Unit held daily Capacity and Safety meetings which involved a wide range of staff.
- The outpatients' clinics for children and young people had procedures in place to check reasons for non-attendance. This safeguarded children who might have missed appointments due to abuse or neglect.
- The competence of new clinical staff was checked before they were allowed to work unsupervised.

Areas in need of improvement

Action the hospital MUST take to improve

- Review the current A & E and children's A & E provision and assess what planned improvements can be brought forward or interim measures can be employed to mitigate risks to patient safety.
- Improve the quality, completeness of people's care assessments, care plans and care delivery records on the acute medical wards to ensure that people do not receive inappropriate or unsafe care.
- Improve the care and security storage of patient records on acute medical units.
- In Intensive/Critical care improve access to 24 hour cleaning support in the critical care unit and improve space for the storage of equipment.
- In surgery, improve patient flow by alleviating pressure on beds and reviewing bed capacity in operating theatre recovery area.
- Ensure full completion in all cases of the WHO surgical checklist to help prevent "Never Events".
- The trust must ensure that the paperwork for patients who have been assessed as not requiring resuscitation is always fully completed.

Action the hospital COULD take to improve

- Provide information for non-urgent patients presenting at A&E about other services available to them and

Good practice and areas for improvement

review repeat patient visits to identify opportunities to educate where appropriate. Site the information screen in A&E reception where the majority of seated patients can view it.

- Consider whether staffing levels support the need to chaperone and whether staff could act as champions for vulnerable groups visiting A&E.
- Improve the provision in all areas in the trust of written information to patients whose first language is not English. Improve patient information to visually and hearing impaired patients in A & E.
- Consider the possibility of utilising voluntary groups or other means to provide food and drink to patients in A&E.
- Improve patient flow through the AMU onto general wards to relieve pressure on the unscheduled care pathway.
- Wards should be provided with information about any trends in datix incident data to ensure any required improvements can be implemented.
- The assessment medical unit (AMU) could have physiotherapy or occupational therapy support over the weekend to support discharge at these times.
- The AMU could have a dedicated acute medical consultant to help the future development of the unit.
- Ensure the rollout of dementia awareness training for care staff on all wards.
- Ensure environmental improvements are made to the elderly care wards and the AMU to improve the hospital experience for people with dementia.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use the service were not protected against the risks associated with unsafe or unsuitable premises. Improvements are needed in relation to the environment in the accident and emergency department. Regulation 15 (1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use the service were not protected against the risks of unsafe or inappropriate care and treatment arising from lack of proper information about them by means of the maintenance of 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. Improvements are needed in relation to patient assessment and treatment records on the acute medical wards Regulation 20 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use the service were not protected against the risks of unsafe or inappropriate care and treatment

This section is primarily information for the provider

Compliance actions

arising from lack of proper information about them by means of the maintenance of 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.

Improvements are needed in relation to the security of patient records on the acute medical wards

Regulation 20 (2) (a).

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 **Assessing and monitoring the quality of service provision** **10.**(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 (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (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. Improvements are needed to ensure that the World Health Organisation (WHO) Surgical Safety Checklist is completed fully in 100% of all patients undergoing a surgical procedure (including local anaesthesia).

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Surgical procedures

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

Assessing and monitoring the quality of service provision

10.(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

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(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.

Improvements are needed to ensure that the World Health Organisation (WHO) Surgical Safety Checklist is completed fully in 100% of all patients undergoing a surgical procedure (including local anaesthesia).