Care Quality Commission

# Barking, Havering and Redbridge University Hospitals NHS Trust

# Queen's Hospital

## Quality Report

Rom Valley Way
Romford
Essex
RM7 0AG
Tel: 01708 435000
Website: www.bhrhospitals.nhs.uk

Date of inspection visit: 2 to 6 March, 14 March and 20 March 2015
Date of publication: 02/07/2015

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.

## Ratings

| | |
|---|---|
| **Overall rating for this hospital** | **Requires improvement** |
| Urgent and emergency services | Requires improvement |
| Medical care | Requires improvement |
| Surgery | Requires improvement |
| Critical care | Requires improvement |
| Maternity and gynaecology | Requires improvement |
| Services for children and young people | Requires improvement |
| End of life care | Good |
| Outpatients and diagnostic imaging | Requires improvement |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. Queen's Hospital is the trust's main acute hospital.

The private finance initiative (PFI), Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for people living in Havering, Dagenham and Brentwood. The Accident and emergency (A&E) department has one of the highest number of attendances in the country. The hospital has 786 beds, including a hyper acute stroke unit and delivers nearly 8,000 babies a year.

The hospital predominantly covers three local authorities; Barking & Dagenham which has very high levels of deprivation, Havering which is closer to the national average but has a relatively elderly population by London standards and Brentwood which is a less deprived area.

We inspected the trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. I recommended to the Trust Development Agency (TDA) that the trust be placed in special measures in December 2013.

Since the inspection a new executive team has been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team has been supported by an improvement director from the TDA.

The trust developed an improvement plan ('unlocking our potential') that has been monitored and contributed by all stakeholders monthly and published. The purpose of this re-inspection was to check on improvements, apply ratings and to make a recommendation on the status of special measures.

Overall, this hospital requires improvement. The end of life care service was rated as good and all other services were rated as requires improvement. Of the five key questions that CQC asks, we rated the trust as good for caring; safe, effective, and well-led require improvement and responsive was inadequate.

**Our key findings were as follows:**

- Improvements had been made in a number of services since our last inspection.
- The culture had significantly improved. It encouraged pride, responsibility candour, openness and honesty.

**Safe**

- There was a backlog of serious incidents and the quality of investigations into serious incidents lacked detail to ensure failings were understood and lessons were learned.
- There were insufficient systems, processes and practices to keep patients safe. Lessons were not learned and improvements were not made when things went wrong.
- Recruitment had been on-going however there was not always enough medical and nursing staff to meet the needs of patients.
- The management of medicines needed improving to ensure safe administration and a reduction in medication errors.
- The majority of clinical areas were visibly clean and staff adhered to good infection control practices.
- Most staff groups achieved completing 85% of mandatory training.

**Effective**

- Patients needs were assessed and care and treatment was delivered in line with evidenced-based guidance.
- Patient outcomes were varied.
- Some staff were not competent in carrying out their roles.

# Summary of findings

- Pain relief and nutrition and hydration needs were assessed and met.
- Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were well understood by the majority of staff and part of a patients plan of care.

**Caring**

- Some national surveys have found that staff are not always compassionate. In response, staff had focussed on involving patients, keeping them informed and treating patients with dignity and respect.
- During our inspection we saw and heard of compassionate, kind care and emotional support being provided.

**Responsive**

- There was a focus on understanding the needs of local people and the community the trust served.
- Urgent and emergency, children and young people and outpatients services were not always responsive to meet patients needs.
- The emergency department was not meeting the national four-hour waiting time target introduced by the Department of Health.
- The hospital was persistently failing to meet the national waiting times target. Some patients were experiencing more than 18 weeks from referral to treatment time (RTT).
- The access and flow of patients throughout the hospital had improved since our last inspection. The introduction of the Elders Receiving Unit (ERU) met patients needs.

**Well-led**

- The new executive team was making improvements. The board was visible and engaging with patients and staff.
- The leadership and culture were open, transparent and focussed on improving services.
- At an executive level there was a vision and strategy in development to deliver good care and ensure sustainability. At a service level staff were less clear and many told us they were "fire-fighting".
- The governance structures did not ensure that responsibilities were clear and that quality, performance and risks were understood or managed.

We saw several areas of outstanding practice including:

- The values of the trust - passion, responsibility, innovative, drive and empowerment (PRIDE) were well known and embedded in the culture of the people working at the trust.
- The new executive team were visible and engaged.
- There was lots of involvement from the local community and voluntary organisations. The foyer had lots of people giving information for patients and visitors about services in the local area. For example dementia care, stop smoking and healthy eating.
- Radiotherapy was one of the top five units in the country.
- The genitourinary medicine (GUM) clinic had an excellent service with appropriate protocols and processes and support for patients.
- There had been a number of initiatives to provide a responsive service for general surgery patients. The surgical assessment unit provided a timely service in emergencies and the 'hot clinic' reduced delays for patients.
- The hospital was a regional centre for upper gastro-intestinal conditions. Outcomes for patients receiving oesophago-gastric cancer services were good.
- There were good outcomes for stroke patients and the stroke service demonstrated good team work.
- Play specialists had developed a way to distract children awaiting MRI scans which involved joining other children and families on a ‘train journey’ from the outpatient’s clinic down through the hospital corridors, using storytelling and positive reinforcement on the way. This had proved a good distraction for children and reduced their anxiety. We walked with one child and found them to be very engaged in the trail.

# Summary of findings

- Consultant paediatricians undertook short notice or 'HOT clinics', whereby GPs could make a consultant to consultant referral reach a joint decision on action including if needed early assessment. GP's reported positively to their commissioners on the success of this system.
- The consultant led critical care outreach team's seven day service had improved the outcome for patients through appropriate identification of deterioration and appropriate escalation.
- The critical care outreach team provided a 'critical care follow up outpatient clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their discharge.
- Neuro-intensive therapy unit encouraged diaries for patients who were staying for longer periods of time in the unit. Patient's families kept a record of daily activities such as visits, progress and treatments, items of news and the weather. A free newspaper was offered to patients in general critical care to help orientate them.
- The development of the Elders' Receiving Unit had improved frail, elderly patient care.
- A dedicated team to support patients living with dementia . Wards could book a dementia trained health care assistant to support one or more patients in a bay on the ward. We were told this was, "A huge improvement" as they were dementia trained. Previously this role was done by a different bank nurse every day.
- The nurse led oral chemotherapy service was the first in the country.
- The hospital performed well in the National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme carried out in 2014.
- The end of life care service was patient focussed and end of life care needs was well understood by the majority of staff from all staff groups.

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

Importantly, the trust must:

- have clear governance with integrated systems and processes to support staff to provide care and treatment safely.
- ensure serious incidents are understood, investigated and lessons are learned promptly.
- review systems for sharing good practice across the divisions and trust wide.
- ensure compliance with all national guidelines and trust policies for medicines management.
- improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
- improve the IT systems so they are up to date and the IT strategy is implemented and supports clinical staff to carry out their duties.
- ensure all services for neonates, children and young people are responsive to their needs.
- ensure the radiology is fit for purpose and fulfils its reporting timescales, particularly for CT scans.
- continuously review staffing levels and act on them at all times of the day.
- include a dietician as part of the critical care multidisciplinary team in line with the core standards for intensive care guidance.
- comply with the Duty of Candour legislation.
- comply with infection control code of practice in respect of hand hygiene audits, training and monitored improvement.
- ensure locum and agency staff are competent and implement a formal induction process for all locum and agency staff in the relevant areas they care for patients.
- ensure processes are in place for locum and agency staff in respect of accessing and using IT systems required for their role.
- ensure patient risk assessments are acted upon.
- Review the general medicine on-call rota to ensure it meets the needs of patients.
- meet the Emergency Care standards in the Elder's Receiving Unit.

# Summary of findings

- audit and monitor the patient outcomes from the trust discharge strategies.
- comply with the National Dementia Strategy.

In addition the trust should:

- consider increasing the target rates for mandatory training.
- review the effectiveness of the rota co-ordination for junior doctors
- review the accessibility of the radiology services and consider a duty radiographer structure.
- review the service level agreement for accessing therapies to ensure it meets patients needs promptly.
- continue to improve patient record availability at outpatient clinics.
- the culture of staff within radiology and the anti-coagulation to ensure they feel part of the organisation.
- review the environment in outpatients to improve the waiting and reception areas.
- review the environment and the staffing levels of the day-care surgery unit.
- review nurse staffing levels and skill mix on surgical wards, particularly out-of-hours.
- review the availability and presence of consultant obstetricians and speciality registrar level doctors so that labour ward cover is in line with local and national recommendations.
- consider an increase in establishment in the dementia team and the pain team.
- review the audit programme in surgery so that internal audits are completed and implemented.
- review the theatre electronic recording system to ensure accurate data is available.
- consider ways to increase multidisciplinary team working within critical care.
- consider ways to make the overnight accommodation for visitor to patients in general intensive care less austere.
- consider ways to engage patients in providing feedback specifically related to critical care services.
- continue to increase the availability of medical records.
- monitor the impact on patients from the reduction in Coronary Care Unit beds.
- review the processes for medicines to take away on discharge.
- consider undertaking a needs analysis in respect of those whose first language is not English.
- improve engagement between junior doctors and management.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| **Urgent and emergency services** | Requires improvement  | We found there were improvements in responsiveness to patient's needs since our last inspection. The patient flow had improved. However, at times, there were still significant delays in initial clinical assessment. Implementation of evidence-based guidelines was variable. Outcomes of treatment were monitored but the results of monitoring were not always used effectively to improve quality.<br>We observed people being treated with kindness, dignity and respect and people told us they were satisfied with the care and treatment that they had received.<br>Safety was not a sufficient priority in the A&E department. There were not enough skilled staff and staff did not always recognise concerns, incidents or near misses. There was little evidence of learning from events or incidents in order to improve treatment or care. We identified that some medical staff were not competent in providing emergency care and treatment. The leadership and governance of the department did not always support the delivery of high quality care and treatment. Clinical governance arrangements did not always operate effectively and risks were not always recognised or dealt with in a timely manner. |
| **Medical care** | Requires improvement  | There were shortages in medical, nursing and therapy staff groups. The trust was recruiting, but this was taking time. The shortages impacted on staff's ability to complete all their duties within each shift, take up additional training opportunities and for junior medical staff to undertake professional mandatory training. Where this was prioritised the result was gaps in the doctors' rota, which in turn affected patient safety and the other doctors covering the shifts. Middle grade and junior doctors raised significant concerns about the rota. We found there was a lack of coordination of the rota, the electronic version was not up to date, and there was no formal forum for this to be discussed and managed. |

# Summary of findings

Patients were cared for on non-specialty or other specialty wards due to inpatient capacity issues. There was a team on the rota to oversee care and treatment for medical outliers, but we found that there were some delays in doctors being able to see all the patients in the different areas. This also resulted in several ward moves for some patients as they did not get the right care in the right clinical area first time.

We found nursing staff did not comply with the trust policy for intravenous administration where there should have been two registered nurses involved in the checking process. Nursing staff told us that staff shortages made this difficult to comply with.

Governance processes were not clear for all staff across all the specialties. Staff provided kind, compassionate care that preserved patients' dignity.

Patients were supported emotionally and received enough information to be involved in their care and treatment. There was multi-disciplinary working to plan care to meet each individual patient's needs.

The executive team were accessible and visible. Staff felt well supported by their peers and line managers.

**Surgery** **Requires improvement**

There were examples of learning from incidents but there was not a systematic approach to the reporting and investigation of, and learning from, incidents. The standard of investigation of serious incidents was inconsistent and there was a backlog of investigations.

There was a daily assessment of the acuity and dependency of patients on each of the surgical wards. Staff on a ward with patients with complex needs, however, reported there was limited flexibility in providing additional staff. The number and skills-mix of theatre staffing was suitable.

Patients were observed post-operatively and nursing staff had access to medical and surgical staff when needed. Patients were further protected from the risks of surgery by the focus on improving engagement in the 'five steps to safer surgery' in theatres, which was resulting in increased consistency in its use.

There had been number of initiatives to promote adherence to national guidelines. Outcomes for

# Summary of findings

patients were similar to national expectations. Many patients had not been receiving services in a timely way because of a backlog in clinic appointments, and it was not yet known if the delays would affect patient outcomes.
Information technology (IT) was underdeveloped, and there was duplication of electronic and manual patient records. The theatre electronic recording system was not fit for purpose and manual verification was necessary in order to access accurate data.
Patients and relatives we spoke with were happy with the care and treatment they had received, and praised the medical and nursing staff. We observed positive and respectful interactions between patients and staff. We found effective teamwork and a focus on the needs of the patient.
There had been developments in surgical specialties to provide an improved and responsive service to patients. However, many patients had not received a timely response following their GP referral. There were challenges in managing the level of demand. Staff worked hard to address these challenges, but some patients were not receiving a responsive service because of delays in access to theatre or, post-operatively to an appropriate bed.
The clinical governance structures were immature. Work was underway to integrate risk management systems. There were concerns about the sustainability of meeting the current, and future, level of demand on the service.

## Critical care

**Requires improvement**

There were insufficient critical care beds available for the population served by the trust in comparison with other London Trusts. Despite four additional beds being made available, capacity has remained high at an average of 95%. It was estimated that critical care bed shortages affect 100-200 patients each month, with cancellation of planned procedures and significant waits in A&E when waiting for a GICU bed.
Incident reporting was variable and staff were unclear about which issues to report. Learning from reported incidents was not always apparent and staff told us there was little change after raising issues. Patient records, including consent and mental capacity assessments, were completed in

# Summary of findings

most cases but we found some gaps in care plans and inconsistency in prescribing resulting in controlled drugs being administered without a valid legal prescription.
There was limited space. This resulted in small bed areas and no space for dedicated hand wash facilities or waste bins for each patient space. There was limited available storage for equipment. In most cases, equipment was cleaned in line with the infection control policy but some areas of the unit were not cleaned to the highest standard.
There was little multidisciplinary team working evident on GICU. Physiotherapists attended handovers but access to other professionals was on a referral basis. On NITU, structured MDT meetings were held for long term patients. Pastoral support was available across critical care 24 hours a day.
The leadership team had a strong vision for future expansion of critical care services but this had not been shared with the ward staff. Staff had a mixed understanding of the vision for critical care and the reconfiguration had left some uncertainty about the future expansion plans.
Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams. There was suitable medical cover provided by specialist consultants and junior doctors.
Policies and protocols we observed were based on national guidance and international guidelines. The critical care units completed local audits and evidence based work when no national guidance was available. The GICU participated in a national database for adult critical care. Patient outcomes and mortality were within expected ranges when compared to similar services. The outreach team supported ward based staff in the early identification of patients at risk of deteriorating and who may require an HDU or ICU bed. CCOT also provided an outpatient clinic to support previous critical care patients in the months after their admission and to ensure they continue to progress.

| | | | |
|---|---|---|---|
| **Maternity and gynaecology** | **Requires improvement** |  | There had been significant improvements to the maternity services since our last inspections. |

# Summary of findings

Including improvements in the way women felt about the service, leadership and culture, staff engagement, medicines management and access and flow.
Governance arrangements were, in the main considered to be sufficiently robust. Dashboards were utilised and offered staff a snap-shot of a range of quality indicators and outcomes to ensure that clinical performance could be assessed. Audits programmes were utilised to underpin the existing governance arrangements.
However, the existing governance arrangements did not always encompass the totality of clinical and maternity services provided to women; those working in foetal medicine and the ante-natal screening service were not always included in, nor received timely feedback from incidents which may have impacted on the management of the woman and her unborn baby and so there was the potential for delays in lessons learnt and service improvements being implemented as a result of clinical incidents.
The service did not employ sufficient numbers of consultant obstetricians to ensure that the labour ward was appropriately supported; the existing establishment was not in-line with national and London based recommendations. A business plan had been submitted to the executive team to increase the number of substantively appointed consultant obstetricians.
Evidenced-based care and treatment was delivered. Outcomes for women were similar to other services when compared. Midwives were competent and kept up to date with their mandatory training.
Women received their choice of pain relief and were supported to feed their babies in their preferred method.
Women's needs were met through the way services were organised and delivered. The configuration of maternity services at the hospital meant the service was more responsive. However the gynaecology services were not always responsive.

**Services for children and young people** **Requires improvement**

Staff told us they were encouraged to report incidents, though we noted that there was limited learning from all reported incidents, including those that caused serious harm. Most environments in

which children were cared for were appropriate, though children were seen in adult departments for ENT, ophthalmology and dermatology. Staffing levels were prioritised for safety. However, there was a lack of appropriate high dependency beds, and the inpatient unit was often closed to new admissions when it had a patient requiring high dependency care and hospitals who are commissioned to provide this service did not have available beds to ensure children were safely cared for the ward was closed to new admissions at such a time so that safe staffing could be maintained. We also found checks on paediatric resuscitation trollies were missed for 9 days over a period of a month.

Evidence based guidelines and recommendations from the National Institute for Health and Care Excellence (NICE) and the royal colleges' were reviewed by specialty areas though we could not identify whether they were implemented consistently in practice.

There was limited evidence and limited audit activity undertaken by the children's directorate that was recent or specific to the specialties within the division. From the information collated, we identified that the division was not always performing in line with national standards; this was especially true for some outpatient and surgical services.

The children's directorate lacked a formal vision or strategy, and some staff were unaware of the trust's values. Staff spoke highly of the medical leadership in the division. Recent changes to the structure of the trust's divisions meant that there had been a number of new appointments to the leadership of the division which meant leaders had limited management understanding and oversight of the division. The divisions that served children and young people worked in isolation, and although the women's and children's division had overall responsibility for children and young people, pertinent information was not always appropriately shared between the divisions.

**End of life care** — **Good**

Patient's do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were accurately completed in all cases. Patients had a clear care

plan which specified their wishes regarding end of life care, staff were aware of their wishes in regards to the preferred place of death. There was good coordination across all divisions to ensure consistency of approach in end of life care. Staff knew how to report concerns. Staff were respectful and maintained patients' dignity, there was a person centred culture. Patients told us staff were caring and compassionate. They also said they had appropriate access to pain relief and were happy with the food and drink offered. Specialist palliative care team members were competent and knowledgeable. There were examples of good multidisciplinary team working.

| | | | |
|---|---|---|---|
| **Outpatients and diagnostic imaging** | **Requires improvement** |  | The services had made some improvements in recent months as part of the trust's overall improvement plan. Improvements needed to continue and others areas identified during the inspection also required attention.<br>The services had not been organised to meet the need of the local population, however this had started to be addressed. There was a large backlog of patients that required appointments that had waited over 18 weeks. Radiology reporting timescales were only partly met. Cancer waits were variable depending on the pathway.<br>There were multiple capacity, scheduling, staffing and environmental concerns for patients using the radiology and phlebotomy services. Rates of patients that did not attend appointments, hospital cancellations and hospital changes were high.<br>Radiotherapy was one of the best five units in the country and there was positive outcomes for the Genito-Urinary Medicine (GUM) service and some other services. |

# Queen's Hospital

## Detailed findings

**Services we looked at**
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

# Detailed findings

## Contents



## Background to Queen's Hospital

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. Queen's Hospital is the trust's main acute hospital.

The private finance initiative (PFI), Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for people living in Havering, Dagenham and Brentwood. The Accident and emergency (A&E) department has one of the highest number of attendances in the country. The hospital has 786 beds, including a hyper acute stroke unit and delivers over 8,000 babies a year.

The hospital predominantly covers three local authorities; Barking & Dagenham which has very high levels of deprivation, Havering which is closer to the national average but has a relatively elderly population by London standards and Brentwood which is a less deprived area.

We inspected the trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. I recommended to the Trust Development Agency (TDA) that the trust be placed in special measures in December 2013.

Since the inspection a new executive team has been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team has been supported by an improvement director from the TDA.

The trust developed an improvement plan ('unlocking our potential') that has been monitored and contributed by all stakeholders monthly and published. The purpose of this re-inspection was to check on improvements, apply ratings and to make a recommendation on the status of special measures.

## Our inspection team

**Our inspection team was led by:**

**Chair:** Ruth May, Regional Chief Nurse, NHS England (Midlands and East)

**Head of Hospital Inspections:** Alan Thorne, Care Quality Commission (CQC)

**Inspection Lead:** Hayley Marle, CQC

The team of 35 included CQC inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, anaesthetist, physician and junior doctors; midwife; surgical, medical, paediatric, board level, critical

care and palliative care nurses', paramedic, an imaging specialist, outpatients manager, child and adult safeguarding leads, a student nurse; and experts by experience.

## 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:

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS Trust Development Authority, Health Education England, General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN); NHS Litigation Authority and local branches of Healthwatch.

We carried out an announced visit between 2 and 6 March and unannounced visits on Saturday 14 March 2015 and Friday 20 March 2015. We observed how people were being cared for and talked with patients, carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, midwives, allied health professionals, and administration staff. We interviewed senior members of staff at the hospital and at the trust. Approximately 45 members of staff attended our 'drop in' sessions to talk with a member of the inspection team.

The CQC inspection model focuses on putting the service user at the heart of our work. During our inspection we had a stall in the main reception of the hospital for a day. Approximately 31 people shared their current views and experiences of the services. Many people were dissatisfied with the outpatients appointments and wait times for taking bloods, however many people told us about the good care and treatment they or close family members were receiving.

## Facts and data about Queen's Hospital

**Context**

Areas covered: Havering, Barking and Dagenham and Brentwood

Services provided: Full range of general inpatient, outpatient and day-case services, as well as maternity services and a 24-hour Emergency Department and Urgent Care Centre.

Main clinical commissioning group: Redbridge CCG on behalf of Barking, Havering and Redbridge

Population served: Approximately 470,000 people.

Life expectancy:

Havering: Approximately 75 for men and 81 for women in the most deprived areas in the borough.

Barking and Dagenham: Approximately 75 for men and 80 for women in the most deprived areas in the borough.

Brentwood: Approximately 76 for men and 81 for women in the most deprived areas in the borough.

# Detailed findings

Deprivation: (out of 326 local authorities, 1st is most deprived)

Barking and Dagenham: 6 out of 326

Havering 177 out of 326

Brentwood 295 out of 326

Number of beds 786:

674 General and acute

80 Maternity

32 Critical care

Number of staff employed 4,075

739 Medical

1,416 Nursing

1,920 Other

Annual revenue: Not available by individual hospital site

Surplus: Not available by individual hospital site

**Activity**

Inpatient admissions - Excluding emergency admissions (2013/14): 46,987

Outpatient attendances (2013/14): 306,375

A&E attendances (2013/14): 146,984 (of which) 138,045 Type 1, 8,939 Type 2

Births (2013/14): 9,479 (2013/14)

Deaths in hospital (2013/14): 1,653

**Bed occupancy**

Average bed occupancy: 93% (a reduction from 2013/14 average bed occupancy of 97%)

**Incidents**

One Never Event (2014)

125 Serious incidents (2014) (Includes 21 grade 3 pressure ulcers, 21 slips/trips/falls, 17 unexpected admissions to maternity, seven ambulance delays, six unexpected deaths and three child deaths). However there was a significant backlog in investigating and reporting serious incidents.

**CQC Inspection History**

Number of inspections since April 2012 registration: 23 (for the trust as a whole)

Most recent outcome Trust placed in Special Measures December 2013

Non-compliant for care and welfare of patients - outcome 4

Non-compliant for staffing - outcome 13

Non-compliant for records - outcome 21

Non-compliant for safety and suitability of premises in the outpatients department - outcome 10

Non-compliant for assessing and monitoring the quality of the service - outcome 16

**Intelligent monitoring**

Total risks and breakdowns 5 ‘Elevated Risks’ and 10 ‘Risks’ at trust level in the December 2014 Intelligent monitoring report. (breakdowns by individual hospital site not available).

Number of ‘risks’ and ‘elevated risks’ highlighted in the December 2014 Intelligent monitoring report.

**Note:** Risks are determined mainly through use of statistical tests where indicator scores are compared to an expected value (usually an average), and then flagged as a "risk" or "elevated risk" depending on the difference between the actual and expected values. Other risks are determined by a rules-based approach, for example: concerns raised by staff to CQC (and validated by CQC) are always flagged as a risk in the model, whereas repeated concerns are flagged as an ‘elevated risk’.

Breakdown of ‘elevated risks’ from December 2014 IM report (trust level)

- **Effective** - Composite of knee related PROMS indicators (risk in previous IM report)
- **Caring** - Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (Elevated risk in previous IM report)
- **Responsive -** Composite indicator: A&E waiting times more than four hours (Elevated risk in previous 3 reports).
- **Well-led -** TDA - Escalation score (Elevated risk in previous 3 IM reports)

# Detailed findings

- **Qualitative information -** Whistleblowing alerts (Elevated risk in previous IM report)

Breakdown of 'risks' from December 2014 IM report.

- **Effective -** Composite indicator: In-hospital mortality - Infectious diseases (Risk or elevated risk in previous 3 IM reports)
- **Effective -** SSNAP Domain 2: Overall team-centred rating scores for key stroke unit indicator.
- **Caring -** Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (Risk in previous IM report)
- **Caring -** Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (Risk in previous IM report)
- **Caring -** Composite of PLACE indicators
- **Caring -** A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you?
- **Caring -** A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you?
- **Caring -** A&E Survey Q22: If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you?
- **Responsive -** Composite indicator: Referral to treatment (Risk in previous IM report)
- **Responsive -** A&E Survey Q18: Were you given enough privacy when being examined or treated?

### Key intelligence indicators

#### Safety

- one never event in 2014 (misplaced NG tube).
- 125 serious incidents in 2014 (Including 21 grade 3 pressure ulcers, 21 slips/trips/falls, 17 unexpected admissions to maternity, seven ambulance delays, six unexpected deaths and three child deaths). However there was a significant backlog in investigating and reporting serious incidents.
- Clostridium difficile: A total of 19 cases were reported by the trust between April 2014 and January 2015.
- MRSA: Three confirmed (and one unconfirmed) case between April 2014 and January 2015.

#### Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – no evidence of risk at trust level
- Summary Hospital-level Mortality Indicator (SHMI) – no evidence of risk at trust level
- Data not available at individual site level.

#### Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 17%, which was worse than the national average of 53%.
- The average Friends and Family score for inpatients was 71, which is less than the national average of 74. The response rate was 54%, which was better than the national average of 30%.
- The Friends and Family score for maternity (antenatal) in July 2014 was 71, which was better than the England average of 62. The score for maternity (birth) was 55, which was worse than the England average of 77. The average score for maternity (postnatal) was 45, which was worse than the England average of 65.

#### Responsive

- A&E, four-hour target – Average of 80% of patients seen within four hours in 2014

#### Well-led

- Staff survey 2013, overall engagement score: 3.70. Slightly worse than the England average of 3.73.
- The results of the 2013 NHS Staff Survey demonstrated that for Barking, Havering and Redbridge Trust, the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
  - as expected in 16 key areas
  - better than average in one key area
  - worse than average in 11 key areas
- The response rate for the staff survey was lower than the national average with a response rate of 33% compared to 49% national average.
- Breakdown by individual hospital site is not available.

### What people who use the trust's services say

Friends and Family Test (FFT)

- As above in 'Caring'

NHS Choices ratings:

Overall 3.5/5 (346 ratings)

# Detailed findings

Staff co-operation 3.5/5 (358 ratings)

Dignity and respect 3.5/5 (354 ratings)

Involvement in decisions 3.5/5 (348 ratings)

Same-sex accommodation 4/5 (294 ratings)

## Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Critical care | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Maternity and gynaecology | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Services for children and young people | Requires improvement | Requires improvement | Good | Inadequate | Requires improvement | Requires improvement |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Requires improvement | Not rated | Good | Inadequate | Requires improvement | Requires improvement |
| Overall | Requires improvement | Requires improvement | Good | Inadequate | Requires improvement | Requires improvement |

**Notes**

Currently we do not have efficient evidence to rate Effective in outpatients and diagnostic imaging

# Urgent and emergency services

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

## Information about the service

The service comprises an accident and emergency (A&E) department, an urgent care centre and a small dedicated children's A&E department in an area within the main department. The A&E department is open 24 hours a day, seven days a week.

It treats people with serious and life threatening emergencies. People with less urgent problems and those with minor injuries are treated in the urgent care centre until midnight. The department was originally built to care for 90,000 patients. The trust has one of the highest number of attendances in England, with 146,000 people attending the hospital in the financial year 2013/14. Approximately 27,750 attendances (19%) were aged under 17.

The department has an eight bay resuscitation room with one bay designated for children. The major treatment area has 25 trolley bays and the children's department has 10. There is a new treatment area called 'majors lite', which has seven patient trolleys. There is a dedicated room suitable for the assessment of people with acute mental health issues. There is no designated health-based place of safety for people detained under section 136 of the Mental Health Act at the hospital.

We visited over four days from 4 March 2015 to 6 March 2015 and returned unannounced on Saturday 14 March 2015. We spoke with over 12 patients and their close family members or friends, and over 30 members of staff, including doctors, nurses, administration staff and ambulance crews, as well as clinical, nursing, governance and managerial leads. We also reviewed 22 patient records and observed care and treatment.

# Urgent and emergency services

## Summary of findings

We found there were improvements in responsiveness to patient's needs since our last inspection in October 2013. The patient flow had improved. However, at times, there were still significant delays in initial clinical assessment. Implementation of evidence-based guidelines was variable. Outcomes of treatment were monitored but the results of monitoring were not always used effectively to improve quality.

We observed people being treated with kindness, dignity and respect and people told us they were satisfied with the care and treatment that they had received.

Safety was not a sufficient priority in the A&E department. There were not enough skilled staff and staff did not always recognise concerns, incidents or near misses. There was little evidence of learning from events or incidents in order to improve treatment or care. We identified that some medical staff were not competent in providing emergency care and treatment. The leadership and governance of the department did not always support the delivery of high quality care and treatment. Clinical governance arrangements did not always operate effectively and risks were not always recognised or dealt with in a timely manner.

## Are urgent and emergency services safe?

**Inadequate**

Safety was not a sufficient priority. Staff did not always recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes were insufficient or too slow.

There was not enough nursing and medical staff to care and treat for the number of patients attending the department, in particular children's nurses.. Patients often experienced long delays before an initial clinical assessment. Safeguarding procedures for adults and children were not always well understood. Uptake of mandatory staff training was below the standards set by the trust.

### Incidents

- There were 210 incidents reported in total in October to December 2014. Most were reporting delays in treating patients and extreme crowding in the department.
- At the time of our inspection there was a backlog of 9 serious incidents, across the trust's emergency care services which had not been investigated within the agreed timescales.
- There were delays in investigating incidents and taking actions to prevent them happening again. For instance, the investigation of a serious incident that had taken place in January 2014 was not commenced until August 2014.
- We looked at the investigation reports of the two most recent serious incidents. One of these, regarding an intravenous infusion pump, lacked detail. Therefore it was not possible to be certain that the ensuing plan (to prevent a repeat of the incident) contained all the actions that were necessary. The actions that had been identified were not fully implemented. Although further training had been delivered to 80% of doctors, it had only been delivered to 22% of nurses. Staff had been asked to sign that they had seen and understood the new chart for recording the amount of intravenous drug that had been administered. Only 50% of nurses had done so.
- There was little evidence of learning from events or action taken to improve safety.

- We looked at minutes of departmental governance meetings held on 7 January and 28 January 2015. They did not contain any references to learning from incidents.
- We asked a variety of staff if they reported incidents. We received differing responses depending on the grade and profession of staff we spoke with. Junior staff said that they would report incidents such as patients who were admitted with pressure ulcers or safeguarding concerns but rarely needed to do so. None of the staff that we spoke with could recall receiving feedback from any of the incidents that had been reported.
- Senior staff did not recognise concerns, incidents or near misses. During our inspection we observed the rapid deterioration of a patient who had been brought in by ambulance. The situation fulfilled the criteria of an incident that should have been reported. However, when we later discussed it with senior medical and nursing staff, there were no plans to report or investigate the incident.
- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate, or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Medical staff told us that they had been informed of this new requirement for openness and transparency but had not had cause to implement it. The governance lead demonstrated a detailed knowledge of the practical application of this new responsibility.
- Nurses that we spoke with had not received any training in the Duty of Candour. Senior nursing staff were not aware of the requirements associated with it.

**Cleanliness, infection control and hygiene**

- In the national A&E survey, the trust scored worse than others in patients' opinions about the cleanliness of the department. However, during our visit we found the department to be clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- Hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection.
- Sluices were clean and well organised and clinical waste was handled and disposed of safely.
- We observed staff treating a patient who was in isolation in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.

**Environment and equipment**

- There were separate waiting areas for children and for the urgent care centre. The children's waiting area was well designed and contained a selection of toys suitable for different ages of children.
- The major treatment area was circular in design with a large staff base in the centre. This enabled staff to observe patients at all times.
- A side room was available for patients who presented with a possible cross-infection risk. We saw this room being used appropriately.
- There was a small x-ray department within the A&E department. This was well equipped and easily accessible from all areas.
- There was a good range of resuscitation and medical equipment. The equipment was regularly checked and ready for use.

**Medicines**

- Most medicines were stored correctly in locked cupboards or fridges. We found that controlled drugs and most fridge temperatures were regularly checked by staff working in the department. However, the drugs fridge in the resuscitation room had only been checked three times in the previous month, rather than daily. This meant that drugs may not have been stored at the correct temperature which could reduce their effectiveness.
- Medicines in two transfer bags, used when transferring patients to other hospitals, were six months out of date. We brought this to the attention of the nurse in charge who took immediate action to replace the medicines.
- Staff were observed to be administering intravenous fluids safely and correctly. They methodically completed details on the medication chart.
- Unused drugs were disposed of in accordance with hospital policy.

# Urgent and emergency services

**Records**

- Patients were registered on the A&E computer system and this was also used by nursing staff to record details of the initial clinical assessment.
- Thereafter, the computer system produced a paper record that was used to plan and record a patient's treatment.
- The records we looked at were clear and easy to follow. There was space to record appropriate assessment including assessment of risks, investigations, observations, advice and treatment. These had been completed in the majority of cases.
- Injury charts and pain assessment charts were at the back of the record document and were rarely used. This reduced the clarity of the information recorded.

**Safeguarding**

- Safeguarding was not given sufficient priority. Although all patients, both children and adults, were assessed for vulnerability and the risk of abuse, many staff were unaware of the action to take if a patient was considered to be vulnerable. They did not always understand safeguarding procedures or how to report concerns.
- Children's nurses and doctors with were clear about the action to take if a child was thought to be at risk of abuse. However, children were sometimes cared for by staff trained to work with adults, who did not always have this awareness.
- Very few staff had undertaken training in child or adult safeguarding in the previous 12 months. We asked to see relevant training records for nursing staff but none could be found.
- We saw evidence that some doctors had undertaken recent safeguarding training but no-one was able to demonstrate how many doctors were up to date.

**Mandatory training**

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual handling. Training took place on-line and uptake varied.
- Completion rates varied from 60% to 84% which was less than the 85% target set by the trust.

**Assessing and responding to patient risk**

- Safety concerns were not consistently identified or addressed quickly enough.
- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation room or to an allocated cubicle space. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for their arrival.
- Other patients arriving by ambulance were taken to the rapid assessment and treatment area. The aim of this area was for a senior doctor to rapidly assess and initiate treatment for the sickest patients. However, we observed many of the doctors spending time talking to ambulance crews and checking their paperwork rather than talking to the patient or assessing their condition. Some doctors subsequently spoke to the patient but others initiated a treatment plan without physically assessing the patient. This meant that opportunities to prevent or minimise harm were missed.
- In the national A&E survey the trust scored worse than others on the question: "Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to A&E staff?". We observed that the assessment process was often lengthy and sometimes resulted in ambulance patients queuing in the corridor before seeing a doctor. We raised our concerns about the assessment of ambulance patients with senior members of trust staff. When we returned for our unannounced visit we observed patients being assessed quickly and effectively so that the risk to their health was minimised.
- Patients who walked into the department or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room. They were told that they would be rapidly assessed by a senior nurse.
- This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their ongoing care. This is often known as triage.
- We observed the triage of four patients (with their consent) and found it to be thorough and effective. Pain relief was quickly offered and an explanation of the next stage of treatment was given. Triage nurses had undergone specific training before carrying out the role. However, they were not able to request x-rays for minor injuries, which caused delays for some patients.
- Guidance from the Royal College of Nursing and Royal College of Emergency Medicine (RCEM) states that, "Triage is a face to face encounter which should occur

within 15 minutes of arrival." The A&E department at Queen's Hospital was not meeting this standard. During our inspection we often saw patients waiting 50 minutes to be triaged.

- Senior staff had recognised that this was a problem and told us that, after 10am, a 'streaming' nurse would briefly assess patients before they registered with a receptionist. However, during our inspection this only happened once and for a period of about two hours. We were told that this was due to a shortage of nurses.
- Figures produced by the hospital stated that, on average, patients waited seven minutes before being assessed by a nurse or doctor, but that 5% waited up to 40 minutes.
- We looked at records of all patients who arrived from midnight until midday on the day before our inspection started. Of 132 patients who attended, only 67 (49%) were clinically assessed within 15 minutes. Ten patients (8%) waited for an hour or more. These delays meant that a patient's condition was at risk of deteriorating. We shared our concerns with senior members of staff. When we returned for our unannounced visit, all non-ambulance patients were being assessed by a senior nurse before registering at reception. This ensured that patients with serious illnesses or injuries were identified swiftly and given appropriate treatment.
- We were told that the national early warning score was not used in the department but that something similar was in use. An early warning score (EWS) is a quick and systematic way of identifying patients who are at risk of deteriorating. Scores should be calculated on a regular basis in order to assess whether a patient's condition is improving or deteriorating. Once a certain score is reached, treatment is escalated.
- We found that the EWS was not fully embedded in A&E and was not recorded for every patient. Many scores were estimated. For example, we saw that patients had been given scores of '1– 4' or '5 – 6'. This meant that there would be delays in detecting whether a patient was improving or deteriorating.
- We looked at the records of four patients in the major treatment area. Two had correct scores, one had not had any scores calculated and one score had been incorrectly calculated as zero rather than two.

**Nursing staffing**

- The lead nurse tried to achieve the staffing levels recently recommended by the National Institute for Health and Care Excellence (NICE), but there were not always enough nurses available.
- There was a particular shortage of children's nurses and nurses with additional training in caring for children in emergency departments.
- National standards for children and young people in emergency care settings state that there must be a nurse with an advanced paediatric life support qualification on each shift. This did not happen.
- The NICE recommendation to have a band 7 sister in charge of the department on each shift was not always achieved.
- In January it was reported to the board that the highest proportion of band 5 staff leaving the trust was from the emergency department and a high proportion of these were children's nurses.
- We examined the duty rota for the first day or our inspection. There were insufficient staff in the children's area, the resuscitation room and triage rooms. There was no nurse available to assess patients as soon as they arrived in the department.
- The nursing allocation sheet showed that there should have been three children's nurses on duty in the children's area. Instead there was one children's nurse and a nursery nurse. The 'majors lite' area should have had three nurses but only two were on duty. There was only one triage nurse working, rather than the two which were required to assess the patients coming to the department during the day.
- During the first night of our inspection a third of the nurses on night duty were temporary nurses from an agency. We were told that this was not unusual. Although agency nurses are fully qualified they do not always have the specialist experience needed in A&E and may not have often worked in the department before.
- We asked to see the induction checklist for agency nurses working in the A&E department, but it could not be found.

**Medical staffing**

- There were insufficient senior medical staff in the department. Eight consultant medical staff were shared with King George hospital in Ilford.
- Locum consultants were employed to boost numbers and accounted for almost 50% of consultants. Despite

this, there were only consultants in the department from 8am to 10pm. The RCEM states that there should be a consultant presence for a minimum of 16 hours a day. Queens hospital was not meeting this standard as there were only sufficient consultants for 14 hours per day.

- The department treats a high number of patients and at night, one registrar was in charge. The registrar was sometimes a locum. There was a consultant on-call for both sites from 10pm.
- Standards set by the RCEM state that there should be a minimum of eight middle grade doctors employed by an A&E department of this type. In view of the shortage of consultants most departments would increase this to 12 or 14 middle grade doctors. During our inspection only seven were employed.
- The trust had a higher number of junior medical staff (54%) than the England average (25%) that worked across both hospitals.
- Locum medical staff are fully qualified doctors but they do not always have the specialist skills required for treating patients in an emergency situation. Some locums had not worked in the department before. Those that had did not take part in training sessions and so there was no assurance that their clinical skills were up to date. We observed sub-standard clinical skills among locum medical staff during our inspection which we raised immediately.
- Two emergency paediatric consultants had recently been appointed to care for children in the department. Staff told us that they had raised clinical standards and improved working practices. They also worked at King George Hospital for part of the day. There were two weekends a month without any senior children's doctors in the department. We were told that adult consultants were available but they did not always have qualifications or experience in treating childhood emergencies.

### Major incident awareness and training

- The hospital had an up-to-date major incident plan. This provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients with a range of injuries, including those caused by burns or blasts and chemical contamination.
- Staff in the A&E department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT)
- Regular training took place and the department had been commended for the training that it provided for HAZMAT emergencies. There was clear and appropriate major incident signage throughout the department.
- Major incident audits had been carried out in 2013 and 2014 and showed good compliance with the requirements of a major incident response.
- A&E staff told us there were sufficient security staff in the hospital and that they responded rapidly when called to the department. They were trained and competent in the safe restraint of violent people.
- We observed security staff walking through the department on a regular basis. Their presence was calm and reassuring. When we spoke with them they demonstrated a good understanding of conflict resolution and the security needs of an A&E department.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Care and treatment did not always reflect current evidence-based guidance and standards. The outcomes of patient treatment were not always monitored regularly or robustly and the outcomes of monitoring were not used effectively to improve quality. Staff were not supported to participate in training and development and essential skills such as resuscitation and trauma care were lacking. There was little evidence that staff's competency to carry our emergency care had been assessed.

### Evidence-based care and treatment

- The results of monitoring of patient outcomes were not always used effectively to improve quality.
- The A&E department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided. However, they were not always followed. For instance, measurements

of patients' blood pressure, heart rate and respirations were not always recorded soon enough and rapid assessment and treatment (RAT) protocols were not followed by all staff. Minutes of a Clinical Governance meeting dated 20 August 2014 stated "Non-compliance with three or four NICE guidelines has been identified". The clinical director was planning to seek clarification. We could find no further reference to this in the minutes of later meetings

- A&E did not meet all of the national Standards for Children and Young people in Emergency Care Settings. For instance, there were times when none of the nursing staff on duty had an advanced paediatric life support qualification. There was also no clear policy regarding the admission of teenagers to adult wards.
- The department had taken part in five national clinical audits in the last four years. The results showed that they were not always complying with best practice. For instance, in 2012, an audit of diagnosis and treatment of fractured necks of femur (broken hips) took place. The results showed that 34% of patients had to wait more than an hour for pain relief and 71% of patients waited between 1-2 hours for and X-ray. Despite this poor performance, no further audits had been undertaken.
- There was particular concern regarding their treatment of sepsis. This is a life-threatening condition that can result from a serious infection. An initial audit had taken place in 2013 and the results were not as good as other A&E departments. We were told that extra training had been given to staff and that a second audit had taken place. The results had not yet been published. Despite this additional attention we observed a patient displaying the signs of sepsis being treated in a way that did not comply with national guidance.
- An audit of the number of high risk patients seen by, or discussed with, a senior doctor (Consultant sign-off) showed that the department performed slightly better than the national average.

**Pain relief**

- The A&E department participated in two College of Emergency Medicine (CEM) audits (Fractured neck of femur and renal colic) which included the management of moderate or severe pain. The audit of patients with a fractured neck of femur (a broken hip) showed that pain relief was administered in line with national guidance. Patients presenting in moderate or severe pain caused by renal colic often had to wait for an hour or more for pain relief. The audit took place in 2012 and there was no evidence of action being taken to improve treatment and there were no plans to carry out another audit.
- Although formal pain scores were not always assessed, four of the five patients that we spoke with reported that they had been offered appropriate pain relief. Records showed that this had been administered promptly and in line with hospital policy.
- We observed triage nurses offering appropriate pain relief to patients during their initial assessment.

**Nutrition and hydration**

- A new system of regularly offering drinks and snacks to patients had recently been introduced. This was known as a 'comfort round' and took place every two hours.
- We saw staff offering refreshments during the course of our visit.
- Following the assessment of a patient, intravenous fluids were prescribed and administered when clinically indicated. However, the staff we spoke with did not have any knowledge of recent NICE guidance about intravenous fluid therapy and it was not included in the list of A&E clinical guidance that we were told was followed.

**Patient outcomes**

- The department participated in RCEM audits so that it could benchmark its practice and performance against best practice and other A&E departments. In addition to audits already described, we also saw results for consultant sign-off and recording of vital signs in the major treatment area.
- Consultant sign-off looks at the number of patients that are seen by or discussed with a consultant or senior doctor. Results for Queen's Hospital were similar to other departments in England.
- The audit of recording of vital signs was undertaken in 2010. Results were not as good as other A&E departments in England and yet there had not been another audit to monitor any progress.
- Junior medical staff reported there were not enough senior staff to support them with carrying out audits.

**Competent staff**

- It was not demonstrated that staff had appropriate training and qualifications to effectively treat patients. We asked, but staff could not provide documentary evidence to demonstrate that staff in A&E were competent to perform their roles.
- Doctors and nurses told us that they had been appraised in the last year. However, some nurses had told us that this had been a rushed process and that there had not always been an opportunity to discuss the development of their skills and knowledge.
- Discussions with nurses in the department revealed that they often had not received training before carrying out vital roles. For instance, a nurse working in the resuscitation room did not have an advanced or intermediate life support qualification. They had not received any training in the care of patients with traumatic injuries.
- Staff were not supported to participate in training or professional development. Training records held in the department showed that four nurses had a valid qualification in advanced life support. We were told that intermediate life support training was restricted to band 7 nurses and above. The same records showed that none of the nurses had undertaken training in major trauma nursing and only nine nurses were competent to apply plaster casts to broken limbs.
- We asked, but staff could not provide us with evidence of staff who had completed basic life support training. Resuscitation training staff, however, told us they provided training.
- We were told that job descriptions did not include details of the competencies required for senior roles. We asked for documentary evidence but this was not provided.
- We were shown the training records of one of the doctors in the department. This contained evidence of appropriate training and qualifications. However, records for other doctors were not offered and no alternative evidence for the competency of doctors was supplied.

**Multidisciplinary working**

- We observed multidisciplinary working within the A&E department. This included effective working relations with specialty doctors and nurses, social workers and GPs.
- There was a good working relationship with the child safeguarding team and the community paediatric team.

**Seven-day services**

- The department had access to radiology support 24 hours a day. However, we were told that response times at night were sometimes very slow and that this sometimes had an adverse impact on patient care. We observed an example of this during the course of an evening and saw details described in incident reports.
- Emergency department consultants provided cover 24 hours a day, seven days a week, either directly within the department or on call. However, the on-call consultant was shared with King George Hospital and there was a possibility that they would not always be available when needed.
- The A&E department has access to an on-call pharmacist at night who is able to provide emergency medicines and who attends to deal with any queries or issues with medicines on the ward.

**Access to information**

- Staff had access to electronic patient records and this enabled them to view previous inpatient and outpatient attendances, care and treatment given and plans in place. This helped to ensure duplication did not occur, and that up to date information was available.
- Paper records were filed methodically and were readily available when staff needed to view them.
- A&E staff were able to view blood results through the pathology laboratory computer system. On two occasions during our inspection the computer system stopped working and it was difficult to obtain blood results. The problems had been escalated to senior staff.

**Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had extensive knowledge about consent and mental capacity.
- Senior staff spoke of a commitment to the use of new mental capacity assessment forms but they were not able to show us any examples during the inspection.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious,

we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

## Are urgent and emergency services caring?

Requires improvement

The national A&E survey indicated that patients were not always provided with compassionate care and were not always involved in their care and treatment. In the NHS Friends and Family Test, only 75% of people said that they would recommend the service. However, we observed staff treating patients in the department with respect, kindness and consideration. Patients, their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures and background.

### Compassionate care

- In the national A&E survey 2014, the trust was one of the worst performers in the country and scored worse than other trusts in 13 out of 24 indicators relating to caring. It scored the same as other trusts in the remaining 11 indicators. However, throughout our inspection we observed patients being treated with compassion, dignity and respect.
- The emergency department participated in the NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received). A reasonable percentage of people (20%) who attended the department took part. This is above average compared to the rest of England. Seventy-five per cent of people said that they would recommend the service.
- We observed that patients were given enough privacy when being examined and having discussions about treatment plans. However, the national A&E survey reported that the trust was worse than other trusts for giving enough privacy when being examined.
- We saw that staff respected patients' choices and preferences and were supportive of their cultures and background.

### Patient understanding and involvement

- All patients we spoke with said that they had been involved in the planning of their care and had understood what had been said to them. The parents of children were particularly complimentary about involvement in treatment plans.
- Patients we spoke with were satisfied with the amount of information they were given.

### Emotional support

- We observed staff giving emotional support to patients and their families. They were given enough privacy when being examined and having discussions about treatment plans.
- Records following deaths in the department showed that relatives had been offered appropriate support by A&E staff.

## Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement

Improvements had been made since our last inspection so that people were more likely to be able to access the right care and treatment at the right time. Progress was being made in achieving national targets for patients being treated, admitted or discharged within four hours. Delays in initial clinical assessment remained but there was an increased focus on meeting people's individual needs. There was little evidence that the department used learning from complaints to improve patient care.

### Service planning and delivery to meet the needs of local people

- As part of the trust's improvement plan to improve the emergency pathway for patients, commissioners and other stakeholders had been involved in planning services. For example the redesign of 'majors lite' and the implementation of the elderly receiving unit.
- We saw a copy of the department's escalation plan that described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances which would create significant demand for services. Staff were

familiar with this and knew the actions that they needed to take if it was implemented. Since our last inspection staff were more confident in escalating patient flow concerns.

- The clinical site managers visited the A&E department day and night to discuss patients who may need admission with the nurse in charge. There was an increased visibility of senior clinical staff and managers to facilitate planning to meet the needs of patients. Wards were identified at this point and capacity was constantly monitored.
- Processes had been streamlined to ensure patients were referred quickly from the emergency department into the medical and elderly units. This allowed patients to be seen by the most appropriate healthcare professional and freed up the emergency department for patients who needed emergency care.

**Meeting people's individual needs**

- People with dementia and learning difficulties were given special consideration. Discussions were held at a pace that suited the individual and simple terms were used to help people understand what was happening. However at a trust listening event some members of the public raised that greater awareness of dementia and learning disabilities was needed by all staff.
- There was a lead nurse for people with learning disabilities who taught nursing staff about the needs of this group of people and helped them respond appropriately.
- The lead nurse for people with dementia had recently introduced the 'Butterfly scheme' to A&E. This is a national scheme where staff are taught essential skills to allow them to care well for these patients. Although there had not been time to teach everyone there was a heightened awareness of the needs of people living with dementia and information displayed throughout the department.
- Staff in the children's department showed us a copy of the protocol that they followed for children with complex needs. This had recently been introduced and ensured that competing clinical needs were prioritised appropriately. There was no similar protocol for adults with complex needs. We were told that they would be treated by a senior doctor who had the experience necessary to meet their needs.
- The 'majors lite' area was used for patients with moderate illnesses and injuries and who were unlikely to need to be admitted to the main hospital. It was well used but not well signposted. Two relatives that we spoke with found the name confusing.
- There were two quiet sitting rooms where distressed relatives could sit in a private space. There were noticeboards containing helpful information about the hospital and support services.
- It was not always possible to maintain patient confidentiality at all times. Patient cubicles were separated by curtains and it was possible to overhear sensitive or confidential conversations from the adjacent cubicle.
- Staff described the translation services that were available to the department. They were familiar with their use.
- Children's needs were met by the provision of age appropriate toys and activities, a separate waiting area and different pain scoring tools. However, the department did not employ a play therapist to distract children while they were receiving treatment.
- The children's reception area was small and people often had to sit next to the reception desk. This meant that confidential information about children was often overheard.
- Care provision for children with autism had recently been reviewed and an information document had been given to staff who regularly worked in the children's department.
- We saw there were leaflets available about a number of health conditions, about the A&E department and about what patients could expect from the service.

**Access and flow**

- In the past there have been long waiting times for the majority of patients who attended A&E.
- Ambulance crews often had to wait for extended periods of time before they could handover a patient to clinical staff in the department. For instance, in November 2014 nine crews had to wait for more than an hour before they could handover their patient. During that month fewer than 80% of patients were treated, discharged or admitted within for hours. Standards set by the government state that 95% of patients must be admitted or discharged within four hours. Queens Hospital had failed to meet that target for all of 2014.

- In addition, during 2014, approximately 5 % of patients left the department without being seen. This is more than the national average.
- We were told that six weeks ago the hospital had implemented a Full Capacity protocol. This streamlined processes throughout A&E and the whole hospital so that patients could be treated more quickly.
- We looked at records of all patients in the department on the day before our visit and two weeks previously. On both occasions 92% of patients had been discharged or admitted within four hours. This was a considerable improvement compared to our last inspection.
- As previously described, the rapid assessment and treatment process was not always as efficient as it was designed to be. On occasions we saw ambulance crews queuing to handover their patients, but never for more than 20 minutes.
- We do not have official figures for ambulance waiting times for the last six weeks. However, crews that we spoke with reported much shorter waiting times than previously.

### Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would formally log the complaint and attempt to resolve the issue within a set period of time. PALS information was available in the main waiting room.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant in an agreed timeframe. One of the consultants told us that he often gave a verbal explanation to people as it was easier to explain complex situations.
- We saw that staff working in the children's department learned from complaints and changed practice if necessary. For instance, the care and treatment of children with autism had recently been changed.
- We could find little evidence that practice was changed or that learning was shared in the rest of the A&E department. We looked at two sets of clinical governance meeting minutes and, on both occasions, discussions of complaints had been deferred.
- Minutes of sisters' meetings showed that discussions of two complaints had taken place. However, there was no action plan and no-one was given responsibility for ensuring that all nursing staff were aware of the complaints or the actions required to improve care.

## Are urgent and emergency services well-led?

Requires improvement

There was no clear vision and strategy for the service. Leadership was visible and directly involved in clinical activity. However, department leaders' understanding of risks and issues did not always correspond with those described by the majority of the staff. There was a positive culture of passion, responsibility, innovation, drive and empowerment (PRIDE) and putting patients first. Leadership and governance of the department did not always operate effectively and risks were not dealt with in a timely way.

### Vision and strategy for this service

- The executive team and senior stakeholders were aware of a five year plan for the emergency department, however we were told there were a number of different visions, and staff had their own views, but there was no cohesive vision and strategy that staff in the service were engaged with. There was no statement of vision or guiding values.
- There was a consensus from staff that the service as 'fire-fighting' to meet the increasing demand.

### Governance, risk management and quality measurement

- The governance structure of the department included a dedicated lead and fortnightly meetings to discuss governance and quality issues.
- We found that arrangements for governance and performance management did not always operate effectively. Clinical governance meetings did not routinely discuss actions to address the backlog in serious incidents, complaints and inquests.
- Risks and issues were not always dealt with appropriately or in a timely way. For instance, an unexpected death did not result in an immediate

investigation to see if it could have been avoided. Instead, the department relied on a coroner's report to investigate the treatment provided. This often took many weeks and immediate action could not be taken.
- The highest risk on the A&E risk register was severe crowding in the department resulting in long delays in the treatment of patients. We were told that this was not listed on the hospital risk register. Senior staff were unaware of the actions necessary for it to be escalated onto the hospital risk register.
- Risks and issues described by staff did not correspond with those that were understood by departmental leaders. Staff told us they were very concerned about delays in performing CT scans for severely injured patients and also delays in receiving the reports. We observed these delays during our inspection but when we discussed them with senior consultants they were unaware of many of the details of the problem.
- Senior consultants were unaware of a serious incident that took place in the resuscitation room 10 days previously.

**Culture within the service**

- Staff knew and believed in the corporate values of passion, responsibility, innovation, drive and empowerment (PRIDE). They felt the new executive team were making a difference to the hospital.
- Staff in the children's department told us that they felt valued and respected. One said, "This is a great team."
- Clinical staff in the rest of the department were not always so positive. There was a sense of weariness from many of them. Staff shortages and lack of training were seen as long-term problems.
- Reception staff were positive and well-motivated. They felt supported by senior staff.

**Leadership of the service**

- Leadership and management of the A&E department were shared between the clinical lead and matron. Both were visible within the department and the clinical lead took an active role in the treatment of patients.
- The matron was supported by a lead nurse who was actively involved in patient care and supporting staff.
- Leadership of the department on a day-to-day basis was clear and visible. Nurses always knew who was in charge and who they could call on if help was needed.
- Administration staff were not always made aware of changes or the rationale for them. There was a high turnover of non-clinical managers, which affected the leadership of the service.

**Public and staff engagement**

- There was no evidence displayed in the department of changes made as a result of patient feedback such as waiting times, the NHS Friends and Family Test or the 'patient-led assessment of the care environment' (PLACE).
- Although staff told us that they looked after each other after disturbing incidents they also said that there was no time for structured debriefing sessions. There was no knowledge of support that might be available from the rest of the hospital.
- The majority of staff were not aware of the guardian service - an anonymous whistleblowing service.

**Innovation, improvement and sustainability**

- Significant improvements have been made in the time taken to see and treat patients.
- The introduction of a treatment area (known as the observation ward) dedicated to patients who could go home after treatment had greatly improved patient experience.
- The hospital was working closely with the London Ambulance Service to ensure a safe and quick handover of patients. The London Ambulance Service based the hospital ambulance liaison officer (known as a HALO) at the ED. The role of the HALO was to work in partnership with the ED to support the effective and efficient management of patient streams, particularly patient handover and ambulance turnaround times within the department. Staff at both trusts reported this partnership working well.

# Medical care (including older people's care)

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

## Information about the service

The medical care and care of the elderly services are managed by the acute medicine clinical division. This division includes the specialties of acute assessment, ambulatory care, respiratory medicine, renal medicine, cardiology, gastroenterology, hepatology and diabetes and endocrine care.

The services have a bed complement of 786 beds, of which 684 are inpatients beds, and provides around 38,700 episodes of care per annum (2013/14).

We spoke with 24 patients and 12 relatives/visitors. We spoke with 41 doctors including clinical leads and 14 consultants, nine middle grade doctors and 12 junior doctors. We spoke with more than 40 registered nurses, including five matrons and nine specialist nurses. We spoke with 18 healthcare assistants, seven Allied Healthcare Professionals, two technicians and five senior managers. We observed care and the environment in which it was delivered, and we looked at records, including patient care records. We reviewed documents including audit results, action plans, policies and management information reports. During our inspection we visited all the acute medical care wards, all the care of the elderly wards, the coronary care unit, the clinical diagnostic unit, the elderly receiving unit and the medical receiving unit.

## Summary of findings

There were shortages in medical, nursing and therapy staff groups. The trust was recruiting, but this was taking time. The shortages impacted on staff's ability to complete all their duties within each shift, take up additional training opportunities and for junior medical staff to undertake professional mandatory training. Where this was prioritised the result was gaps in the doctors' rota, which in turn affected patient safety and the other doctors covering the shifts. Middle grade and junior doctors raised significant concerns about the rota. We found there was a lack of coordination of the rota, the electronic version was not up to date, and there was no formal forum for this to be discussed and managed.

Patients were cared for on non-specialty or other specialty wards due to inpatient capacity issues. There was a team on the rota to oversee care and treatment for medical outliers, but we found that there were some delays in doctors being able to see all the patients in the different areas. This also resulted in several ward moves for some patients as they did not get the right care in the right clinical area first time.

We found nursing staff did not comply with the trust policy for intravenous administration where there should have been two registered nurses involved in the checking process. Nursing staff told us that staff

# Medical care (including older people's care)

shortages made this difficult to comply with. Governance processes were not clear for all staff across all the specialties. Staff provided kind, compassionate care that preserved patients' dignity.

Patients were supported emotionally and received enough information to be involved in their care and treatment. There was multi-disciplinary working to plan care to meet each individual patient's needs. The executive team were accessible and visible. Staff felt well supported by their peers and line managers.

## Are medical care services safe?

Requires improvement

There were processes in place to report incidents and staff demonstrated understanding of these. It was mainly nurses that reported incidents with less reported by doctors. Incidents were investigated and discussed at appropriate departmental and trust forums, but escalation further was not clear. We saw changes made following investigation but it was not always clear how wider learning happened. There was a backlog in the investigation of serious incidents.

Patients were cared for and treated in an appropriate, well maintained environment that met their needs. Equipment was well maintained. The IT systems were inefficient. The environment was clean and staff used recognised methods to prevent the spread of infection. There was poor compliance with the weekly hand hygiene audits.

There were known concerns regarding nursing, therapy and medical staffing levels. There were high vacancy levels across the service, particularly in care of the elderly areas. There was on-going recruitment and new staff were starting regularly. The constant work to cover wards so that they did not become unsafe put pressure on all staff and impacted on many aspects of their work. For doctors it was sometimes difficult to get to all patients, particularly medical outliers on surgical and other medical wards. For nursing staff, fully completing the complex nursing documentation whilst undertaking care and treatment was difficult when understaffed. However, generally staff were well trained for their roles.

Middle grade and junior doctors raised significant concerns about the general medicine rota. We were told that it was uncoordinated, rarely up-to-date and created gaps in shifts.

We found non-compliance with the trust medicines policies in respect of IV medicines. Otherwise medicines were prescribed, administered and stored well. Record keeping was of a good standard. There were systems to identify deteriorating patients and systems to safeguard vulnerable adults and children.

**Incidents**

- Staff reported incidents on the trust electronic system. Nursing staff described incidents they had reported, for example following a patient fall. Junior doctors we spoke with understood and were aware of the reporting process, although few had reported incidents recently.
- We were given examples such as grade two pressure ulcers on one ward following a period of over 12 months where there had been none. These were reported, investigated and action was taken. Immediate action included discussion on pressure ulcers at handover for the following two weeks.
- Feedback was emailed to the staff who reported the incident. Incidents were discussed at ward meetings and specialty meetings such as the weekly stroke meetings.
- There was a backlog of 35 serious incidents not being investigated for acute and specialist medicine and care of the elderly. We were told wards held a 'round table' initial discussion on what had gone wrong and to ensure any immediate actions had been taken.
- There had been one reported Never Event in 2014 (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken). Staff were aware of action taken following this Never Event including staff training and presentation at a clinical governance meeting.
- We observed the discussion about a reported incident where a patient had been aggressive to staff. The required support for the patient was reviewed, in particular their mental health needs and support on discharge.
- There was a trust lead for the duty of candour (DoC). Most staff we asked were unaware of the DoC that had been in place for NHS trusts since November 2014. However, they all demonstrated an understanding of informing patients and relatives and offering support when something had gone wrong.
- The matron for elderly care was aware of the DoC and said that they had started to invite patients and relatives to hear what actions and changes had been put in place following an incident investigation. It was described as embryonic, but starting.
- Mortality and morbidity meetings were held within departments and were specialty specific for lesson learning. We were told there was no process to highlight and share learning more widely.

**Safety Thermometer**

- Wards displayed their monthly quality data on boards. We saw several boards, for example where an elderly ward had had no pressure ulcers, MRSA or Clostridium difficile (C. difficile) up to 19 March 2015. There had been three falls and one medication omission. We found only one ward where this information was not displayed.
- A new dashboard was being rolled out during the inspection. We saw evidence of these on two wards we visited. Senior nurses were positive about these as all the information was included in one report. These included, for example, acuity and dependency of patients, falls, length of stay, pressure ulcers and NHS Friends and Family Test results. The report also provided monthly data from July 2014, which enabled ward managers to monitor trends on a regular basis.
- Where the new dashboard was not yet in place the information came from a variety of sources. These included falls, pressure ulcers, infection control and infection rates. All wards but one that we visited had these monthly reports displayed on staff boards and told us they were discussed at the ward meetings. One ward did not display them and was unclear on how they were discussed.

**Cleanliness, infection control and hygiene**

- All areas we visited were visibly clean and tidy. We saw housekeeping staff supplied with colour coded cleaning equipment to assist in avoiding cross contamination.
- We observed staff complying with the trust's dress code, which included being 'bare below the elbow' to facilitate full hand washing. Staff were seen using personal protective equipment such as gloves and aprons. There was good access to personal protective equipment in all the areas we visited.
- There was access to hand washing and drying facilities and we observed staff hand washing during the course of their duties. Hand hygiene was monitored in weekly audits.
- Between April 2014 and January 2015 there were 12 cases of C. difficile compared to a target of 37 for both hospitals for 2014/15.
- There was one case of MRSA compared to the expected zero up to January 2015.
- Trust-wide data showed that 73% of nursing and midwifery staff had completed level 2 training, below the trust target of 85%. Fewer medical staff had completed the training (59%).

- Equipment was cleaned by staff on the wards and labelled so that they were ready for use. We observed cleaning while on various wards.
- There were processes in place to ensure scopes were properly cleaned in the endoscopy unit. We saw that machines were checked on the first run of the day and signed off. The print outs for all cleaning cycles were checked and kept. There was a computer system for all decontamination and all checks that we observed.
- Clinical and non-clinical waste was segregated. Sharps bins were in situ, dated and not overfull.
- We were provided with audit reports undertaken by four wards as a baseline peripheral line compliance audit, after an identified case of cellulitis following cannula removal. These demonstrated that most areas complied with best practice.
- The trust's associate medical director was holding the role of director of infection prevention and control on behalf of the medical director and had been in post for two weeks.
- The trust-wide infection control team consisted of one matron, three band 7 and three band 6 nurses plus a data analyst and administrative support. Advice was accessed 24 hours a day, seven days a week. Unplanned visits were made to clinical areas across the two hospitals, both in and out of hours.
- There was one medical ward with an outbreak of diarrhoea and vomiting during our visit. Patients had been grouped into one bay on the ward and there were clear signs for other patients and visitors to be aware. We saw that extra hand washing facilities had been brought to the ward. Staff observed infection control practices by leaving all protective clothing used in bins on the bays and thoroughly washing their hands. There had been no new cases since the infection control team had been involved so the bay could be thoroughly cleaned and returned to normal use.
- The infection control team were involved in bed management every day at 3pm even if there was nothing to report. Every evening the team updated the trust microbiologist. There were link practitioners in all clinical areas.
- Monthly reports were prepared for the wards and we reviewed the January 2015 report for acute medicine and care of the elderly. Staff on the wards were responsible for carrying out infection control audits but there were many areas where this had either not happened or the wards had not passed the results to the infection control team. There were high numbers of nil returns and particularly poor compliance with hand hygiene. It was not clear how this was fed back to the wards, or how compliance was to be improved. Trust data provided for weekly hand hygiene audits between 4 November and 2 December 2014 showed that within medicine and elderly care at Queen's Hospital, out of a possible 18 wards and units only three had completed the audit every week. These included the clinical decision unit, which had reasonable results, Sahara B Ward (with 100% for each week) and Sunrise B Ward with generally poor results. We did not see any evidence of action plans or proposals for raising standards.

**Environment and equipment**

- The patient-led assessments of the care environment (PLACE) for Queen's Hospital in 2014 achieved a score of 94% for cleanliness and 88% for condition, appearance and maintenance. Concerns identified included refurbishment of public toilets and lack of bedside televisions and radios. An action plan was in place and work to address these concerns was on-going.
- We saw resuscitation equipment accessible in all clinical areas we visited. We saw evidence that the daily checking processes had been completed to ensure they were ready for use.
- All staff told us and we observed that the IT systems were inefficient and archaic. Locum doctors did not have access to the systems, which resulted in trust doctors being pulled away from their work to support them. Many requests such as for CT scans and phlebotomy required paper forms to be completed and hand delivered to the relevant department. This resulted in a great deal of time taken away from providing patient care to complete all the patient details and take forms to the relevant departments.
- There was a general lack of computers on most of the wards. The computers held patient information, procedures and policies for staff to follow.
- We observed and found evidence that equipment on the wards was regularly serviced, maintained and, where relevant, calibrated. These included equipment such as hoists, electronic assisted bathing equipment and weighing scales.
- There was a checklist in place for staff to sign on each shift to assure that, for example, suction, oxygen, emergency buzzers and call bells were working. We saw evidence that these were completed for each bay.

- There was a checklist in place for staff to sign on each shift to assure that, for example, suction, oxygen, emergency buzzer, call bells were working. We saw evidence that these were completed for each bay.
- Occupational therapy staff worked with four different boroughs to arrange necessary equipment in order for patients to return to their homes. This meant that staff had to order equipment through four different systems. This was particularly difficult for patients on the border of their borough and could cause delays to discharges.

**Medicines**

- We observed many occasions of non-compliance with the trust's current 'Medicines care, custody, prescribing and administration' policy in respect of intravenous drug administration. The policy stated in paragraph 4.7.1 that a second person must be involved for intravenous drug administration. We found that this did not happen for a high number of administered doses.
- The four wards we focused on included general medical and chest patients, oncology patients and elderly care patients. We looked at a total of 30 medicine charts that included 789 drug doses. Of these 35% were signed by a single nurse only. Staff we spoke with were aware of the policy. We were told that, due to staff shortages, it was not always possible to have double checking.
- We were told that on the oncology ward it was usual practice for some intravenous doses to be checked by one member of staff, for example Tazocin. Others, such as magnesium sulphate, would be checked by two staff, but the trust policy did not state this or reference any other policy. A patient checklist for chemotherapy had been introduced. Patients read the name on the bag of chemotherapy and confirmed it was for them. If the patient was visually impaired or had communication difficulties then they would check with the family or have a second nurse check.
- We observed two examples of poor practice on the oncology ward. In one instance the nurse did not check the patient's date of birth, only their name. This could pose a risk as there can be two patients with the same name on the same ward. The other instance was where the nurse drew up three patients' intravenous medications at the same time. The nurse then took the three trays to the first patient, resting the other two on the patient's bed. This increased the risk of medication error and was also poor infection control practice. These findings were escalated to the executive team at the time of the inspection visit.
- Patients and relatives told us that their medication was reviewed by staff and we saw evidence in the patient records we looked at.
- We saw safe storage of medicines in locked cupboards in entry controlled rooms. Compliance with controlled drug storage was in place. There were processes for undertaking routine counts of stock, with signatures to support such checks. There were medicine fridges with temperature checks in place for medicines requiring cold storage.
- We spoke with a pharmacist who provided a top-up service for the ward. They described a good working relationship with ward staff who were equally positive about the pharmacy service provision.
- We received information about medication errors from a relative. They were told that these had been reported through the incident process. Staff described another medicine incident and how this had been investigated. This had been discussed with the patient and their family and support offered. Nursing staff had been supported and learning had taken place. Medication errors was a consistent incident theme reported to the board.

**Records**

- The quality and detail of documentation had improved since our last inspection.
- Trust-wide figures showed 75% of nurses and midwives attended training on information governance in the year to November 2014. The figure for medical staff was 78%. The trust target was 85%.
- Patients had medical records that were stored securely on the wards that the doctors completed. Any other confidential information was also recorded in those records. There were also nursing notes for each patient and these were stored at the entrance to the bays, in view of staff.
- Following nurse handover we saw that the senior nurse on the ward checked the patient nursing records.
- Nursing staff told us there was too much documentation, not all of which was required for all patients, as well as considerable duplication in some areas of care. Staff said they spent too much time completing documentation, which impacted on their

time caring for the patients. However, the hospital was introducing new documentation and we saw where it was in place on one ward. All nursing staff we spoke with were very positive about the new documentation and it releasing them to spend more time giving patient care.

- We looked at a selection of patient records in different specialty areas and found they covered all aspects of care, were up to date and reflected the care and treatment the patient received. There were some instances where there were gaps, for example the visual infusion phlebitis score was not always recorded (this is an international tool for monitoring infusion sites).
- We found inconsistent documentation in respect of falls risk assessments and bed rail assessments. We also found an incident where the wrong assessment was completed.
- A records audit completed in January 2014 in the care of the elderly found poor results, for example there was no specific filing order and an increase in the percentage of deletions that were not signed. An ongoing monthly audit of 10 records with the results discussed directly with staff and at ward meetings was introduced.

**Safeguarding**

- The deputy chief nurse was the trust safeguarding lead. The role was supported by a lead nurse for safeguarding vulnerable adults and they worked as a team with the children's safeguarding leads and the lead nurse for learning disabilities.
- There were trust safeguarding policies and processes in place. Staff demonstrated a good understanding of the process and knew how to raise a safeguarding alert and who to contact.
- We saw that the majority of staff had received training in safeguarding children and vulnerable adults at level 2. Trust-wide nursing and midwifery staff exceeded 95%. However for medical staff the rates were lower, at 63%.
- On Clementine B Ward staff had completed level 1 training instead of level 2. We asked for and were not given an explanation about why this was.
- We were provided with evidence of shared learning from safeguarding incidents. One example related to information on wound care following discharge. This was incorporated into the trust training programme.

**Mandatory training**

- All training was recorded on the trust database and all staff had access to their own account on the electronic system. Reminders for mandatory training were sent out. We saw examples of ward staff completion of mandatory training. Reports could be generated by the trust database.
- Nursing staff told us they were supported to attend mandatory training. We saw evidence that the majority had completed most mandatory training. On Clementine B Ward we saw that 25 out of 27 had completed infection control training, and 22 out of 27 were in date for fire safety training. On Sky A Ward we saw 18 out of 30 nurses were trained in infection control and 25 out of 30 had had fire safety training.
- Ninety-one per cent of nurses had completed sepsis training. This was an improvement from our last inspection.
- Health and safety training as well as fire safety training formed part of the mandatory training programme. Trust data provided for the year to November 2014, which showed that 95% of nurses and midwives attended health and safety training and 75% had had fire safety training. The target for both subjects was 85%.
- Where trust-wide data were provided we saw that overall nursing staff were achieving the 85% target of completing training. For medical staff the rates were lower. For example, resuscitation training was at 88% for nursing staff and 79% for medical staff.
- Recently appointed staff we spoke with said that their mandatory training had been included in their induction programme.
- We found there were areas with a low uptake in mandatory equality and diversity training. On Clementine B Ward, only seven out of 27 staff had completed the training. However, 22 out of 30 had completed the training on Sky A Ward. We were told this was improving, and trust data for acute medicine showed 77% of staff trained, with 83% trained in care of the elderly.

**Assessing and responding to patient risk**

- There was an early warning system (EWS) in place to identify deteriorating patients. The majority were completed and accurate recording and escalating was audited monthly. We found one chart clearly showing patient deterioration but no escalation to doctors had been noted at the time. Audits also identified some miscalculations and lack of escalation. These were clearly monitored and fed back to the wards at the time the audit was undertaken.

- The EWS protocol directed what action should be taken and we saw evidence where this had happened. The critical care outreach team was accessible and responsive when called to support a deteriorating patient.
- Required risk assessments had been undertaken for patients when we looked at their records. We found a few examples where action following risk assessment or observed changes had not been acted on. One example was where bedrail use had not been updated following a change in the patient's orientation and confusion level. Another was where a patient assessed as being at a high risk for falls had not been put on the falls pathway. We found some gaps in risk assessments and reassessments. For example, reassessments for a patient with a high risk of pressure ulcers were not recorded as regularly as would have been expected. However, care and treatment, for example the turning charts, were fully completed.
- Each ward had a dedicated member of staff known as the 'falls champion' and a revised falls assessment was due the week following our inspection. We saw many examples of actively mitigating the risk of patient falls. Examples included patients wearing slipper socks and utilising a low bed if they had been assessed as at risk of falling out of bed. Staff understood that using bedrails could make a fall worse. We found that bed rail assessments were not always completed, or reassessments done, in a timely manner.
- There was a lead tissue viability nurse to support and advise on conditions such as pressure ulcers and wound care. Staff used universal screening tools to assess the level of risk for patients. Turning charts were seen in place for patients assessed at high risk.
- We saw clear and detailed documentation about individual patient risks in the medical notes we looked at.
- There were daily ward rounds to reassess and check patients, and these were recorded in patient records.

**Nursing staffing**

- We found that all the medical and elderly wards we visited had vacancies and experienced shortages of nursing staff. For some wards this was less of an issue, for example the stroke ward and the coronary care unit. Senior staff were aware and had a workforce improvement plan. New staff were regularly being employed and the numbers were slowly improving. This work was monitored and demonstrated by the twice monthly updated workforce project plan. The vacancy rate data showed care of the elderly at 21% and acute medicine at 11% (care of the elderly registered nurses at 23% and acute medicine at 11%, care of the elderly medical career grades at 29% and acute medicine at 16%).

- Staffing levels were displayed on all the wards we visited. These showed planned and actual numbers. We saw several examples where there were nursing shortages. Sunrise B Ward for elderly patients was short one registered and one non-registered nurse for both early and late shifts, but the night shift was covered. On discussion with the ward sister and checking the rota we saw that earlier in the week staffing levels had been sufficient but with one day covered by agency staff.
- The high acuity ward were two registered nurses down on the early shift (four instead of six) and one on the late shift (four instead of five).

- On the elderly receiving unit (ERU) there had been a recruitment drive since its opening in November 2014. At the time of the inspection it had recently appointed 14 registered and five non-registered nurses, and was advertising for two vacancies.
- Short-notice sickness was difficult to cover. However, we saw safe staffing levels were discussed at the bed meetings held three times a day. Senior nursing staff decided where staff could be moved from better staffed wards to try and cover a ward considered unsafe.
- On the oncology ward the healthcare assistants looked after 10 patients in the day and 15 at night.
- Staff on the elderly care wards said the staffing issues were of great concern. We were told there were not always enough nurses to care for patients who needed extra attention. Sometimes two nurses cared for 31 patients. We saw an example where one of the elderly care wards were short two registered and one non-registered nurse on the early shift, and short one registered on both the late and night shifts. These concerns were reflected as a "Shortfall of Nursing Staff" on the care of the elderly risk register that we were provided with.
- Staffing levels were calculated using acuity tools such as the NHS Development Institute for Innovation and

Improvement Safer Nursing Care tool. On two wards we were shown that there had been an increase by one registered nurse because of the identified increase in patients' acuity.

- There were known concerns about the increasing clinical needs of patients and the increased requirement for rehabilitation and we were told that this was not resourced fully with the current staff numbers.
- We observed nursing handovers and heard comprehensive discussions for each patient. Discussions included: emotional needs, communication, observations, mobility and activities for daily living. Patient safety was discussed, for example a do not attempt cardio-pulmonary resuscitation (DNA CPR) had been put in place for a patient and this was highlighted during handover. Patients with catheters and intravenous access were also handed over. Tasks required were clarified at handover.
- Handover took from 45 minutes to one hour to complete. Staff told us they stayed after their shifts in order to complete handover. One nurse told us that this issue had been discussed among themselves with ideas for improvement put forward to management, but they did not feel listened to.
- Integrated therapies at the trust included occupational therapy, physiotherapy, speech and language therapy (SALT), cardiac rehabilitation and dietetics. SALT and dietetics had been managed for many years by another NHS organisation under a service level agreement. Access to the therapies had been on the departmental risk register for a few years but the business cases put forward were rejected.
- The SALT service level agreement had not been regularly reviewed. This had been identified through a national stroke audit (the Sentinel Stroke National Audit Programme, SSNAPP) and staff described difficulties accessing SALT staff with the required skills to fully support patients such as those with tracheostomies. We were told that there were about 10% vacancies for occupational therapy and physiotherapy.

**Medical staffing**

- We were told that there were 25–30% unfilled posts in elderly care. This was reflected on the care of the elderly risk register. We were told that the quality of locum doctors was variable. Efforts were made to use regular and known locums. There was a consensus that the adequacy of medical staffing had improved in some areas.
- Trust data showed vacancies for all staff groups was 12%, with care of the elderly at 21% and acute medicine at 11%. Medical career grade doctor vacancies were 29% in care of the elderly and 16% in acute medicine. These rates were higher than the trust average. Senior and middle grade doctors worked on both hospital sites.
- The trust was constantly recruiting to all medical staffing levels. Trust-grade posts at middle and junior levels had been introduced to increase cover. These posts were not part of the Deanery trainee programme.
- There was an on-call rota for general medicine and one for care of the elderly. The majority of medical staff raised concerns that there was a lack of rota coordination. There was no system to feedback that the rota coordination was insufficient and needed addressing.
- All junior doctors in acute medicine were part of the general medicine rota. This meant they were frequently not available on their specialty ward from 8am Monday to Friday. When working nights they were unavailable for a full week at a time.
- We heard from a number junior medical staff that their rota did not allow for mandatory professional study time, or provide sufficient cover for annual and sick leave. Locums did not always turn up. They also had to cover medical outliers on other wards. On the first day of the inspection we found one ward with one first year junior doctor doing the ward round alone. We were told they had requested senior support several days in advance but this had not been arranged.
- Most junior doctors worked 8am to 4pm Monday to Friday and 8am to 9pm at weekends. We were told that the ratio was 1:60 (doctors to patients) when shifts were fully covered. They had only one weekend off per calendar month.
- Some middle grade doctors (specialist registrars, registrars and trust-grade registrars) were also part of the general medicine rota, with others purely covering their particular specialty.
- Medical staffing for the medical receiving unit (MRU) and ERU consisted of two consultants in the morning, one in

the afternoon and then the on-call rota for out of hours. Each consultant had two junior doctors on their team. There was consultant cover from 8am to 8pm Monday to Friday.

- Two consultants for elderly care were on site on Saturdays and Sundays. One started the ward round and one went to the ERU where all patients were seen. New admissions and patients where concerns had been identified were seen on the wards.
- We were told that the consultant on call worked well. They worked one in eight weekends and one in 17 days night cover. At nights there was one chest physician, one gastroenterologist and one general physician working across both sites'. At weekends, during the day, there were one acute medical consultant and one general medical consultant.
- There was a cardiology consultant on call 24 hours a day for both hospital sites at weekends. There was a consultant ward round on Saturday at one hospital and on Sunday at the other.
- The stroke unit was planned to be and was sufficiently staffed.
- During the inspection we found some examples of poor staffing levels. In the coronary care unit (CCU) there was only one out of three registrars. We were told they "sometimes have two". On Clementine B Ward there were three registrars and no junior doctors. Of the four juniors, two were on the same study day, one was on nights and one was on annual leave. On Sky A Ward there were three instead of six doctors. There should be two registrars and four junior doctors. On that day there were three junior doctors. One registrar was on call, there was one vacancy and one junior doctor was on call. We were told it was rare that they had the full complement of six doctors.
- We were constantly told by medical staff we spoke with of risks and concerns such as: lack of a medical consultant on site from 8pm to 8am, the high number and variable quality of locums, delays in seeing medical outlier patients, the high number of wards and patients to cover when on call, and long working hours due to frequent gaps on the rota.
- We observed good, thorough and well attended morning medical handover. Overnight patients were discussed systematically and staffing needs for patients were reviewed.

**Major incident awareness and training**

- The trust had a major incident and emergency plan and we saw clearly identified areas for management, such as command, control and communications.
- We found that staff were aware of the plans and had a broad idea of their responsibilities. Staff were clear about where they would find guidance if needed.

## Are medical care services effective?

Good

The service participated in national audits and local audit programmes were in place. Pain relief was assessed and well managed with specialist support available. Patient's food and drink needs were assessed and provided for. There was multidisciplinary working, putting patients first and the majority of staff had an understanding of the Mental Capacity Act 2005 and deprivation of liberty safeguards.

Care was evidenced-based. Patient outcomes were variable from national audits, in some cases worse than the national rate or average. There was on-going work to meet the dementia standards. Readmission rates were higher than the national average.

**Evidence-based care and treatment**

- The trust had an electronic system for staff to access clinical guidelines, trust policies and protocols. There were processes in place to ensure that practice remained in line with current guidance. National Institute for Health and Care Excellence (NICE) guidance was presented at the various clinical governance meetings.
- We saw that evidence-based pathways and protocols were in operation. Examples included: a thrombolysis protocol, an early inflammatory arthritis treatment pathway and an acute asthma pathway for adults.
- Research studies were resourced and we saw participation in national research projects.
- The respiratory guidelines we saw on the trust system had old review dates of 2011. We were informed that the 2015 guidelines were not yet live.
- The hospital was not meeting the London Emergency Care Standards in the ERU.

- All patients admitted to the MRU and ERU were reviewed twice a day by consultants and their teams. At the weekends, all patients were seen at least once a day.
- Once patients had been transferred to the medical wards they were all reviewed at least once by a consultant every 24 hours Monday to Friday. At weekends, new admissions and patients where concerns had been identified were seen on the wards.

**Nutrition and hydration**

- We saw that nutrition risk assessments were completed for patients using the malnutrition universal screening tool (MUST) in the patient records we looked at. Where indicated referrals to specialists such as dieticians and speech and language therapists were made. Food charts were completed and dietary supplements provided to maintain patients' nutritional intake.
- A nutritional audit was carried out in July 2013 in care of the elderly which demonstrated generally poor results. In response training on the wards was undertaken and a re-audit done early in 2014. The re-audit results showed a marked improvement across nutritional screening (MUST), weights and heights recording and appropriate referral to dietetics.
- Water was available in all bays and single rooms during our visit. This was confirmed by the patients we spoke with. We observed regular rounds with hot drinks offered to patients. Patients said they could also request a hot drink at any time.
- One elderly care ward had a nutrition healthcare assistant working mornings, Monday to Friday. The healthcare assistant reviewed the MUST scores for all patients and ordered food supplements and other suitable choices for any patient not eating. They described how they supported confused patients to ensure they had something they liked and therefore ate. One example was where they had made a banana mousse for one patient.
- We observed relatives and visitors helping patients with their food, such as cutting it up. Student nurses also assisted patients with eating.
- Catering staff brought food to the wards and then took the appropriate tray to each patient. Meal times could not be protected as the visiting hours were from 10:30am until 7.30pm. Family and visitors were encouraged to assist at meal times as patients were more familiar with their visitors. Most wards stopped other activities such as blood tests and doctors visits during meal times.
- Patients and relatives told us that conditions such as diabetes were catered for with a specific pink menu. Patients were offered a choice of meals and that the food was cut up for them if needed. Patients said they were offered alternatives if there was nothing they liked on the menu and that if they were away from their bed staff ensured that the meal was brought back when they returned.
- Specific foods for religious or cultural needs were available.

**Pain relief**

- Patients told us their pain was well managed.
- Pain relief was discussed at the nursing handovers we observed. We saw pain management recorded in the patient records we looked at. Staff said that if they needed additional support for a patient they could contact the trust pain team or the specialist palliative care team.
- The pain team were reduced by 50% at the time of our visit, there should have been six specialist nurses but there were only three. They were therefore providing a limited service to both hospital sites. They provided support Monday to Friday from 8am to 8pm at the Queen's Hospital site and ad hoc provision at King George Hospital. The on-call anaesthetist provided support at weekends and nights. They had recruited to the posts with one nurse on induction.

**Patient outcomes**

- The view from the majority of patients was that they were satisfied with the outcomes of their clinical care. One comment that summarises the feedback we received was, "Mum's clinical care has been fantastic, the systems though are abysmal."
- Data presented to the September 2014 care of the elderly clinical governance meeting stated that deaths related to pneumonia, sepsis and acute myocardial infarction (heart attack) were high across the trust. Sixty-eight cases in May 2014 were discussed in detail at the meeting. We saw evidence that the Summary Hospital Level Mortality Indicator (SHIMI) was monitored and discussed at acute medicine clinical governance

meetings. This is the ratio between the actual number of patients who die following treatment at the trust and the number expected on the basis of average England figures.

- The standardised relative risk of readmission in medical care services at Queen's Hospital for elective admissions (122) was worse than the national expectation of 100 for 2013/14. Gastroenterology was 111, general medicine was 139 and clinical oncology was 289 – more than double the national average. This questioned the hospital's care and discharge arrangements. For non-elective admissions, the standardised rate was 111 compared to an England average of 100.
- The trust's deteriorating patient policy reflected NICE and National Patient Safety Agency guidance relating to acutely ill patients.
- The hospital participated in the UCL Partners collaborative for reducing in-hospital cardiac arrests by 50%. Data were shared between all participants and continuous learning built in.
- The hospital participated in audit programmes both nationally and internationally. The Sentinel Stroke National Audit Programme (SSNAP) recently published national results for the period July to September 2014, which demonstrated that the hyper-acute stroke unit was improving, with its overall level within the top 18% nationally. The acute stroke unit results showed that its good results were being maintained.
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, the hospital performed better than the England average in 12 of the 22 standards. These included all aspects of meal provision as well as staff answering questions and providing emotional support. Where the hospital performed worse included foot risk assessments. A diabetes awareness week was held in June 2014 at both hospitals.
- In a national audit of care of patients with non-ST segment elevation myocardial infarction (nSTEMI, a form of heart attack), as part of the Myocardial Ischaemia National Audit Project (MINAP, 2012/13), Queen's Hospital performed better than the England average for patients who were admitted to a cardiac unit (88% against 53%), better than the England average for patients who were seen by a cardiologist or member of the team (98% against 94%) and also better for patients who were referred for angiography (79% against 73%).
- In the National Heart Failure Audit (2012/13), Queen's Hospital performed the same as the England average in five out of 11 areas. These included patients who received echocardiograms (100% against 91%) and referral to cardiology follow up (60% against 53%). Areas where the hospital performed worse included cardiology inpatient care (19% against 50%), input from consultant cardiologist (26% against 57%) and received discharge planning (71% against 83%).
- Results for the National Dementia Audit (2012/13) showed, for example, that there were dementia pathways in place with senior clinician review and dementia champions. However, readmissions, delayed discharge/transfer and inpatient falls for patients with dementia were not reviewed by the executive board. There was variable performance against the national data and the audit had clear recommendations for improvement. These were reflected in the trust's dementia strategy, which was developed from the national dementia strategy, and had a clear action plan.
- Results for the National Lung Cancer Audit covering 2013 were below the London Cancer group and the England averages. One example was whether the nurse specialist was present at diagnosis. The hospital scored 53% against London Cancer 72% and England total of 84%.
- Queen's Hospital participated in the National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme carried out in 2014. The organisational score was 43 of a possible 51 (the highest actual score was 48) which placed the hospital 8th out of 198 participating organisations and demonstrated a high quality service.
- There was an audit programme for 2013 and 2014 for the acute medicine and care of the elderly wards. Audits completed included medical record keeping in line with the generic medical record keeping standards prepared by The Royal College of Physicians, and a leg ulcer audit on the care of the elderly wards.
- The endoscopy department had a rolling audit programme with a consultant lead for audit. For example, intubation rates for colposcopies were at 92%. Detection rates as well as perforations and complication rates were audited. There had been no Never Events over the previous 12 months in this service. Case studies

were anonymised for peer review. All audits and results were presented at the gastroenterology clinical governance meetings. This was confirmed by the minutes we looked at.
- We saw examples of the outcome and trend reports introduced recently by the trust. These were in place on some wards and included, for example, pressure ulcers, falls and infection rates. Data were shown from July 2014 to January 2015 and was provided on a monthly basis. However, these had not been rolled out to all wards we visited.

**Competent staff**

- Junior doctors were well supported by their consultants. We were told that from 10pm to 9am consultants were contactable by telephone for advice and support.
- One locum junior doctor said that, while well supported, they had not received formal induction although they had been working in the hospital for one week. A new consultant we spoke with had received a full induction programme together with mandatory training.
- The trust was working to an action plan following concerns raised about junior doctor training in June 2013. The October 2014 update demonstrated improvement through monitoring and progress against the action plan.
- Nursing staff had a trust induction including three days mandatory training. The induction was opened by the chief executive.
- We saw that staff had attended some additional training such as pain control, palliative care and behaviours that challenge.
- The dementia team had provided training in behaviours that challenge since February 2014 following an identified need. However, take up had been very low. The first session was 22 February 2014 and nine nurses attended. The second session on 1 April 2014 had three nurses. The next nine sessions were cancelled due to lack of bookings.
- The Practice Development Team worked with staff and supported ward-based training such as nutrition and percutaneous endoscopic gastrostomy feeding.
- Ward staff had competency packs that were signed off once completed.
- Dementia awareness training was accessible for staff, and most staff on the elderly care wards had completed training.
- Staff were encouraged to undertake mentorship training to support student nurses. However, low staffing numbers impacted on staff ability to take up some opportunities.
- Student nurses said they were confident to raise any concerns if required.
- We saw that annual appraisals were carried out. These included the needs of the individual members of staff. We were provided with evidence that 27 out of 28 staff had been appraised within the last 12 months on one of the wards we visited. However, trust data provided showed that 70% of staff in acute medicine and 72% of staff in care of the elderly had been appraised. This was low against the trust target of 85%.

**Multidisciplinary working**

- We found evidence on several wards where there was good multidisciplinary working between medical, nursing, pharmacy and therapy staff and social workers to ensure care and treatment were in place for patients. Examples included the twice daily board rounds and the weekly multidisciplinary meetings on the acute stroke unit, weekly respiratory multidisciplinary meetings and multidisciplinary working on the Clementine Wards.
- Internal referrals were made, for example to the respiratory specialist nurse and to therapists. We observed this and saw referrals recorded in the patient records we looked at.
- We found that referrals to external services were discussed and recorded, such as to a specialist named nurse for a patient's mental health needs on discharge. The multidisciplinary teams discussed the decisions required for any rehabilitation needs and the referrals needed.
- Community matrons came to the wards and worked with staff and patients on discharges.
- Elderly care consultants had Skype discussions with GPs, about patients with repeated admissions.

**Seven-day services**

- New admissions were seen every day, seven days a week, in all specialties.
- At weekends, new admissions were seen by the consultant on call in acute medicine. There was always a geriatrician on call for elderly care.

# Medical care (including older people's care)

- There was increasing access to therapists and social care services seven days a week. The service at weekends was limited and focused on assessments that enabled patients to be discharged.
- Endoscopy was working towards a seven day service. There was emergency on-call team cover for nights and weekends.

**Access to information**

- Clinical staff told us they had access to current medical records and diagnostic results such as blood tests and imaging to support them to care safely for patients.
- Ward staff explained the arrangements for receiving handover when patients transferred from other areas. We observed handover for a patient from the high dependency unit.

**Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- We saw there were consent protocols on the oncology ward and consent forms completed in the records we looked at.
- Patients over 65 years old underwent a mind and memory check. We saw risk assessments that informed staff when a patient was on the dementia and delirium pathway. Mental capacity assessments were carried out and families were involved in care and treatment.
- Training on the Mental Capacity Act 2005 was not mandatory.
- Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They demonstrated understanding of informed and valid consent and when a best interests meeting would be required. Nurses said that if they had concerns about capacity they would escalate to the doctors.
- We were told of a patient who was refusing treatment and was non-compliant with any treatment. A mental capacity assessment had been completed. Support had been provided by the psychiatric team. We saw that there were multidisciplinary discussions and all efforts had been made to ensure the patient had information and support, including advocacy. A Deprivation of Liberty Safeguard was under discussion. The trust lead for Deprivation of Liberty Safeguards supported the staff with the process.
- Band 6 and 7 nurses undertook the Deprivation of Liberty Safeguards training and then disseminated this to other staff. This was confirmed by band 5 nurses we spoke with.

## Are medical care services caring?

Good

Care was delivered compassionately. Patients and their relatives told us they felt well supported by staff and that they were able to ask for help. Patients told us their privacy and dignity were protected. The NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received) response rates were consistently high and results were often better than the England average. Patients and relatives said they felt involved in their care and treatment, and that they were given adequate information by both doctors and nurses.

**Compassionate care**

- Patients and relatives we spoke with were very positive about their care and treatment with comments such as, "The nurses are lovely." and "They look after you very well."
- We saw examples of thank you cards displayed in the ward areas.
- We observed that visitors' enquiries were dealt with promptly and kindly.
- We saw student nurses carrying out 'comfort rounds' with compassionate care, and spending time talking with patients. We saw evidence that these were carried out twice a day in most of the patient records we looked at.
- None of the patients we spoke with had concerns about their privacy and dignity, stating that staff always closed curtains round the beds in the bays.
- We did observe on a few occasions that medical staff discussed patient care and treatment in detail in the main ward area that visitors and patients had access to. We saw that efforts were made to protect confidentiality with the doors to the bays and rooms being closed, but full patient names were used. There was a lack of meeting rooms on some wards and therefore there was no other suitable space for these discussions.

# Medical care (including older people's care)

- The patient boards on the wards had shutters to cover the whole patient name to protect confidentiality. The majority of times we observed that these were closed.
- The NHS Friends and Family Test response rate was at 45% from April 2013 to July 2014. This, as well as trust-wide (45%), was higher than the English rate of 30% for the same period. Two of the elderly care wards had response rates as high as 70% and 73%. However, the results averages were variable for different wards. Sahara B Ward, with a response rate of 73%, showed fairly steady results with an average score of 69 out of 100, close to the England average of 71. Sky A Ward, with a response rate of 70%, showed poor results until April 2014 with an overall average of 38 out of 100. There was a marked improvement between April and July 2014 showing an average of 92, much higher than the England average. Most of the clinical areas showed some improvement from April 2014. The lowest response rate was 33% on Bluebell B Ward, with an average result of 55 out of 100.

**Understanding and involvement of patients and those close to them**

- We observed discussion and decision making about information to be provided to a patient's relatives and who would ensure this happened.
- Patients said that the doctors and nurses explained their care and treatment and that they were able to ask questions. Patients felt that information was provided in a way that they could understand.
- Relatives that we spoke with said staff involved them in the patients' care and treatment when it was appropriate. We were told that doctors explained what treatment was planned and provided good information. Relatives were encouraged to assist at meal times and some also translated information if the patient did not speak much English.
- We observed staff carefully checking with patients about their mobility and other needs when they requested help with personal care.

**Emotional support**

- The chaplaincy service provided good support for patients and relatives. We heard that it was accessible and responded promptly when requested.
- Patients had access to specialist nurses, for example the palliative care team. They were able to provide emotional support in addition to care and treatment. The psychiatric team were also available on request to support patients and staff.
- Staff demonstrated awareness of the need to provide emotional support to patients and their families.
- Staff encouraged families to be involved with patients' care wherever possible. Staff said this was particularly important for patients with learning disabilities or a dementia-type illness. The long visiting times facilitated this and allowed families to support their relatives.
- Staff expressed concern for patients who did not have visitors, particularly on the elderly wards. Nursing staff do not have the time to sit with patients, although student nurses managed to on some occasions.

## Are medical care services responsive?

Requires improvement

Staff met patients' individual needs and demonstrated awareness of those needs. There were difficulties in accessing some therapy services but staff could access other specialist advice and equipment. Some developments such as the Elder's Receiving Unit (ERU) had demonstrated a positive impact on patient care.

A high number of patients were cared for in non-specialty beds and moved around the wards. Medical staff were not always able to visit these patients when requested.

We found there were insufficient arrangements to ensure that patients for whom English was not their first language were offered professional interpreting services when required.

**Service planning and delivery to meet the needs of local people**

- To meet the needs of the local population the trust had on-going recruitment processes in place and were aware of both the nursing and medical staff shortfalls. Trust grade doctors had been recruited to improve middle grade cover. Oversees nursing staff had been recruited. The workforce improvement plan was in place for 2014/15 that demonstrated 63% of milestones met at November 2014.

# Medical care (including older people's care)

- The recent introduction of the 30 bedded Elders Receiving Unit (ERU) reflected the known increase in elderly patients attending A&E with complex conditions. Staffing had improved and all staff we spoke with said it was an improvement in care for frail older patients.
- The Medical Receiving Unit (MRU) was well staffed and staff were positive about the separation of the ERU. There were no cardiac monitors on the MRU but eight monitors had been ordered. The plans for continued development of these areas were well underway.
- We saw discussions regarding the increase in complex spinal patients in the care of the elderly service. These included pathway planning and patient information.
- There were plans in place to work towards meeting the required dementia standards. A specialist dementia team had been introduced consisting of two registered and four non-registered nurses to cover both hospitals. Therefore the service was provided 8am to 6pm Monday to Friday with no out of hours or weekend cover.

**Access and flow**

- The Frail Older People Advice and Liaison (FOPAL) nurses were based in A&E. They assessed all frail elderly patients, generally 75 years and over. Those patients who needed to be admitted went to the Elders Receiving Unit (ERU). Patients could be directly referred to the Community Treatment Team. This avoided unnecessary admissions to hospital for frail older people.
- The 30 bedded ERU had been set up in November 2014. This helped maintain patient flow by working together with the community teams to help manage complex patients.
- Stroke patients were seen by the stroke registrar in A&E and referred to CT. Thrombolysis was started in A&E and/or CT and completed in the HASU. We were told that beds were not an issue for stroke patients as they worked closely with neuroscience and bed managers. The recent introduction of stroke nurses working with the doctors had improved thrombolysis times for patients.
- There was a rapid access transient ischaemic attack mini stroke (TIA) service at weekends. The on-call consultant came in to assess patients.
- A triage telephone for chemotherapy patients was held by the day unit in hours; for nights and weekends it was held by the oncology ward. This enabled patients to be admitted promptly from day case or A&E if required.
- Some patients had to be moved to different wards. Due to the pressures on bed capacity, medical patients were not always admitted to the most appropriate ward in the first instance. Patients were admitted to other medical wards where possible but also to surgical wards. These patients were monitored with matrons and bed managers working together to try and move patients on to the correct ward as soon as possible. While this meant that patients had to move wards it was known to be better for their safety and care for them to be treated in the most appropriate place. For a few patients there were multiple moves, which could be detrimental and confusing. Trust data provided from April 2014 to November 2014 demonstrated that the majority of patients (57%) were not moved, 30% were moved once, 8% were moved twice, 3% were moved three times and 2% were moved four or more times. The 2% equated to 363 patients. There were medical outliers on a daily basis.
- Wards with a high number of medical outliers told us that the medical teams the patients were under were not always able to come to the ward when needed.
- Monthly data provided showed that in each month from August 2014 to November 2014 there were 67, 67, 94 and 81 medical outliers recorded.
- The stroke unit monitored use of its beds by medical outliers but said that the information was not passed on within a governance structure.
- The CCU had lost four of the previous eight beds to the intensive therapy unit. Staff were concerned that there were not enough beds and that this impacted on patient flow. Concerns were also raised about the impact on the environment and equipment storage.
- We heard that there were delays for patients awaiting a CT scan as one of the scanners was broken.
- Daily meetings were held to plan discharges. These were multi-disciplinary meetings and enabled a plan for the day with required tasks picked up by the matrons and general managers to support what was needed to ensure discharge.
- Due to the pressure on beds in the hospital we found a focus on discharge across all areas we visited. Several initiatives had been introduced, for example 'ward of the week'. One ward achieved this by getting two patients home by 8am, two patients by 10am and two

patients by 12pm. We asked whether the quality of the discharges was reviewed or monitored and whether any failed discharge data were collected. Staff were unsure and we did not find any evidence of this.

- Another initiative was the 'plus one' process. Where a ward had a patient ready for discharge, another patient would be brought up early to await the bed. This meant that patients could be in the corridor on the ward for some time if there was any delay in the proposed discharge. We saw one patient having their observations in the corridor. We were told of a patient with learning disabilities who sat in the corridor and of an occasion where an elderly patient's dignity was compromised. Staff told us that they did not like the policy and said it was not a good experience for patients. Some staff also said there was an impact on patient experience for those having to be in the discharge lounge before 8am.
- There were two daily board rounds in the ERU to effect discharge from the unit. Patients were transferred predominantly to the short stay ward. Patients who required a cardiac bed would remain on the unit until one was available. We were told of a patient who had waited four days for a bed and had just been sent to the ward. They would not be admitted as a medical outlier to another ward from the ERU.
- There was a pharmacist on the ERU 9am to 5pm, seven days a week and then an on-call service was provided. This helped facilitate prompt treatments and discharges.
- Stoke service facilitators managed patients that did not live locally and needed on-going support at services closer to home (known as repatriation). We saw evidence of delays of 13 and 34 days to other NHS facilities. Most repatriations took two to four days to complete.
- Wards referred patients to the early support discharge team that was started in January 2013. These consisted of ward based therapy teams who facilitated prompt discharges. They also worked with other hospitals to enable patient discharge directly home. This was described by ward staff as, "A brilliant service."
- We observed community matrons visiting the wards to work with ward staff to enable prompt discharges.
- Patients ready for discharge were accommodated in the discharge lounge while waiting for their medicines and transport. Medicines required to be taken home on discharge were ordered by the ward and sent by pharmacy to the discharge lounge.
- We were told of delays due to patients waiting for their medication. We were told that junior medical staff were not always able to complete the relevant documentation for the pharmacy to process the medicines for patients to take home in a timely manner and that this could cause delays. Sometimes the medicines were sent back to the wards rather than to the discharge lounge which also caused delays.
- Some patients also experienced waits for transport that had been booked. This service was provided by an external company and the trust were working with them to improve the service provision for patients.

**Meeting people's individual needs**

- For the many patients whose first language was not English, we found some reliance on relatives to translate required questions and information for patients. We were given an example where staff called in a patient's daughter in order to translate for the patient. They told us that staff had compiled a list of useful words in the patient's first language to help when the relative was not present. The relative felt fully involved and was happy with the care provided. Another patient's relatives said that they regularly translated but when they were not there they were concerned that the patient would not be able to communicate their level of pain and other needs. This meant an over reliance on relatives to undertake interpretation which, in some cases, may not be appropriate.
- There was access to language services, both by telephone and in person, through the Patient Advice and Liaison Service (PALS). We were told this could take some time and was rarely used. There were many staff who spoke a variety of languages and were called upon to help. However, we were told by some relatives that a member of staff called to translate for their grandparent spoke only a similar language.
- Information leaflets on the wards were in English, as were the large signs that encouraged patients to ask for anything they needed and how to complain.
- Patients were accommodated in single sex bays and we did not identify any breaches during the visit.
- Patients told us there was sometimes a delay in responding to the call bell. On one occasion on an elderly care ward we heard a call bell ringing for five

minutes. We drew this to the attention of a member of staff who then responded. In other areas, such as the ERU, we were told that call bells were responded to very quickly.

- We observed discussions about patients with complex needs at the various multidisciplinary meetings we attended. These included speech and language needs, nutrition, patient history, discharge planning and equipment needs for going home. We saw evidence of a holistic approach to patient needs.
- Following multidisciplinary discussions, decisions made were updated on the patient boards on the wards which meant that all staff were aware if, for example, a patient needed an x-ray.
- We visited a ward with high acuity patients where all patients with a tracheostomy were cared for. We had been told that another provider ran the SALT service and that there was a shortage of therapists. We found that there was good multidisciplinary care provided for these patients. Normal staffing levels were one registered nurse to four tracheostomy patients. When they were short staffed they would also have one less acute patient to care for in addition. The ward sister (band 6) supported this care. The critical care outreach team and intensive therapy unit doctors were available when required. The ear, nose and throat (ENT) teams would come to the ward when requested. Both community and hospital SALT teams also supported patients and there was a tracheostomy physiotherapist. However, the ward was extremely busy with staffing vacancies and staff shortages. Staff covered extra shifts where possible because agency staff were not able to care for the high acuity patients. This was reflected on the risk register.
- Other wards experienced some difficulty accessing SALT support. The process was to refer patients by fax and telephone, or to go through the patient's GP for referral. Where a mental capacity assessment was required for a patient with communication difficulties, staff relied on additional support from therapists on the stroke ward.
- Patients requiring an echocardiogram were referred to the cardio-respiratory unit in the hospital. Patients were collected by the unit's porter and results were sent to the ward either at the end of the morning or the afternoon.
- We were given examples where staff were aware that a patient was hard of hearing and ensured they understood what doctors were saying to them.
- The trust lead for learning disabilities was informed of all patients with learning disabilities admitted to the hospital. Their care was reviewed and we found examples where parents stayed overnight on the ward. Staff demonstrated awareness of learning disability needs and patients had a passport that described them, their needs and their likes and dislikes. At the trust listening events it was highlighted by the public that improvements for caring for people with learning disabilities had been made but more was needed.
- The trust was aware of the risk of failure to comply with the National Dementia Strategy and this was reflected on the care of the elderly risk register. A dementia screening tool had been introduced but we found that this had not always been completed for all patients on the elderly care wards. The tool included a mental test assessment for patients over 65 years old. Dependant on the score patients would be put on the dementia pathway and we saw examples of these having been completed.
- The trust-wide dementia team supported patients, relatives and staff where a diagnosis of a dementia-type illness had been made. Wards could request support and would place patients with the diagnosis in the same bay. This meant that the dementia trained healthcare assistant could provide care for patients in one place. Monthly dementia coffee mornings for patients and their families had been introduced.
- Relatives of patients told us that staff completed 'This is me' with them to help staff better understand patients with a dementia-type illness. The hospital used the 'Butterfly' system. Where patients and relatives agreed, a blue butterfly was placed against the patient's name on the white board. This alerted staff that the patient had a dementia-type illness.
- There was a lack of facilities and equipment for patients with a dementia-type illness. There were no televisions on the wards. There were some large sized clocks and jigsaws for activities.
- We heard from medical staff that there were long waits for CT scans as one of the scanners was broken. They also described difficulties in requesting and accessing radiology reports. This could delay appropriate treatment.

**Learning from complaints and concerns**

- Patients and relatives told us that they would feel confident if they wanted to complain.

# Medical care (including older people's care)

- We observed that there was information on posters for patients and their relatives on how to complain and make comments in all clinical areas we visited.
- The general managers for acute medicine and care of the elderly were aware of some backlog in complaints and were working to a clearance plan. Prior to the change in clinical structures acute medicine had 42 open complaints and geriatric medicine had 24 at the end of November 2014. We saw from clinical governance meetings that the response rates during 2014 were very low compared to the trust target, for example 25% in July against the 85% target.
- We saw that individual complaints were presented and discussed at various clinical governance meetings.
- We saw evidence that the trust monitored complaints and highlighted where there had been a breach of the time frame. There was a complaints log provided.

## Are medical care services well-led?

Requires improvement

Staff were aware of the trust and ward based vision and values. They demonstrated these in their work. Communication had improved with a visibility and access to the executive team.

While there were governance and quality measures in place in some areas, these were at a senior level and very specialty focused. We found inconsistent understanding in middle and junior staff understanding of the structure and processes. It was not clear where, as a division, these separate structures were brought together and communicated to all in the division together with the benefits of escalation, shared actions and learning.

There was work in progress to improve patient and staff engagement.

### Vision and strategy for this service

- The trust vision and strategy were displayed around the hospital and on the trust website. This was encapsulated in the word PRIDE (passion, responsibility, innovation, drive and empowerment) – behaviours to support the vision of placing excellent patient care at the centre of what staff do. There were training sessions that some staff had attended. Many staff we spoke with were aware of the trust vision.
- The overarching strategy within acute medicine and care of the elderly was discharging patients to improve access and flow for new patients. The 'ward of the week' award was based entirely on achieving the required number of discharges at various times in the day.
- We were told that care of the elderly did not have a current strategy, but was continuing work on the delirium clinics and integrated community management introduced the previous year.
- The renal service strategy included improving treatment and outcomes for acute kidney injury and building on the audit programme.
- The trust had recently been awarded the authorisation to run as a stand-alone centre for bowel cancer screening. This would increase activity and revenue.
- The cardiology department was working towards seven day consultant cover and moving the catheter laboratory to the hospital site.

### Governance, risk management and quality measurement

- The clinical directors attended the trust integrated governance group meetings that started in October 2014 and were chaired by the chief nurse. Serious incidents, harm reviews and risks for escalation to the trust risk register were some of the agenda items discussed.
- Both acute medicine and care of the elderly services had risk registers in place. These included identified concerns such as staffing issues and recruitment, equipment that required updating and readmission rates.
- We saw examples of minutes at departmental and clinical directorate level. For example, all stroke incidents were taken to the neurosciences clinical governance meetings. They were also discussed at the weekly stroke meetings that were split between teaching, clinical issues, incidents and other information such as NICE guidelines to be disseminated. Care of the elderly clinical governance and acute medicine clinical governance meetings were held every two months. Items included numbers of incidents and their management, relevant NICE guidelines, mortality rates, training and complaints. Respiratory clinical governance meeting minutes seen included serious incident discussion, staffing issues, tuberculosis cohort review and audit results and recommendations.

- The endoscopy department was Joint Advisory Group (JAG) accredited and we saw that it achieved the 2015 accreditation during this inspection. There was a rolling audit programme and good clinical governance structures within gastroenterology.
- All stroke patients were tracked on a spreadsheet that showed, for example, where they were on the stroke pathway, thrombolysis times and whether they were awaiting onward referral. If there were delays in thrombolysis the reason was recorded and fed back to the A&E department and ambulance crews. Data collection and quality assurance were part of everyday practice.
- We saw evidence of shared learning where points from a mortality meeting were emailed to staff. These concerned a documentation issue for thrombolysis and the information recorded on a death certificate. However, changes to protocols and other information from these meetings was passed by 'word of mouth' to the nursing staff.
- Senior staff we spoke with were aware of the risks to their specialty and governance arrangements. Some expressed concern that there was a lack of local audit and quality assurance at a hospital wide level.
- We found that some middle grade and junior staff, both medical and nursing, had little understanding of the governance and risk management processes in place within their department and division. They demonstrated reasonable knowledge at ward level.

**Leadership of service**

- Most staff we spoke with recognised the division's managers, and most of the executive team.
- There were conflicting views expressed on communication between the board and wards. The majority of staff we spoke with said there had been improvements and that they could access the executive team if required. However, junior doctors told us that managers did not attend their meetings to discuss issues raised. There was no executive lead for dementia, which impacted on development of the service. The use of some social media was found helpful.
- We heard very positive comments about leadership for individual specialties such as stroke, oncology and endoscopy.
- Staff on the wards spoke highly of the ward sisters and matrons. We were told that they were always available for help and advice and were very supportive.

**Culture within the service**

- Many staff were very positive about working for the hospital, telling us of the "great team work", and that they had "no hesitation in asking anyone for help".
- The PRIDE strategy for the trust had helped improvements in some clinical specialties. However, with the drive to discharge patients together with staff shortages, some clinical staff felt it was impossible to complete everything that was expected of them, or complete everything they did to the standard they would like to achieve. This applied to medical, nursing and therapy staff. Several staff raised concerns that they did not have sufficient time to spend with patients.
- Staff told us they were able to raise concerns and issues with their line management.
- We saw the chief executive visit the endoscopy unit to congratulate the staff on achieving their 2015 JAG accreditation.
- We were given an example of a member of staff taking concerns to the executive team who had felt supported by the trust. We were given another example where a member of staff had felt threatened by a patient's relative. They had been supported by security staff and the chief executive. We were told this would not have happened a few years ago.

**Public and staff engagement**

- Patient feedback was collected on discharge by a patient experience facilitator. The information was manually entered on a spreadsheet and results distributed by ward. The survey included an opportunity for patients to comment on what could be improved. This method had replaced an electronic data collection process as patients had found that difficult. The main areas for improvement were lengthy waits for discharge medicines and transport.
- The oncology ward ran patient satisfaction surveys with the feedback analysed by the lead chemotherapy nurse. We were provided with examples of changes resulting from patient input. Patients were not aware of all the benefits available to them so this information would be displayed in relevant areas. The free prescriptions for cancer patients would also be better advertised.
- A team building package was purchased for staff on four wards to meet and share ideas. Despite the staffing

shortages, staff were released and cover provided by, "Goodwill and good team working". One member of staff said that it was exciting and had built up morale on the ward.
- Some HCAs said there was nowhere for ideas and thoughts to be put forward. However, others felt able they were able to do this with their ward managers.

**Innovation, improvement and sustainability**

- Senior and junior medical staff told us that the development of areas in emergency care such as the ERU had led to better and safer care for patients. They also said that there was collective working with social services and community providers. However, there remained some difficulties in communication between staff in the emergency department and medicine.
- A dedicated team to support patients living with dementia . Wards could book a dementia trained health care assistant to support one or more patients in a bay on the ward. We were told this was, "A huge improvement" as they were dementia trained. Previously this role was done by a different bank nurse every day.
- The nurse led oral chemotherapy service was the first in the country.
- The chemotherapy triage telephone system run by the day centre was efficient and provided a high quality of service to patients. The service was available Monday to Friday in working hours. Outside these hours the service continued from the oncology inpatient ward.
- There had been considerable increases in patients with viral hepatitis and chronic liver disease over the past five years. This, combined with new treatments due to be authorised in 2015, was been identified as an area where there were insufficient clinical staff. There was ongoing recruitment but this had so far been unsuccessful.
- The renal service was also highlighted as an area where there were not sufficient medical staff to ensure sustainability. The trust had one of the highest numbers of patients with acute kidney injury in the country. There was a dedicated acute renal ward at Queen's Hospital, but the directorate business plan stated that most patients with acute kidney injury were not treated on the acute renal ward. This was not reflected on the acute medicine risk register.
- There was an active research and development department and research projects across the trust. The trust was one of three UK sites undertaking trials with robot arm therapy for stroke patients. We were told that research staff had discussions with line managers and the chief executive about increased resources and that these would be included in longer-term planning.

# Surgery

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

## Information about the service

There were 23,200 surgical episodes in 2013/2014. 55% of these were day-case, 14% elective inpatient and 32% emergency inpatient. The surgical services provided to the local population include: general; vascular; ear, nose and throat (ENT); ophthalmology; trauma and orthopaedics, and maxillofacial surgery. Upper gastrointestinal and neurosurgery services are regional centres for the local catchment population, and parts of North East London and Essex.

There is a surgical assessment unit for rapid assessment of patients referred by their GP or by the Accident and Emergency Department. The day-care unit provides a pre-assessment service, and an admissions area for ambulatory patients. There are five surgical wards, 16 operating theatres and a recovery area.

We talked with over 20 patients and over 60 members of staff, including administrators, porters, healthcare assistants, nurses, theatre staff, junior and trainee doctors, consultant surgeons and anaesthetists, senior nurses, managers, clinical nurse specialists and therapists. We visited clinical areas, observed care and looked at records and the electronic systems for storing patient information. We reviewed national data and policies and information provided by the trust.

## Summary of findings

The clinical governance structures were immature, but work was underway to integrate risk management systems. There were examples of learning from incidents, but the standard of investigation of serious incidents was inconsistent and there was a backlog of investigations.

Nursing staffing numbers and skills-mix on the wards were assessed, but there was limited access to additional staff on wards when there were patients with complex needs. The number and skills-mix of theatre staffing was suitable.

Patients were observed post-operatively and nursing staff had access to medical and surgical staff when needed. Patients were further protected from the risks of surgery by the focus on improving engagement in the 'five steps to safer surgery' in theatres, which was resulting in increased consistency in its use.

There had been number of initiatives to promote adherence to national guidelines. Outcomes for patients were similar to national expectations. Many patients had not been receiving services in a timely way because of a backlog in clinic appointments, and it was not yet known if the delays would affect patient outcomes.

Patients and relatives we spoke with were happy with the care and treatment they had received, and praised

# Surgery

the medical and nursing staff. We observed positive and respectful interactions between patients and staff. We found effective teamwork and a focus on the needs of the patient.

There had been developments in surgical specialties to provide an improved and responsive service to patients. However, many patients had not received a timely response following their GP referral. There were challenges in managing the level of demand. Staff worked hard to address these challenges, but some patients were not receiving a responsive service because of delays in access to theatre or, post-operatively to an appropriate bed.

## Are surgery services safe?

**Requires improvement**

Staff were encouraged to report incidents that might affect the safety of patients. There were examples of learning from incidents, such as improving risk assessments for falls and taking action to reduce the identified risk. Nevertheless, there was not a systematic approach to the reporting and investigation of, and learning from, incidents. The standard of investigation of serious incidents was inconsistent and there was a backlog of investigations.

There was a daily assessment of the acuity and dependency of patients on each of the surgical wards and staffing levels were determined by the matron for the ward in conjunction with the duty matron and site manager. Staff on a ward with patients with complex needs, however, reported there was limited flexibility and data indicated this ward performed less well than other wards. The numbers and skills mix of theatre staffing was suitable, but the increase in the number of theatre lists had resulted in staff working harder, and there had been no assessment of the sustainability of this level of throughput. There were appropriate levels of medical and surgical cover.

Patients were observed postoperatively and nursing staff had access to medical and surgical staff, when needed. Patients were further protected from the risks of surgery by the focus on improving engagement in the 'five steps to safer surgery' procedures (Patient Safety First campaign) – an adaptation of some of the steps in the WHO surgical safety checklist in theatres, which was resulting in increased consistency in its use.

There were appropriate processes in place for cleanliness, infection control and hygiene. There were suitable arrangements for the storage, recording the administration of medicines. Records were well maintained.

### Incidents

- Nursing and theatre staff in surgical wards, theatres and the day-care unit knew how to report incidents and gave us examples of when they had done this. We observed a nurse in the day-care unit contacting theatre staff to gain more information to complete a report about an incident that had occurred earlier in the day. Healthcare assistants and junior doctors we spoke with were less

likely to say they reported incidents and said they would raise an issue with a senior member of staff. We saw examples of incident reports completed by consultants. Other consultants discussed incidents with nurses or managers who submitted an incident report.

- Frontline staff identified changes in practice, such as the work to reduce falls on surgical wards and to monitor pressure care, which had been implemented in all wards in response to incidents. Wards had a process for disseminating information about incidents. In Amber A Ward, for example, there was a folder in which incidents and the outcome of the review were reported. Ward staff were expected to sign when they had read the information. However, there was no record of discussions about incidents in theatre and day-care unit team meetings.
- Unit leads and matrons automatically received reports submitted by their staff, and decided on the most appropriate person to review the incident. There was a box for the investigator to tick, so that the information went to the reporter and their line manager, but we were told that this was not always done. For example, wards did not always receive feedback for incidents they had reported relating to patients transferred to the ward from A&E, so staff could not be sure that action had been taken.
- There had been no Never Events (Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in surgery services and theatres between April and December 2014.
- Incidents and serious incidents were reviewed at monthly divisional clinical governance meetings. There were also regular reviews of incidents at specialty meetings, in addition to mortality and morbidity case discussions. We found that an increase in clinical governance staff, and greater ownership by medical and surgical staff was bringing improvements to the response to incidents. However, the system for recording incidents was not being used to identify trends in incidents within, or across, directorates.
- Action following the investigation of medication administration errors on wards often related to the competency of staff. However, only one member of staff in surgery services had been disciplined as a result of a medication error in 2014, indicating that there was not a focus on individual error. Medical and nursing staff said there was increased openness and the expectation that errors would be reported.
- The investigation of serious incidents did not follow best practice, for example, in the analysis of factors, such as staffing or the environment, which might have contributed to incidents. Clinical staff were not always involved in the investigation.
- We saw examples of a prompt response to serious incidents in the surgery division. After a routine check failed to identify a displaced nasogastric tube, a change in practice was introduced to minimise the risk of a recurrence. However, this action appeared to be parallel to the investigation of the incident, and we were not clear that the clinical team had seen the final report.
- There was work to improve the review of incidents. In the anaesthetics division, a retained swab was discovered directly after a procedure, which had not been found at the swab count. A multidisciplinary 'round table' discussion was held, the case was sent to the trust serious incident panel for discussion and the local standard operating procedure was amended.
- There had been difficulty accessing training for staff given responsibility for investigating serious incidents in the recent past, but there were plans for a programme of training. There was a backlog of investigations into serious incidents. Action had been taken to reduce the backlog and 12 investigations into surgery services (including anaesthetics), remained over the 45-day target without an investigation. This might result in a delay to measures being introduced to prevent the recurrence of a similar incident.
- We were told that patients or relatives were informed when there was an incident that caused harm. We were given examples of the medical director supporting staff in meeting patients and their families to explain what had happened and provide an apology, meeting the expectations of the Duty of Candour requirements. Other action to meet the requirements included: new guidance to staff, new fields in the local risk management system for collecting information on patient involvement following an incident, and a new template letter for patients or families. Further work was required to monitor whether these actions were being implemented.

**Safety Thermometer**

- The NHS Safety Thermometer measures a snapshot, once a month, of four areas of harm: falls, pressure ulcers, catheter-related urinary infections and venous thromboembolism (VTE). The national target is for 95% of patients to be free from the four areas of harm.
- Trust data showed that for the six months up to January 2015, the surgery wards at the hospital were meeting, or exceeding, the national target most of the time. However, Amber A Ward (trauma and orthopaedics), scored 61% and Amber B Ward (general surgery) scored 87%, below the target. We were told this was because pressure ulcers acquired in the community were counted in the figures and this contributed to the low score.

**Cleanliness, infection control and hygiene**

- The environment in theatres, wards and the day-care unit was visibly clean. There were adequate hand washing sinks and hand gel dispensers throughout the areas, and we observed good hand hygiene practice. We saw that the sharps boxes were assembled correctly and there were appropriate processes for the disposal of waste. There were cleaning schedules in all areas, and in theatres there were night and day cleaners.
- Some areas of the day-care unit were in need of refurbishment and we observed damaged walls, which made it more difficult to maintain good infection control practices. There was an expectation that there should be a member of domestic staff on duty, to keep the area clean, empty bins and clear patients' refreshments, but staff told us that this was not always the case in the afternoons and evenings.
- There was training and support from the hospital team for infection prevention and control for the designated link nurses in the areas we visited. These nurses disseminated information to their units, and there was a monthly bulletin from the central team.
- A number of infection, prevention and control audits were carried out across the surgical division, which were broken down by unit and results were fed back to staff. The audits included hand hygiene, use of personal protective clothing such as aprons, safety spectacles and gloves, catheter insertion and aseptic technique. Information provided to us by the trust on the December audit of infection control standards reported Wards Amber B and Ocean B scoring over 95%, Ocean A ward scored 90%. However, Amber A ward was not included in this report.
- The results of the hand hygiene audits we were given for three wards showed that consultants performed worse than all other staff (88% compared to 100% for health care assistants and 93% for junior doctors in the September 2014 observational audit). We were told of follow up action agreed at a clinical governance meeting to address poor consultant compliance.
- There was MRSA screening for elective patients and three clear swabs were required before surgery. The number of infections for antibiotic resistant bacteria, such as meticillin-resistant staphylococcus aureusis (MRSA) were within the expected range for a trust of this size. There was one case of MRSA and four cases of Clostridium difficile reported by surgery services.

**Environment and equipment**

- The trust recognised that the day-care unit was no longer adequate for the volume of day cases, which had risen since it was built.
- There were currently no items on the risk register relating to equipment. The clinical engineering department was in the process of developing a database for repairs and stock to enable cross-links. There had been a programme of replacement of equipment and a budget had been agreed for a new laparoscopic stacking system.
- We reviewed the processes for maintaining the environment and the equipment in theatres and found these were adhering to national standards. Records demonstrated there was an annual service and revalidation on air flow in theatres and checks were carried out quarterly. There was also annual servicing of medical gases. There were regular water quality tests.
- There were recorded checks for equipment in the anaesthetic room, theatre and the recovery room and we saw that these were completed daily. The checks on the anaesthetic equipment were completed in line with best practice guidance by an operation department practitioner and signed for by an anaesthetist.
- There were twice daily checks on resuscitation equipment in the day-care unit and on the wards that were recorded. Electronic equipment had service records and the date of portable appliance testing.

**Medicines**

- Medicines were stored safely. Controlled drugs were appropriately stored and were checked twice daily in the areas we inspected. The fridge temperature was

checked twice daily. Storage facilities for medicines were locked when not in use. There were regular audits carried out by the trust pharmacy teams to check medicines were stored appropriately and securely.

- The regular record checks carried out by senior staff included looking to see if medicine administration record (MAR) charts had been completed
- Pharmacy technicians saw all new patients and reviewed their prescribed medicines. If they had queries they asked a pharmacist, who visited the ward daily during the week. Pharmacy staff were also available on the wards to provide medicines to patients on discharge and could be contacted quickly when not on the ward.
- The surgical assessment unit had a supply of prescriptions so patients were able to get their medicines dispensed at their local retail pharmacy rather than at the hospital.
- We saw examples of medication errors reported, including omitted doses. However, the hospital was not compliant with the 2010 National Patient Safety Agency rapid response alert 'Reducing harm from omitted and delayed doses'. Nursing staff on the wards did not know which medicines were on the critical medicines list (medicines which must be given within two hours of prescribed time).
- The trust-wide safe medicines practice group reviewed medication errors and any audit results.
- We were told by staff on recovery, in the discharge lounge and in the wards that delays in dispensing resulted in people waiting for their take home medicines and that this affected timely discharge. It was not clear that the reasons for these delays were being analysed and addressed.

**Records**

- The records we reviewed on the surgical wards, on the day-care unit and in recovery contained a medical history, a full assessment on admission, and evidence of multi-disciplinary input into the care and treatment of the patient. The notes were legible, complete and signed.
- During our last inspection in October 2013, we found that risk assessments were not always updated and fluid balance charts were not always completed on surgical wards. On our recent inspection, we found nursing documentation in patient files had been well maintained and contained assessments and care plans that covered patient needs. There were monthly documentation audits as part of the 'quality of care' programme, which was resulting in improvements. In January 2015, a documentation audit had found standards were being met in most wards. However, Amber A Ward had scored only 20% on ensuring the fluid chart was present and recorded accurately, and Ocean A Ward had scored only 50% on ensuring all risk assessments were in place. Wards were expected to take action to address low scores and to demonstrate compliance with standards.
- Ward staff commented on the difficulties in finding time to complete the amount of recording expected. They felt that this left them less time to provide care to patients. Senior nursing staff explained these comments had been listened to and new records had been piloted and had recently been printed. These were easy to follow and reduced the need for monitoring when no risk had been found at assessment.
- In surgical pre-assessment, assessments were undertaken and recorded prior and during consultations, and before the day of the procedure. The assessment was valid for a maximum of three months in case procedures were delayed or cancelled.
- The documentation booklet for day-case surgery patients was easy to read and divided into clearly marked sections for the stages of the patient journey from pre-assessment to discharge, However, the booklet had been printed in 2004 and was not referenced, so it was not clear if it reflected current best practice.
- We observed that records were kept securely. For example, on the day-care unit, records were kept in a trolley, which was kept securely by the receptionist.

**Safeguarding**

- All the staff we spoke with had completed safeguarding training and were aware of how to escalate concerns to the safeguarding team. There was dissemination of learning through the Adult Safeguarding Group, which was attended by representatives of all directorates.
- There were safeguarding crib sheets and information was available on the intranet. All staff attended training on induction and as part of mandatory updates. The safeguarding adults nurse worked with ward teams in investigations of concerns or referrals.

**Mandatory training**

- Processes were in place to keep mandatory training up to date, with unit managers allocated responsibility for ensuring their staff were given time to complete the training. For example, on the day-care unit mandatory training was put on the rota to ensure staff were free to complete their training.
- Training figures showed that over three-quarters of nursing staff were up to date with training and others had training booked.

**Assessing and responding to risk**

- All risk assessments had been completed in the records we reviewed on the wards and in recovery. These included assessment of the risk of pressure sores and falls, a cognitive assessment and the malnutrition universal screening tool (MUST). Care plans addressed identified risks in addition to needs such as communication and personal hygiene. There had been a decline in the number of falls on the wards as a result of improved risk assessments and access to preventative measures, such as ultra-low beds.
- The percentage of patients receiving venous thromboembolism (VTE) risk assessments before surgery (97%) exceeded the target of 95% from April to October 2014.
- Observation charts measured early warning (EWS) escalation scores which were calculated daily. These were recorded for patients post-operatively and on the wards. Recovery staff and staff on the day-care unit were receiving support from an anaesthetist or a consultant surgeon when the score indicated this was needed.
- Nursing staff undertook 'quality of care' audits on the wards, which covered records, the safety thermometer and other aspects of patient care. When standards fell short, the matrons and ward leads reviewed the findings and took action to improve them.
- Since our last inspection, there had been a programme to improve understanding of sepsis and all staff we spoke with were aware of the sepsis protocol.
- Patients admitted for day surgery who were not medically fit to return home were kept overnight. If the stay was for less than 24 hours, they remained in a bay in the recovery area and staffing levels were adjusted to provide appropriate care.

**Use of the 'five steps to safer surgery'**

- A trust steering group had been meeting to improve adherence to the five steps to safer surgery (the pre-list team brief, the three steps of the World Health Organisation (WHO) surgical safety checklist and the post-list team debrief). We observed all five steps during our inspection and saw staff were attentive and completed the checks. An incident report had been completed when a member of theatre staff did not pay attention during the checks, and the anaesthetic clinical lead addressed any reports of poor staff engagement among theatre staff. We were told that pre-list briefs were also standard practice and that there good engagement with these. We were given an example of theatre staff insisting on the presence of consultants at the brief.
- Adherence to the three steps of the WHO surgical safety checklist was audited by reviewing 100 checklists each month at the hospital across all specialties. Some specialties, such as trauma and general surgery, had demonstrated almost complete compliance in November and December 2014. The overall compliance rate was 96% and 97% for these months. However, adherence to the pre and post-list brief was not audited, and notes were not recorded during the debrief. This meant that good practice and learning from the briefs and debriefs was not shared. Observational audits were planned that would focus on the way that staff engaged with the five steps.
- The WHO surgical safety checklist had been adapted following consultation with theatre and consultant staff and was felt to better reflect practice. There was multidisciplinary presence on the steering group. However, it was not clear that learning had been disseminated because there had been no action points from the steering group. Following an incident of a wrong eye being injected the ophthalmology service had taken prompt action to introduce the WHO surgical safety checklist in treatment rooms. However, the steering group had not applied this to wider learning in other specialties, such as dermatology.

**Nursing and theatre staffing**

- Staff in the day-care unit, wards and theatre worked hard to meet the increase in the number of patients admitted for surgery. However, it was not clear that this was sustainable without changes to staffing levels.
- The agreed nursing staffing levels on the wards at night were met or nearly met (more than 95%) in October and

November 2014. Staffing levels for wards during the day were below 90% on Ocean B ward, Sahara B ward and Amber B ward in November and on Amber A ward in both months.

- During our inspection in October 2014 we found that staffing levels on surgical wards were not adjusted to accommodate fluctuating conditions. At our recent inspection we saw that staffing levels and patient dependency scores were calculated every day and the matron informed. These figures were also sent to the deputy chief nurse, together with other information such as falls and delayed discharge, for assessment of the establishment levels. However, nursing staff told us patient care would improve if there was more flexibility in providing additional staff when acuity levels were high, for example on Amber A ward for patients with fractured neck of femur.
- There were particular challenges at night, when staffing levels were lower than in the day, except on Sahara B ward, the neurosurgical ward. There were more falls at night than during the day on Amber A ward.
- At weekends nursing staff carried out administrative and clerical staff tasks such as answering the telephone because ward clerks were not working, which took them away from providing patient care. The ward clerk on Amber A ward did not work on Fridays. On the Friday of our inspection an additional health care assistant had been deployed to assist with administrative tasks, but she was being used to provide patient care because of the complex needs of patients on the ward.
- Theatre staff had recently been recruited and staffing was in line with recommended levels. The clinical director was assured that the number and skills mix of staff met patients' needs. The theatre rota included grades of staff as well as numbers to check that the skills mix was appropriate. There were night staff available for use of the emergency theatre, with two further staff on call should a second theatre be required. Nevertheless, the increase in the number of lists because of the work to decrease the backlog of patients waiting for surgery, had resulted in longer working hours for theatre staff.
- Staffing levels for qualified nurses on the day-care unit were below establishment on six of the 10 shifts of the week's rota. We were told the shifts were covered by their own staff working overtime or bank.
- Recovery was staffed at night for overnight patients, when necessary. For example, when a day-case patient had to stay overnight. The discharge lounge also had processes in place for bank and agency staff to work at night if patients remained overnight.
- There had been a reduction in the reliance on agency staff, which was below 5% for surgical ward nursing staff.

**Surgical and medical staffing**

- The surgical and anaesthetic consultant and medical staffing levels were adequate, but there were pressures because of the increase in the number of patients.
- Additional consultant surgeon appointments had been made to meet expectations for emergency surgery cover and to comply with national expectations of a specialty regional centre for vascular surgery.
- There was 24-hour consultant-led surgical care, with consultants free of other duties when on call. Trainee and junior doctors and nursing staff told us consultant surgeons were available when needed, and gave examples of when consultants had come to see patients when on call, or in their own time. Trainee doctors in general surgery said there had been improvements in working across the specialties so they felt able to approach any consultant when they wanted advice.
- A consultant anaesthetist was free of other duties when on duty so as to be able to assist with 'troubleshooting'. There was increased consultant anaesthetist cover at preassessment. The job plans incorporate duties, such as supporting trainee and junior doctors. Additional lists were undertaken in the consultants' own time (but with additional payment), which were above activities and duties in their job plan.
- Consultant surgeons were supported by senior trainee doctors (registrars) and junior doctors. In general surgery there were three registrars on call, during the weekdays, one to attend the surgical assessment unit or A&E when needed, one available for emergency surgery, and one to cover the wards. During the weekends there were two registrars; one to cover the wards and emergency lists and another to cover A&E and the surgical assessment unit. The registrar were supported by a junior doctor.
- Two doctors' assistants had been working on the surgical wards for 18 months with the role of arranging investigations ordered by medical and surgical staff, taking bloods and making sure results of tests and

investigations were ready for round wards. Consultants were positive about their contribution to the management of patients, although the effectiveness of the role had not yet been formally evaluated. They relieved the pressure on junior doctors.

**Major incident awareness and training**

- Major incident training was mandatory for all senior nursing staff and awareness for other staff was covered in induction.
- A consultant described the way multi-disciplinary teams in A and E and the wards had worked together to deal with patient flow to avoid the need for a declaration of an incident when there was unprecedented levels of demand on the hospital.
- Senior staff had completed 'gold command' training. All on-call senior staff were required to come in during a major incident. We were given an example of last 'standby' incident and how the debrief identified how to use walkie-talkies as a learning point.

## Are surgery services effective?

Good

There had been a number of initiatives to promote adherence to national guidelines and most specialties submitted data to national audit programmes. Outcomes for patients were in line with national expectations.

Patients received effective pain relief through on-going monitoring and specialist support. Nutrition and hydration needs were being appropriately assessed and monitored. Patient care was supported by multi-disciplinary, patient-focused care.

Nursing and theatre staff had access to opportunities to develop their qualifications and skills. However, they were not receiving consistent competency training and assessment.

**Evidence-based care and treatment**

- Clinical staff had access to National Institute for Health and Care Excellence (NICE) guidelines and standards set by the Royal Colleges and professional associations.

Surgical services submitted data to most relevant national databases and to national enquiries. Anaesthetists contributed data to the Royal College of Anaesthetist national audit project.

- A steering group promoted adherence to national best practice in emergency general surgery, which included the appointment of two consultants for the emergency general surgery list, and the availability of an operating theatre for emergencies at all times. A second theatre and staff were available if required. An audit had found a reduction in readmissions and in length of stay since the service had been introduced.
- The hospital is a regional centre for upper gastro-intestinal conditions affecting stomach, oesophagus, gall bladder and pancreas. The service submitted good quality data to the National Oesophago-Gastric Cancer Audit.
- The neurosurgical unit is a regional centre, providing emergency and elective surgery, with seven consultant neurosurgeons covering the main subspecialties. We found no data on its performance from the Neurosurgical National Audit Programme (NNAP), which has begun reporting on activity and patient outcomes for neurosurgical units.
- Compliance with fractured neck of femur best practice standards was tracked and a steering group drove improvements. The number of trauma theatre lists had been increased, and a geriatrician assessed patients. However, the 2014 figures from the National Hip Fracture database reported that only one-third of patients received were assessed pre-operatively, compared to a national figure of over one-half. The service was not currently compliant with the recommended implant, but was working to rationalise the supply of prostheses for trauma and elective orthopaedic surgery.
- The ophthalmology service had introduced toolkits to promote compliance with standards, such as those used for the treatment of glaucoma. The ophthalmology diabetic screening service was delivered in line with quality assurance standards.
- The vascular surgery service had been consolidated in order to meet the expectations for a specialist regional centre. The service had a vascular laboratory to facilitate timely investigations. The appointment of two interventional vascular radiologists had increased the number of patients undergoing angioplasty, who

previously would have had by-pass surgery. The service submitted data to the National Vascular Registry. There had been no recent reports of outcomes from the registry.

- There were enhanced recovery pathways for trauma, neurology, colorectal, upper gastrointestinal and vascular surgery patients. There was appropriate multi-disciplinary participation in the pathways, which were overseen by clinical nurse specialists. However, staff told us there were not enough occupational and physiotherapy staff to provide optimal services to all patients. In addition, speech and language therapy services were provided by an external service, and there were delays in accessing the service.
- There was a local programme of approved audits to assess compliance with guidelines and good practice, such as preoperative testing and patient outcomes following emergency surgery. However, some audits had been abandoned and others had not been completed to the expected deadline. These included trust-wide surgical audits to monitor compliance with national guidelines for intravenous fluid and electrolytes management, and nutritional assessment in general surgical inpatients. An action point from a clinical governance meeting was a monthly review of approved audits to check whether they were likely to be completed.
- Junior doctors told us of their involvement in service improvement projects using 'Plan, Do, Study, Act' cycles, in which improvements were planned, rapidly introduced and measured and the plan adapted to take account of the results.
- An evidence-based practice group met on a monthly basis and looked at evidence, outcomes and improvements to be made.

**Pain relief**

- Pain was regularly assessed and recorded on the surgical wards and early warning scores also documented pain levels. 'Comfort rounds', which were completed every two or four hours on surgical wards included a check on whether the patients' pain was being effectively managed.
- Staff praised the work of the three members of the trust pain management team, who worked with the wards on pain assessment. There were limits to their availability and they were not available out of hours.
- The pain team had developed packs to monitor patients' pain postoperatively. For example, the pack for intravenous patient-controlled analgesia had a guide for nursing staff, an algorithm for intravenous opioid titration to aid decision making, and specific instructions for when an anaesthetist or a member of the pain team should be contacted. There was a chart for nurses to record safety checks.

**Nutrition and hydration**

- Staff on the wards and in the day-care unit described the nil by mouth policy. They said that theatres contacted them if there was a delay in an operation so that they could offer more fluids to patients. However, there were no audits to measure compliance with the policy, and a patient told us he had waited without fluids from 6 am to 5 pm for an operation. The operation was postponed until the next day.
- Patients had access to sandwiches and drinks in the day-care unit and post-operatively in recovery. When they stayed longer than expected, staff contacted catering for suitable refreshments, such as a hot meal.
- Everyone we spoke with on the wards and in recovery said they were frequently offered drinks. There were mixed views about the food, with some people praising the quality of the cooked meals. We were told of a project to gather further patient feedback about the food available on wards and to make improvements.

**Patient outcomes**

- There had been a decrease in the number of readmissions following surgery and, overall, the level of risk of readmission for surgery was lower than the national average. The number of readmissions for planned and emergency general surgery and for trauma was better than expected. For planned and emergency ear, nose and throat and planned neurosurgery it was worse than expected.
- The rate of surgical site infections for orthopaedic surgery was low for a hospital of this size.
- Outcomes for patients were better than the national average for upper-gastrointestinal cancer.
- Results from the National Bowel Cancer Audit in 2013 showed that data collection for patients having surgery was incomplete and the number of cases having major surgery was not recorded in the audit. Only half the patients were seen by a clinical nurse specialist, significantly worse than the national figure of 88%.

- The trust submission to the National Emergency Laparotomy Audit published in 2014 indicated that they provided many of the expected services, such as the availability of an operating theatre, the presence of a senior anaesthetist and a surgeon, when indicated, as well as a defined pathway for patients. The Trust confirmed it had a policy of formal handovers available to staff.
- The 2014 national hip fracture database showed the trust was worse than the England average for surgery on the day or day after admission, and mean length of stay. It was better than the England average on patients developing pressure ulcers, bone health assessment, falls assessment and mean length of post-acute stay.
- Patient Reported Outcome Measures (PROMS) were significantly worse for knee replacements than the English average and worse on some measures for hip replacement and groin hernia.
- Patient lengths of stay were often longer than the national average for older patients. We were told this was because of delays in access to rehabilitation or social care services.

**Competent staff**

- Most nursing staff had received an appraisal in the last year.
- Induction and orientation was carried out over a period of a month for new nurses, with a six week induction for nurses recruited overseas. We spoke with a nurse from overseas who told us their induction covered the importance of learning the differences between the NHS and services in their home country. We were told by student nurses that staff were always willing to help and that there was good teamwork. They felt they were never pushed beyond their capability.
- We were given many examples of development for nurses and health care assistants. There were links with universities for day-release courses such as advanced nurse practitioner and anaesthetic courses at a local university for staff to attend on a day release basis. Senior nursing staff said they had valued the leadership training that had been developed in the trust. Theatre staff were finding it difficult to access non-mandatory training at the time of our inspection because of requests to work additional theatre lists.
- The arrangements for recording competencies of nursing, theatre and health care assistant staff were underdeveloped, particularly in theatres, and it was difficult for matrons to demonstrate to us that staff were up to date with the assessment of their competencies. Senior nursing staff told us it was difficult to organise on the floor training and competency assessment because the wards were very busy. Clinical nurse specialists were not always available to develop staff competences in caring for patients requiring nursing and care relating to their specialty.
- A practice development nurse had been appointed to work with unit leads to improve access to on-the-floor and other forms of training.
- There were link nurses for each ward, which included a dementia link nurse, who attended trust dementia meetings and training, then updated the ward on practice issues. There were also link nurses for diabetes, pain, infection control, tissue viability and nutrition. There was also a system of link nurses in theatres. This included infection control, dementia, pharmacy and the WHO surgical safety checklist.

**Multidisciplinary working**

- There were systems in place for a multidisciplinary review of patients in all surgical services. The general manager of cancer services and the clinical nurse specialist held a daily conference call every morning, with radiology and pathology to track each patient individually. Radiology had provided dedicated slots for cancer patients.
- There was a multidisciplinary trauma meeting every morning, which had been introduced following an investigation of a serious incident that found shortcomings in the review of patients. We observed one of these meetings, which was attended by 20 clinicians, including surgeons, a geriatrician and trainee and junior doctors. Each patient was discussed and the record made in real time of these discussions, assisted by facilities to view x-rays digitally.
- There were multidisciplinary ward rounds. For example, the review of vascular patients was attended by consultants, medical staff, the clinical nurse specialist, nurses and therapists. There was also a weekly meeting of the vascular surgery team, led by a consultant vascular surgeon.

- Patient care on wards was supported by occupational therapists and physiotherapists, who attended morning meetings to help manage discharge. There was also input from the pain team, dieticians, anaesthetists and social workers, when needed.
- Porters were allocated to the wards and the recovery area, and staff commented on their responsiveness and their willingness to take the initiative, for example, in making sure that mattresses were replaced.
- We observed multidisciplinary, patient-centred care. For example, between therapists and pharmacists and ward staff. The day-care unit staff worked closely with theatres, recovery and the discharge lounge. They also arranged follow-up tests for day surgery patients and contacted outpatients on their behalf.

**Seven-day services**

- The day-care unit was open seven days a week at the time of our inspection. Emergency theatres were open at all times and there was seven day consultant cover. We were told consultants in general surgery did not rely on middle grade doctors to perform procedures, but attended themselves when there were high risk patients.
- The pharmacy department was open seven days a week, with limited hours on Saturday and Sunday. There were pharmacists on call out of hours. On weekends and bank holidays there was an extra discharge team comprising, a pharmacist and two pharmacy technicians.
- Critical care outreach was not available at all times. Physiotherapy and occupational therapy services were available on some wards seven days a week, but there was a limited service.
- The pain management team was not available at weekends.
- There was access at all times to interventional radiology, radiology and computerised tomography (CT) scans and an on-call system exists for radiotherapy.

**Access to information**

- Clinical and nursing staff had access to records with information about patient that was comprehensive and easy to read.
- There had been cases of delayed access to records, in particular when patients arrived at the hospital, with the result that temporary records were created. There was a plan to address this, and the ward clerks showed us how they made sure that all the records needed by medical and nursing staff were available. There was a tracking process for records.
- There were processes in place to make sure information was passed onto other parts of the trust when a patient was transferred. For example, there was a 'checklist prior to notes going to ward' to check that x rays, blood results, electrocardiogram (ECG), MRSA, blood tests on day of admission, were available. Porters collected patients from the day-care unit or the ward to take to the theatre with a checklist, which was reviewed by ward and theatre staff. There was also a checklist to make sure all relevant information was handed over by theatre staff to recovery.
- Some surgical specialties had introduced new handover processes for day to night and at weekends to improve the quality of information passed on to medical staff. An audit of the process in general surgery, which included a review of documentation and interviews with staff, had found that these processes were not always followed and had made suggestions for action.
- There had been recent investment in information technology (IT) to improve the recording of, and access to, patient information, including the introduction of a new electronic patient record system. The patient information stored was available to other systems, for example the clinical patient management and handover system used by the trauma team, and the system to manage discharge. However, at the time of inspection, the systems were still underdeveloped, with duplication and a mixture of paper and electronic records.
- IT systems had been underfunded in the past and there was a strategy to improve and invest in the IT systems. The IT system for theatres was out of date and failed to provide the data required to manage the service. Administrators reviewed data manually in order to ensure that the data were accurate.
- Reliable patient data for use in management information and audits was available, but was time consuming to access, and was derived from a number of sources.

**Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- Consent to treatment was in line with current expectations and staff demonstrated a good

understanding of the process. Consent forms were signed and completed in the notes we reviewed. There was a process of assessing mental capacity, including involving relatives in decision making.
- Senior nursing staff understood the impact of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards on the patients they cared for. Guidance was now being included in mandatory safeguarding training. A ward lead gave us examples of when deprivation of liberty safeguards were used to keep people safe, following the trust procedures.

## Are surgery services caring?

Good

Patients and relatives we spoke with were happy with the care and treatment they had received, and praised the medical and nursing staff. We observed positive and respectful interactions between patients and staff.

Patients told us they felt involved in their care and had received the explanation they needed to understand their treatment.

### Compassionate care

- Most patients we spoke with on the wards praised the nursing staff, saying, "Nothing is too much for them." They said there was "wonderful care" at the hospital and that night and day staff were caring.
- We observed staff treating patients with respect in the areas we inspected. People were asked what they wanted to be called.
- Patients had access to bells to call staff, and we were told, and observed, that there was a prompt response when these were used. A patient told us the response was not so prompt at night and at weekends.
- We spoke with someone visiting the hospital, whose husband had been treated last year on Sahara B Ward (neurosurgery) before his death. She was very grateful for the compassionate care her husband received. These sentiments were echoed in the 'thank-you' cards on the ward.
- The surgical assessment unit had a score of 74 in the January 2015 NHS Friends and Family Test, higher than the national average of 65. Additional patient feedback demonstrated improved patient experience for people referred to the unit.
- Patients on the day-care unit were full of praise for the friendly staff "who always had a smile" in spite of the very busy environment.
- Amber B ward and Sahara B ward regularly scored higher than the national average for NHS friends and family test, with scores of 75 in January 2015. Ocean B ward regularly scored lower than the national average in the test, with a score of 55 in January. Amber A ward scores had fallen in recent month, and had a low response rate in January and a low score of 31.

### Patient understanding and involvement

- Patients said they felt involved in their care and treatment and that doctors and nurses explained things clearly. One of them said the orthopaedic surgeon used diagrams to explain the treatment and she felt 'put at ease'. A patient on Amber B ward asked to speak to us to praise the standard of care. She said the senior sister in charge spent time with patients explaining things to them and speaking in a way they understood.
- Several patients, on the surgical assessment unit, at pre-assessment and in the day-care eye unit said they felt able to ask questions and were involved in decision-making. A patient who went to the surgical assessment unit 'hot clinic' said the receptionist was very helpful, explaining how things worked and when she would be seen.
- A patient who had unexpectedly stayed overnight following a day surgery booking, said that the consultant had explained why an additional procedure had been necessary. We observed that nurses kept patients in recovery informed about when they would have a medical review, and contacted medical staff to seek clarification.
- We observed an anaesthetist explaining every step of the preparation for pre-operative anaesthesia to a patient.

### Emotional support

- We heard examples of the emotional and practical support clinical nurse specialists provided to patients.

- The chaplaincy service, which was available during the week, provided an on-call service to both patients and relatives.

## Are surgery services responsive?

Requires improvement

There had been developments in surgical specialties to provide an improved and responsive service to patients. However, a high number of patients had not received a timely response following their GP referral. There were increasing theatre lists to address the number of patients waiting for operations.

There were challenges in managing the increased level of demand. Some patients were not receiving a responsive service because of delays in access to theatre or, post-operatively to an appropriate bed.

The day-care unit facilities were not adequate for the volume of patients attending the unit.

Surgical services addressed the needs of individual patients, such as those with learning disabilities. Nursing staff undertook 'comfort rounds' to make sure that each person on the ward had their individual needs met.

There had been a poor response to formal complaints in the past, and there was work to reduce the time taken to respond. Senior nursing staff on the wards were addressing any patient or relative concern early so that a solution was quickly found.

### Service planning and delivery to meet the needs of local people

- There was multidisciplinary engagement with developments to vascular surgery, neurosurgery and gastrointestinal services. The services were providing information, and working with commissioners in planning service developments.
- General surgery services had engaged local GPs and patients in an emergency surgical away-day, which had looked at national guidance, and the access and flow of patients. The 'emergency surgery policy' had brought information together to set out the improvements, including the changes to the way the surgical assessment unit at the hospital was located and staffed.
- The surgical assessment unit was open at all times, with clinics running from 9am to 5pm. The unit reviewed patients referred by GPs and A&E, or by consultants who wanted to follow-up a patient who had been discharged. The team, which consisted of an administrator receptionist, healthcare assistant, nurse and registrar on duty each day, provided an efficient and effective service. The service was continually reviewed by the senior sister on Ocean B ward. Their unit had prevented admission and reduced the length of stay. Surveys had found 90% satisfaction levels among GPs and patients.
- There were two dedicated emergency theatre lists, in line with national expectations, with access to an additional list when required. There was appropriate medical and consultant staffing for emergencies out of hours.
- ENT services ran an assessment unit in a treatment room on Ocean A ward. Patients were examined and minor procedures performed. This prevented long waits in A&E.
- The ophthalmology service had introduced a 'one-stop shop' so that patients only needed to visit the hospital once prior to surgery. A consultant-led eye casualty service were operated from 8am to 6pm on weekdays. According to patient groups, the service was welcomed by local people, but some patients continued to be referred to the central London hospital for emergency treatment. The service was also reviewing the cataract pathway to streamline the service and exploit the new theatre facility at King George Hospital.
- It was recognised that the trust had limited ability to plan ahead for an expanding population because of the focus on reducing waiting times of clinic appointments and the backlog of patients requiring operations. One clinician summarised the situation as, "We are playing catch up while the number of patients is increasing."
- The day-care unit did not have sufficient space to easily accommodate the beds, trolleys and chairs needed for patients. There were no lockers and patients' clothes were placed on chairs. There were toilet and shower facilities, but it was difficult to segregate male and female patients because of the volume of patients. The kitchen facilities were in a corridor. Other limitations of the hospital building included doors that did not open automatically, which we observed resulted in difficulties

for porters transferring patients, the long distances between different parts of the building, and the lack of natural light in some of the wards. We were not informed of plans to address these limitations.
- There were facilities in the wards for same sex areas, and single rooms were available for patients with special needs or for infection control.

**Access and flow**

- There was a trust-wide referral-to-treatment (RTT) backlog, which was identified when there was a change in the patient administration system (PAS). This led to the discovery of a possible 10,000 new patients since September 2014 and the trust has worked to establish how many of these were 'real' patients and not a system anomaly.
- There were 772 surgical patients with a RTT of over 18 weeks (306 orthopaedics, eight maxillofacial, 152 ophthalmology, 11 gynaecology, 10 neurology, three dermatology, 164 general surgery, 13 pain related). Some of these did have booked appointments, but the majority did not. Ten patients had waited over 52 weeks.
- A programme to address the long RTT times had been put in place and resulted in a reduction in the backlog of people waiting to be assessed and treated. Additional clinics and theatre sessions had been introduced and surgical, anaesthetic and theatre staff were working the additional theatre lists. There was work to reduce the number of late cancellations of clinic appointments and surgery.
- Ophthalmology had improved the efficiencies of clinics, with few short notice cancellations of appointments, compared to up to 60% of appointments being cancelled at the beginning of 2014.
- The waiting time for ENT was currently 30 to 35 weeks, but was on a trajectory to be 18 weeks by the end of May. The service had introduced a telephonic, nurse-led review clinic to follow-up on the results of tests and 'do not have to return to clinic' patients.
- Maxillofacial surgery was the only service to have completed their directory of services and clinic profiles and had cleared their RTT backlog. Clinic capacity had been increased by revising the assessment process. Capacity modelling had demonstrated the need for two additional consultants and additional theatre time.
- There had been a review of the pre-assessment clinics to reduce the number of cancellations due to inadequate assessment preoperatively. Suggested improvements were being implemented, including additional consultant anaesthetist sessions and improved training for nurses. An audit of three months' worth of data found that clinics ran efficiently.
- Theatre utilisation across the two trust sites was 88%, higher than the national average. No surgical specialty had a utilisation rate lower than 83% and the rate for maxillo-facial surgery was 94%. The divisional manager and service manager for theatres planned lists six months in advance and expected consultants to inform them when a list would be cancelled because of leave. The list was then offered to another specialty.
- A working party oversaw the work to reduce cancellations of operations. In spite of the problems with the theatre IT system, administrative staff undertook manual checks in order to produce a report on cancellations, which was reviewed daily. Over half the theatre cancellations in January 2015 were because the patient did not attend, was unfit, or the operation was no longer required. Patients who indicated they would take an appointment at late notice were contacted when there was a cancellation to see if the slot in the list could be filled.
- There were sometimes delays in patients coming to theatre, which reduced the number of operations on a list. The length of time to prepare patients for theatre, in particular when they had complex needs and the ward was under pressure, was cited as a reason for this. However, it was not clear that information about the reason for delays was being collected and analysed.
- The recovery area had enough beds to care for patients postoperatively, unless they were unable to transfer patients to the ward. There were six beds on the theatre recovery unit for patients who unexpectedly required an overnight stay, for stays of up to 23 hours. There were appropriate facilities for overnight patients, which had been installed following the last CQC inspection. Patients were discharged directly from recovery. Nurses were trained to perform nurse-led discharge by colleagues on the day unit.
- Surgeons told us the ITU had worked closely with surgery services to provide beds for patients requiring intensive care following surgery, both planned and emergency. There were sometimes difficulties finding step down beds for patients from recovery, including those requiring high dependency care. It was now unusual to care for patients with high-dependency needs in the recovery area, and on these occasions, staff

were supported by a high-dependency nurse, or by the outreach team. Recently, four beds in the coronary care unit had been allocated as high-dependency beds. A surgeon told us that he was likely to have to postpone a time-critical operation for a second time because there was no high-dependency bed available.

- There were bed management meetings three times a day to review demand for beds There were high-occupancy levels on the wards.
- Lack of beds for neurosurgical patients postoperatively has been identified as a risk. Patients are kept on recovery or given a bed on a general surgery ward. The risk has been mitigated with decision-making by the neurosurgical matron and neurosurgeons about allocation of beds.
- Patients from the trauma ward in Queen's Hospital were transferred to the Intensive Rehabilitation Service at King George Hospital, where a team of physiotherapists assessed and engaged patients on the ward and supported them on discharge.
- Discharge planning began at pre-assessment. Nursing staff on the wards worked closely with the multidisciplinary team and with social workers to plan discharge, and an electronic discharge programme was used to record when each professional's task had been completed. Discharge documentation was begun the day before discharge so that the medicines to take home would be ready promptly, transport arranged and the appropriate people informed. Patients often went to the discharge lounge prior to departure, but there were delays because medicines did not arrive or transport was delayed.

**Meeting people's individual needs**

- Staff were well-trained and supported to meet the needs of patients with learning disabilities. There had also been initiatives to improve support for patients with dementia through staff training and the appointment of 'dementia champions'.
- There had been work with the healthcare assistants (HCAs) and nurses on the wards to decide on the symbols that should be used to indicate patients' needs (such as dementia and diabetes), so that these were easy to understand for staff. They were made square instead of round so they were easy to remove. Boards at the head of the beds also had the names of the consultants, nurses and HCAs who were responsible for the care of that patient.
- The proportion of the population from non-English backgrounds who required interpreters was lower in Romford than for other parts of London, but staff told us they accessed interpreters when this was necessary. Leaflets, for example information for surgical patients about deep-vein thrombosis, included information in the main community languages about how to obtain the leaflet in other languages or in brail or large type.
- Comfort rounds were completed every two to four hours on surgical wards to check on patients' comfort, pain, drink, bell caller positioning and the question was asked: "Anything else I can help you with?"

**Learning from complaints and concerns**

- The trust reported 99 complaints received in the year to January 2015 related to surgery. Sixty-one per cent had been responded to within the agreed timeframe. This was set against a trust target of 85%. Figures showed that response times had improved as the year had progressed. However, the trust had achieved its timeframe for responding to complaints for only one month during the year.
- As of 17 February 2015, the surgical division had ten overdue complaints out of a total of 49 for the trust as a whole. Two of these were serious incidents and we looked at the outcome of the investigation of these. Three were awaiting executive signature. The complainants had been updated and were aware of the delays.
- The trust complaint team were working with directorates to improve the quality of responses to complaints, in addition to the timeliness of response. Some wards, such as Sahara B ward, had received no formal complaints in recent months and we were told this was because any concerns raised by patients were addressed promptly and resolved.

## Are surgery services well-led?

Requires improvement 

There had been a change in culture that was leading to an increase in patient safety. The clinical governance structures were immature and work was underway to ensure governance, risk management and quality measurement was reliable and robust. There was good communication and team work.

# Surgery

There were concerns about the sustainability of meeting the current, and future level of demand.

### Vision and strategy for this service

- At the time of our inspection, the trust was focusing on addressing the key risks to the service: reducing the backlog to operations, improving referral to treatment times for surgery, and improving the IT infrastructure. Senior staff were coordinating the work of front-line staff to make the improvements required.
- There was some concern that other risks might be missed. A number of staff commented that the service was continuously 'fire fighting'.
- The leadership of the newly aligned divisions, however, were aware of the extent of the challenges and felt that with the support of the trust executive, clinical staff were 'willing and able' to meet them.

### Governance, risk management and quality measurement

- There was awareness at all levels of the immaturity of clinical governance processes. We found all the elements of a clinical governance system had been in place within the service in the past, but these had been poorly supported, partly because of insufficient staffing levels and inadequate IT systems. This resulted in a risk management process that was not integrated.
- Improvement measures were being taken, to clear the backlog of serious incident investigations and to incorporate the Duty of Candour requirements into the incident reporting system. A governance facilitator post had been created to lead a more systematic approach to the review of incidents and learning, and was sharing good practice to promote a common approach to clinical governance.
- The monthly management information for each specialty report included an outline of incidents, the number and types of risks on the register, response times to complaints received and responses within the timescale, a summary of legal claims. Department-specific safety alerts, information and themes for further discussion were shared. A monthly summary of the departmental report was produced for the trust quality and safety committee.
- There were monthly specialty meetings to discuss governance, and some of these were arranged to allow staff to attend without other duties. Medical and surgical staff from some specialties were positive about the discussion and dissemination of learning at these meetings. However, not all lists were cancelled to allow attendance, and this affected not only surgical and medical staff, but meant that anaesthetic and theatre staff could not always attend their divisional governance meetings. Wider learning outside specialties was limited.
- Good practice had been shared across several surgical wards when an internal assessment found variation in performance.

### Leadership of service

- The surgery and anaesthetics divisions for the trust had a management structure of divisional director, divisional manager and divisional nurse. The trust divisions had recently been reorganised and at the time of our inspection it was too soon to assess their effectiveness.
- We saw many examples of close working between lead consultants, service managers and matrons in surgical specialities. Consultant surgeons took responsibility for their specialties and were present at complex operations.
- Matrons kept ward staff informed of trust developments and encouraged ward leads to attend meetings, such as the serious incident panel. Nurses and healthcare assistants said they could approach senior nursing staff if they had any clinical questions or other concerns. They also said they were well-supported in professional development, and rotas were flexible to meet the needs of staff with caring responsibilities. However, there was concern that because staff were under pressure to meet the demand on the service they were less likely to take up training opportunities. We were told of the cancellation of a training session organised by a consultant anaesthetist because theatre staff were working additional theatre lists.
- Junior and middle grade doctors training in surgical services were well supported by consultants. They said they were given opportunities to develop their skills as well as take the study days they needed. The service had a good reputation for training in surgery.

### Culture within the service

- Many members of staff made comments on the improvements to the culture of the service. Staff said that the focus on patient care, begun by the previous chief executive, had produced tangible results and that they felt empowered to challenge for example by using the 'yellow card' to remind colleagues about the

behaviour and values expected of staff. Many of the staff we spoke with, in groups or individually, said the current executive group were visible and there was an increase in confidence in problems being tackled.
- We found examples of good teamwork and a positive approach to solving problems. Staff on the wards, in theatres, and in the surgical assessment unit and on the day-care unit said that good team work enabled them to take on the challenges in their work.
- There was good communication between nursing, medical and surgical staff, and administrative staff were valued for their contribution.

### Public and staff engagement

- There had been a number of initiatives to encourage patients and their families to provide feedback and to involve the local population in developments at the trust. One of the deputy chief nurses was responsible for coordinating this work.
- To engage with the public, staff had created information boards illustrating the different uniforms worn by hospital staff and signs encouraged patients and their families to use interpreters if they needed them. Boards in clinical areas provided an explanation of the service provided and had pictures and names of senior nursing staff. There were whiteboards on the wards and units showing the NHS Friends and Family Test scores, which also included comments gathered from patients and their relatives and a 'You said, we did' section, noting what the ward had done in response. When there were themes in comments, such as food, this was explored further to look at ways of making improvements.
- Staff valued their teams and their line managers.

### Innovation, improvement and sustainability

- We saw examples of improvements as a result of clinical engagement in meeting the nationally agreed standards, and greater accountability for these standards.
- Trainee doctors in surgical specialities said they were encouraged to contribute to improvements. When new consultants were appointed in general surgery, a first year trainee raised there was no increase in the number of junior doctors to do the additional work for consultants. Doctors' assistant posts were created, and were valued for their efficiency.
- We were told improvements developed by clinical staff were delayed or cancelled by the trust. A revised World Health Organization (WHO) surgical safety checklist had been developed in theatres after consultation with staff. It had taken five months to be 'signed off', without any changes being made to the format. Neurology had piloted the use of rehabilitation beds, but this had been cancelled in spite of an audit finding improved outcomes for patients. Some staff felt that the focus on addressing the key risks resulted in innovation being neglected, in particular if there was an initial cost to an initiative.
- There were concerns that the level of effort required to address the key risks and backlog of operations was unsustainable. Financial sustainability was a concern, there had been an increase in theatre throughput but no additional funding was available. Furthermore, the population of the areas was increasing, but the service was unable to meet current demand.

# Critical care

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

## Information about the service

The service provides general intensive care and high dependency, as well as neuro-intensive therapy and high dependency service.

The intensive care and high dependency units are specialist hospital wards. They provide intensive care, treatment and monitoring for people critically ill (level three) or in an unstable condition but not considered critically ill (level two).

There are 24 general critical care beds in the hospital. The general intensive care unit (GICU) is located on the ground floor where there are ten beds allocated to general intensive care, two of which can be downgraded to high dependency care. There are ten general high dependency beds (GHDU) within the general critical care unit and further four GHDU beds located in the coronary care unit on the fourth floor.

The hospital's neuro intensive care unit (NITU) is based on the ground floor next door to the GICU/HDU. The 12 bed sub-specialty intensive care unit is made up of six intensive therapy beds and six high dependency bed spaces. All the bed spaces had intensive care capability if required. The service supports a large catchment area of around 2 million people from north east London and Essex.

The hospital operates a critical care outreach service (CCOT) to support staff and patients on other wards in the hospital. They advise staff on caring for patients who have specialist needs while admitted to the general wards and help identify deterioration patients who may require a higher level of support in HDU or ICU.

The critical care team is led by 20 consultants six of which are neuro intensivists who work in NITU. There is a multi-disciplinary team of general ICU nurses, specialist neuro ITU nurses and physiotherapists. There was access to pharmacists, speech therapists and dieticians. The staff in the units are supported by healthcare assistants and administration staff.

Immediate family and friends can visit patients from 6am to 3pm and from 5pm to 9pm. There is a rest period for patients between 3pm and 5pm.

We spoke with a full range of staff that included: four consultants, three medical students, 14 nursing staff of different grades and included the senior nurse leads, four allied health professionals which included physiotherapy, dietetics and pharmacy, and four support staff, such as ward clerks, healthcare assistants and domestic staff. We also heard the views of staff attending focus groups.

We spoke with three patients and six relatives and friends. We observed care and the environment. We looked at a ten patient's records and hospital data such as audits and policies and procedures.

# Critical care

## Summary of findings

There were insufficient critical care beds available for the population served by the trust in comparison with other London Trusts. Despite four additional beds being made available, capacity has remained high at an average of 95%. It was estimated that critical care bed shortages affect 100-200 patients each month, with cancellation of planned procedures and significant waits in A&E when waiting for a GICU bed.

Incident reporting was variable and staff were unclear about which issues to report. Learning from reported incidents was not always apparent and staff told us there was little change after raising issues. Patient records, including consent and mental capacity assessments, were completed in most cases but we found some gaps in care plans and inconsistency in prescribing resulting in controlled drugs being administered without a valid legal prescription.

There was limited space. This resulted in small bed areas and no space for dedicated hand wash facilities or waste bins for each patient space. There was limited available storage for equipment. In most cases, equipment was cleaned in line with the infection control policy but some areas of the unit were not cleaned to the highest standard.

There was little multidisciplinary team working evident on GICU. Physiotherapists attended handovers but access to other professionals was on a referral basis. On NITU, structured MDT meetings were held for long term patients. Pastoral support was available across critical care 24 hours a day.

The leadership team had a strong vision for future expansion of critical care services but this had not been shared with the ward staff. Staff had a mixed understanding of the vision for critical care and the reconfiguration had left some uncertainty about the future expansion plans.

Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams. There was suitable medical cover provided by specialist consultants and junior doctors.

Policies and protocols we observed were based on national guidance and international guidelines. The critical care units completed local audits and evidence based work when no national guidance was available. The GICU participated in a national database for adult critical care. Patient outcomes and mortality were within expected ranges when compared to similar services. The outreach team supported ward based staff in the early identification of patients at risk of deteriorating and who may require an HDU or ICU bed. CCOT also provided an outpatient clinic to support previous critical care patients in the months after their admission and to ensure they continue to progress.

# Critical care

## Are critical care services safe?

Requires improvement

We found there was limited use of systems to record and report safety concerns and incidents. Some staff were unclear about the types of incident to report and were wary about raising concerns.

Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams. There was dedicated consultant cover between 8am and 9pm. An on-call consultant covered outside of these hours. The consultants worked on a week-by-week rota to promote consistency in care. Records were completed in most cases however we found recording gaps in patient records and inconsistent prescribing resulting in controlled drugs being administered without a valid legal prescription.

Space was at a premium within the GICU/HDU and NITU/HDU. Bed spaces were generally below the Department of Health's 'Health Building Note 04-02' requirements for critical care units. This meant dedicated facilities such as hand wash basins and clinical waste bins could not be accommodated in each bed space.

There was an ample supply of equipment and medical supplies to meet peoples' needs. However there was limited storage space and surplus equipment was stored in empty bed bays. In most cases equipment was cleaned in line with the infection control policy.

### Incidents

- There had been no data reported via the Patient Safety Thermometer for critical care from July 2013 to July 2014.
- Staff were encouraged and supported to report any incidents as they occurred using the hospital's electronic incident reporting system. All staff we spoke with felt confident to raise any concerns and they described how they could report incidents. Most staff would report incidents if it was something that affected a patient's safety, such as a fall or pressure ulcer.
- However we found some staff would not always report issues or concerns such as recording errors and chose to speak to individuals on a one-to-one basis.
- We reviewed 71 incidents reported between August and December 2014. Reportable incidents included: medications and documentation errors, falls, and bed shortages. There were some staff shortages reported but not as many as we would have expected. The staff/patient allocation book indicated shortages on most days resulting in staff doubling up on level three (L3) patients. This was contrary to national guidance of one nurse to one patient care for L3 patients.
- We noted when incidents of staff shortages were reported necessitating the need to double up L3 patients the rationale/risk assessment as to which patients were doubled up was not was not recorded.
- The 71 incidents we reviewed indicated that in most cases incidents had been investigated or were waiting for further information. In some cases the incident had been discussed with the individual(s) concerned. We saw some written reminders for staff regarding procedures and protocols, such as labelling specimens, had been posted in the staff meeting room after incidents had been identified.
- Incidents and complaints were reviewed and discussed at the weekly consultants meeting. Morbidity and mortality was also discussed at these meetings each week.

### Safety Thermometer

- A Safety Thermometer (an improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care) was produced for the critical care units. Information relating to hospital mortality, audits for discharge, hospital acquired infections and the quality indicator dashboard was displayed for staff in their staff room.
- Information boards were situated at the entrance to the units for the patients and visitors. These displayed information relating to the nurse in charge, planned number of nurses against the number actually on duty, and some safety data such as the number of falls within the unit and complaints received. The information was clear and up to date.
- Quality reports, audit results and a summary of incidents at CCU together with the changes made were displayed in the staff room. However, visitors to the unit were unable to see this information.

### Cleanliness, infection control and hygiene

- Intensive Care National Audit and Research Centre ICNARC 2015 data showed there were no concerns at

Queen's Hospital GICU/HDU in relation to hospital acquired infections such as meticillin-resistant staphylococcus aureusis (MRSA) or Clostridium difficile, and scored better than its comparator.

- In late 2014 the presence of MRSA had been found in GICU through swabbing. It was present in two neighbouring bed spaces. It was thought it to have been passed through low level patient to patient contact. This was subsequently decolonised and we saw all patients and staff were swabbed regularly for a period of time to ensure it had been eradicated.
- Patients with infections were risk assessed on how the spread of infection was controlled and could be isolated in a side room. Micro-biologists visited the unit regularly to discuss any cases or concerns.
- Signage was used to remind staff and visitors about hygiene measures when providing care, or visiting patients with infections. At our unannounced visit, there were two non-infectious patients in side rooms. However, the isolation notices were still displayed. We pointed this out to the senior nurse in charge and they agreed that staff could become immune to signage if it was always in place and could miss certain control measures if unaware of the patient's status.
- We noted that the environment appeared to be clean and tidy. Stickers were used to indicate when equipment had been cleaned and by whom. There was some dust on high level shelves around the nurses' station.
- Due to lack of space in the GICU, it was not possible to place a clinical waste and general waste bin within every bed space. Staff used bins located around the nurses' station in the centre of the unit. Approximately two to three bed spaces shared a bin. We observed the bins were overflowing, occasionally, preventing the bins lids from fully closing.
- Hand washing facilities were not available at every bed space in any of the critical care units at the hospital. The number of basins and positions varied in each unit. We noted that the basins, taps and soap dispenser were clean however there was a little corrosion to some of the metal taps.
- We observed there were a number of items such as oxygen cylinders and cardboard boxes containing fluids on the floor at the head end of bed spaces. This would make it hard to clean the floor and could harbour germs around the edges.
- We found some small spots of blood on the blood gas machine in GICU.
- All the commodes which included the seat and frames were clean and unmarked, including the underside of the seat.
- We found the cupboards containing dirty items such as linen, sharps bins and clinical waste in GICU and HDU were easy to push open despite having a key-code lock on the door. These cupboards were accessible to the public. The cupboard in the corridor leading to the GICU could not be seen by a member of staff and therefore could be accessed by anyone without staff knowledge. The cupboard in HDU could be seen by staff at the nurses' station if they were present. This cupboard also smelt strongly of rubbish as there was a bin for food waste also located inside. Dirty cupboards were appropriately locked in the other critical care units. We pointed this out to staff at the inspection and they told us they would report it. We found the same issue when we returned on our unannounced inspection. The senior nurse in charge showed us how the doors should be locked and told us the housekeeping staff were always unlatching the door for easy access. They told us they would take it up with the cleaning contractor.
- Sharps bins were available at every bed space. The containers were placed in low level trolleys specifically designed for the bins. They were positioned at the head end of the bed space to keep them less accessible to visitors to the unit and easily moveable for staff if they required them closer to the patient during medication administration.
- We observed staff following hand hygiene protocol. Weekly hand hygiene audits took place. Any areas of concern were discussed with staff. Hand gels were available at every bed space although they were not uniformly placed so difficult to locate if you moved from one space to another.
- Personal protective equipment (PPE) was available at every bed space. In GICU each bed space had a different colour apron to the bed space next to it. This meant it was easy to identify staff that had not changed their personal protective equipment prior to entering the neighbouring bed space to assist a colleague.
- There was an area available for visitors to the unit to hang their coats outside the ward area. However we saw

patient's visitors were not reminded to remove their coats when they entered the unit and a number of them hung them on the back of chairs at the patients' bedside.

### Environment and equipment

- The GICU and HDU were located within the same unit adjacent to one another. NITU was located in a unit across from GICU. There were a further four HDU beds on the 4th floor in the coronary care unit.
- The Department of Health's 'Health Building Note (HBN) 04-02' for critical care units stipulates that the bed space should be a minimum of 25.5m2 in order to: accommodate the required equipment and furniture and to allow for staff access to the patient from all sides of the bed, to manoeuvre the patient, themselves and equipment safely and for five members of staff to attend to the patient in an emergency situation. Bed spaces in the ICU, HDU and NITU were smaller than 25.5m2. Staff we spoke with were aware the bed spaces within the units were generally below HBN guidance.
- The beds were modern and appropriate for the critical care unit. Each bed space had pendant mounted monitoring and ventilation. Additional equipment was generally securely mounted, however, we found a number of unsecured oxygen cylinders at the head end of the bed space.
- The unit had an ample supply of equipment required to meet patients' care needs. The label on the equipment demonstrated that it was regularly maintained and serviced. As the building came under a 'private finance initiative' (PFI) equipment was replaced and repaired as part of the contract. Staff told us they found that any equipment issues were dealt with promptly. However, space was at a premium and it required them to ensure that some equipment was stored in empty bed bays.
- Resuscitation equipment was available on GICU, HDU and NITU. The content of the trolleys was checked every day and we saw records supporting these checks. The resuscitation officer audited the records on an annual basis. The trolley contained appropriate equipment which was easily accessible during an emergency.
- Emergency/difficult intubation equipment was available, and staff were aware of its location in the event of an emergency. Emergency tracheostomy equipment was readily available next to the tracheostomy patients' bedside.
- Nursing and medical handover for GICU and HDU took place in the staff coffee/changing room. The room was a narrow 'L' shaped room and this made it difficult for all staff to hear adequately or see properly. It was particularly difficult during the medical handover as nursing staff going off duty entered the room to collect their personal belongings from their lockers. Although they tried to be quiet it was difficult for us to hear the doctors' conversations above staff coming and going.

### Medicines

- GICU, HDU and NITU received daily weekday visits from a pharmacist.
- Staff told us it was rare for any medication errors to occur. Out of the 71 incidents reported between August and December 2014, 22 related to medication errors. These errors included incorrect administration of medications (either to the wrong patient, the wrong dose or via an incorrect route, such as noradrenaline being given via a peripheral line) and discrepancies in the controlled drugs (CDs) stock control.
- The practice development nurse told us that an increase in medication errors had been identified and refresher medication competency training was given to staff.
- A new style pre-printed prescription chart called the 'Continuous Intravenous Infusion Prescription Chart' had been devised by the consultants in NITU. This was to minimise errors by standardising the prescriptions and ease repeat prescription. The consultant did not need to write out drug names each time they prescribed it and were only required to sign and date against the drug required on the pre-printed chart. It had been trialled in all the critical care units for two weeks in summer 2014. We found that this chart was being used on each of the units, however, there was some confusion as to whether it should be used in GITU and HDU, as the charge nurse did not seem aware of its use since the trial. When we spoke with the practice development nurse, she told us that, after the two-week trial last year, the form had "floated back to the unit".
- We spoke with staff in GITU about the form and we found inconsistency as to how long the perceived prescriptions on this form lasted. Some thought it lasted for 24 hours from signing and, therefore, required a further signature from the prescriber within 24 hours, others told us it lasted until 1pm each day. Another

member of staff told us the doctor signed it for 24 hours, but they could be late to repeat the prescription, so the chart allowed the nursing staff to continue administering the infusions.

- During our inspection, we reviewed medication charts and observed inconsistent prescribing. For example, we reviewed one patient's notes and found Remifentanil (a controlled drug, which requires a prescription) had been prescribed on the pre-printed drugs chart on 21 to 23 February 2015 and again on the 1 to 3 March 2015. The CD book confirmed the patient also received this drug on the 26 and 27 February. This was signed out by two nurses, in accordance with guidelines on the administration of CDs. We looked at the back of the observation charts and in the patient's notes to see if a prescription had been located elsewhere. We also asked the practice development nurse to see if they could locate it, but they also could not find it. This meant that a controlled drug had been administered without a valid, legal prescription.
- We spoke with the charge nurse, who was the most senior member of nursing staff on duty, and the practice development nurse to bring to their attention the seriousness of this concern. The charge nurse told us they would not expect a nurse to discontinue a drug a patient required for their own safety. We reiterated that this drug should not be given without a legal prescription and this practice puts nurses' registrations at risk. We were not given a clear understanding as to why a prescription was not sought as soon as it was identified the patient required the drug and no longer had a prescription. No one had picked up on the error until we found it six days after administration. It was suggested that this was not uncommon practice within the trust. The unit took the decision to withdraw the pre-printed prescription chart and resume using the medication recording area on the back of the observation chart as they had done previously. The issue was brought to the chief executive and medical director's attention.
- After our findings, CQC pharmacy inspectors checked medication administration records (MAR) in critical care. They checked a further four MAR charts and found they had been correctly signed for medicines. We also checked five MAR charts in NITU and found they had been correctly signed for medicines.
- At our unannounced inspection, the GICU had made several changes with regard to prescribing, drawing up (preparation) and administration of medication to safeguard against prescription and administration errors. This included an escalation procedure should a prescription not be written up, a clear signature system for the drawing up and administration of the medicine, which included best practice guidance of including the prescribers GMC number. On a daily basis, the pharmacists were auditing all medication charts and highlighting errors and missing information. This was then discussed with the individuals involved.
- The NITU had continued with the 'Continuous Intravenous Infusion Prescription Chart', which had been designed specifically for the unit and all staff had received guidance and training in how to use it.

### Records

- Records were securely stored in a way that promoted confidentiality. All patient records were located in the nurse desk at the end of each patient's bed. Records were taken with the patient when they were discharged from the ward.
- We found gaps in some records. For example, we looked at a patient's notes on Tuesday 3 March 2015. They indicated the patient had started on a skincare pathway and dressings were being applied. There had been no update since the 25 February 2015, and the daily review had not been completed on 1 March 2015.
- Records included risk assessments, such as pressure ulcer risk factors and the use of mittens for patients who were at risk of pulling out tubes and causing injury to themselves.
- We found that patient records included a daily summary and treatment plan completed by the consultant. This included clinical assessments, impressions, care bundles and care pathway.

### Safeguarding

- The staff we talked with demonstrated a good understanding of what safeguarding vulnerable adults and children meant in practice and were able to describe how to escalate any safeguarding concern. They were aware of how to contact the trust's safeguarding link nurse.
- The safeguarding policy and procedure were available on the hospital's intranet, however, we found there were two policies available, one of which was out of date (the review was due in December 2011).

- The local induction checklist for all temporary staff included awareness of the policy for child protection, however, it did not include safeguarding vulnerable adults.

### Mandatory training

- The trust's target was for 80% of staff to have completed mandatory training. Records showed this had been achieved by critical care staff in every module apart from one: conflict resolution, which was close to the target at 79% compliance.

### Assessing and responding to patient risk

- The Richmond Agitation Sedation Scale (RASS) was used to measure the agitation of sedation levels of a patient. It is mostly used in mechanically-ventilated patients in order to avoid over and under-sedation.
- The Glasgow Coma Scale (GCS) was used to record the conscious state of a person with a traumatic brain injury.
- Early warning scores (EWS) were completed on patients prior to discharge to the ward.
- Patients were monitored for different risk indicators. Each ventilated patient was monitored using capnography, which monitors carbon dioxide in respiratory gases. It was available at each bed on the unit, and was always used for patients during intubation, ventilation and weaning, transfers and tracheostomy insertions.
- Delirium assessments were in the template for nursing records. (Delirium is an acute, fluctuating change in mental status, with inattention, disorganised thinking, and altered levels of consciousness. It is a potentially life-threatening disorder characterised by high morbidity and mortality. Delirium is common in intensive-care patients, especially among mechanically-ventilated patients. In critically-ill patients it is associated with an increased length of stay and increased mortality.)
- Staff identified areas on patients' bodies that were more susceptible to getting pressure ulcers, such as where nasogastric tubes touch the face and ears. As soon as any redness in the skin was identified staff protected the areas to ensure they did not become ulcerated.

### Nursing staffing

- Each unit was overseen by a matron. One was responsible for GICU and another for neurocritical care.
- A charge nurse and senior sister were responsible for the day-to-day running of GITU and NITU respectively.

#### General care unit and high dependency unit

- There were 7.92 whole time equivalent (WTE) band 7, 23.5 WTE band 6, 46 WTE band 5 nurses, 6.69 WTE band 2 healthcare assistants, two WTE band 4 administration staff and one WTE band 3 ward clerk. The divisional director told us there were 16 vacancies, however, there was funding for an extra 10 staff.

#### Neuro intensive care unit and high dependency unit

- There were 5.77 WTE band 7, 15.75 WTE band 6, 32.22 WTE band 5 nurses, 5.5 WTE band 2 healthcare assistants and 1.83 WTE band 3 ward clerks. At the time of our inspection, the unit was fully staffed. However, there were two band 5 vacancies expected within four weeks, however, these would be filled immediately as there was a waiting list of staff wishing to work within the unit.

#### Critical Care Outreach Team

- There were 11 band 7 nurses, three of whom worked on a part-time basis.
- Staff absences in GICU/HDU or NITU/HDU were covered by regular in-house bank (IHB) staff or agency staff. The CCOT nurses could cover absences on the ward in an emergency.
- The Faculty of Intensive Care Medicine Core Standards for intensive care units states that all ventilated level three patients are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and all level 2 patients have 1:2 care.
- We found that, while the GICU and NITU, aimed to support patients within the guidelines this was not always possible, due to the acuity of patients admitted and staff absences. Staff perceived that this happened about once a month, however, we found this was a regular occurrence. The GITU allocation book showed that between 2 and 8 February 2015 staff did not have to care for a level 2 and level 3 patient at the same time on one out of seven day shifts. On one of these days during this time, two staff members looked after a level 2 and level 3 patient. The night shift for this week also showed

that, on four nights out of seven, a member of staff was required to look after two patients and on two of those occasions they were caring for two level three patients at the same time.
- The following weeks showed that allocating staff to care for more than one patient was more common than staff appeared to think.
- The senior staff in NITU confirmed that, although they always had ten staff rostered, there were occasions when someone may have to look after two patients, due to unexpected staff absence. They added that they would aim to obtain another member of staff through the IHB system or agency.
- Despite the staff shortage, we saw continual efforts to ensure the patients were receiving the support they required safely. For example, the senior staff assessed the stability of the patients, whether there were any infections that could easily be transmitted if a staff member was nursing two patients, and the location of the patient in the unit. It would be harder for a member of staff to nurse two patients who were not situated in beds next to one another. Only experienced staff supported another patient when already caring for a level three patient.
- If extra support was urgently required, a member of the outreach team supported GICU/HDU until agency staff was found, however, this meant the outreach team was suspended to support staff and patients in another part of the hospital. We saw this in action on the last day of our announced inspection.
- In GICU, the nursing handover meetings took place at 7.30am each morning. The most senior member of staff working overnight fed back to the whole nursing team coming on for the day. This included the charge nurse. We found the handover was clear, organised and well structured. The senior lead for the day allocated the patients to the oncoming staff. These meetings were conducted in a businesslike manner and all key data and progress was described in sequence.
- Following this meeting, nurses had a one-to-one handover meeting with the nurse who had previously been looking after the patient at the bedside. This was more detailed and allowed for a full update on treatment, care and any changes. This took around ten minutes.
- In NITU, the senior nurses held a handover together. The patients were allocated to the nurses as soon as they came on shift and they had a one-to-one handover with the outgoing nurse. Senior staff told us this allowed more time for the nurses to share information about the patient and go through checks together. They had found this to be a more beneficial use of the time, as not all nurses were required to know about every patient, this allowed them to focus primarily on the patient they were working with.

### Medical staffing

- The consultant to patient ratio across ICU was 1:9, if all the beds in the unit were occupied. This was in line with the core standards for intensive care units guidelines that state the ratios should not exceed 1:8 to 1:15. The divisional director told us there were currently two consultant vacancies.
- There were a total of 20 consultants who participated in intensive care, six of whom were consultant neurointensivists who worked in the NITU.
- Eight specialist trainees, year three to seven (ST year 3-7) supported the six consultant neurointensivists in NITU.
- Foundation year 2 (FY2) doctors and core trainee doctors (CT1-2) supported consultants in GICU and HDU.
- Four consultants were responsible for the CCOT. Their responsibility also included providing consultant cover for the four GHDU beds based in coronary care. The CCOT consultant cover changed on a daily basis and some staff said this made continuity of care more difficult as each consultant needed to familiarise themselves with the patient before assessing their progress, physiotherapy support and discharge planning.
- Medical handover meetings took place each morning for an hour from 8am. The doctors on duty overnight updated the day-shift team on any new patients admitted overnight, changes or concerns in current patients and any patients who could be stepped down to a ward. We observed a morning handover meeting and found there to be good attention and discipline.
- Between 9am and midday, the consultants held a detailed bedside ward round with trainees. There was variable attendance at these rounds from physiotherapists, pharmacy and dietetics.
- There was one consultant available in each of the critical units from 8am to 6pm. One consultant covered all the units between 6pm and 9pm. Between 9pm and 8am, a trainee/junior doctor was on duty with consultant on-call cover provided by a first and second responder.

# Critical care

### Allied Health Professionals (AHP)

- The core standards for intensive care units states there must be a dietician as part of the critical care multidisciplinary team. The British Dietetic Association recommends that there should be 0.05 to 0.1 WTE dieticians per one bed and that the lead dietician for ICU should be at least a band 7. Apart from the NITU weekly ward round, there was minimal input from the dietetic department only, which was provided via a referral system.
- The physiotherapy team consisted of one band 8, one band 7, two band 6 and one band 5 members of staff. They supported staff across the hospital and also supported patients who have critical care or surgical physiotherapy needs. The band 7 and band 8 generally supported patients in GITU/HDU, paediatrics, the resuscitation area in A&E and preoperative. The NITU has its own physiotherapy staff, 2 band 7's, 1 band 6 and 1 band 5. The service ran weekdays from 8am. There was an on-call rota at the weekend.
- There was access to three occupational therapist covering ITU and surgical wards at the hospital. Staff reported that there was limited input from the team, as they were unable to manage the workload due to the size of the team.
- There were no tracheostomy-trained speech and language therapy staff, therefore, the physiotherapy team supported patients with some swallowing difficulty techniques.

### Major incident awareness and training

- All staff attended fire safety training as part of their mandatory training. Staff were able to explain what they were expected to do should they be required to evacuate the critical care areas. None of the staff we spoke with had rehearsed a fire evacuation, however, a film on how to evacuate critical care units had recently been made for Queen's Hospital. It had not been released for viewing at the time of our inspection.
- Senior nursing staff were able to verbalise all aspects of preparing for an external major incident. Junior nursing staff told us it was their responsibility to continue caring for their patient and waiting to be told what to do by senior staff.
- Staff told us that, in the event of a power outage, there would be failure of lighting, monitoring equipment and probably IT. We found there was no consideration of what to do in the event of total failure and no generator back up. There was no access to torches or lanterns should this happen at night.

## Are critical care services effective?

Good

Policies and protocols were based on and referenced to national guidance and international guidelines. The critical care units participated in national and local audits and the data showed patient outcomes and mortality were within expected ranges.

All staff received an induction to the critical care units. Nursing staff were required to achieve specific competencies prior to working alone with patients. Further intensive care training was available to nursing staff. Nursing staff were encouraged to become an expert and lead in specific clinical areas such as infection prevention and control or pressure ulcers. Consultants had a specialist intensive care qualification and NITU consultants were specialist neuro intensivists. Staff spoke positively of their training and opportunities to learn and develop.

There was sufficient consultant cover throughout the week, including an on call response overnight. An outreach service operated daily and audits had shown it to have a positive outcome for patients and decrease the number of patients being referred from wards to GICU.

Records showed discussions held with patients and families around consent and formal documentation was completed. Mental capacity assessments were completed and best interest conversations were held with family or independent advocate. Deprivation of Liberty Safeguards (DoLS) assessments were completed where appropriate, such as in the use of mittens.

There was little multidisciplinary team working evident on GICU. Physiotherapists attended handovers with nursing and medical staff but access to occupational therapists, speech and language therapy and dieticians was by a referral basis. However structured MDT meetings were held in NITU for long term patients.

# Critical care

## Evidence-based care and treatment

- Policies were based on NICE/Royal College guidelines where appropriate and care was provided in line with NCEPOD guidelines.
- We saw protocols and guidelines used for medical and nursing management were referenced to national and international guidelines. For example, aneurysmal subarachnoid haemorrhage neurocritical care management guidelines for the patient's initial 48 hours were referenced to guidelines from the American Heart Association, the Stroke Association and from recommendations from the Neurocritical Care Society's Multidisciplinary Consensus Conference.
- Nursing protocols and guidelines were available in a folder at each bed space. These included, amongst others: sepsis screening tool, priority list for isolation, insulin administration during diabetic ketoacidosis, care bundles for ventilated patients and phosphate replacement. We noted that there were limited review dates and some protocols, although procedures may not have changed and were very old, such as the 'priority list for isolation', which was last updated in December 2006. We also observed the nasogastric tube-feeding protocol had a note taped over it stating: "Until further notice NG tubes must not be used until a consultant has reviewed the x-ray and confirmed its position." We saw that this note had become detached in a couple of the folders. If the note was lost it could put patients at risk of being fed when a NG tube was not correctly positioned as a member of staff maybe unaware of the change in protocol.
- The units participated in a number of local clinical audits, such as 'Referrals to Critical Care', 'Specialty Involvement in Critical Care' and 'Prescribing in Critical Care'.
- The critical care team took part in multi-centre trials such as Eurotherm. This was a trial to establish the benefits of cooling the body to reduce the metabolism against not cooling the body.
- The critical care outreach team (CCOT) audited compliance to the deteriorating patient policy. The policy reflected NICE guidance CG50 and NPSA guidance relating to the treatment and care of patients who are acutely ill or at risk of physical deterioration. The audit looked at appropriate use of the early warning scores (EWS) and escalation. The audit showed that all patients in the audit had an appropriate EWS chart, 23% of the total EWS scores calculated were incorrect. Of this group, 31% did not receive escalation and had a EWS score of more than 3 placing them at greater risk of deterioration. Recommendations from the audit, included: further training, colour-coded observation charts and senior staff to monitor the number of patients requiring escalation at staff handover.
- A consultant gave us examples of evidence-based work they did when there was no national guidance available. For example, they had set up a Propofol infusion audit.

## Pain relief

- The critical care units used a standardised pain scoring tool.
- Patients reported being regularly asked about their pain levels and offered appropriate medication, if required.
- If treatment was no longer benefiting a patient, a decision was made in conjunction with family members/advocates to withhold life-sustaining therapies, care and medication. A move was then made towards providing comfort and palliation to reduce any distressing symptoms in the last stages of the patient's life.

## Nutrition and hydration

- Nutrition and hydration requirements were assessed and reviewed daily by the medical teams. A dietician attended a ward round once a week to discuss nutrition needs for patients admitted to the neurointensive therapy unit. Staff could refer patients of concern to the dietetics service.

## Patient outcomes

- The GICU participated in a national database for adult critical care as recommended by the core standards for intensive care units. They contributed data to the Intensive Care National Audit & Research Centre (ICNARC) database for England, Wales and Northern Ireland.
- Results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with other similar services.
- ICNARC 2015 data showed the number of unplanned readmissions to GICU/HDU within 48 hours was within acceptable limits and, on average, with comparative hospitals. However, it was worse than the clinical reference group's threshold that was based on the median across all critical care units in 2012/13.
- GICU/HDU hospital mortality rates were slightly better than the national average, at 0.9 against 1.0.

- The NITU had previously contributed to ICNARC, however, due to lack of staff to collect and input the data they had not been able to participate. They had recently employed someone to do this work and had re-started contributing data to ICNARC for neurosciences, this commenced in April 2014. The results for April to June 2014, indicated there were no concerns regarding patient outcomes, however, 10% of patients were discharged out of hours, this included discharges to the wards.
- A report written by the clinical lead for intensive care medicine indicated that the CCOT was one of the first in the country to provide a consultant-led service with daily consultant rounds. This meant there was early and consistent senior input for patients treated in non-critical care areas of the hospital. As a result, the incidence of admissions to the GICU following an in-hospital cardiac arrest had improved to just over 2%, which was below the national average and a 34% reduction in cardiac arrest calls.
- We noted the audited results for 'Prescribing in Critical Care' dated 7 October 2014 (presented 11 April 2014) had identified poor practice from record samples taken on two random days in November and December 2013. The trust's policy required all prescribers to write their professional registration number next to their signature on all prescriptions. Results showed that fourteen out of fifty-nine (24%) of drug charts and one out of twenty-three (4%) of fluid/infusion charts were compliant. Reasons for this included: lack of knowledge, precision, inconvenience, no repercussions, multiple prescriptions and lack of space. Solutions included: education, cultural change, space on charts and pharmacy to highlight errors. However, at the time of our inspection we found this policy was not being adhered to and, following our concerns relating to inconsistent prescribing, the trust reinforced the need for the prescriber to include their registration number. This extended to include the nursing staff.

## Competent staff

### Medical Staff

- Seventeen out of twenty consultants had a specialist intensive care qualification.
- Consultants in the NITU were neurointensivists and dual trained in either critical care or fellowship trained.
- When starting their neuro rotation junior medical staff were provided with an information leaflet about the neuroscience module's standard operating procedures. This outlined the NITU's background, admission criteria and what was expected from them during their rotation in the unit.
- Junior doctors and specialist trainees spoke positively of their training. They told us it was a challenging hospital to have your rotation at, but the learning was immense. They felt supported in their clinical work and were given enough freedom to develop and practice their skills through formal training, ward rounds and bedside handovers. We observed junior doctors summarising at handover and consultants advising on their technique and teaching, by example.
- Each weekday afternoon a formal teaching session was held between 2pm and 4pm by the consultants with the trainee doctors and specialists.

### Nursing Staff

- The GICU employed a full-time practice development nurse, who was trained in critical care. They supported junior staff in specific intensive care bedside training.
- A nurse in NITU had recently been supported in gaining the advance nurse practice role on the unit. They will be required to meet advanced educational and clinical practice requirements relating to neurointensive therapy.
- Nurses in NITU were trained in haemofiltration. This was a better outcome for patients as they no longer needed to be moved to the GICU for this procedure.
- Forty-three out of eighty-four GICU nurses had completed an intensive care course and nine were currently taking the course. This was in line with the Faculty of Intensive Care Medicine Core Standards that a minimum of 50% of registered nursing staff should be in possession of a post registration award in critical care nursing. The practice development nurse had requested a further ten places on the course, which would be split between Queen's Hospital and King George Hospital.
- NITU nurses took part in the hospital's foundation NITU course, which took one year to complete. Senior staff reported positively about this course, saying it increased recruitment and staff retention. NITU staff completed a general ITU course and/or a neurology ITU course.
- Nursing staff had to achieve required competencies, such as tracheostomy care, nasogastric tube administration, suctioning, citrate and sepsis before working alone with patients. Once staff acquired the relevant competencies, they were allocated to patients

who required the staff member to embed their learning prior to moving on to a higher acuity patient. Once they were deemed proficient in the areas identified, they could progress and with support from an experienced colleague care for a patient with different critical needs.
- Agency staff were shown how to use equipment and their competencies were checked by a senior member of staff.
- All GICU staff, including some regular agency staff, completed competency training, as required. The practice development nurse kept records of who had completed training and when further training was required.
- Records showed that 93% of nursing ITU/HDU staff had received an annual appraisal. Staff we spoke with were positive about the experience and described the value of an annual review to discuss their achievements and goals.
- Each nursing team had a 'champion' on particular clinical areas, such as amongst others: falls, pressure ulcers, infection prevention and controls, safeguarding and nutrition. Staff reported positively about this experience and felt valued members of the team by being an 'expert' in their chosen subject. One nurse told us they were the nutrition champion and attended monthly meetings with the nutrition department.
- A scheme to allow band 6 nurses to 'act' up to a band 7 nurse for a six-month period had recently come into place. This allowed them the opportunity to try the role before applying for a band 7 position. It gave them invaluable experience while being supported by other band 7 staff.

### Allied Health Professionals (AHP)

- The senior occupational therapist (OT) had received suctioning training from the physiotherapy department, so they could support patients with a tracheostomy when taking them on a home visit.

### Multidisciplinary working

- All care and treatment for patients admitted to the GICU was the responsibility of the anaesthetists or intensivists on the unit. Responsibility for care transferred to the medical or surgical consultant, who initially referred the patient to critical care once they were discharged to the ward.
- Patient care and treatment when admitted to the NITU remained the responsibility of the neurology doctor who referred them to critical care. However, it was the anaesthetist or intensivists decision that, when a patient could wake up, as there may be other concerns, such as respiratory issues that needed to be considered first.
- Once a neurology patient was awake and alert they were discharged to an appropriate ward, back to their referring hospital, or a rehabilitation unit. It was the responsibility of the team at Queen's Hospital to transfer patients back to their admitting hospital or rehabilitation centre by an ambulance staffed with paramedics and a neurology nurse from the unit. The nurse provided a detailed handover once they reached their destination.
- There was little multidisciplinary team working within the GICU. The lead nurses and physiotherapists attended the medical handover each morning, following the nursing handover. This allowed for the senior nursing staff to raising any concerns and current status of the patient with the medical team who may not have had recent contact with the patient.
- The physiotherapists were present at the medical handover meeting. They showed chest x-rays for each patient discussed. However, we noted the images shown did not always correspond with the patient being discussed, which could cause some confusion and was a little distracting at times. We were unable to get a clear understanding about the use of the images during the handover meeting. We observed the physiotherapy team worked closely with patients. They supported staff in extubation (removal of a tube from a patient's airway), tracheal suctioning when required, patient positioning and rehabilitation.
- Support from the dietetics department was on a referral basis. We were told this was a historic arrangement, due to a past consultant's views on dietetic support in critical care. We were also told there was no funding for a dietician to regularly provide support in GITU.
- Multidisciplinary team meetings for long-term neurology patients were structured and included the referring neurology doctor, critical care consultant, occupational therapist and family. The physiotherapy team and specialist nurses for organ donation (SNOD) supported staff and patients in the NITU on a daily basis, and a dietician attended a structured ward round on a weekly basis.
- Speech and language therapists (SALT) were available on request. However, we were told there were no tracheostomy trained staff at the time of our inspection.

- Occupational therapists were involved in discharge planning for patients returning home. This was supported by the physiotherapy team through joint home visits to assess a patient's home for any equipment, or access needs.
- Pastoral support was available 24 hours a day and the chaplain visited the ward a couple of times each week.
- Patients from critical care were followed up on the ward by the CCOT, within 24 hours of being discharged from the unit.

### Seven-day services

- One consultant worked in each of the critical care units on a rota system of one week out of every five. There was a consultant in each critical care unit (GICU, HDU, NITU) from 8am to 6pm each day. From 6pm to 9pm, one consultant covered all the units.
- Specialist trainees (STs) in years 3-7 were based in the NICU at all times. On some days, supernumerary foundation year two (FY2) doctors supported the unit.
- Foundation year two (FY2) and CT1-2 doctors were on duty in the general ICU at all times.
- Consultant cover out of hours, from 9pm to 8am was covered by a first and second on-call responder who lived no more than 30 minutes away from the hospital.
- The CCOT was available seven days per week form 7.45am to 8.15pm.
- Critical care patients were prioritised for scans and imaging. Staff reported no problems with accessing services quickly at any time of the day.
- The physiotherapy team worked Monday to Friday, during the day and started at the medical handover meeting at 8am. An out-of-hours, on-call service was provided.

### Access to information

- Patients and their families were given an information leaflet on what to expect during their admission to the critical care units.
- All staff we spoke with found the IT systems frustrating to navigate and difficult to access due to a lack of computer terminals. For example, we searched for blood products guidelines and found the page was not available and identified as an error. However, we were told by a number of staff that there was a plan to have a new IT system and software interface.

### Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Consultants described how they obtained consent from the patient and/or relative whenever possible. Records showed details of discussions and formal consent was documented, where appropriate.
- Mental capacity assessments were completed for people who were suspected as not having capacity to consent. Best interest conversations were held with family, or an independent advocate, where appropriate. Assessments were also completed for people who chose to discharge themselves.
- Staff had access to the trust's consent policy on the hospital's intranet.
- Deprivation of Liberty Safeguards assessments were completed, where appropriate, such as in the use of mittens to prevent patients from pulling at tubes and hurting themselves. However, under Havering Local Authority there was no need to inform them of depriving a patient of their liberty unless they were known to have a mental health concern. Families were informed of Deprivation of Liberty Safeguards, as soon as practicable.

## Are critical care services caring?

Good

We observed patients were treated with dignity and respect most of the time. Staff were described as "kind" and "professional". On most occasions we saw patients' needs were met. One relative said "[the GITU staff] are absolutely fantastic, they can't do enough". A relative of a patient in NITU told us, "amazing attention, I cannot fault the attention".

Patients and relatives told us they were involved in the care planning process and felt well informed. A relative told us the staff had dispelled everything that was worrying them and answered all their questions. Staff told us they encouraged visitors to help care for their relative through talking to them or performing some personal care tasks.

Patients' families told us difficult conversations were held in private, handled well and in a sensitive manner. Discussions were held in a way the patient and their family could understand. The staff told us they supported

patients, relatives and friends however they could. A member of staff said, "they [patients and visitors] all have their own individual needs and ways of coping. We help however we can."

### Compassionate care

- We reviewed 30 patient surveys for NITU, all of them had positive ratings and comments. One patient's relatives, told us their family member had even taken the time to write onto his newspaper about the nurse caring for them describing them as, "Nice and professional."
- Inscriptions in 'thank you' cards displayed at the entrance to the units indicated how much patients and their families had appreciated the friendly and supportive staff during the difficult time they had been through.
- We observed staff displaying concern for their patients and heard them speak with respect. Consultants greeted patients and their relatives and friends and enquired how they were. All interactions were caring, professional and appropriate.
- All staff worked quietly and did not hold any unnecessary conversations amongst themselves. They showed respect to the patient and explained what they were doing throughout any treatment or care, even when the patient was in an unconscious state.
- We observed staff giving unconscious patients human contact through holding their hand, or stroking their arm while talking to them quietly. However, we observed a conscious patient who was due to be discharged from the GICU sitting in a slumped position in their bed. Their lunch was placed out of their reach. A member of staff assisted this patient in repositioning their oxygen, but did not address their slumped position, or think to move their food closer to them.
- Relatives and friends told us they were encouraged to support the patient with some aspects of care, such as washing their hair, or applying cream to their feet, if they felt comfortable to do it. Other ways visitors could support their relative was through reading to them and helping to feed them.
- Curtains were used to maintain patients' privacy and dignity. Staff had tried to find ways to remind staff and visitors about requesting permission to enter a curtained-off area. For example, they used notices taped to the top of the curtain tracks, however, these were high and not easy to see and fell off. They had also tried fixing a notice to the curtain, but these were lost when the curtains were changed for cleaning.
- On three occasions, we observed that curtains had not been closed fully around patients' beds in GICU, while the doctor was performing a procedure. People passing by could see through the gap to the side of the closing.
- In the medical and nursing handovers, we noted that patients were talked about by bed/bay number and medical condition, as opposed to by their names. This approach made staff appear less connected to the patients as human beings. These conversations were held in private and, therefore, patient privacy would not be compromised. We spoke with senior staff about why patients' names were avoided and they said, "We were told the CQC wouldn't like it, as patient privacy should be maintained at all times." They told us that all boards displaying patient details had been removed from the ward, although boards had been placed in every bed space with the patient's and doctor's names on them. They told us they would prefer to discuss patients by name, as it is easier to identify them.

### Understanding and involvement of patients and those close to them

- Patient's records showed discussions with patients and their relatives relating to care, treatment, prognosis and progress.
- Relatives of patients spoke positively about the staff involving them in their family member's care and treatment. One person said, "[We] have had a good explanation from the doctors and nurses."
- We heard a nurse explaining to a patient the rationale for taking sips of water in a clear and kind manner.
- The CCOT had devised a tracheostomy discharge checklist for patient's leaving the hospital with a tracheostomy. The checklist addressed teaching patients, family and carers in how to support a person with a permanent tracheostomy. Key competencies, such as: suctioning, care of stoma site, equipment and action to take in the event of an emergency were checked and signed off. This meant patients and their carers had a clear understanding of the equipment, care required and support they needed.

# Critical care

### Emotional support

- Consultants reported that they broke bad news to patients' relatives in private, with the support of a nurse and additional pastoral support if the family requested it.
- A patient's family told us that staff had told them to call the unit at any time, even overnight, if they were at all worried.
- A chaplaincy service was available for patients, families and staff. We were given examples of when chaplaincy support had been accessed for families and staff. The chaplain could offer Christian and spiritual support, as well as access to local spiritual leaders from other religions.
- If a patient had mental health concerns, psychiatric support could be accessed through the hospital.
- The outreach team described how they supported patients coming to terms with lifelong changes, such as a permanent tracheostomy.
- The specialist nurses for organ donation (SNOD) explained the support they gave families in considering donating their relatives organs once they had been identified as dying and were suitable for organ donation. The SNOD nurses support was unconditional and they remained with the family through the dying stages, even if they had decided not to donate.
- The CCOT told us patients who had left hospital and were finding it emotionally difficult to live with a tracheostomy often called them. A member of staff said, "We can spend quite a time on the phone offering friendly support and advice. We also suggest they attend the monthly outpatient clinic."

## Are critical care services responsive?

**Requires improvement**

There were insufficient critical care beds available for the population served by the trust in comparison with other London hospitals. Some attempt to mitigate bed shortages was made by opening an additional four GITU beds but capacity has remained high at an average of 95%. It was estimated that critical care bed shortages affected 100-200 patients each month resulting in long waits in A&E or cancellation of planned operations.

Facilities for visitors to critical care were variable. The waiting area was not large enough for the number of visitors waiting. There were two rooms available for visitors to stay in overnight. The room for GITU visitors, was stark in comparison to the room provided for NITU visitors, which had ornaments, rugs and cushions decorating it. There was little privacy for confidential conversations and one relative told us they had a family discussion with the doctor in the corridor. The outreach team assisted ward-based staff in the early identification of patients who were at risk of deteriorating and who may require an HDU or ICU bed.

CCOT also provided an outpatient clinic to support previous critical care patients in the months after their admission and ensure they continued to progress. Staff told us they used a variety of communication tools, such as pictures and translators, when needed. Free newspapers were offered to patients and visitors on GITU and the NITU worked to orientate patients by keeping patient diaries and dressing patients in their own day/night clothes. No complaints had been received by NITU in three years. Fourteen complaints had been received by GITU from April to December 2014 and records did not show the outcome of learning from them.

### Service planning and delivery to meet the needs of local people

- Based on the London average of seven acute critical care beds per 100,000 population (Intensive Care Society/ Faculty of Intensive Care Medicine data January 2014) the trust should have 50-70 critical care beds to support its local population.
- The trust is the seventh busiest for general critical care in the country by the number of admissions, but only 30th by the number of general critical care beds. Queen's Hospital had 12 ICU beds (two of which could be downgraded to HDU beds), eight HDU beds and a separate 12 bed subspecialty neurocritical care unit
- The clinical lead for intensive care medicine had produced a paper on 'Planning General Critical Care Capacity'. The plan estimated an expansion of service would realistically take three to five years to relocate the critical units, possibly in a new building.
- An immediate interim plan was to increase the critical care capacity by eight beds to mitigate the winter pressures. However only four beds in the coronary care unit on the fourth floor of the hospital were converted to HDU beds. Following the winter period these beds became permanent HDU beds.

- The NITU clinical lead told us as there was very little availability for neuro-rehabilitation in Essex. This meant there was a huge waiting list for stroke and brain injured patients to be supported outside of the hospital. This could cause some delay in discharging patients who no longer required hospital support but required support in living with their brain injury.
- The CCOT provided a 'critical care follow up outpatient clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their discharge.

### Meeting people's individual needs

- NITU encouraged diaries for patients who were staying for longer periods of time in the unit. Patient's families kept a diary with a record of daily activities such as visits, progress and treatments, items of news and the weather. Staff gave us an example of a patient who had no recall for about a month of their stay; the patient had described the diary as "life-saving" as they were able to look back on the month and read about their own experience and outside world events.
- Relatives of NITU patients were asked to bring in day and night clothes for rehabilitating patients. This helped normalise their routine and orientate them.
- The physiotherapist on GITU brought in a quantity of free daily newspapers for patients. The refreshment hostess offered these to patients as part of their daily routine in engaging with them. This gave patients the opportunity to know what was going on in the world, or gave relatives something to read to their family member, who may be unconscious.
- The waiting room for patients' families was small and not large enough for the number of visitors waiting to see their relative or friend. On one occasion, we observed that there were not enough seats for everyone, which left people standing in the corridor outside the unit.
- There was little privacy for private conversations, one relative told us they had a family discussion with the doctor in the corridor. Staff showed us were they held sensitive and difficult conversations with patients' relatives. This space was essentially a fire exit within the GICU. This space was also used for staff training, when required.
- GICU and NITU had one room each to accommodate visitors overnight, if required. The rooms were approximately a five-minute walk from the GITU and NITU and located next to one another. They had a shared kitchen area and each room had a private shower and toilet facility. We observed that the NITU visitor's room had been softened with cushions, a rug, table lamp, ornaments and pictures. The GICU room was stark and less welcoming in comparison.
- Patients were screened for dementia and delirium within 72 hours of admission. The dementia screening tool included assessing, investigation and referral options.
- Patients with learning difficulties used the Hospital Passport, which was a communication book. It provided a picture of the whole person, by including information that was not only about illness and health. For example, it included a list of likes, dislikes and interests. This helped the hospital staff know how to make patients feel comfortable.
- Communication books with pictures were available to use with patients who could not understand English or who had learning difficulties. The NITU gave us an example of how they communicated with one adult patient with learning difficulties by showing them what they were going to do for them on their favourite teddy-bear. On some occasions, the staff had also spoken with their paediatric colleagues about communication techniques with young children, as they had found they could use the same approach with an adult who had a lower learning age.
- Translation services were available through a telephone service or a face-to-face interpreter with prior booking. Staff reported the translation services were rarely used as the over-the-phone system was difficult to use and interpreters were hard to organise at a time when all parties were available. Staff told us they did not face the issue often, as there was usually someone in the family who understood English, although they would not ask a child to translate. There were also some staff that spoke other languages and could, occasionally, be used to translate.
- Due to late discharges limited number of intensive care beds mixed sex breaches happened occasionally. Patients were placed in the unit on a clinical decision as opposed to gender, although staff were mindful to keep breaches to a minimum. Over the last six months, there had been 40 mixed sex breaches, the best month was August 2014, where there were two and the worst case was 12 in January 2015.

- Visitors to the unit told us it was difficult to park a car at the hospital and car parking was very expensive.

### Access and flow

- Patients were admitted to GITU through A&E, after surgical procedures or from wards where the patient was identified as deteriorating and requiring high dependence or critical care, and occasionally from King George Hospital.
- NITU patients were admitted through A&E, post-operatively or from other Essex hospitals.
- Staff aimed to have bed occupancy at around 75-85% but this was a challenge because the demand outstripped number of beds available. In the five years up to 2013 the number of admissions within the trust had more than doubled to nearly 400 per year. Bed capacity was an average at 95% over the last year, reaching 100% on some occasions.
- Staff reported considerable pressure for beds within all areas of critical care, especially for GICU. A recent report by the hospital on 'Planning General Critical Care Capacity' identified that the lack of capacity directly affected 100 to 200 patients every month. This resulted in cancelled major operations including those patients with cancer, delayed initiation of emergency treatments, patients not receiving optimum or timely interventions and evidence of worse outcomes in some patient groups.
- The hospital's planning report indicated over a six-month period from April to October 2014 that 229 critically-ill patients were treated in A&E for more than six hours while waiting for a GICU bed,15 patients were admitted to a medical ward then transferred to GICU, 91% of this group were medical patients, 46% (138 of 300) of surgical patients with a severe systemic disease that is a constant threat to life had no access to GICU postoperatively, 11% (36 of 317) patients aged 86 and above were admitted to GICU postoperatively (this excluded a day-case and overnight stay), 16% of patients with fractured neck of femur were admitted to GICU.
- ICNARC 2015 data showed that, for GICU/HDU, there were no concerns regarding non-clinical transfers (out), or delayed discharges (12 and 24 hour), which all came within an acceptable range and were slightly better than the comparator.
- However, the ICNARC 2015 data indicated that out-of-hours discharges to the ward and out-of-hours discharges (not delayed) were worse than the comparator, but were still within an accepted range, although out-of-hours discharges (not delayed) was very close to falling outside an acceptable standard. The lead consultants told us the hospital was a national outlier for out-of-hours discharges.
- The outreach team assisted and supported ward-based colleagues to ensure consistent standards of care for patients who required extra nursing support regardless of where they were located in the hospital. They supported ward-based staff in the early identification of patients at risk of deteriorating and who may require an HDU or ICU bed.

### Learning from complaints and concerns

- We reviewed the complaints data provided by the trust. Between April and December 2014 there were 14 complaints made about GICU/HDU. The NITU had not received any complaints in the last three years.
- We noted the complaint records showed they had been investigated. However there was nothing to indicate whether there had been any learning or changes in policy and procedures.
- Staff we spoke with could not readily identify any changes or learning from comments or concerns patients or their relatives made while admitted to the unit.

## Are critical care services well-led?

Requires improvement

We found the leadership team had a strong vision for the future expansion of the critical care services but this had not been shared with the ward staff. The staff had a mixed understanding of the vision for critical care and a recent silence on the reconfiguration had left some uncertainty about the future expansion as part of the future plans for the local health economy.

All the staff we spoke with were focussed on delivering high quality, safe and effective care to patients. At a local level there was strong support within each individual team, but the consultants, doctors, nursing staff and other allied health professionals tended to work in silos and there was little opportunity for multi-disciplinary shared learning or innovation.

# Critical care

Staff did not always raise concerns as they did not always receive feedback or support. Staff reported that the Trust had a "fire-fighting approach" to concerns and incidents which took them away from their day-to-day work or from completing and embedding actions from a previous "fire".

**Vision and strategy for this service**

- The senior management, senior nurses and consultants were committed to their patients, staff and the unit. The vision of the unit was to achieve the best quality care and outcome for seriously ill patients provided by highly qualified, skilled professionals. One member of senior staff said "although we are under resourced we still turn out good results – better than the national average. Nursing staff are engaged in providing the best quality care."
- Staff had mixed understanding of the vision for critical care at the hospital. They told us there had been plans in the past as to how the service was going to change but recently the acute reconfiguration was not a priority. This lead to some ambiguity about the future.
- The senior management team had a strong vision for critical care services. They spoke passionately about proposals to expand the service once an appropriate location and funding was secured. They had not shared the plans with the staff working in critical care as the senior team were aware there had been many discussions in the past which lead to uncertainty while plans were tentative.

**Governance, risk management and quality measurement**

- The divisional director spoke openly about a lack of clinical governance over the past decade. It was thought this had developed a culture of under reporting as there was little feedback or learning from incidents or opportunities for sharing good practice. The trust was in the process of recruiting a clinical governance facilitator and a duty of candour lead. It was envisaged this would support the reporting culture driving openness and transparency when concerns or issues were identified.
- The senior management team told us staff were encouraged to use the IR1 to report incidents or raise concerns. They said they could only respond to issues if they were made aware of them, however they were aware that they needed to respond to reports in a timely manner otherwise staff would disengage.
- The senior team thought there had recently been a small positive change in how incident reporting was viewed. They acknowledged that disseminating the learning was difficult and ensuring the information reached all staff could not always be assured. This was due, in part, to releasing staff from their duties to attend meetings
- We found learning from incidents was not always apparent. We tracked three medication related incidents on the IR1 system with a senior member of staff in GICU. The charge nurse could not identify any changes to practice after three quite serious incidents. We noted the audited results for 'Prescribing in Critical Care' dated 7 October 2014 (presented 11 April 2014) had identified poor practice from record samples taken. Recommendations had been made as a result of the findings. However at the time of our inspection we found the same poor practice was still evident and not being challenged by senior staff.
- We were told that some incidents relating to the unit may not have been logged by them as it had been identified by another service within the hospital so there was little way of knowing about the issue, outcome or learning as they were investigated and closed by the governance team.
- The consultants held a monthly clinical governance meeting. The divisions risk register was emailed monthly to the consultants and discussed at their Monday morning meeting. Consultants told us they had received two inaccurate radiology reports from the Australian overnight reporting service in the past year. This had been discussed at the neurosurgical clinical governance meeting however no one knew what the outcome was or whether it had been resolved.
- The senior sisters met regularly to discuss any concerns and share learning. The sisters disseminated this information to the staff on the wards via the team handover or team communication folders. Staff signed off new procedures to say they had read them.
- The nursing teams were encouraged to meet once a month, however this was variable. Senior staff reported reminding teams about the importance of meeting. Regularly. There was no opportunity for all staff to meet together.
- The critical care units performed a number of audits such as quality of care, nursing documentation and an

observation audit which focuses on a different topic each week. These audits picked up prevailing problems or themes which were discussed at the senior nursing staff meeting.

**Leadership of service**

- There was a matron responsible for overseeing the general intensive care and high dependency unit and one for overseeing neuro intensive therapy. They reported directly to the divisional director, divisional manager and divisional nurse (vacant position). Senior staff spoke positively of the critical care management team. They told us the clinical leads were accessible and knew of concerns and issues. We were told both matrons were visible and visited their respective units each day.
- Some staff expressed concern that trust issues were dealt with as they happened. They told us this approach took their focus from work which hadn't been completed or from day-to-day tasks that was target driven such as completing audits. One person said, "the trust tries to support you but I find it goes from fire-fighting [one thing] to fire-fighting [another thing]. It [the trust] doesn't have time to complete its action plans on one task before dealing with another fire. We have to respond immediately and the focus moves from the previous issue before the learning's shared or changes are made."
- The charge nurse and senior sister spoke positively of the support they had from their respective matrons. Both were described as being open to discussions and challenge where appropriate.
- We observed staff were able to approach the charge nurse and senior sister responsible for the day-to-day running of the wards with any queries or concerns at any time. Staff spoke positively of the support they received form the ward managers and respected and valued their experience and advice.
- The NITU senior sister and GITU charge nurse had clinical and non-clinical duties. The charge nurse told us their job role had expanded considerably in the years they had worked at the Trust. They were originally responsible for a 12 bed unit and this had grown to a 24 bedded unit, of which 4 beds were located on a different floor in the hospital. There had been no discussions with them about whether they could support the extra patients, staff and work load. They were finding it increasingly difficult to get the necessary time to do their job effectively and have complete oversight.
- Junior doctors and specialists told us the consultants were easy to reach when they were on-call and very visible during office hours.
- Consultants felt supported by their colleagues and told us they felt they could always seek their advice or request a second opinion.
- The physiotherapy team reported good working relationships between the nursing and medical staff they were in daily contact with. We were told medical staff respected their opinion and nurses often asked for advice. However they felt there was a large gap between the physiotherapy team and senior clinical leads. They said their expertise was not used, needed or requested when it came to understanding how the physiotherapy department fitted in within the trust.

**Culture within the service**

- Staff worked hard and had a flexible approach to ensure as many patients as possible could be safely cared for in units already running at full capacity most times.
- The units worked well in their teams. Senior staff were supportive of the junior staff and very much part of the team. We observed them taking on tasks such as preparing bed spaces and covering staff breaks in order to support a busy unit.
- Consultants reported good relationships between the GICU, HDU and NITU. However they thought there was some difficulties with their colleagues in cardiology since the critical care unit had been allocated four HDU beds in the coronary care unit.
- A fixed team and four weekly rota pattern was introduced last year. Most of the staff were positive about this change. They said it allowed them to get to know their colleagues and felt it provided cohesive and supportive team working. Senior staff noticed team working had created some mild healthy competition as each team wanted to be the best. Senior staff found it easier to identify any learning gaps and provide appropriate support quickly.
- It was reported that the negative side of working with the same team was that some people preferred not to work continuously with the same people. They had also considered the risk of complacency setting in if there was not room to challenge each other's practice when

necessary. There were discussions of band five and band seven nurses rotating between teams for practice development. The new way of working was due for review very shortly.

- Substantive and regular agency nurses reported a good working relationship. We were given examples of suggestions agency staff had made to improve treatment or care for patients as they saw other practices by working at other hospitals. For example one member of agency staff had suggested a different method of endotracheal tube securement. This was adopted by the unit.

**Public and staff engagement**

- Staff had mixed opinions on how visible the board and executive team were. However the chief executive was well regarded and a number of staff told us they had seen him on the ward talking with staff and enquiring about their role. Staff knew of the monthly meetings held by the chief executive, but most of them were unable to attend due to the time of day it was held.
- One staff member told us how they had suggested introducing 'team member of the month'. Comments relating to staff members 'going above and beyond' were collected in a box and at the end of each month the team member with the most positive comments was deemed to be the team member of the month and a small prize of a coffee from the coffee shop was bought for them.
- A patient survey was given to patients and relatives in GITU and HDU. However patients rarely completed the survey until they were discharged from the hospital via the general wards and therefore the information did not necessarily relate to care given in critical care. Staff told us they did not know how well they were performing and there was little opportunity to improve the patient experience as there was little feedback from surveys.

**Innovation, improvement and sustainability**

- The critical care unit had no more room to expand within the environment it was in and had already encroached on the coronary care unit to add four further HDU beds. However the senior staff told us this was not ideal as the unit was remote from the rest of the team and it was difficult to provide immediate support to the critical care nurses allocated to the unit on a daily basis.
- The hospital's 'Planning General Critical Care Capacity' presentation indicates that the future for critical care required significant expansion in order to improve and sustain critical services for patients in the local area.
- The senior management team were acutely aware that the service was running "very hot". They told us the hospital's drive to get back in balance with the 18 week referral to treatment targets meant the theatres were working hard. However the number of available critical care beds had an impact on theatres as some patients' required an ICU or HDU bed post-operatively. At the time of our inspection we heard about one admitted patient whose surgery had been cancelled twice previously. The unit did everything they could to discharge a HDU patient safely to a general ward to create a bed for this patient and prevent cancellation for a third time, however it was not possible.
- The consultant led CCOT's seven day service had improved the outcome for patients through appropriate identification of deterioration and appropriate escalation.
- The CCOT monthly outpatient clinic was not funded by commissioners. The divisional director told us audits showed the clinic was improving patient outcomes by providing support once they returned to the community. They were hoping to get the audit data included in the critical care ICNARC data.
- Although consultants met on a weekly basis and nursing staff met in their individual teams on a monthly or bi-monthly basis, we found there were no formal MDT opportunities for shared learning or discussion about changes in protocols, concerns or serious incidents. The charge nurse for GITU had a vision for more shared learning opportunities between nurses and medical and allied health professionals, such as a weekly meeting to discuss a different case of interest each week.
- Implementing nursing teams that worked together regularly and consistent consultant cover in the unit meant that delay to patient care was reduced and admissions were faster.
- The senior sister expressed a future aspiration to get the foundation NITU course validated and accredited with a university.
- NITU raised funds from former patients and families to decorate the relatives' overnight room to make it more comfortable and welcoming.

# Maternity and gynaecology

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

## Information about the service

In 2013/2014 there were 7,730 women who gave birth at the Trust. The Queens Birth Centre, a midwife-led service, opened in January 2013 and manages deliveries for those women who have been risk assessed as being low-risk pregnancies. The Queens Birth Centre was commissioned to manage approximately 15% of all women who choose to book to deliver. It has eight individual side rooms and a four bed post-natal area.

The labour ward has 16 delivery rooms and two theatres; the ward also hosts a dedicated bereavement suite. The service has a 22 bed high-risk post natal ward for women and babies who require additional care and support; this ward consists of six side rooms and four bays with four beds. In addition to the high risk post-natal ward, the service has a 24 bed low/intermediate risk post-natal ward (Coral ward); Coral ward comprises of four side rooms and five bays with four beds.

Maternity triage services are provided by way of six couches and two beds; this is a short stay area and is open 24 hours per day, seven days per week. The six bed obstetric assessment unit allows for the monitoring of pregnant women seven days per week; this unit operates by way of an appointment system.

Women who undergo elective or emergency caesarean sections, or who developed complications either before, during or after birth are supported by a team of high dependency nurses and midwives; the six bed unit functions as a maternity high dependency and post-operative recovery area.

Cornflower B ward hosts a range of gynaecology services including 23 inpatient beds, an open-access emergency gynaecology unit and an early pregnancy assessment unit.

An inspection of the maternity service on 19 March and 4 April 2012 identified a number of areas of concern relating to the care and welfare of women and their new-born babies, the availability, or lack thereof of equipment and staffing levels. A follow-up inspection in December 2012 revealed that the trust had made progress in all three of these areas. A further comprehensive review of the hospital, including maternity services and family planning services was carried out using our new methodology in October 2014. Women who used the service said they felt the care they received was adequate and that staff were positive about working for the hospital. Some improvements were required with regards to the security and stock control of medicines, ensuring that a full cycle of learning from incidents was embedded and a review of consultant obstetrician cover was required.

We spoke with over 15 women who were accessing either antenatal care or had recently delivered their baby, eight patients who were receiving care on Cornflower B ward or from the associated emergency services. We spoke with over 40 members of staff including doctors, nurses, midwives, administration staff, as well as clinical, nursing and midwifery governance leads and managers. We visited each of the clinical areas including the antenatal clinic, sonography unit, Cornflower B ward, maternity triage, obstetric assessment unit, Coral ward, labour ward and the

# Maternity and gynaecology

Queens Birth Centre. We reviewed 10 sets of patient records and a range of equipment including resuscitation equipment, birthing pools, beds, mattresses, resuscitaires and cardiotocography (CTG) devices.

## Summary of findings

There had been significant improvements to the maternity services since our last inspections. Including improvements in the way women felt about the service, leadership and culture, staff engagement, medicines management and access and flow.

Governance arrangements were, in the main considered to be sufficiently robust. Dashboards were utilised and offered staff a snap-shot of a range of quality indicators and outcomes to ensure that clinical performance could be assessed. However, the existing governance arrangements did not always encompass the totality of clinical and maternity services provided to women; those working in foetal medicine and the ante-natal screening service were not always included in, nor received timely feedback from incidents which may have impacted on the management of the woman and her unborn baby and so there was the potential for delays in lessons learnt and service improvements being implemented as a result of clinical incidents.

The service did not employ sufficient numbers of consultant obstetricians to ensure that the labour ward was appropriately supported; the existing establishment was not in-line with national and London based recommendations. A business plan had been submitted to the executive team to increase the number of substantively appointed consultant obstetricians.

Evidenced-based care and treatment was delivered. Outcomes for women were similar to other services when compared. Midwives were competent and kept up to date with their mandatory training. Women received their choice of pain relief and were supported to feed their babies in their preferred method.

Women's needs were met through the way services were organised and delivered. The configuration of maternity services at the hospital meant the service was more responsive. However the gynaecology services were not always responsive.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Requires improvement

The service did not employ sufficient numbers of consultant obstetricians to ensure that the labour ward was appropriately supported; the existing establishment was not in-line with national and London based recommendations. A business case had been submitted to the executive team to increase the overall number of substantively appointed consultant obstetricians and the service operated an on-call system to ensure that junior staff had access to a consultant outside of normal working hours.

The uptake of mandatory training among nurses and midwives was consistently better than the trust target of 85% but was below 85% for medical staff.

Internal audit mechanisms identified that improvements had been made with regards to the robustness of handovers between midwifery staff and medical staff respectively. However, we found handovers to be unstructured, disorganised and routinely interrupted; staff commonly used poor, non-descriptive terminology to describe clinically relevant events that had taken place.

Staff were aware of how to reports incidents; most staff reported that they received feedback from the incidents they had reported; a newsletter as used to disseminate learning from incidents and staff could describe the lessons learnt from the most recent serious incident which had required investigation.

Clinical areas were found to be visibly clean and tidy. The management of medicines had improved since our last inspection and the service was now supported by a pharmacist.

### Incidents

- A total of 483 incidents were reported by maternity services between 1 September 2014 and 23 December 2014. Of those, seven were categorised as having major impact, 36 had significant impact, 150 had moderate impact and 277 had low impact. Four were reported as 'near miss' incidents.
- Twenty-four serious incidents requiring investigation (Serious Incident Requiring Investigation – SIRI) had been reported during 2014. Seventeen were associated with the unexpected admission of a baby to the neonatal intensive care unit, two as unexpected neonatal deaths, two because of a suspension of maternity services, one intrauterine death, one related to the management of a postpartum haemorrhage case and one categorised as "other". There was evidence that SIRI outcomes included lessons learned.
- Root cause analysis (RCA) of three incidents where babies were unexpectedly transferred to the NICU demonstrated that contributing factors, which led to babies being born in a poor condition included human error on one occasion, due to incorrect recording of a spontaneous rupture of membrane date, poor documentation and recording of care planning for a second case and failure of staff to follow local guidelines and delay in the woman being reviewed by an obstetrician in the third case.
- We found that incident review meetings were held regularly, during which, a full review of incidents took place. Medical staff also reported they were learning from the process of root cause analysis reviews of events. Regular "near miss" and occasional CTG meetings took place. Junior medical staff said they were invited to attend and to participate in the meetings leading to additional opportunities to learn from incidents.
- The maternity 'Risky Business' newsletter circulated to staff demonstrated evidence of discussion around learning from reviews, such as care of cold babies as well as feedback from audits, which had been conducted as a means of measuring quality and safety outcomes. Examples of this included a spot check audit of resuscitaires to ensure that they had been checked and were ready for use. This was in response to an incident in which the oxygen supply to a resuscitaire had been exhausted, indicating that the resuscitaire had not been appropriately checked prior to its use.
- Most staff spoke positively about reporting incidents. They reported the process of raising concerns and for completing incident forms and that they received feedback from the incidents that they had been involved in. Weekly 'near miss' meetings and fortnightly governance meetings routinely took place. These meetings were attended by a range of health professionals, including: consultants, junior doctors, midwives and nurses.

- Nine members of staff considered that the incident reporting culture was one of openness, transparency and was fair. Three staff told us that they had "lost confidence" in the incident reporting system because they either did not receive feedback, felt that there was a lack of support after having completed an incident form, or they had been questioned about why they had completed an incident form in the first instance. Additionally, some staff raised concerns with us that medical staff "could do better" to engage with learning from incidents. Delays in receiving written statements from medical staff was noted as a particular "area of frustration" amongst staff.
- Regular multidisciplinary perinatal meetings took place, which were attended by obstetricians, midwives, paediatricians and junior doctors. It was noted that members of the sonography team were not routinely invited. Nor did they always attend the perinatal meetings and so were not always actively involved in learning from incidents relating to antenatal screening.

### Safety Thermometer

- The NHS Safety Thermometer is a national initiative, a local improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. It was not being used, midwifery staff reported that they were looking to amend the existing Safety Thermometer so that it was more applicable to maternity services.

### Cleanliness, infection control and hygiene

- The clinical areas we visited were seen to be visibly clean.
- There was evidence that domestic staff followed guidance regarding the required cleaning standards, practices and frequency of cleaning. Women who spoke with us told us they were satisfied with the level of cleanliness, including the toilets and shower facilities.
- Domestic staff had access to colour-coded cleaning equipment and we observed the use of such items in the course of their cleaning duties.
- Staff were noted to be following the hospital dress code policy to be 'bare below the elbows'. There was access to decontaminate hand gels on entry to all areas and also at the point of care. Staff had good access to, and were seen using, hand washing and drying facilities between the delivery of care activities. Staff also had access to, and were seen using, personal protective equipment, such as gloves and aprons.
- Ninety-two per cent of nursing and midwifery staff working within the women's, children and support services directorate had completed training in infection prevention and control (level 2). This was better than the trust-wide standard of 85%. However, only 69% of medical staff had completed the same training.

### Environment and equipment

- The design of the environment for emergency gynaecology services on Cornflower B ward did not ensure the safety of women and staff. The service could be accessed 24 hours a day but the ward and staffing levels were not set up to ensure safety at all times.
- Emergency equipment was readily available, was visibly clean and checked routinely. However, we noted that on 4 March 2015, when we visited the labour ward at approximately 4pm, two resuscitaires had last been checked the previous day. An audit process was in place to ensure that equipment was consistently checked and ready for use. We reviewed a resuscitaire compliance checking audit, which demonstrated that there had been sustained improvement over an eight-month period in the frequency with which resuscitaires were checked.
- We noted that a number of resuscitaires held a stock of nasogastric enteral feeding tubes, which were not compliant with National Patient Safety Agency (NPSA) recommendations, in that syringes designed for the administration of intravenous medications could be connected to the tubes, therefore posing a potential risk that solutions and medications designed to be administered enterally could also be connected to intravenous devices. These were located on the Queen's Birth Centre and Coral Wards. We spoke with four staff to ascertain the reason as to why the tubes were stocked. Three staff reported that the tubes were used as originally designed, to be passed as a naso/orogastric tube during a neonatal emergency resuscitation situation. One staff member reported that the tube was used as a means to provisionally diagnose the presence of a tracheoesophageal fistula and was not intended to be left in situ as a naso/orogastric tube. We spoke with the neonatal intensive care team who were responsible for responding to neonatal emergencies that occurred on the postnatal wards, Queen's Birth Centre or labour ward. We found that they routinely took their own supply of emergency equipment and that appropriate, NPSA-compliant enteral tubes were readily available.

# Maternity and gynaecology

## Medicines

- During our inspection of the maternity service in 2013, we raised concerns that processes pertaining to the management of medicines was not suitably robust; medicines were found to have expired, with some not being stored in secure cabinets.
- We reviewed a range of drug cabinets and refrigerators. Controlled drug stock levels were found to be correct and a register was being appropriately maintained. Fridge and ambient air temperatures were being monitored and action taken, as required, when temperatures deviated outside recommended levels. Medicine cabinets were kept locked and access was restricted to qualified midwives, nurses or operating department practitioners. We found that, on labour ward, an epidural trolley was being stored in the corridor. This trolley was found to contain a stock of local anaesthetics which were not securely stored. We escalated this to the labour ward coordinator, who took swift action to ensure the trolley was moved to a locked clean utility.
- An internal audit conducted in September 2014 identified that, over a period of 12 months (June 2013 - May 2014), 86 incidents had been reported that related to medicines. Seventeen incidents were excluded from the audit, due to duplication or recategorisation of the incident. This was a significant reduction on the number of incidents reported for the previous year (192 incidents in 2012). Administration errors accounted for the majority of incidents (43%) followed by dispensing errors (33%), prescribing errors (18%) and transcription errors (6%). There was clear analysis of each incident to determine whether there were any patterns, such as time of day, weekday versus weekend, staff group involved and location of the incident. Fifty per cent of the incidents resulted in low harm, 47% in moderate harm and 3% in high harm. While there were no identifiable trends, consideration had been given to any possible improvements that could be made to further reduce the incidence rate and to reduce the impact of harm to women.

## Records

- The maternity service used a mix of electronic and paper-based care records.
- We found that the completion of booking assessment forms was inconsistent, with some being completed and others not.
- We found that staff utilised a Clinical picture, History, Assessment, Plan, Sharing of information (CHAPS) handover sheet, which was filed in the paper care records. The form was 'tick-box' based and so lacked any demonstrable evidence that effective communication had occurred between healthcare professionals. However, there was evidence of appropriate care planning and from the notes we reviewed there was evidence of multidisciplinary working and engagement to ensure that care was appropriately planned and delivered. This was reflected in the contemporaneous notes made by healthcare professionals as compared to the use of the CHAPS handover record.
- Paper-based notes were found to be well filed and maintained.
- An audit carried out in October 2014 identified that venous thromboembolism (VTE) assessments were not always being routinely carried out by midwifery staff. The audit demonstrated that 78% of women had a completed VTE risk assessment at the time of booking. Fifty-one per cent of the audit cohort were admitted to the antenatal clinic, where 96% had a VTE assessment recorded. Only 12% of women had a VTE assessment on admission to the labour ward and 54% had a revised VTE assessment on admission to the postnatal ward. Antiembolism stockings were only prescribed in 34% of applicable cases. Pharmacological prophylaxis was prescribed in 100% of applicable cases. A review of ten sets of care records demonstrated that staff were appropriately using risk assessments, including the identification and management of (VTE). Staff were found to be routinely updating VTE assessments following delivery, and was specifically noted for women whose conditions had changed either during or after labour, which may have increased their risk of VTE.
- Seventy-nine per cent of nursing and midwifery staff, 69% of administrative and clerical staff and 81% of medical staff working within the women, children and support services directorate had completed mandatory training in information governance. This was below the trust target of 95%.
- The community midwifery team raised some concerns regarding the electronic care records systems they were required to use. We were told that the team utilised three different systems depending on where the mother was being seen. Staff reported feeling "bogged down" by the changes in information technology (IT) systems.

Examples were given where two versions of "E3"[ST1] were being used. The systems did not communicate with each other and so midwifery staff were required to check both systems to determine whether there were any pre-existing safeguarding concerns that they needed to be appraised of.

### Safeguarding

- The service had a named safeguarding midwife who undertook a range of audits and quality assurance checks to ensure that staff were following trust policies. A recent audit had identified that not all midwives were recording domestic violence screens. An enhanced level of monitoring had been instigated with the named safeguard midwife contacting each midwife who had been identified as not recording the assessments in order that they could receive additional support and training, as necessary.
- Midwifery staff received a least one safeguarding supervision session each year. This had been incorporated into their mandatory training to ensure supervision was consistently accessible. The named safeguarding midwife reported that they had provided 10 midwives with additional training so they could support other members of the team as necessary.
- The named safeguarding midwife reported that their caseload had "doubled" since 2013 and that administrative support was "fragile", resulting in the named midwife having to carry out additional administrative work.
- Eighty-nine per cent of nursing and midwifery staff within the women's, children and support services directorate had completed level 3 safeguarding of vulnerable children and 90% had completed training in safeguarding vulnerable adults to level two. This was above the 85% trust-wide standard.
- Seventy-one per cent of medical staff within the women's, children and support services directorate had completed level 3 safeguarding of vulnerable children and 75% had completed training in safeguarding vulnerable adults to level 2. This was below the 85% trust-wide standard.
- The safeguarding midwife had developed close working relationships with specialist midwives, including those who specialised in mental health, substance misuse, teenage pregnancy as well as creating links with the local perinatal mental health team. Therefore, women who presented with specific concerns could be referred to an appropriate team of specialist healthcare professionals in order that appropriate management and support plans could be developed for the woman, their family and the unborn or newborn child.
- The community midwifery team raised some concerns that antenatal visits were not routinely carried out at the woman's home and so housing conditions were not routinely being assessed until the woman and newborn had been discharged home and were being followed up during their first postnatal check.

### Security

- Access to clinical areas was monitored and controlled by members of the clinical team. We observed visitors being greeted by staff upon entering the clinical areas.
- A range of staff raised concerns regarding the suitability of the emergency gynaecology unit which was co-located on Cornflower B ward. We heard of incidents whereby staff had been threatened by patients because of long waits in the unit. The emergency gynaecology unit operated an open-access system which allowed for patients to report to the unit 24 hours per day. Staff reported that whilst the trust security team responded to any incidents on the unit, there was no constant presence of security and so staff reported feeling vulnerable at times.

### Mandatory training

- Midwifery staff, including students reported having mandatory training in areas such as emergencies, safeguarding, mental health and mentorship. Training was provided via a range of medians including e-learning, skills and drills sessions and face-to-face facilitation.
- Forty-seven per cent of medical staff and 80% of nursing and midwifery staff had completed mandatory conflict resolution training. This was against a trust target of 85%.

### Management of deteriorating patients and assessment of risk

- The early pregnancy unit was an open-access service. We noted that a large proportion of patients self-referred to this service. Due to the increase in demand, the service had opted to use a triage system in order to identify women who were acutely unwell upon presentation to the unit. We were told of plans to extend this service and recruitment to the posts were underway at the time of the inspection.

- Women who presented to the maternity triage service were initially assessed by a midwife to determine the acuity of their condition upon presentation and to allow staff to prioritise the care women required. A spot check audit carried out in January 2015 identified that three out of five women (60%) had a documented initial triage assessment. Four women were seen within 30 minutes of attendance, as per the requirements of local guidelines. One woman had no documented time of when she was to be seen by a midwife. The maternity dashboard demonstrated that the majority of women were seen within 30 minutes of arrival, with an overall performance rate of 97% over an eight-month period.
- Midwifery staff used an early warning assessment tool known as the modified early obstetric warning score (MEOWS) system to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond to additional medical support if required. The records we reviewed contained completed MEOWS observations and appropriate escalation took place, where required.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures, in accordance with best practice principles. This included completion of the World Health Organization (WHO) surgical safety checklist in operating theatres. We reviewed care records for women who had undergone caesarean section and saw all parts of WHO records present had been completed.
- During the inspection, we observed a clinical emergency occurring in real time. The response to the emergency was timely, responsive and well led.
- Midwives, nursing staff, maternity care assistants and medical staff all participated in "skills and drills" scenario-based training to help keep their competencies up to date. The midwifery education team facilitated skills and drill scenarios based on previous incidents that had occurred in the unit, such as the safe transfer of a woman presenting to the obstetric day assessment unit with umbilical cord prolapse.
- Ninety-three per cent of nursing and midwifery staff working within the women's and children's division had completed mandatory training relating the management of sepsis. This compared with 81% of medical staff. The trust target for this training was for 85% of staff to have completed the training.
- Ninety-four per cent of nursing and midwifery staff and 83% of medical staff had completed adult basic life support training. The trust target was 85%.
- Ninety-four per cent of nursing and midwifery staff and 66% of medical staff had completed newborn basic life support training. The trust target was 85%.
- Where women had been identified as being high risk, requiring an emergency caesarean section within the recommend time period of 30 minutes, compliance with this performance indicator was consistently poor. Data from the maternity dashboard demonstrated that between April and November 2014, an average of 70% of women could expect to undergo an emergency caesarean section within 30 minutes. The trust target was that 100% of women would undergo an emergency caesarean section within 30 minutes if they had been identified as a "grade 1" case.

### Midwifery staffing

- For the financial year 2014/15 the midwife-to-birth ratio was funded to be 1:29.
- Between April and November 2014, the vacancy rate for the service ranged between 10% and 13%. This vacancy rate was higher than the trust target of less than 5%. We found that where there were insufficient numbers of midwives to fully support a shift, these shifts were referred to be back-filled by bank or agency staff.
- Between April and November 2014, the sickness rate amongst midwifery staff ranged between 3.3% and 5.3%, which was mainly in line with the expected range of less than 5%. 5 of the 8 reported months had been rag rated as amber, 2 as green and 1 as red.
- Turnover of midwifery staff had peaked to 13% in November 2014. The preceding seven months had seen a midwife turnover rate of between 11% and 13%. Again, the turnover rate for the service was higher than the planned target turnover rate of no more than 10% monthly.
- Between April and November 2014, the rate of women reported as receiving one-to-one care during labour was consistently reported as 100%.
- Almost every midwife that we spoke with raised concerns about the frequency with which they were redeployed to other clinical areas either at the beginning or during the middle of their shift. We ascertained that the midwifery staff were accepting of the reasons for the redeployment in that they were required to work where women required care and

support. However, some staff felt that they were moved more frequently than others and that this was leading to low morale amongst the workforce. We discussed this concern with the midwifery matrons, who acknowledged that they were aware of the concerns amongst the staff. Recruitment for additional midwifery staff was ongoing at the time of the inspection.

- Members of the community midwifery team also raised concerns with the concept of the internal rotation programme to the Queen's Birth Centre. While one midwife spoke positively about working both in the community and in the Queen's Birth Centre, others were not so positive. They considered that they were competent in normal births, but that they lacked the competency to use the "K2MS™ Guardian" computer system. They reported that they had raised their concerns with the senior management team but "did not feel listened to".
- Arrangements for the orientation of agency midwifery staff required improvement. We found that processes for checking Intention to Practice forms was not sufficiently robust. We found that staff accepted ItP forms which were dated for the following year. For a midwife to legally provide midwifery care in the United Kingdom to women and babies, and to be called a 'practising midwife', they must be registered appropriately with the Nursing and Midwifery Council and have completed and submitted an Intention to Practise notification to their named supervisor of midwives to confirm that they intended to practise for the following year. ItP's for midwives should have been dated to cover the time period that they intended to provide midwifery care. We noted that the local agency folder contained a number of ItP's dated for the forthcoming 2015/16 year and did not always contain an individuals current ItP. We raised this as an issue with the labour ward coordinator at the time of the inspection, who was unaware of the relevance of ensuring that midwives were able to present a current ItP. We discussed our findings with the head of midwifery and also with the labour ward matron the following day. They took immediate action to rectify the issues relating to the induction of agency midwives, including ensuring that appropriate checks were carried out to check that individuals could legally provide midwifery care.
- We observed the handover process between shift changes for midwives. The process was found to be fragmented. There was no use of a formal handover tool, such as Situation, Background, Assessment, Recommendation (SBAR). The handover process was interrupted with telephone calls and with staff members talking over each other.

### Medical staffing

- The service employed 66 whole time equivalent (WTE) doctors. The demographic of medical staffing within obstetrics and gynaecology demonstrated that the trust employed fewer consultants (32%) when compared to the national average of 34%. The service had more specialist trainee registrar (StR) years 1 to 6 posts when compared to the national average. Fifty-six per cent versus 52% nationally. The number of foundation year (FY) doctors (year 1 and 2) was also lower than the national average, with 5% locally, versus 7% nationally.
- The maternity dashboard indicated that consultant obstetricians provided 98 hours of labour ward presence each week. This was below the 168 hours recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) when considering the number of deliveries that occurred at Queen's Hospital. Further, the service was supported by only one registrar (StR grade) at night. This also was not consistent with national and London standards, which recommends that units with more than 6,000 deliveries per annum should have at least two junior doctors available to support the labour ward at night.
- A supplementary document submitted to us by the trust titled "Maternity Staffing Spreadsheet" included a summary of the "average number of hours per week [of] consultant cover on [the] labour ward". The data within this document reported that the average level of consultant presence on the labour ward consistently totalled 98 hours each week. Consultant cover had been identified as an area of concern during our previous inspection of the service in 2014. The concern was also recorded on the maternity risk register.
- While the consultants that we spoke with told us that the risk of a lack of 168 labour ward cover was mitigated through an on-call system, midwifery staff and junior doctors told us that, during busy periods at night, it was sometimes difficult to focus and proactively manage multiple clinical and operational issues. We were told of one recent incident where, due to increased activity on the labour ward, the senior trainee doctor and labour ward coordinator were not able to "step back" and consider how best to prioritise a range of clinical

concerns. The lack of appropriate prioritising resulted in a CTG not being reviewed in a timely way and a delay in a decision being made to open a second theatre. The baby was born in a poor condition and consequently had to be unexpectedly admitted to the neonatal intensive care unit. A review of the root case analysis (RCA) determined that contributing factors included delays in the woman being reviewed by an obstetrician.

- Consultants acknowledged the need for additional medical cover on the labour ward. This was especially applicable at nights, where some consultants raised concerns regarding the skills mix of a minority of junior doctors. Staff envisaged that two middle grade doctors and two consultants present on the labour ward 24 hours per day was the "final goal" for the service.
- Consultants were present on the early pregnancy assessment unit from 8.30am to 5pm daily and were supported by a team of junior doctors.
- Data submitted by the trust suggested that the medical team utilised a formal handover tool referred to as CHAPS. The audit data demonstrated that the presence of consultants arriving to provide labour ward cover in the morning had improved from 20% in 2013, then to 76% in 2014. For those providing evening cover the data showed that improvements were from 14% in 2013 to 53% in 2014. The consultant presence had also improved from 14% in 2011 to 35% in 2014 (morning handover) and from 11% in 2013 and to 48% in 2014 (evening handover). 'Presence of senior trainee doctors' had also improved, although there were improvements to be made regarding ensuring that both the arriving and leaving senior trainee doctors were consistently both present at each handover. Anaesthetist presence at handovers had also improved from 8% in 2010 to 45% in 2014. However, there remained scope for further improvement.
- We observed a handover between medical staff. This was found to be as fragmented and unstructured as the midwife-led handover process. Despite the presence of real-time clinical information being available during the handover, which captured CTG tracing, this information was not utilised. Staff used non-standard phrases such as a "bit of a PPH" (PPH refers to postpartum haemorrhage").
- Consultant-led ward rounds took place on Cornflower B Ward. We noted that the ward round was attended by a range of healthcare professionals, including nursing staff and junior doctors.

### Major incident awareness and training

- The trust had in place business continuity action plans to support the emergency planning and preparedness policy, which the staff in maternity were aware of.
- Closures of the maternity service were reviewed via root cause analysis mechanisms, with findings fed back to local commissioners and stakeholders.

## Are maternity and gynaecology services effective?

Good

Evidenced-based care and treatment was delivered. Outcomes for women were similar to other services when compared. The local supervising authority commended the level of competency midwives who ensured their skills were up to date and annually reviewed.

Women received their choice of pain relief and were supported to feed their babies in their preferred method.

### Evidence-based care and treatment

- There was evidence available to demonstrate that women using the services of the hospital were receiving care in line with National Institute for Health and Care Excellence (NICE) quality standards 22, relating to routine antenatal care, including screening tests for complications of pregnancy. In addition, NICE guidance 32 was being adhered to regarding caesarean sections and guidance 37 for postnatal care. Additionally, the high dependency nursing team had introduced an enhanced recovery pathway for women undergoing caesarean sections.
- Due to a lack of substantive hepatologist, the trust was failing to meet the national screening standard for Hepatitis B. This was listed as a risk on the maternity risk register.
- We saw evidence of audits being carried out to ensure that the performance of the unit was consistent with national standards. Examples included reviews into caesarean section rates, induction of labour processes and intrapartum care of Group B Streptococcus infection.
- Outcomes of audits were disseminated to staff. Examples included an audit into the management of Group B Haemolytic Streptococcus, which was conducted in 2014. Thirty-four per cent of audited

women had a positive result documented in their notes. Sixty-four per cent of eligible women received intrapartum antibiotic prophylaxis, however, only 70% received the correct antibiotic. A range of recommendations had been made to ensure that staff better complied with the local trust policy.

### Pain relief

- The service operated a 24-hour anaesthetist-led epidural service. Between April and November 2014, 96% of women could expect to be seen by an anaesthetist within 30 minutes from the time of their initial request.
- Women who spoke with us told us they had been offered and provided with a choice of pain relief. This included for example epidurals or with controlled medicines such as Pethidine.

### Nutrition and hydration

- We saw that, where women had needed intravenous fluids to support their treatment, staff had followed a prescription for this and recorded fluid intake and output as part of the monitoring process.
- A food service was provided to women using the maternity inpatient facilities. This included provision of cultural and religious specific menus, such as halal and Asian vegetarian meals. In addition, medical-related diets could be catered for, such as nut allergies or gluten, wheat and dairy free, or diabetic.
- Women had been supported to feed their babies in their preferred method, be it through breastfeeding or bottle feeding. Staff were able to provide additional support to those choosing to breastfeed, including maternity support workers who had been trained to help in this area. Verbal information was supplemented by written leaflets. The maternity dashboard demonstrated that an average of 78% of women were reported as being supported to initiate breastfeeding following the deliver of their baby.

### Patient outcomes

- At the time of the inspection, the trust was listed as a maternity outlier, specifically relating to the reportedly high rates of emergency caesarean sections being performed at the hospital. It was identified that the data provisionally submitted by the trust was incorrect. Correct figures were subsequently submitted and, at the time of publication of this report, we considered the outlier alert to be closed.
- Elective caesarean section rates were lower than the England average (9% versus 11% nationally).
- The number of women who required instrumental assistance during delivery was in line with local performance indicators.
- Over an eight month period (April to November 2014) the service reported one case in which a woman required admission to an intensive care unit. The target was for fewer than two women monthly to be transferred to an ITU, therefore, the service was performing well in this criterion.
- The maternity dashboard demonstrated that there were no reported cases of eclampsia during an eight month period (April to November 2014).
- The number of women who experienced a postpartum haemorrhage of more than 1,500mls of blood was within the expected range for five of the eight months. We noted that there had been a minor rise in the incidence of PPHs with greater than 1,500mls loss over the last three months (September to November 2014 inclusively), which had resulted in the unit's performance being red/amber/green (RAG) rated 'amber'.
- The number of major postpartum haemorrhages (greater than 2,000mls) remained in line with expected targets.
- Rates for third degree vaginal tears following delivery were RAG-rated 'green' (in line with expected performance limits) over an eight month period. The frequency of fourth degree vaginal tears following delivery varied, with four out of eight months being RAG-rated 'amber'.
- The trust used the 11 RCOG indicators set out in the 'Patterns of Maternity Care in English NHS Hospitals 2011/12' to help develop and improve pathways available to women.

### Competent staff

- The maternity service had 17 supervisors of midwives, with an average number of supervisees of 1:13 and had completed 96% of the required annual reviews. Thirteen members of the team had achieved 100% of annual reviews. This was reported as a commendable achievement by the local supervising authority (LSA). The LSA report further alluded to the fact that, following discussions with eight midwives about the annual

review process, the process was "widely appreciated with each midwife giving a rating of four or five (one [being] unsatisfactory and five [being] excellent) and an average of 4.4".
- The average appraisal rate over an eight month period (from April to November 2014) was 89%. This was better than the trust target of 80%. Midwifery staff spoke positively about the appraisal process and considered it an opportunity to reflect on their previous year's practice, as well as to consider future development opportunities.
- Newly qualified midwifery staff were supported by a team of educational support midwives whose role it was to enhance the competency and skill set of all staff. Newly qualified midwives were afforded the opportunity to undertake a preceptorship programme, which was run in conjunction with the registered general nurses preceptorship programme. The programme included six set days to facilitate competency skills, such as intravenous cannulation, as an example.

### Multidisciplinary working

- Following a reconfiguration of maternity services in 2012, a range of postcodes were assigned to alternative hospitals. Members of the community midwifery team explained that, as a result, they were not always informed of postnatal discharges which had occurred out of their area. This had led to some postnatal mothers not being followed up in line with national timescales. In response to these concerns, the service had appointed a "failsafe officer" for newborn bloodspot screening to ensure that babies were appropriately screened and followed up, as necessary.
- One community midwife reported that they spent four to five shifts each month working on the Queen's Birth Centre in order that their skills could be fully maintained. The community team told us that they felt "listened to" and were "part of the wider team".
- There were arrangements in place for ensuring that women who were admitted to the intensive care setting continued to receive appropriate medical and midwifery support from the maternity team.
- Both maternity services and gynaecology services were supported by having access to physiotherapists, occupational therapists and pharmacists, as required. A pharmacist visited the clinical areas daily and carried out reviews of medication charts. Nursing and midwifery staff reported that the pharmacists were a useful source of information and were readily available to provide advice.
- While there was no dedicated transitional care service for term babies who required additional levels of support, a dedicated member of the neonatal intensive care was allocated to oversee the provision of care to babies on the postnatal ward. This level of support included the administration on intravenous antibiotics, as an example.

### Seven-day services

- While the dedicated level of consultant presence on the labour ward was not in line with national and regional standards, there were arrangements in place to ensure that a consultant was always available to be on call. Each of the consultants we spoke with said that it was not uncommon for them to remain present in the hospital overnight. This was supported through our discussions with the midwifery team.

### Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The service conducted very low numbers of termination of pregnancies. Women who opted for a social termination were referred to an external provider. Where a termination was required on medical grounds, women were managed in line with national standards. We noted that consultants were using appropriate consent forms and documented the specific reasons for the procedure. There were no pre-written consent forms, nor Certificate A's (HSA01 certificates). This was in line with best practice.
- Staff on Cornflower B Ward were conversant with the trust policy relating to the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We observed that, in practice, the policy was being applied for an inpatient on the ward.
- Women told us that procedures were explained to them; explanations included the risks, benefits and any potential alternative treatments available. Women said that receiving this information, and being able to ask the clinical team any questions allowed them to make informed decisions prior to consenting to treatment.

- Staff were able to describe the process for seeking consent from young people who were deemed as being underage. Staff were conversant with the requirements of assessing and determining Gillick competence and advised that a local policy was available to support staff.

## Are maternity and gynaecology services caring?

Good

Women were supported, treated with dignity and respect and involved in their care. There had been improvements in the way women felt about the service since our last inspection.

Women were cared for and treated with compassion, they were supported to cope emotionally with their care and treatment.

### Compassionate care

- As of October 2014, gynaecology services had attained a year to date family and friends response rate of 93%; this was better than the trusts target of 90%. However, the aggregated response score for the gynaecology service was 45.7 versus a trust target of 65.
- Between November 2014 and February 2015 the percentage of people who would recommend the antenatal services, labour ward services, postnatal ward services and community postnatal services was consistently the same as or better than the national average. The only exception was that in December 2014 and January 2015, the percentage of women who recommended the postnatal service was lower than the England average (Dec 2014 - 90% locally versus 93% nationally and January 2015 - 88% locally versus 93% nationally). Community postnatal services attained a 100% recommendation rate for both December 2014 and January 2015.
- Results from the Care Quality Commission Survey of Women's Experiences of Maternity Services (2013) identified that the service performed worse than the national average in eight key questions. It performed about the same as other trusts in the remaining 9 questions. However we spoke with a range of women who had recently given birth. They spoke positively about the care they received, as well as speaking positively about the support their partners had received.
- We spoke with 15 women who were accessing either antenatal or post natal care and with eight women who were receiving either inpatient or ambulatory care on Cornflower B ward. Comments from women and their partners were varied although in the main remained favourable and included for example; “The staff have been so professional and caring", "Things have improved drastically since I had my last child here", "I felt as though the midwives listened to me; this was something I did not experience the last time I gave birth here"., "My midwife was brilliant; she made it a really intimate experience and I knew I could count on her". Other women said "I feel as though I could have been involved more in my care; the communication amongst staff could be better", "The staff have been kind but they could have explained more about the post-operative pain relief options that were available".

### Patient understanding and involvement

- We spoke with patients about the support that they had received from allied health professionals such as physiotherapists and occupational therapists whilst they received care on Cornflower B ward. They reported that they had been encouraged to learn to do the exercises when on their own and that the way that these had been explained to them had empowered them to feel more in control of their condition.
- The majority of women told us that they had been kept informed regarding the care that they were receiving and that the medical, midwifery and nursing staff were approachable when they had had any concerns.

### Emotional support

- A designated room was provided for the care and support of women and their respective partners to be cared for during and after the loss of their baby. This was noted to be located toward the end of the main corridor on labour ward. Staff reported that the room had recently been refurbished which had included additional sound-proofing however it was still possible for bereaved women and their partners to hear labouring women and crying babies from the main ward area to reduce distress and enable more direct support.

Staff told us that they raised awareness amongst the clinical teams when the bereavement room was occupied so that all efforts could be made to ensure that the environment was as peaceful as possible.
- Bereaved women and their partners were supported by a team of midwives who had specialised in providing holistic bereavement support.

## Are maternity and gynaecology services responsive?

Requires improvement

Women's needs were met through the way services were organised and delivered. The configuration of maternity services at the hospital meant the service was more responsive. However the gynaecology services were not always responsive.

The services access and flow had improved and women received one to one care in labour. However there were avoidable delays in leaving the hospital and some clinics did not run to time.

Complaints were investigated within agreed timescales and there was evidence of learning from complaints.

### Service planning and delivery to meet the needs of local people

- Historically the number of deliveries undertaken by the trust exceeded 10,000 births annually. Issues with quality and safety had been identified, specifically for births undertaken at King George's Hospital. The maternity service engaged with external stakeholders and conducted an assessment to determine a safe and appropriate number of deliveries that could be carried out by the trust. A cap of births was introduced in 2012 which resulted in the closure of the maternity service at King George's hospital. With the exception of some antenatal care services, all other maternity services were relocated to Queens Hospital, Romford.
- The gynaecology services were not always responsive or planned to meet women's needs. Women sometimes experienced long waits on Cornflower B ward.

### Access and flow

- Whilst flow was observed to be good across the post-natal wards during the inspection, staff reported that they often experienced delays in being able to discharge women in a timely way; this was attributed to delays in qualified staff attending the ward to carry out "baby checks" prior to them being discharge home. A small number of midwives had undertaken additional training in order that they could undertake "Baby checks" in order that the discharge process could be improved. Midwifery staff reported that whilst this had improved the overall discharge process, delays continued to exist because of the overall activity of the service.
- The service reported three closures of the maternity service between June 2013 and November 2014 (July 2013, April 2014 and October 2014). Where closures of the unit took place, Serious incidents were reported and escalated for each closure and an investigation completed for each incident to determine whether alternative actions could have been taken, or whether the closure was unavoidable.
- Women told us that they had been offered a number of choices throughout their pregnancy. When women had been assessed as suitable for delivering their baby on the Queens Birth Centre, they had been offered this choice. The service aimed for and achieved 15% of deliveries to take place at the Queens Birth Centre.
- 1% of births were taking place at home as of October 2014; the service acknowledged that further work was required to increase the number of deliveries that took place in woman's' home as per national recommendations.
- 92% of women who presented to the emergency gynaecology unit could expect to be seen by a clinician within 30 minutes; this was against a trust target of 95%.
- As of October 2014, the 62 day cancer performance rate for the service was 92%; this was better than the trust target of 83%.
- The percentage of women who were being seen within two weeks from referral for cancer treatment was 91.6%.
- Theatre utilisation for the gynaecology service was better than the trust target; 90% against a target of 85%.
- The average length of stay for elective cases was 2.2 days. The average length of stay for non-elective cases was two days.
- The maternity dashboard demonstrated that 100% of women received one-to-one care from a midwife during labour.

# Maternity and gynaecology

### Meeting people's individual needs

- Both the antenatal and gynaecology clinics were co-located in the same area. This meant that women who may have miscarried, who were experiencing complications with their pregnancy or who were having difficulty conceiving in the first instance were observed to have to wait for their appointment in the same area as pregnant women, or those who were accompanied by children or babies.
- We spoke with five women who were waiting for an antenatal appointment. They each reported that they were frustrated with the delays in clinic. One woman said, "Could they not use a whiteboard to let us know how long it was likely they would have to wait?" Another woman told us that they needed to have an antenatal scan before seeing their consultant. While anecdotal, they said, "The last time I came, the scan was booked for 9am and the appointment for 11am. Because the clinics always run late, I had to wait two and a half hours to see the doctor."
- Two women said that the receptionist staff could be "very rude" and "abrupt, not very welcoming". Another said, "They don't say hello and they don't look at you, although they have been OK today." We noted that the reception area of the antenatal clinic and gynaecology clinic were divided into booths with a separate member of staff at each. The first booth, allocated for the gynaecology clinic, was only recognisable by a laminated sign attached to the side of the dividing panel. When the inspection team arrived at the clinic area, it was not immediately identifiable that the two booths were for separate clinics. We observed two women present to the reception desk. Both had to instigate a conversation with the reception staff, both were signposted to the next booth.
- Midwifery staff reported that translation services were readily available. These services were provided via telephone interpreter services and also from face-to-face interpreters.
- A range of specialist midwives were available to support the needs of vulnerable women. Specialist roles included a teenage pregnancy midwife, clinically high risk consultant midwife whose role it was to support women to have as normal a birth as possible, mental health midwives and safeguarding midwives. Staff were supported with a range of protocols and pathways for supporting vulnerable women and young people.

### Learning from complaints and concerns

- Reports were handled and overseen by the head of midwifery and were managed in line with the trust local policy. We reviewed three complaints and found that they were each managed in line with trust timescales. Complaints were acknowledged, investigations undertaken and responses sent to the complainant. Action logs were generated in response to complaints, so that changes to the service could take affect to enhance care in the future.

## Are maternity and gynaecology services well-led?

**Requires improvement**

The leadership and culture of the service had improved and ensured the services were well-led. Staff were engaged and committed to improving the service.

Governance arrangements were, in the main considered to be sufficiently robust. Dashboards were utilised and offered staff a snap-shot of a range of quality indicators and outcomes to ensure that clinical performance could be assessed. Audits programmes were utilised to underpin the existing governance arrangements.

However, the existing governance arrangements did not always encompass the totality of clinical and maternity services provided to women; those working in foetal medicine and the ante-natal screening service were not always included in, nor received timely feedback from incidents which may have impacted on the management of the woman and her unborn baby and so there was the potential for delays in lessons learnt and service improvements being implemented as a result of clinical incidents.

### Vision and strategy

- The women's health service which encompassed both gynaecology and maternity services, had produced a strategic business plan for 2015/16. The plan was developed in partnership with the head of midwifery, clinical director, associate director of operations and the service general manager. The directorate vision was to:

"Support the trust in achieving the corporate objectives and delivery of the improvement plan," and to, "manage the financial position of the division and ensure expenditure is within budget".

- The vision of the service was for the maternity team to meet the North East London commissioning arrangement to deliver 8,000 babies annually, of which 15% of births would be carried out on the Queens Birth centre and to move to a paper-light system so that midwives could spend more time providing direct care. The gynaecology service aimed to achieve its 18 week referral to treatment time target, 14, 32 and 62 day cancer targets, achieve national colposcopy screening targets and to support the emergency care pathway by continuing to facilitate a direct access emergency service.
- A range of service development plans had been generated to support the women's health directorate to deliver its strategy and vision including an information technology strategy, increase of consultant and junior doctor cover on labour ward, development of midwifery led advanced practitioners for high risk and specialist antenatal clinics and development of private obstetric service to support the financial performance of the service and trust. Gynaecology development plans included introduction of a satellite IVF unit in conjunction with another London trust, development of nurse-led uro-gynaecology services as well as developing clinical pathways for emergency gynaecology services, one-stop hysteroscopy services and further development of the complex endometriosis service.
- From our discussions with the clinical director and head of midwifery, the main priority for the service was to resolve the longstanding consultant obstetrician deficit. With the exception of a business case to increase the number of consultant obstetricians, it was not clear from our discussion with the clinical director, what mitigation or contingencies had been introduced in the interim period to ensure that, while the business case was being given due consideration by the executive team, the delivery of care remained safe.

### Governance, risk management and quality measurement

- There was a maternity risk management strategy that was ratified by the maternity quality and safety committee in October 2012. The strategy was due for review in October 2015. The strategy gave due regard to the trust risk management strategy, claims policy and procedure, complaints policy and investigating and learning from the incidents policy.
- Monitoring of morbidity, mortality, key performance indicators and other significant service utility indicators was achieved through the use of a balanced maternity dashboard, which we reviewed as part of the inspection process.
- Risk management processes also included processes for ensuring that clinical guidelines and processes were reviewed in line with changes to national developments and guidance, as well as ensuring that policies nearing their expiration were referred to the appropriate committee for review.
- The risk management strategy was underpinned by a comprehensive audit programme. There was evidence that, where audits had identified areas for improvement, these improvements were implemented through the use of action plans. Risks were transcribed to the departmental risk register and mitigation and controls were recorded.
- Governance arrangements between the antenatal scanning team and maternity services were found to be insufficiently robust. There were no formal processes for ensuring that, where incidents such as undetected foetal abnormalities occurred, the antenatal screening team were informed in a timely way, with anecdotal examples given of delays of up to one month before the team were informed of an event. This led to delays in lessons being shared and quality improvement taking place.

### Leadership and culture of service

- Oversight of the maternity and women's health service was in the form of a triumvirate, including a clinical director, head of maternity and a general manager.
- Each of the clinical areas, including: antenatal, labour ward and postnatal ward were managed by a named consultant.
- The majority of staff that we spoke with reported that leadership of the service had significantly improved over the last three years prior to our inspection. Consultants commented that the role of the labour ward coordinator was functioning well and individuals within the role led the labour ward well and provided high levels of support to junior colleagues.

# Maternity and gynaecology

- Staff working on the Queen's Birth Centre reported that the culture was such that, where they felt there was a need to transfer a woman to the labour ward for on-going management, their views and clinical opinion were respected by the medical team.
- Staff working on Cornflower B ward reported that whilst the unit was extremely busy 24 hours per day, the ward sister led the team consistently, and always from the "Shop floor"; we observed the ward sister engaging in ward rounds during the inspection. The ward sister was seen to encourage junior nurses to engage with the medical team during ward rounds and was observed to delegate tasks.
- The general consensus amongst the staff that we spoke with indicated that the service was supported by a workforce who were highly committed to providing holistic care to the women and their partners. Staff were committed to ensuring that mothers-to-be and women accessing gynaecology services received care that was of the highest quality.

### Public and staff engagement

- While there was evidence of staff engagement, most midwives that we spoke with raised concerns that the engagement process was simply a "tick box" exercise and that the perception was the management team had already decided to implement changes. We noted that a two-year rotation of all midwifery staff had led to some level of discontent and anxiety amongst the workforce. Further, a small number of midwives raised concerns that the management team were considering a change of shift start and finish times. Staff felt that the management team had not considered the safety implications of midwives leaving the hospital at 10pm, especially for those who were reliant on public transport.
- The service hosted a maternity service user group, which was chaired by a someone who had previously used the service.

# Services for children and young people

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

## Information about the service

The hospital serves a population of 270,000 children and young people, mainly across the London boroughs of Barking and Dagenham, Havering and Redbridge and parts of Essex. 92% of cases are elective, 7% are day case, are 1% emergency. In outpatients for children under the age of 16 there were 1430 new attendances and 1742 follow up attendances in 2014.

There is a 30 bedded inpatient ward for medical and surgical admissions, Tropical Lagoon, which includes 5 short stay beds. There is no designated high dependency unit for children, though children with high dependency needs are admitted onto Tropical Lagoon.

There is a day case facility, Tropical Bay, with 12 short stay or day case beds, for surgery (general surgery, ear, nose and throat and trauma), oncology and haematology. An assessment area for children requiring short term observation and children's outpatients' services are also on site providing general and specialist medical, surgical and oncology care including cystic fibrosis, coeliac, asthma, diabetes, haematology, immunisation, genetics, ophthalmology, orthodontics and orthopaedics. Joint clinics with other specialist children's hospitals are also provided for, cardiology, orthopaedics and ear, nose and throat (ENT). The paediatric home care team provide nursing care to children in the community for children living in the London Boroughs of Barking and Dagenham or Havering.

There is also a 25 bedded neonatal intensive care unit (NICU), 4 cots equipped to provide intensive care, 14 special care baby unit beds and 5 providing high dependency level 2 care. In total 3.7% of the beds within the trust were dedicated to children and young people's care.

During our inspection, we spoke with 31 parents, families, children and young people, observed care and treatment including handovers, checked 11 pieces of equipment and looked at 10 care records. We also spoke with 49 staff members at different grades, including allied healthcare professionals, nurses, student nurse, health care assistants, junior doctors, consultants, managers, play specialists, matrons and members of the senior management team. We received comments from people who contacted us to tell us about their experiences. In addition, we reviewed performance information about the trust and undertook an unannounced inspection on Friday 20 March 2015.

# Services for children and young people

## Summary of findings

Staff told us they were encouraged to report incidents, though we noted that there was limited learning from all reported incidents, including those that caused serious harm. Most environments in which children were cared for were appropriate, though children were seen in adult departments for ENT, ophthalmology and dermatology. Staffing levels were prioritised for safety. However, there was a lack of appropriate high dependency beds, and the inpatient unit was routinely closed to new admissions so that safe staffing could be maintained. We also found checks on paediatric resuscitation trollies were missed for 9 days over a period of a month.

Evidence based guidelines and recommendations from the National Institute for Health and Care Excellence (NICE) and the royal colleges' to determine were reviewed by specialty areas though we could not identify whether they were implemented consistently in practice.

There was limited evidence and limited audit activity undertaken by the children's directorate that was recent or specific to the specialties within the division. From the information collated, we identified that the division was not always performing in line with national standards; this was especially true for some outpatient and surgical services.

The services not consistently responsive to the needs of the people that it was caring for. All children over the age of three who required blood testing were only seen in areas shared with adults that were not child appropriate. An increasingly high number of children required high dependency care however the service was not a designated as a provider of a high dependency services. Some specialty surgical clinics, and the recovery area, were in adult settings which meant children were seen in areas mixed with adults.

Some staff were concerned that there was insufficient cot provision to meet demand in the neonatal service following a reconfiguration of the service in November 2014.

There was a lack of transitional care arrangements for young people. Staff told us that the decision to admit young people aged 16 to 18 was made on a case-by-case basis, and that there were occasions when admissions were made to adult wards without consulting the young person.

The approach to meeting the needs of different groups, for example those who required translation service, was reactive. Though the few complaints were recorded, action taken in response to feedback and complaints was narrowly focused and learning was not widely disseminated.

The children's directorate lacked a formal vision or strategy, and some staff were unaware of the trust's values. Staff spoke highly of the medical leadership in the division. Recent changes to the structure of the trust's divisions meant that overall leadership that there had been a number of new appointments to the leadership of the division which meant leaders had limited management understanding and oversight of the division. The divisions that served children and young people worked in isolation, and although the women's and children's division had overall responsibility for children and young people, pertinent information was not always appropriately shared between the divisions.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement

Nursing and medical staffing levels met children's' needs and the requirements of national guidance for safe staffing for in paediatric care. Staffing ratios were based on a standardised, evidence based formal dependency and occupancy tool. There was a high standard of record keeping and staff were aware of how to recognise and report safeguarding concerns.

There was a lack of evidence of learning from incidents that had caused or could potentially cause harm. We found occasions where serious incident report investigations had not been completed for over six months, and there was limited evidence of identification of root causes.

### Incidents

- There was contradictory evidence regarding the number of reported serious incidents. Data shared with us prior to the inspection indicated that there were two serious incidents reported within the division, between July 2013 and the end of 2014. However, according to the children's division governance report for February 2015, we saw there were at least six incidents reported in the same timeframe that may have caused serious harm.
- A total of 355 incidents attributed to the division were reported on the trust's electronic incident reporting system between the 1st of April 2014 and February 2015. Due to the way the data was shared with us, we could not identify which specialties these incidents related to and were made aware that the quoted figure includes incidents reported across children's inpatient and outpatient areas across Queen's Hospital and King George's Hospital. Six of these incidents were classified as near misses, 278 of these incidents were low harm, 56 as moderate harm, six as high harm, one as major and five as non-serious incidents, non-harm.
- The children's division's quality and governance report of November 2014 showed the top five categories of reported incidents were medications, a staffing shortfall in nursing and midwifery, problems with diagnostic tests, documentation/confidentiality/medical records and delays in clinical intervention or review.
- Staff described and showed us how to use the incident reporting system and the process for reporting incidents, although some staff told us that that whilst nursing staff proactively reported, other staff groups including medical staff were not as proactive. Staff reported "a senior staff member has taken the fear out of incident reporting and leads the way in documenting incidents."
- Ward staff received on a monthly basis reports of all reported incidents. They also told us that staff received feedback when an incident was closed. Senior staff told us the timelines for closure of incidents was monitored and met, though this was not evidenced in patient safety committee reports, the children's governance report or the monthly audit reported for the division.
- There were processes in place for the investigation of reported incidents. Whilst there was evidence that incidents were reviewed and investigations occurred, we were not able to identify if lessons learned were generated or disseminated consistently to ensure all staff were engaged with learning from when things went wrong.
- Some staff told us incidents that affected patient care were reported but near misses, that did not cause harm, were not.
- Senior staff told us that most investigators were trained in root cause analysis techniques. Training records we requested showed that 60% of named investigators received some training in 2011 or 2012 and a smaller proportion received accredited training i.e. from the patient safety functions now managed by NHS England.
- 17 of the reported incidents were recorded as unexpected admissions to NICU. We spoke with senior staff about these incidents and they told us that the outcomes for neonates were not poor, and that the NHS England serious incident guidance was followed which explained the number of reports. Admissions of babies from low risk pregnancies to NICU must be classified as an incident.
- The duty of candour was not consistently applied. Staff with responsibility to investigate incidents had to identify whether patients involved in incidents, or their relatives, had been notified if an incident that caused moderate, severe harm or death had occurred. A box was ticked on the relevant form for these incidents.

However, staff had not received training on the new duty of candour legislation and senior staff could not assure us that this was being followed for each relevant incident investigation.

- Mortality and Morbidity and child death was reviewed by the division's senior clinicians and managers in monthly audit meetings. Meeting minutes showed that there was often low attendance at these meetings, and morbidity was not always reflected. We therefore could not be assured that all serious harm and child deaths were properly learned from.

**Patient Harm Data**

- Safety thermometer data was not collected within the division and there were no plans to develop use of a suitable tool. However, the nursing monthly dashboard reported that there was 100% compliance with the safety thermometer between December and February 2015 and therefore it was not clear if the reported compliance was accurate.

**Cleanliness, infection control and hygiene**

- During our observations of the immediate environment in which children and babies received treatment and care, including between bed spaces we found all areas to be visibly clean.
- The wards had a range of equipment, which were seen to be visibly clean.
- Where cleaning took place, domestic staff maintained check lists and reported that they had access to policies and visual guides, which included instructions to staff on how to safely clean areas such as toilets.
- The company providing in house cleaning had recently increased the number of cleaners on Tropical Lagoon and Tropical Bay in response to comments made about cleanliness in recent feedback from parents and families.
- We observed that staff complied with the trust's policies for infection prevention and control. This included wearing personal protective equipment such as gloves and aprons, using alcohol gel before and after patient interactions and keeping bare below the elbows.
- Results of a quarterly audit of infection control practice were shared with us. Use of personal protected equipment, hand hygiene, compliance with sharps policies, isolation, commodes and peripheral cannulas was reviewed. Results were regularly in line with or better than the trusts reported requirement of 90% compliance.
- Hand hygiene compliance rates were requested by the infection prevention and control team for all inpatient areas within the hospital. Rates were not shared for Tropical Lagoon for the first two weeks of January or February 2015. We raised this with senior nursing staff but they could not identify why this had not occurred.
- Cleaning audits were conducted for children's and neonatal services though no audit data were available during the inspection.
- Infection control nurses provided supported and guidance to staff, but there were no specific training sessions available to staff. A link nurse had recently been allocated from the paediatric nurses on Tropical Lagoon.
- There had been no reported cases of Clostridium difficile or MRSA blood stream infection between 2014 and March 2015. Ten cases of wound infections following a procedure were reported in 2014.

**Environment and equipment**

- Staff were aware of who to contact or alert if they identified broken equipment or environmental issues that needed attention. Staff told us that maintenance teams attended soon after faults were reported and we saw this happened in practice during our inspection.
- There was a hoist on Tropical Lagoon which was regularly serviced and maintained for safe use.
- Some staff we spoke with told us the ward often had no stock of some sizes for tubes that let medicines and fluids into the body, known as peripherally inserted central catheters or PICC lines. These were obtained from ITU when required, and could lead to delays in providing timely care.
- Resuscitation trollies in Tropical Bay, paediatric outpatients, main theatres and recovery were reviewed and found to be in maintained, appropriately stocked and checked as required.
- There were two resuscitation trolleys on Tropical Lagoon. Current guidelines (2010 Resuscitation Council Guidelines UK) were attached to these trollies. A new system of checks were introduced in January 2015, which meant that there should have been detailed weekly checks of equipment and dates each week documented on the safety fly list, and a daily check that

the seal was intact. We saw inconsistencies in equipment kept on each. The first trolley had an intraosseus introducer (for rapid fluid infusion during resuscitation) and a neonatal box and the second did not, and the second had a defibrillator and the first did not. We also saw gaps in the daily checking of the seals for the trollies. These were not completed for nine days between January and February 2015. Staff we spoke with were not aware that the nurse in charge for the shift was responsible for checking these items. We raised these concerns immediately with a senior nurse who made arrangements to improve the checking system and told us only one defibrillator was required on the ward.

- All the clinic areas that were mixed adult and children (ENT, ophthalmology, orthopaedics, phlebotomy) did not have paediatric resuscitation equipment and had items missing from their trolleys. Staff told us they would normally go to paediatric outpatients to get resuscitation equipment in the event of an emergency.
- An equipment bag to accompany patients to MRI scans contained an equipment list but this was not checked.
- We saw equipment had service labels attached showing that equipment was routinely serviced within date. All equipment we checked had received a portable appliance test (PAT) within the last three years.
- We saw that clinical waste bins were not overflowing operated according to instructions and staff told us they were changed regularly.

**Medicines**

- There were processes for ensuring that medicines were kept securely in cabinets and fridges on the ward. Medicines fridges were locked.
- Fridge temperatures were taken daily across the paediatric areas in the hospital. Temperature records on Tropical Lagoon were recorded as over 8 degrees Celsius, or the maximum temperature for safe storage of medications requiring refrigeration, for the first two weeks of February 2015. Staff told us they had responded by including reminders to the ward team at the end of each handover. These reminders were to report any abnormal fridge temperatures to the ward pharmacist immediately.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs.
- Staff had access to national formularies such as the British National Formulary (BNF) for Children and medical staff we spoke with actively showed us how they used the antibiotics prescribing mobile phone application developed by the trust pharmacy team.
- Staff told us they could not issue prescriptions for any medications on Tropical Bay. Out of hours drugs to take away had to be prescribed and given by the adult day care unit if available, otherwise the child could not be discharged which some staff said caused delays.
- Pharmacy checks were completed weekly and staff checked ward stock daily.
- A paediatric pharmacist undertook regular audits on vancomycin and gentamicin prescriptions and provided regular feedback to ward staff to improve prescribing.

**Records**

- We reviewed 10 sets of patient records and found risk assessments were completed. The nursing and medical records, including risk assessments that we reviewed were completed appropriately and were up to date.
- Risk assessments had been completed and there were evaluation records of whether patients' health and emotional needs had been met.
- Tools designed specifically for use with children and young people in assessing risks to pressure areas and assessment of pain were found to be in use.
- Senior staff told us that a documentation week was held in February 2015, though staff we spoke with did not know of the impact of event.
- Pre-operative checklists we reviewed for children who had gone to theatre were completed.

**Safeguarding**

- Staff we spoke with had a clear understanding of their roles and responsibilities when reporting safeguarding concerns.
- The safeguarding strategy encompassed a number of safeguarding policies, adults, children, transition, and supervision. Staff showed us they were able to access these policies in hard copy on the ward areas and on the trust intranet and we saw were in date and ratified by the hospital's committees. The policy was cross referenced with national policies, procedures and guidance including the Pan London Safeguarding

Children Procedures (2012), Royal College of Paediatrics and Child Health, Safeguarding Children and Young People (2010) and the Department of Health's Working Together to Safeguard Children (2013).
- The hospital had a named nurse, named doctor and named executive for safeguarding children.
- The areas within the children's division were supported by a safeguarding nurse.
- The trust has set an expectation of 85% compliance with training. Of all groups of staff within the children's division, 95%, 88% and 85% had completed training in level 1, 2 or 3 safeguarding children, respectively.

**Mandatory training**

- Data provided by the trust demonstrated that 86% of staff working in the division were up to date with their mandatory training. Topic areas that were covered and had attendance over the 85% mark were equality, diversity and human rights, fire safety, health, safety and welfare, infection prevention and control, information governance and moving and handling. The data showed that the rate of compliant was lower for one area only, whereby 70% of staff had attended training in conflict resolution.
- Although over 85% of all clinical staff within the division were reported as having attended sepsis detection and management training and resuscitation training, we could not be assured that all staff that required it had been identified as requiring resuscitation training. Only four staff within the whole division were listed as requiring to attend paediatric immediate life support training (PILS). PILS had not been completed by all recovery nursing staff working in recovery. Staff were expected to complete basic paediatric life support training every two years, but training records held in theatres showed that approximately 30% of recovery nursing staff had not completed this training. Simulation sessions were run on a monthly basis, but attendance rates for these sessions were not available when requested.

**Assessing and responding to patient risk**

- The division had adopted the use of a national tool to identify and monitor children who may have been at risk of deteriorating, the Paediatric Early Warning Scoring (PEWS) system. A trust wide audit of early warning scores in January 2015 identified that for Tropical Bay and Tropical Lagoon frequency of observations were not always recorded for the within a 12 hour shift. Learning from this audit had been implemented as we reviewed 10 records during our inspection and found PEWS charts were appropriately completed.
- A neonatal early warning score system was used to identify the deteriorating neonate on NICU.
- Staff told us that they would rely on their knowledge and experience to recognise a deteriorating or acutely unwell child. Nursing staff could seek additional support and clinical guidance from either a consultant paediatrician or an experienced junior doctor.
- A child or young person who had been identified as being critically ill was transferred to other children's services within London through the Children's Acute Transfer Service (CATS). The hospital had amongst the highest rates of referral to the CATS team across London, but they were awaiting confirmation of data from the team to establish whether this reflected how children and young people were being managed. Staff told us that these transfers were managed on a case-by-case basis. Staff had access to protocols issued by CATS and these guidelines were designed to support staff to stabilise acutely unwell children before they were retrieved. CATS would not take children requiring high-dependency care where the hospital had decided that the ward or intensive care unit could provide what was required.
- The trust guidelines for stabilisation, escalation and transfer of the critically ill child had not been reviewed by the trust committees and was not available on the trust intranet. The trust's 2009 Patient Safety Transfer Policy was over two years overdue for review.
- Pre-assessments for paediatric surgery would, on occasion, have a telephone pre-assessment for complex paediatric patients.
- We were told that the World Health Organization (WHO) 'five steps to safer surgery' checklist was used for all children and young people that underwent surgical procedures in the hospital. There was no specific audit or feedback of the use of the checklist for paediatric surgery.

**Nursing staffing**

- Some nurses were on a roster to rotate between the inpatient services run by the trust at Queen's Hospital and King George Hospital. The nursing establishment was therefore combined accordingly. Information provided by the trust indicated that, as of February

2015, the establishment for the children's division was 91.36 whole-time equivalent (WTE) posts, with an overall vacancy rate of 8.89 WTEs or 9.7%. We found that the department was spending more money than had been budgeted on temporary staff to ensure that shifts were appropriately covered.

- Nurse staffing levels were adjusted daily according to the admissions on the ward to ensure minimum recommendations advised by the Royal College of Nursing were met. For general medical care, this was one nurse to four patients and one to three for under two year olds. If there were children requiring high dependency care, staff numbers were increased to provide one to two or one to one care depending on level of assessed need. If ward staffing levels were down by two nurses, a bed would be closed. Bed closures were escalated to divisional management for sign off.
- We found that the nurse in charge of the clinical area was not supernumerary in line with Francis recommendations. The nurse in charge was required to take charge of patients while also being responsible for managing the shift.
- We saw that nursing staff were supported on each shift by one health care assistant during the day and one during the night.
- There were a number of vacancies on inpatient areas. Staff told us there was a 10% vacancy of band 5 nursing staff with no vacancies at band 6.
- Data showed that on Tropical Lagoon, there were 29.3 WTE registered staff and 3.2 WTE or 11% vacancies, and 6.3 WTE unregistered staff and 1.5 or 24% vacancies.
- On NICU, there were 56.6 registered staff WTE and 10.7 or 19% vacancies, and 6.9 WTE unregistered staff and 2.1 WTE or 30% vacancies.
- We were told vacancies were filled by bank or agency staff. We asked for data regarding the fill rates for nursing shifts, to identify if staff were appropriately allocated to shifts. Fill rates for registered nursing staff were 108% for registered nursing and 65% for non-registered nursing staff for the first two weeks in February 2015. This could mean that the designated requirement for one health care assistant per shift was not being met.
- Acuity of patients was measured locally but a tool suitable for children and young people was not used. The trust told us that a recognised tool (Paediatric Acuity and Nurse Dependency Assessment, or PANDA) was no longer meeting the needs of the service and since the division had been working on developing a local data capture system which was not yet fully in use.
- A senior nurse on Tropical Lagoon kept a record of daily acuity, which reflected: bed capacity, the number of nurses on shift, levels of safe staffing required for each patient and whether escalation was required to close beds or request extra staff since September 2014. This was a comprehensive measure and clear evidence of requirements to ensure patients were safe, with clear recommendations for care, for the ward.
- Since the neonatology external review, safer staffing levels recommended by the British Association of Perinatal Medicine (BAPM) guidelines were being met.
- Staffing boards displayed during our inspection showed that staffing levels were maintained at safe levels.
- An advanced neonatal nurse practitioner worked at the equivalent level to a foundation year (FY) doctor under supervision, full time.
- We could not establish whether appropriate nurse staffing levels for theatres were in place. We were told that there was a dedicated registered band 5 children's nurse working in theatres, and that adult trained nurses worked within children and young people in theatres. The trust had a policy that stated that a registered children's nurse was required to collect children from theatre.
- Recovery nursing staff worked with children, but none had undergone specialist competencies, or training. Senior nurses told us that paediatric nurses on the ward and the duty anaesthetist could be sought for advice, if required.

**Medical staffing**

- There were 17.9 paediatric consultants that worked across both sites.
- The unit was supported by a consultant paediatrician between 8am and 8pm, and provided through an on-call service outside of these hours.
- Further medical support was provided by junior doctors who had a range of experience within paediatrics.
- Staff told us that every inpatient child and young person was seen by a consultant paediatrician within 24 hours of admission. There were two, and if required, three daily ward rounds led by a consultant paediatrician. The nurse in charge of the shift also attended these ward rounds.

# Services for children and young people

- We observed that doctor's handovers maintained the privacy and confidentiality of all patients and were held in offices with doors shut. The e-handover system was used for inpatients and could be accessed by staff outside the hospital. Printouts were used during handover.
- Consultants were present from 8am until 8pm daily, and on call at night. However, it had been recognised that on-call senior cover 24 hours a day, seven days a week was not available, and steps to address this had been taken.
- The paediatric and neonatology services were separately staffed, with independent rotas. At the time of the inspection, respective medical staff did not provide cross cover between the units.
- Junior doctor rotas were planned to meet the requirements of the European Working Time Directive and to provide 24-hour on site cover.
- There was a lower proportion of consultant grades and considerably higher proportion of junior grades compared to the England average. There were 74 whole time equivalent doctors across the division.
- There was no formal system in place for ensuring that an anaesthetist with paediatric skills was always available postoperatively to provide support, advice and treatment in an emergency.

### Major incident awareness and training

- There was a hospital-wide major incident plan. The policy referred staff to an action card that would be used in the event of a major incident. There was a large folder, easily accessible with the nurse in charge's action card. We spoke with two members of staff who were clear about what a major incident was and their role is responding to it.
- Protocols were in place for closing the labour ward and unit due to capacity issues affecting NICU.
- A protocol describing escalation options to other hospitals within London and the South East of England for reduced capacity were in place, and senior clinicians we spoke with were aware of the requirements.

## Are services for children and young people effective?

Requires improvement

Outcomes for children and young people were in line with the national average for a number of specialties. Policies and guidelines were in place that were consistent with national best practice and based on recommendations by organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). We saw up-to-date guidelines were accessible on the trust's intranet.

There was limited evidence of learning applied from national or local audit activity. There were no paediatric therapies services provided by the trust and input was ad hoc or reliant on referral to other providers. There was limited cross working between paediatrics and the surgical teams and therefore communication was poor about the overall management of children and young people.

### Evidence-based care and treatment

- Senior clinicians and managers told us they used a range of guidelines that had been produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) to define the treatment provided. For instance, we saw that in line with NICE guideline (Neonatal Jaundice, CG 98) a weekly jaundice clinic was in operation.
- There were pathways and protocols for the management and care of various medical and surgical conditions. Although most staff reported that they would refer to clinical guidelines and pathways, we were not fully assured that this would always be the case.
- There were processes for ensuring that clinical services complied with national standards, reported in the monthly children's division governance report as a percentage of compliance with NICE guidelines. The February 2015 report showed this was 54% which was significantly below the trust benchmark of 90%. When we asked senior clinical staff within the division how this figure was reached they were unclear how this would be representative of all staff regarding compliance with a particular standard, as we could not determine how all staff had been involved in the decision making process.

- In the neonatal unit, a local audit of prevention of readmission of hypothermic babies to post natal care was completed in 2014 due to a reported number of unexpected admissions to NICU, and recommendations directly resulted in changes to practice including temperature monitoring such as use of cot thermometers and provision of hats for neonates.
- Some specialties were part of London wide or national networks and worked within set guidelines. This included neonatology, paediatric oncology and paediatric diabetes network. We asked for copies of any feedback or reports from these networks. The December 2014 report from the paediatric diabetes report identified good practice within the team but commented on serious concerns regarding under resourcing, limited dietetics support, disparity in psychological and nursing support based on patient location, high case loads and some consultants not having received appropriate training and support. The trust had responded by putting forward a business case including an increase in staffing establishment across the identified areas, which had not been approved at the time of our inspection.
- Senior clinicians and managers told us they used a range of guidelines that had been produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) to define the treatment provided. For instance, we saw that in line with NICE guideline (Neonatal Jaundice, CG 98) a weekly jaundice clinic was in operation
- The national audit for epilepsy and seizure management identified a need for a clinical nurse specialist, and senior staff were yet to reach a formal conclusion as to how this would be taken forward.
- There were clear protocols in place for paediatric orthopaedic surgery with established pathways for fractures.

### Pain relief

- Nursing and medical staff had access to a range of medicines and local anaesthetic to ensure pain control was effective during procedures for children and young people.
- There was no paediatric trained pain specialists though two trained link nurses available across the trust.
- A paediatric pain assessment chart was used and incorporated evidence-based assessment tools for children and young people including the Wong Baker FACES Pain rating scale – a tool created with children to help them communicate their pain levels using a series of faces.
- There were trust guidelines for paediatric analgesia and paediatric anaesthetic practice.
- Prescriptions for post-operative pain relief for children and young people were not always written by anaesthetists. Senior clinicians we spoke with were aware that an audit of this practice would be required to ascertain if there were any risks.
- The staff in the NICU had carried out audits to inform, develop and change practice within the unit. For example, developing an understanding of how premature babies experience pain and how to manage it effectively.
- Staff gave many examples of hospital play specialists providing distraction therapy as part of pain management.

### Nutrition and hydration

- There were trust guidelines for fasting recommendations prior to surgery, with specific steps listed for children and young people.
- A standardised tool for assessing nutrition and hydration was not used on Tropical Lagoon Ward. However, nutrition and hydration was monitored by nursing staff and healthcare assistants and patient records we reviewed showed that concerns were escalated to consultants and a dietician, if necessary.
- We observed care over one lunchtime and saw that meals were served in response to items chosen on the menu for each patient.
- We saw that staff presented menus with simple descriptions of the food available for lunch and dinner.
- In the records we reviewed, we saw that food and fluid charts were maintained when required.
- There was a stock of donated expressed breast milk for use by the premature babies on the NICU; this stock was maintained by the a small team located at the Princess Royal Hospital in Farnborough, Kent. The system for its collection, screening and its use was robust and greatly appreciated by the staff and parents.

### Patient outcomes

- There were few child deaths within the hospital. Mortality rates were not benchmarked.

- The standardised risk of readmission for the division was reported as 4.% in 2014 which was in line with the national average. Emergency readmission rates within two days of discharge was lower than the England average with the exception of paediatric medical oncology where the risk was 11.8% compared with a national average of 4.8%. This meant that children and young people requiring services were no more likely to require unplanned readmission, suggesting the hospital's care and discharge arrangements were appropriate for most services.
- Multiple admission rates were better than the England averages for the subspecialties of asthma and epilepsy.
- Multiple admission rates were worse than the England average for diabetes.
- The proportion of children and young people with type 1 diabetes with haemoglobin or hbA1c levels (an important average measure of how well a person's diabetes is being controlled) was less than 7.5% at the hospital which was worse than the England average.
- The emergency readmission for non-elective paediatric medical oncology was higher than the England average. This meant that children and young people were being appropriately and safely admitted to the hospital and ensured continuity for their care.
- The average length of stay was 1.4 days. Less than 0.1% of children and young people admitted to the ward stayed for over 30 days.
- Nursing staff told us about 'fit to fly' audits which were a monthly check on safeguarding, hand hygiene, resuscitation trolleys, quality of care, PEWS, catheter, name bands and results were fed back to staff through a monthly results board. Medical staff told us they had been involved in particular projects but they were unsure of the impact of these local audits on care. The hospital provided us with a list of audits that had been completed but did not provide us with examples of these completed audits and evidence that learning from these audits had been undertaken, or shared.
- In 2012, an internal audit showed the unit was 65% compliant with the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future standards (RCPCH Facing the Future: Standards for Paediatric Services – December 2010). Evidence to demonstrate that recommendations, listed as insisting on the right documentation and prompting communication between on-call doctors and nurses to avoid delays, had since been made could not be shown and the standards had not since been re-audited.
- Surgical pathway audits had not been completed, including the pre-assessment processes for paediatric surgery. It was therefore difficult to ascertain whether national recommendations (Royal College of Surgeon's Standards for Children's Surgery – 2013, Guidance on the provision of paediatric anaesthesia services – 2015) had been considered and acted on.

### Competent staff

- Trust data showed that, as of December 2014 96% of all staff within the division, across the two hospitals, had participated in an appraisal. The staff told us that they considered the appraisal system to be beneficial to their personal and professional development.
- Consultant doctors within the division underwent revalidation as required by the General Medical Council and feedback counted towards professional development.
- We were told all registered nursing staff had received their required competencies. Competencies for medicines, airway ventilation management and paediatric early warning scores had to be completed before staff could commence taking patient observations. Management staff were confident that the competency training courses requested were budgeted for and allocated by the trust. Senior staff confirmed that agency staff, staff from other wards and staff from King George Hospital were allocated to work on Tropical Lagoon to ensure minimum safe staffing levels. However, we were told and records showed that not all staff had received specialist training to work with children with high dependency needs.
- Neonatal nursing staff were trained to provide nitric oxide therapy and to monitor cerebral function of neonates who had swelling of the brain or other brain impairment.
- Five operating department practitioners (ODPs) had completed paediatric immediate life support training within the last two years, so that an ODP with the necessary competency was available on each shift.
- Staff were not trained to provide Biphasic Positive Airway Pressure (BiPAP) pathway – a non-invasive

ventilation requiring equipment that helps patients with respiratory conditions keep their airways open. There had been no arrangements made to provide staff with the training needed.

### Multidisciplinary working

- The hospital did not have therapy services for children and young people. On a case-by-case basis, adult trained therapists were referred to input into children's care. This was an ad hoc arrangement that affected capacity, and was sometimes reliant on referral to other providers. For patients with respiratory conditions, paediatric therapists were contacted for advice though this was not available in emergency situations, or out of hours. Senior staff told us there was a business plan to recruit children's therapy staff. We asked for evidence that this was in place, and the trust told us a business plan to recruit children's therapy staff had been approved but did not confirm specific dates when recruitment would commence..
- There was limited cross working between children's staff and the surgical teams, which effected the management of children's care.
- There were internal multidisciplinary team meetings held on a monthly basis, attended by psychiatrists, matrons, legal and clinical governance teams. However, it was recorded in order for the meetings to take place a minimum expectation of attendance was 15 members of staff. This meant that the meetings were regularly cancelled.
- Breastfeeding advisers worked across maternity and NICU to support mothers, as recommended within best practice guidance.

### Seven-day services

- Routine radiology ran at the weekends with an on-call radiologist on site from 9am to 5pm. Magnetic resonance imaging (MRI) was available during the week and weekends.
- Pharmacists were in the hospital from 9am until 5pm on both Saturday and Sunday. Out of those hours, there was an on-call pharmacist available on the phone.

### Access to information

- Clinical staff told us they had access to current medical records and diagnostic results, such as blood test results and imaging to support them to care safely for patients.
- We saw parents were encouraged to bring their child's personal child health record, or the 'red book' – showing records of routine tests and vaccinations, in the children's outpatient department.

### Consent

- Staff sought verbal consent from parents, guardians or carers when they wanted to physically examine a child.
- Staff understood the Fraser guidelines and explained that the consent process actively encouraged the involvement of young people in decisions relating to their proposed treatment (Fraser guidelines refer to guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords, which apply specifically to contraceptive advice and treatment for children aged under 16 years). Gillick competencies and Fraser guidelines enable staff to decide whether a child is mature enough to make decisions and give consent.
- There was a process for seeking consent from those with parental responsibility before staff administered vaccines and immunisations.

## Are services for children and young people caring?

Good

Feedback from patients and their parents/carers demonstrated that staff delivered a caring and compassionate service. Children, young people and their parents told us felt they were fully informed and involved in decisions relating to the patient's treatment and care.

We found that the majority of parents or guardians and children and young people said they were well-informed and that staff demonstrated a caring nature. Children attending the service were offered consistent emotional support.

### Compassionate care

- Overall, patients expressed a high level of satisfaction with the care and treatment provided.
- Overall, feedback from patients we spoke with was positive. They told us they felt well cared for. A child told us, "All the nurses say hello and introduce themselves."

Another child said, “Staff explained what is happening to me.” A parent told us, “My daughter has received outstanding care. This hospital gets lots of bad press, but they’ve always been so positive.”

- Other comments from parents/carers included, “She’s in the best care, they find time to cuddle her,” and, “Overall, this has been a good experience,” as well as, “There has been significant improvements on the ward since my child was a baby.”
- Throughout our inspection, we observed that staff provided compassionate and sensitive care that met the needs of the child, young person and parents/carers. We observed members of staff engaging with children and young people in a way that we considered to be friendly and approachable.
- Interactions were age appropriate. Staff were observed to use age-appropriate language with children in the children's wards and outpatient areas.
- Different methods to engage children to allow them to provide feedback on the service were used. A child-friendly format of the NHS Friends and Family Test, the ‘Bear goes to’ survey, was used to gather feedback from children, young people and their parents/carers and results were consistently in line with, or better than, national averages, averaging at 71 or over in 2014. Staff told us that changes were made as a result of NHS Friends and Family Test feedback, including adding jelly to the menu following feedback from a child.
- Staff told us that they checked whether English was the child’s first language with their parents or carers, as the survey leaflets was not available in other languages. Younger children were asked to draw pictures of their experiences. Results were fed back to the trust’s patient experience team for analysis, which was then fed back to staff.
- In theatres, one parent or guardian was permitted in the room for anaesthetic induction and recovery to support their child.

**Understanding and involvement of patients and those close to them**

- Parents and carers we spoke with said they had received sufficient information about the care and treatment of their child. They said their children were encouraged to participate in care when it was appropriate to do so.
- Nursing records we reviewed showed that staff had asked the parents or patient for their opinion.
- Young people were not always involved in choosing their preferred place of inpatient care.
- The paediatric diabetic service staff and parents we spoke with told us they worked closely together and provided support and teaching for use of urine and blood testing of insulin levels.

**Emotional support**

- A Child and Family Psychotherapist, employed by a local mental health trust worked in the hospital to support children in the inpatient and outpatient setting.
- Child and Adolescent Mental Health Services (CAMHS) services were provided via a service level agreement with a local trust, seven days a week, and provided for care for children and young people who self-harmed and were diagnosed with eating disorders provided Children with mental health needs are seen age 0-16. Children aged 12 to 15 had been admitted with eating disorders since January 2015. Senior staff told us there was a national shortage of inpatient beds for children and young people with acute mental health illness, and had been raised with commissioners to identify a way forward.
- The paediatric liaison team for Redbridge, Barking and Dagenham and Havering provided psychological support for children with type 1 diabetes, attended the paediatric oncology multidisciplinary team meeting and on call support to the wards.
- For neonates there was a dedicated clinical psychologist, present on the ward 2.5 days per week to offer counselling and support to parents. There were also two family care sisters who offered practical, emotional and social support to the families in NICU. A monthly parent support group was available to parents following discharge. A specialist neonatal palliative nurse was part of the multidisciplinary team and provided advice to staff as well as directly supporting parents/carers of neonates with long term or life-limiting conditions. The ‘Interact’ team saw young people over 12 years old, providing services across the trust for young people in crisis and worked 9am to 5pm Monday to Friday.
- There were three whole team equivalent play specialists. We saw play therapists working with children to reduce anxiety and need for sedation.
- Clinical nurse specialists for oncology and diabetes were employed by the trust.

# Services for children and young people

## Are services for children and young people responsive?

Inadequate

The services not consistently responsive to the needs of the people that it was caring for. All children over the age of three who required blood testing were only seen in areas shared with adults that were not child appropriate. An increasingly high number of children required high dependency care however the service was not a designated as a provider of a high dependency services. Some specialty surgical clinics, and the recovery area, were in adult settings which meant children were seen in areas mixed with adults.

Some staff were concerned that there was insufficient cot provision to meet demand in the neonatal service following a reconfiguration of the service in November 2014.

There was a lack of transitional care arrangements for young people. Staff told us that the decision to admit young people aged 16 to 18 was made on a case-by-case basis, and that there were occasions when admissions were made to adult wards without consulting the young person.

The approach to meeting the needs of different groups, for example those who required translation service, was reactive. Though there few complaints were recorded, action taken in response to feedback and complaints was narrowly focused and learning was not widely disseminated.

### Service planning and delivery to meet the needs of local people

- Children and young people were not always seen in appropriately child or young person-friendly environments. Most areas had toys or books to keep children occupied while awaiting treatment. Other areas, within subspecialties, were stark and unwelcoming to children, particularly the phlebotomy services, and a number of specialist outpatient clinics that were held in adult environments.
- Guidelines for admission to Tropical Lagoon Ward were not in place, specifically when it came to criteria for children under 11 and over 16 years and those with mental health needs. We asked for a copy of the admission criteria for children and young people but the hospital did not provide this evidence.
- Children aged three years and over had to attend the adult phlebotomy services. The waits were often over two hours and the environment that the children and families had to wait were not child friendly.
- The paediatric diabetes service was providing care to over 300 children, and staff and a report by the local diabetes network stated the service was under-resourced to meet the demands of the population.
- Staff told us they saw adolescents on a case-by-case basis, and children aged between 12 and 17 years were not always offered a choice of where they wanted to be cared for. However, one young person we spoke with said they had to attend the children's outpatients department, where babies and very young children were seen, even though this was not their preferred choice.

### Access and flow

- For planned surgery, outpatient clinics were held a few weeks before the surgery. During this appointment, all the relevant information was taken from the parents and the child or young person. The procedure was explained to the parents and the child and consent was taken from the parents (and the young person, where appropriate). Parents were asked to phone the ward on the day of admission to check for bed availability. Planned admissions were occasionally cancelled if emergency admissions had filled the available beds. The data we reviewed showed that less than 1% of paediatric operations had been cancelled between January and March 2015.
- During our inspection, we did not observe any children on wards other than the children's wards, due to capacity issues.
- Some children who had been assessed as needing high-dependency care were admitted to the ward, although it was not a designated HDU. We were told that some children were transferred to a bed if it became available, but others would not be fit for transfer so were looked after on the ward. Staff said they did their best to provide the care required and extra staff were brought in to provide the care and support the child and their family needed.

- There was a high turnover of patients on the ward and there were, on average, eight to 10 discharges per day.
- Staff spoke of some concern that children and young people were not always treated within 28 days of last minute cancellations made because of the lack of bed availability.
- There were few reported children and young people awaiting procedures. The trust backlog of cases for admitted and non-admitted pathways did not continue to impact on children and young people significantly, as they had been prioritised as a high clinical risk. Eighteen-week referral-to-treatment breaches were reported for children and young people requiring magnetic resonance imaging (MRI) scans, and further sessions had been booked in response to avoid further delays.
- There were no adolescent inpatient bays, but staff told us they could group older boys and older girls together so they were separated. We asked for further details on whether there had been any mixed sex breaches amongst adolescents, but the trust did not provide us with this information.
- In theatres, there were four dedicated recovery bays for children and young people with some child-friendly designs on the walls. However, this bay was not separated and, therefore, children and young people would be recovering next to adults.
- We heard contradictory reports regarding the lower age limit for children's surgery. We were told by senior staff that approximately 25 children were operated on per month. Surgery was carried out on children under five in a number of specialties, notably ENT and general surgery. A number of senior leaders told us that emergency surgery for children under five was not conducted. We asked to see a copy of the trust policy to clarify this and any safety measures in place. The trust policy, the '2010 Guidelines for Paediatric Patients Admitted for Elective and/or Non Elective Surgery', was three years overdue for review.
- There were no step down beds for children, as there were no paediatric trained nurses for recovery.
- Staff at varying grades and roles we spoke with were not clear about arrangements for paediatric surgery. In 2011, the local network agreement was that children over one year could be operated on at this trust, but for ophthalmology the age limit was six months. With regards to emergency surgery for children, those under five could not have abdominal surgery on site, though other procedures were permitted. These were not defined. For children under five years of age, who required general anaesthetic, the junior anaesthetist was expected to discuss cases with the on-call consultant, who would provide guidance in accordance with guidelines for paediatric analgesia and paediatric anaesthetic practice.
- General surgery operated dedicated children's lists, though ENT did not. The lead paediatric anaesthetic had raised this with the specialty, but this had yet to occur even though there were sufficient children undergoing ENT surgery to allow for a dedicated list.
- Following the closure of the special care baby unit at King George's hospital in January 2015, the occupancy of the NICU at Queen's hospital was consistently above 95%. Consultant neonatologists raised the occupancy issue as a significant concern to the overall clinical effectiveness of the unit. Whilst discussions had taken place between the service leaders and the executive team, as well as an external review of neonatal services having been commissioned and completed, there remained little progress with regards to how the capacity issue was to be resolved.

### Meeting people's individual needs

- Each ward and department catered to the needs of children. This included ensuring that there was enough space by each bed for a parent to stay and providing play and school rooms. Outside, play space was available.
- Some areas that children and young people were treated were not child friendly. This included paediatric orthodontics and the plaster room for orthopaedic treatment.
- There was a paediatric phlebotomy service for children under the age of three who were nervous around needles, which ran Monday to Friday. This was meant for hospital use only, but a high volume of referrals were made from primary care and the service had become by referral from the patients' GPs only for children under three. During our inspection, we met a number of parents of children older than three but younger than four who had to wait over two hours for their child to have their blood taken.
- There were inappropriate facilities for children in the phlebotomy service, where blood tests were undertaken. Staff told us children would have to be accompanied by their responsible adult and speak to a

phlebotomist at the desk to explain why they needed fast-tracking. However, this desk was in the phlebotomy room itself and meant children and young people walked past the waiting area and could be overheard in the booths and within the waiting area. In addition, only one chair was set up to take children and the only child-friendly facility for this was a lava lamp.

- Education services were managed by the local authorities children lived in. The only on-site provision was a hospital education service based for those whose education was funded by the London Borough of Havering.
- At the time of the inspection staff we spoke with told us elective surgery predominantly occurred on Thursday and Friday each week, and lists were arranged so that children were operated on first. The trust has since clarified that that elective surgery predominantly occurred every Monday to Friday routinely and, to reduce waiting lists, and on Saturday and Sundays.
- We identified that there was a lack of transitional care arrangements for young people. Staff told us that the decision to admit young people aged 16 to 18 was made on a case-by-case basis, and that there were occasions when admissions were made to adult wards without consulting the young person. One 19-year-old patient recently cared for as an inpatient remained on Tropical Lagoon Ward and hadn't been considered for transition to an adult ward at any point during their stay. It was not clear whether formal arrangements were in place for paediatric staff to provide advice to support the care of children on adult wards. We asked the hospital to clarify how frequently this occurred, but were not provided with this data.
- In the outpatient settings senior staff told us children and young people up to 16 were seen, or up to 18 with chronic conditions. They told us that transition was considered at aged 12, however, this is decided with the child and family on a patient-by-patient basis. It was not clear if this was always achieved and this practice was not regularly audited.
- 'Did not attend' clinic rates in outpatient clinics had been identified as a concern as they were worse than the trust average. Senior managers told us that, although the 'did not attend' rates policy was actively used to manage patients, they stated that all patients who did not attend should be reviewed by the clinic doctor to decide if and when further appointments should be offered, or other appropriate action and that safeguarding teams were made aware of these children and young people. Senior managers told us further steps to manage these high rates were planned to be taken, including using mobile phone messaging alerts.
- Findings from an external review of the safety of the neonatology service in November 2014, resulted in the closure of 14 neonatal cots. Staff spoke of their concerns regarding the impact on demand and the effect of reduced capacity and there had since been an increase in the number of transfers made to other local NICU providers.
- The criteria for discharge of neonates was when they were at one to seven kilograms in weight and thirty-five weeks old. Community nurses were funded to provide aftercare to parents who resided in Barking and Dagenham and Havering.
- NICU transitional care was staffed by six nursery nurses and provided care to up six babies.
- There was a high demand for the paediatric diabetes service, with over 350 children and young people on the caseload. Difficulties with staffing capacity meant there were longer waits to access to service for some children and young people
- The service had developed their own postoperative information leaflets in English. These had not been reviewed by the multidisciplinary team.
- Internet access was available across the trust and details for use were displayed prominently in ward areas, so children and young people could communicate with their friends and family throughout their hospital stay.
- There was a disabled toilet, baby changing facility and a parent's room on Tropical Lagoon. The parents room had facilities to heat food and make drinks. The room was clean, though a parent we spoke with shared "The parent facilities are drab and damaged. They let the unit down." There was a counselling room for breaking bad news.
- The NICU had a separate four-room facility for parents to use so they could be near their babies. It included a sitting area, a kitchen and shower facilities. Staff used a counselling room on Tropical Lagoon for breaking bad news.
- Ward staff had been involved in the decoration of Tropical Bay and Tropical Lagoon when it first opened, and many areas were brightly coloured and rooms were

named and coordinated in line with the theme of the ward to make the ward child friendly. We also attended the paediatric outpatient area and found these areas were similarly baby and child friendly.

### Learning from complaints and concerns

- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints. Staff were all aware of the complaints process. Staff told us that they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.
- Many managers and senior staff told us they rarely received any complaints and senior nursing staff told us staff worked proactively to avoid concerns becoming formal complaints.
- Trends and themes from complaints and concerns were discussed at divisional level and information regarding the number of complaints was disseminated to staff each month.
- Staff were aware of complaints that had been made about their own ward, but were not aware of learning from these complaints.
- According to the children's division governance report for February 2015, we saw that 94 PALS contacts, including 80 informal concerns and 11 compliments, had been received. Eighteen formal complaints were received since April 2014, and of those, 64% of complaints had been responded to within the required 25 day timeframe. Within this report there was no reference to the themes of complaints. However, we found that the monthly complaints briefing paper to the trust board did identify reasons for delays in complaints and lessons learned, which was shared with the division. There was no evidence that this occurred in practice and, therefore, we could not be assured that learning from complaints was achieved consistently within the division.
- Some staff told us a proportion of complaints were regarding the behaviour of consultant paediatricians. They had not received feedback on whether these complaints had been resolved or learned from.

## Are services for children and young people well-led?

Requires improvement

There was no strategy in place to identify all the areas that required improvement so that high quality and safe care and treatment was consistently provided.

Staff told us positive changes had started to happen as a result of the new trust board. We were told of a number of new appointments to senior posts that had been made in the weeks before our inspection and those that would be made at the time of our inspection, which meant there would be a period of change for staff. Staff were positive about the culture within the unit and felt well supported and confident to raise concerns internally.

Discussions were on-going with local commissioners regarding risks to the service, including the need for a designated high dependency unit and appropriate funding to provide the service.

Paediatric services had a lack of developed governance systems which meant that risks were not always identified and escalated appropriately within the division to the patient safety team for appropriate management.

### Vision and strategy for this service

- We saw the trust values displayed in a number of areas we visited. All grades of staff knew about the values and some were able to talk about them in detail.
- There was no strategic overview of the service in place. There was no plan to improve quality through identifying long term aims to secure sustained improvement.
- There was no children's champion on the trust board. The hospital saw more children and young people than most acute hospitals within the country.

### Governance, risk management and quality measurement

- The division had limited governance managerial and administrative support due to the changes within the trust's governance department. Leaders told us that a clinical governance facilitator post for children and young people, had been recruited to and was due to commence work by May 2015.

# Services for children and young people

- The division had to investigate and manage incidents involving all children and young people across the trust, though they had limited influence on surgery and A&E, due to the reporting structures.
- For neonatology, there were twice monthly clinical governance and clinical audit meetings.
- Senior clinicians acknowledged that nursing staff responded well to the administrative side of reporting incidents and writing statements, they were not supported by robust systems for learning from these reports across the division. Doctors were less likely to report. Many senior leaders said that learning from serious incidents needed to improve, but told us they felt staff reported all incidents that occurred.
- The governance metrics, which included reports of safety incidents and compliance with guidelines, were reported in the children's services governance report each month, but we saw they were not reported in the children's services divisional report in December and January 2015. Therefore, it was not clear that matters pertinent to patient safety, clinical governance and risk management were consistently escalated to senior management within the division.
- Performance and quality measures were reported and discussed by senior staff on a monthly basis within the children's services divisional report, such as productivity, delivering to local and national targets and complaints responses.
- The divisional risk register had limited descriptions of controls and actions taken to address how these risks would be mitigated. Senior staff confirmed some of these risks were no longer relevant and required reviewing, but the lack of managerial governance support within the division had delayed this. Top risks described by senior staff were in line with concerns we heard about the services during our inspection, including the lack of HDU-commissioned beds, the low number of neonatal nursing staff and lack of paediatric therapy provision. We also saw that some risks regarding children seen in other divisions were not shared. For example, there were adult orthodontic clinics being held in a paediatric area.
- A review of the neonatal services across the trust was undertaken following safety concerns raised by clinical staff due to the lack of neonatal-trained medical cover at night and weekends. The review resulted in the closure of all NICU and SCBU cots at King George Hospital. Short and medium-term recommendations had been implemented, though the demand on capacity remained a risk, according to senior leaders.
- Trainee feedback for neonatology had been acted on since 2013, which had resulted in improved results in 2014 and an increase of trainees accepting placements from two to six junior doctors.
- Many staff we spoke with were unaware of the quarterly paediatric task force meeting, attended by anaesthetics, paediatrics, surgeons, safeguarding lead, matron, paediatrics service manager and chaired by a paediatrician. Although audits, incidents and guidelines were discussed, we identified that this meeting was last held in June 2014, and there were few recommendations followed through by this group.
- There were regular meetings with junior and senior doctors. Junior doctors we spoke with confirmed, and meeting minutes showed, that areas of good practice, concerns and suggestions for change were regularly discussed with support and feedback provided from consultants. This included proactive steps to manage feedback provided to the London deanery for junior medical trainees and the General Medical Council, such as, establishing protected time for training and education.
- One risk staff discussed with us was business cases to meet RCPCH standards and for service improvement that had been repeatedly made and rejected due to financial reasons. This included the intention to establish a short-stay paediatric assessment unit for observation, investigation and treatment in a child-focused environment. This initiative had been approved and subsequently rejected twice since 2012 (recommended by the RCPCH guidance 'Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers, January 2009'). Senior leaders we spoke with felt confident that the new trust board were more supportive of suggestions for improvement.

### Leadership of service

- Every member of staff we spoke with had confidence in the new trust leadership, and some gave specific examples of how the new team had impacted positively on them.
- There was no clinical voice for children and young people on the trust board.

# Services for children and young people

- The divisional structures had changed across the trust in February 2015. The children's division had combined with maternity services to form the women's and children's division. As a consequence of this, a number of senior level appointments had been made shortly before our inspection, in January and February, 2015. Despite the recent changes in staffing, many of the leaders were aware of the main gaps and risks within the services.
- Senior staff spoke of "excellent working relationships" between clinicians and managers.
- The operational management group for children was the trust executive committee. There were was a monthly assurance and performance meeting, and regular quality meetings.
- We saw, and were told, that there was effective team working across matrons, lead nurse, lead doctor and general manager reported.
- Nursing staff reported that matrons were visible in the service. Band 6 and band 7 paediatric nurses had monthly meetings with matrons.
- Although leaders within the division were sometimes asked to advise on, or made aware of, issues regarding children and young people, there was limited accountability for those services provided outside of the division. This included surgery, A&E and a number of outpatient clinics. This meant that there was little oversight of services provided to children and young people across the trust.

### Culture within the service

- Staff we spoke with were aware of the Guardian service for raising staff concerns internally.
- Staff reported they had not experienced bullying and harassment. Despite this, some staff told us that they were concerned about the behaviour of over half of the consultant paediatricians that worked across the two hospital sites. They described instances of being admonished by consultants when they challenged outdated or non-acceptable practice, such as failure to wash hands, or to adhere to the 'bare below the elbows' policy in ward areas and not treating people with dignity and respect. We spoke with senior trust leaders regarding these concerns and saw they had been raised internally and concerns shared with the medical director. Staff were confident that the concerns were beginning to be addressed appropriately.
- We requested information on the number of disciplinary and whistleblowing cases, but the trust failed to provide us with this information.

### Public and staff engagement

- Senior clinicians in the division told us they were looking at ways to better engage parents, children and young people in service development in the future. Feedback from the public was sought from NHS Friends and Family Test results and issues were escalated via the Patient Advice and Liaison Service (PALS) and the complaints department.
- There were monthly paediatric diabetes workshops, which involved children and young people. We asked, but were not made aware of, any other formal children and young people's groups at the trust.
- Staff working within the children's division told us they were aware of the plans to make changes within their ward or clinic area, but were not aware of wider plans to improve and develop services.

### Innovation, improvement and sustainability

- Play specialists had developed a way to distract children awaiting MRI scans, which involved joining other children and families on a 'train journey' from the outpatients clinic down through the hospital corridors, using storytelling and positive reinforcement on the way. This had proved a good distraction for children and reduced their anxiety. We walked with one child and found them to be very engaged in the trail.
- We were told that conversations with the local CCG were ongoing to potentially establish some high-dependency beds on Tropical Lagoon as they often took children who had been assessed as needing high-dependency care.
- Consultant paediatricians undertook short notice or Hospital Outpatient Treatments (HOT) clinics, whereby GPs could make a consultant-to-consultant referral reach a joint decision on action, including, if needed early assessment. GPs reported positively to their commissioners on the success of this system.

# End of life care

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

The service provides end of life care to patients with progressive life limiting illnesses. Conditions include cancer, advanced organ failure, such as heart and renal failure and neurological conditions. The specialist palliative care team provides support to patients and staff at all wards within the hospital. The team worked across two hospitals managed by the trust. It consisted of a lead nurse for palliative care and seven (5.8 whole time equivalent) palliative care clinical nurse specialists.. here were also two end of life facilitators who provided training to staff on the wards in various aspects of palliative care. There were three part time working palliative care consultants, a part time locum consultant, and a part time associate specialist doctor. The team was also supported by an occupational therapist, a social worker, a discharge nurse and three administrative staff. Between April 2013 and March 2014 it was reported that 1143 patients' deaths took place in the hospital. The team received 1527 referrals in the same period of time those were new patients, continuing patients and re-referrals to the service. During our inspection we spoke with nine patients and three of their relatives, We also spoke with 27 members of staff which included; the palliative care team, bereavement services, mortuary staff, chaplaincy, nursing, medical staff, allied health professionals, and porters.

## Summary of findings

Patient's do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were accurately completed in all cases. Patients had a clear care plan which specified their wishes regarding end of life care, staff were aware of their wishes in regards to the preferred place of death. There was good coordination across all divisions to ensure consistency of approach in end of life care. Staff knew how to report concerns. Staff were respectful and maintained patients' dignity, there was a person centred culture. Patients told us staff were caring and compassionate. They also said they had appropriate access to pain relief and were happy with the food and drink offered. Specialist palliative care team members were competent and knowledgeable. There were examples of good multidisciplinary team working.

# End of life care

## Are end of life care services safe?

Good

The end of life services were safe and patients were protected against the risk of inappropriate care. Suitable information in relation to patients care and treatment was available to staff and records were adequately completed. Patients DNA CPR forms were completed accurately. The trust had rolled out end of life training across the hospital, it was accessible to all staff. Staff knew how to report concerns. Staffing establishment had recently been increased to improve patient's care and specialist palliative care team visibility across the hospital.

### Incidents

- The specialist palliative care team told us there had been no serious incidents reported relating to end of life care within the past 12 months.
- The team were aware of how to report an incident or raise a concern. They had access to the electronic system used to record incidents and knew how to use it. Staff gave us examples of how incidents were investigated and told us they had received feedback.
- We observed all hospital deaths with palliative care team involvement were discussed at the specialist palliative care multidisciplinary meeting. Feedback from mortality and morbidity meetings was received by the end of life committee group.

### Cleanliness, infection control and hygiene

- The mortuary was visibly clean and well ventilated. It was cleaned Monday to Friday by a designated trained cleaner.
- The mortuary had been licenced by the Human Tissue Authority in March 2014 to allow post mortem examination and storage of bodies.

### Environment and equipment

- Equipment used in the mortuary was maintained and checked regularly. This included suitably certified and checked trolleys and refrigeration system which were maintained by external contractors. Portable electrical equipment used in the mortuary office was checked by a qualified technician.
- Equipment such as commodes, bedpans and urinals was readily available to patients at their end of life throughout the hospital.
- Staff told us syringe drivers used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner.
- Access to the mortuary was controlled by the mortuary staff, security team and porters office. Although staff were required to use their personal card to access facilities, there was no record of visitors or staff visiting the mortuary. Staff were not required to sign in or out and there was no other monitoring system in place to ensure only authorised people accessed the hospital mortuary.

### Medicines

- Pharmacists visited all wards each weekday to check medicines were being used safely. We saw pharmacists completed the medicines management section on the prescription record for every patient to confirm medication reconciliation had occurred.
- Medicines were stored safely. The service carried out audits every three months to check medicines were stored appropriately and securely.
- Since January 2014 pharmacy staff had access to a patient's GP summary care records. This meant a patient's medication record could be checked quickly and easily reducing the risk of any errors in prescribing.
- Controlled drugs were managed appropriately. The service completed three monthly audits which were reviewed by the safe medicines practice group.
- The safe medicines practice group reviewed medication errors recorded on the trust IT system and any audit results.
- Doctors and nurses used a "net safety protocol" for prescribing and administering use of pain control medicines to prevent adverse drug events.

### Records

- We reviewed 22 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. They were fully completed. They contained information such as who had approved the final decision and who was consulted in the process of decision being made. We observed that occasionally there were delays in completing the

form shortly after the admission as staff were waiting to consult all relevant clinicians and family. Staff were unclear if there was a set timescale for them to put the order in place.
- An annual audit of DNA CPR forms was carried out in February 2014. It included only one ward and was carried out on small sample therefore was not fully reflective of how these were completed across the hospital. Twenty patients were audited on Mandarin B ward, the audit indicated that consultants were the main initial decision makers (80%) and they validated all of the forms being signed by junior medical staff within 24 hours. All of the decisions were documented clearly in the medical notes with legible signature, time and date. All relevant sections on the forms were completed. Discussion with family and patients were documented in 50% of all cases.
- All DNA CPR forms were filed in patient's notes for easy access.
- Risk assessment forms were completed and easily accessible. It included falls and skin integrity risk assessments.
- The mortuary records, which included body release forms, were accurate.

**Safeguarding**

- 89% of the specialist palliative care team members had completed level 2 safeguarding training for adults and children. This mandatory training was to be completed every three years. Two of the three administrative support staff were had up to date safeguarding training for adults and one for children.
- Nurses were able to describe safeguarding procedures and provide us with examples of how these would be used.

**Mandatory training**

- The specialist palliative care team members said they had completed mandatory training which included fire safety, basic life support, moving and handling and safeguarding adults and children. Training summary records were reviewed regularly to indicate how many of them had completed this training and when.
- 95% of the specialist palliative care team members had undertaken up to date information governance training. 82% of the clinical staff had completed training on preventing and responding to sepsis (potentially life-threatening condition triggered by an infection) and the same percentage on health and safety and infection control.

**Assessing and responding to patient risk**

- The specialist palliative care team members participated in ward rounds to support the individual medical teams with referrals and increase visibility of the team. This allowed them to recognise patients who were near the end of life and assess patients promptly. Staff on individual wards knew how to refer patients to the team and told us the team was able to respond promptly.
- Patients had easy access to call bells and we observed their calls were responded to promptly. Additional staff requests were made to support patients who required increased level of support or one to one assistance.
- Handover folders at individual wards had patients with the DNA CPR order highlighted so staff were aware who was not for resuscitation. On some wards it was also discretely indicated with a symbol on the ward board.
- Staff had received training in basic life support. There was standard emergency equipment available to support patients in emergency. Staff discussed patient at increased risk of cardiac arrest and how to act in an event of emergency during ward rounds.
- The results of the national care of the dying audit published in May 2014 showed that 96% of patients had been recognised as dying at the end of their lives, this is much better than the England average of 61%. However, the hospital scored worse than the national average for those patients who had been assessed five or more times in the last 24 hours of life, with a score of 58% compared to the England average of 82%.
- There was a chart in use to record inpatient observations such as pulse, blood pressure and temperature at the bedside and staff calculated an early warning score (EWS) for each patient. It was used to alert staff to patients who may be deteriorating. A nurse told us they received training in how to use the tool and felt confident using it. We noted that patients with raised scores were escalated appropriately during the day and at night time.

**Nursing staffing**

- The hospital specialist palliative care team worked across two hospitals managed by the trust. The team

consisted of a lead nurse for palliative care and seven palliative care clinical nurse specialists (5.8 whole time equivalent). The team was also supported by an occupational therapist and four administrative staff. This was sufficient to provide daily support to patients at their end of life.

- Sickness rate among the palliative care team members was 2.6%, August 2014 to January 2015, was better than the trust average sickness rate (3.6%).
- We were told there was a need for an additional specialist nurse to be available during weekend due to increasing work load. The need was recorded on the risk register and in the business plan, however, it was unclear if the funding had been agreed or any certain plans made to address this issue.

**Medical staffing**

- There were three part time working palliative care consultants, a part time locum consultant, and a part time associate specialist doctor (2.4 whole time equivalent). This was not in line with the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds.
- The team had recognised that there was a need to increase medical staffing to improve services and this was documented in the team's strategy. Although no deadline was given there were plans to present business case for further consultant sessions.
- There was a weekend and a rotational out of hours on-call advice provided by consultants working at the hospital and some who were employed by the local hospice.

**Major incident awareness and training**

- There was an emergency and major incident plan developed in August 2013 it described emergency roles and procedures and how to manage an incident.
- 91% of the specialist palliative care team members had undertaken fire safety training in 2014.

## Are end of life care services effective?

Good

Care and treatment was delivered in line with current evidence-based standards. Specialist palliative care services were provided seven days a week. Patients had appropriate access to pain relief. Palliative care and end of life team members were competent and knowledgeable and there were good examples of the multidisciplinary team working to centre care on the patient.

**Evidence-based care and treatment**

- Following the withdrawal of the Liverpool care pathway, an individual care planning toolkit was introduced alongside the gold standard framework which incorporated the Department of Health end of life care strategy. It aimed to support staff with identifying patients' preferences and wishes earlier in their disease trajectories in order for improved advance care planning to take place. The nurse lead told us both tools were in a process of introduction and only some staff had been trained in how to use them. We noted that training sessions had been planned for staff in March and April to support rolling out of the programme. Two wards across the trust (Mandarin A and Sunrise B) had completed the first year phase of the gold standard framework. The implementation of the project was spread across two years.
- The trust's DNA CPR policy was due to be updated in January 2015. We were presented with an updated version of the policy which was awaiting final sign off from the board. Although it had been developed in line with the Resuscitation Council Framework and The Association of Anaesthetists and General Medical Council's guidance it only partially addressed issues related to DNA CPR. The trust had a standard DNA CPR form, which staff completed and placed in the front page of the patient's notes.
- Although the trust told us the policy was updated in response to a court of appeal ruling which state that all patients with capacity should be consulted and informed before a DNA CPR decision is made. The policy did not clearly specify in which cases staff were required to complete the form and how long time after the admission they had to complete it. We observed that in some cases there were delays in completing the form on the medical receiving unit (MRU). For example a patient admitted with a chronic illness had not had the form completed 24 hours after their admission as staff were awaiting a decision to be formalised by a consultant.
- The trust had a formulary which listed medication the pharmacy stocked with guidance on their prescribing. This was used to promote rational, cost effective

prescribing and any amendments to formulary had to be approved by the drug and therapeutics committee. We saw this formulary, along with the trust antimicrobial prescribing guidelines was easily accessible to all staff via the trust intranet.
- The end of life committee had drawn up an action plan in response to the NICE palliative care guidance and national end of life care strategy to ensure that the trust had a clear action plan highlighting the progress against each agreed action. Progress against this plan was monitored with target dates allocated to each of the actions listed.

**Pain relief**

- Patients told us they had access to pain controlling medication whenever required.
- There were two specialist pain teams which worked under the anaesthetic directorate. It included the acute and chronic pain teams. It was accessible to patients who were not supported by the specialist palliative care team. The services provided by the pain team had been reduced from seven to five days a week due to staff shortages.
- The hospital's results from the national care of the dying audit for hospitals, showed that at the time of the patient's death there was documented evidence that 'use when required' medication had been prescribed for 96% of patients, this was much better than the England average of 51%.
- The bereavement survey completed between September 2013 and August 2014 indicated that pain support was adequate with 96% of patients stating that they received adequate support if required. For those that answered the question in the last two days of life, 75% described pain control as good or excellent this was in line with the national average when compared with the national survey of bereaved people (VOICES 2013).
- Nurses we spoke with had knowledge of the treatments and symptom management to address pain appropriately.

**Nutrition and hydration**

- Most patients we spoke with were happy with the food and drink provided.
- We observed that all patients had access to drinks that were within their reach. We observed nutritional assessments were completed and that nurses records such as nutrition and fluid charts were completed accurately. We saw that menus catered for cultural preferences of patients.
- The national care of the dying audit found that 50% of patients had a review of their nutritional requirements, this was better than the England average (41%).
- 62% of patient's hydration requirements had been reviewed which was better that the England average of 50%.
- 48% of relatives reported in the bereavement survey that the help given to their relative was excellent or good, 52% said it was fair or poor. This survey was completed between September 2013 and August 2014.

**Patient outcomes**

- The hospital scored in line with England's average or better in all organisational key performance indicators and eight out of ten clinical key performance indicators related to patients' outcomes as reported by the national care of the dying audit for hospitals published in May 2014.
- A trust bereavement questionnaire for 2013 which aimed to obtain experiences of people who have died suggested that end of life care provided at the hospital was good or excellent and that doctors and nurses had demonstrated respect and dignity.
- The specialist palliative care team were responsible for arrangements for rapid discharge to ensure patients at end of life died at their preferred place. In October 2013, the average time from decision to case closure was 12 days, in cases where external funding was needed. This had reduced to an average of 5.5 days since October 2014 as all fast track applications were approved within 48 hours by the local brokerage team. The team worked to reduce the time from decision to case closure to 4 days.

**Competent staff**

- Most of the palliative care team members had been appraised within the past 12 months (73%).
- The bereavement office staff told us they had received minimal training. Other administrative staff supporting specialist palliative care team had not been provided with all mandatory trainings and some had not been appraised within the past 12 months.
- The specialist palliative care team members were competent and knowledgeable. They were aware of the

most recent developments within their specialities including changes in national guidance. They were clear on their responsibilities, aware of patients' individual progress and able to answer patients' questions in a confident manner.

- Although we noted the specialist palliative care team members had attended training relevant to their role the trust did not provide all clinical staff with training in end of life care as recommended by national guidance. We noted that training sessions were organised for March and April and staff on wards we visited were aware of it.
- It was not routinely monitored who had received syringe driver training and there was no training log kept by the pain team or the specialist palliative care team. We were told that the specialist palliative care team provided training on an individual basis "when needed for clinical areas". We noted that nurses in charge of a rota on individual wards did not know which members of staff had been assessed competent to operate the syringe drivers. Therefore they were unable to take into account staff competency when planning the rota.
- A bespoke e-learning package on DNA CPR decisions for senior and junior doctors which incorporated changes related to recent court of appeal ruling had been produced to educate clinicians in this area and was launched in January 2015.
- Teaching for junior doctors on the updated DNA CPR guidelines has been incorporated into existing teaching programmes.

**Multidisciplinary working**

- The specialist palliative care team had established close links with other providers of end of life care including charitable organisations, primary care providers and community nurses. These were used to establish educational initiative network with an aim to improve patients experience while they move across care settings.
- The team worked closely with the local hospice at home and community palliative care teams to ensure smooth handover of care between settings.
- There was an end of life committee chaired by the Chief Nurse. This group met regularly with an aim to improve end of life care of patients dying in the hospital.
- We saw some examples of good multidisciplinary team involvement. The multidisciplinary team work was well embedded in clinical practice. There were weekly multidisciplinary team meetings to discuss individual patient's pathway and their clinical needs. We observed that holistic approach to care was taken and that issues discussed at those meetings included meeting physical, psychological, social and spiritual patient's needs. There was a social worker, occupational therapist and discharge coordinator allocated to the specialist palliative care team. We observed that they participated in weekly multidisciplinary team meetings.
- Specialist palliative care team members routinely attended meetings on other wards. We observed patients records included entries made by allied health professionals, doctors and nurses. We noted speech and language therapy and dietician advice was also routinely obtained. Patients were supported by occupational therapist whenever required.

**Seven-day services**

- The specialist palliative care team was available Monday to Friday from 9.00am to 5.00pm. There was one specialist nurse working during Saturday and Sunday across two hospitals managed by the trust (8.00am to 4.00pm). Out of hours on-call support was provided by number of the consultants, on a rotation basis, it included those at the local hospice. The palliative care team was planning to recruit additional staff with an aim to increase staff availability during weekends.
- There was an identified bereavement officer available Monday to Friday. There was no seven day support for families for death certificates.
- The services provided by the pain team had been reduced in 2015 from seven to five days a week due to staff shortages.
- Mortuary staff were available Monday to Friday between 8:00am to 3.00pm. There were arrangements for out of hours provision.
- The pastoral care team were on site six days a week, and on call at other times, to provide support to patients and relatives and to ensure that the spiritual needs of dying patients and their relatives were met.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday and there were pharmacists on call out of hours. On weekends and bank holidays there was an extra discharge team comprising, a pharmacist and two pharmacy technicians it provided a discharge service to the hospital with a focus on discharge prescriptions and urgent items.

# End of life care

### Access to information

- All DNA CPR forms were filed in patient's notes easily available to staff.
- Nurses and doctors told us they had sufficient access to information in order to support clinical decision making.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In all cases DNA CPR forms were signed by an appropriately senior clinician. Patients views related to the CPR resuscitation were clearly recorded in their notes and on the form. However, it was not routinely noted or monitored whether the patients' capacity to make and communicate decisions had been assessed. It was not indicated on the DNA CPR form. The new form which prompted staff to indicate it, and a policy addressing the issue was awaiting a sign off at the time of inspection. The hospital had an online training program on DNA CPR ready to roll out for all staff.
- Staff were provided with appropriate guidance on the actions they should take if they were unclear if a patient had the capacity to consent. This included contacting relatives or friends and check whether patients had made lasting power of attorney related to health and welfare.
- We observed that nurses were aware how to initiate a deprivation of liberty safeguards and referrals were made appropriately, they also sought urgent authorisation whenever it was required.

## Are end of life care services caring?

Good

Patients said staff were caring and compassionate. They were involved in planning their own care and making decisions. We observed staff being respectful and maintaining patients' dignity, there was a strong person centred culture. Patients and their relatives were provided with adequate emotional support.

### Compassionate care

- We observed patients being treated with compassion, dignity and respect. Nursing staff were polite, explaining procedures in simple language and answering patients' questions. Some of the comments made on thank you cards sent to wards by relatives of patients who had died at the hospital talked about; "great care and extreme dignity", "quality time we had in the final moment", "long hours of support and answering million questions". Others told us that "staff have respected that I am at the end of my days."
- Porters told us staff in clinical areas and mortuary staff handled bodies in a respectful way. Porters were mostly able to transfer bodies from the clinical area to the mortuary without any delays. We observed that it took on average 40 minutes for porters to respond to a call during day time, it was slightly longer than the 30 minutes agreed between the trust and the organisation providing the portering service. Nurses told us they did not experience any delays.
- There was a bereavement questionnaire completed between September 2013 and August 2014. The questionnaire was sent out six to eight weeks after an adult death within the trust and asked respondents to report their experience of the end of life care, with particular emphasis on the care received in the last 2 days of life. The trust had sent 1294 questionnaires, 436 completed questionnaires were returned (33%). 77% reported that doctors gave good or excellent care. The same number reported that nurses gave good or excellent care. 64% said their relative had been treated with respect and dignity at all times with 3% who said their relative had not been treated with respect or dignity. 67% strongly agreed or agreed with the statement that there had been "enough help with personal care", this was worse than the national average of 72% (mapped with national survey of bereaved people; VOICES). 72% strongly agreed or agreed that there had been enough help with nursing care; this was in line with the national average (73%).

### Understanding and involvement of patients and those close to them

- Staff provided patients with information on how to contact the palliative care team and where to obtain additional support and information. Patients said they were involved in their treatment and told us staff explained each of the stages and optional treatments available to them.
- Nurses were friendly explaining to patients about their medicines and encouraging them to take them.

# End of life care

- We observed that staff made efforts to contact family members after their relative had died and they had involved them in the decision making process.
- Patient's wishes regarding end of life care and preferred place of death were clearly recorded in patient's notes and staff were aware of it.
- The bereavement survey indicated that there had been mostly enough communication from ward staff with 62% agreeing to the statement; however, 14% of the bereaved families strongly disagreed with the statement.

**Emotional support**

- There was a bereavement office and the staff working there were compassionate and proud of the support they delivered, comforting relatives and making sure people left knowledgeable about what to do following a death.
- The chaplaincy held regular ecumenical services in the hospital. They were available daily to provide spiritual and emotional support when appropriate.
- A group of volunteers worked with the chaplaincy team to offer spiritual support to patients of all or no faiths. Volunteers also supported patients who had no or very few relatives or friends, were providing a 'by your side' service.
- Once a month there was a coffee morning organised by the specialist palliative care team in the local YMCA, it was ran and directed by a senior team member. It was a session where the bereaved were able to share their experiences and to support each other through their loss.
- 60% of relatives reported, via the bereavement survey completed between September 2013 and August 2014, that the psychological support offered to their relative, was excellent or good.
- 40% said it was fair or poor. In answer to the question, "was there enough support for the family at the time of death".
- 80% said definitely yes or "to some extent" with 20% saying no or not at all, this was slightly worse when compared with the national survey of bereaved people (VOICES 2013; 15%).
- 95% strongly agreed or agreed they had been given enough time to sit with the deceased on the ward. Only 1% strongly disagreed or disagreed with this statement.
- 72% of the people who responded to the survey recalled being told that they could view the body of the deceased.
- 92% remembered being given the bereavement information booklet and the same number said staff had been sensitive in dealing with them in bereavement.

## Are end of life care services responsive?

Good

Individual wards were able to provide patients with access to the palliative care and to identify those who needed the service. The hospital monitored whether patients were discharged without delays. There was a fast track system which supported prompt discharge to ensure patients' wishes related to their preferred place of care and death were respected. Staff were aware of patient's wishes in regards to their preferred place of death. The palliative care team was visible on all wards and nursing staff knew how to contact them.

**Service planning and delivery to meet the needs of local people**

- There were no specific designated palliative care beds in the hospital. Most patients at the end of their life were cared for in the main ward areas. Staff told us there was an occasional shortage of single rooms which would allow privacy for these patients.
- Staff told us occasionally they were unable to provide single room to patients in the final days and hours of their life due to there being a limited numbers of side rooms.
- The hospital encouraged a maximum of two visitors at a time for each patient with wards having set visiting times from 10.30am to 7.30pm. Staff and relatives told us that exceptions were made patients' and family requests.
- Patients who required end of life care were referred to the specialist palliative care team, the team visited wards regularly. Nurses told us all patients placed on other wards had received appropriate support coordinated by an appropriate consultant.
- The palliative care team worked in partnership with a local hospice to ensure support was available 24 hours a day.

# End of life care

- The trust had piloted two electronic palliative care planning systems that aim to provide a cross-boundary service for patients and their relatives. It was aimed to improve communication across multiple care providers. The team were monitoring issues and evaluating how many of patients die in their preferred place of care. We were told pilots had been delayed in starting due to technical difficulties with the computer programmes, and that the trust relied on the commissioning group to take a decision which system were to be used.
- The hospital used proactive elderly advance care planning (PEACE) to improve communication in the transfer of clinical information between hospital and care home or other community care settings. This helped to provide an individualised document that recorded the suggested action plans on progression of illness which had been discussed with patients, relatives and carers. A lead nurse told us it helped to reduce inappropriate hospital readmissions.

**Meeting people's individual needs**

- There was various printed information available to patients and their relatives including leaflets on what needed to be done when someone was dying or on services provided by the chaplaincy team. This information was only ready available in English. It was available in other languages upon request.
- Staff told us translation services where available and there was generally no delays in accessing them when required.
- The national care of the dying audit for hospitals in England found that 46% of patients had a spiritual needs assessment at the hospital this was better than the England average 37%.
- Chaplaincy team members visited wards regularly and they were informed of those patients who were at the end of their life so they could provide appropriate support. They also participated in the weekly specialist palliative care team meetings which allowed them to share information about patient's individual needs.
- Mortuary viewing facilities were appropriate and allowed relatives privacy.
- The mortuary was suitable to store the bodies of clinically obese patients equipped with trolleys and large fridges to accommodate them.
- There were specific facilities available in the mortuary to store bodies long term. Staff told us these facilities were sufficient.
- There was no operational procedure for the management of deceased patients' belongings. Usually patient's belongings were left behind on the ward and locked away in the nurses' office until they were collected by the nominated relative.
- The national care of the dying audit for hospitals in England found that only in 15% of all cases a review of the care after death was undertaken, this was worse than the England average (59%).

**Access and flow**

- The specialist palliative care team received 1527 referrals in 2013/2014 those were new patients, continuing patients and re-referrals to the service. The team predominantly saw patients as inpatients but also run an outpatient service and provided telephone advice when needed.
- There was a clear standard set for allocating patients to the specialist palliative care team and who can and how to refer a patient. The team used advance care planning to reduce inappropriate re-admissions at end of life was also prioritised.
- Specialist palliative care team members were visible on all wards and nursing staff knew how to contact them. There was no routine audit of the palliative care team's response times however nurses on individual wards told us they were "quick" for responding to referrals. The team had increased their presence at the elderly receiving unit and A&E to identify patients for rapid discharge home earlier and reduce their hospital length of stay.
- Doctors and nurses told us they had access to diagnostics and test results promptly.
- Nurses were aware of patient's wishes. For example they could tell us the preferred place the patient wished to die. There was a fast track discharge system to ensure patients who were in the last days and hours of life could die in their preferred place. Response times to identify if there were any obstacles to discharge for patients and to ensure patients died in their preferred location were monitored. However, participants of the older's people focus group told us occasionally there were delays with discharging patients out of the hospital promptly. Information we received from the local hospices indicated that occasionally patients were discharged without adequate equipment or when still physically unwell, they felt there were pressures on beds

linked to the high occupancy levels. This information was confirmed by the Clinical Commissioning Group members who said there were pressures on flows in the discharge process linked to pressure on beds.
- The specialist palliative care team were responsible for arrangements for rapid discharge to ensure patients at end of life died at their preferred place. While some patients were able to be discharged within 24hours, we were told there had been historical delays in completion of the documentation for continuing health care funding. In October 2013, the average time from decision to case closure was 12 days. This had reduced to an average of 5.5 days since October 2014 as all fast track applications were approved within 48 hours by the local brokerage team. The team worked to reduce the time from decision to case closure to 4 days.

**Learning from complaints and concerns**

- Information on how to raise concerns or make a formal complaint was displayed on individual wards. The trust had a policy which set out how complaints should be dealt with and timescales for responding to them. Complaints were handled in line with the policy.
- The specialist palliative care team had received one complaint in 2014 relating to end of life service. It had been responded to promptly and appropriate actions had been taken in response which included sharing learning at the clinical governance meeting.
- The hospital's end of life committee was involved with reviewing complaints reports and clinical incidents.

## Are end of life care services well-led?

Good

There was good coordination across the hospital to ensure consistency of approach in end of life care. There were systems for routine monitoring the quality of the service. Action plans developed with a view to improve the service had been implemented effectively. The team leader for specialist palliative care and the clinical lead for the service were aware of issues related to their specialities and had developed appropriate strategies and objectives to ensure continuous service improvement. Staff worked well as a team, they spoke about supporting each other and helping out whenever required.

**Vision and strategy for this service**

- The trust's five year forward view strategy document was published in December 2013 with a view to improve the service for the local population focusing on patients-centred care and encouraging staff to "take pride in care" provided. The trust have developed a set of behavioural values, working with "passion, responsibility, innovation, drive and empowerment", summarised as taking "PRIDE". We noted that 86% of the specialist palliative care team had received PRIDE training in 2014.
- Staff were also aware of the generic corporate objectives set for 2014-15 which focused on improving care, staff retention and engagement, and improving financial stability of the trust.
- There was a five year vision developed by the trust's end of life care committee to "ensure people approaching the end of life receive care tailored to their needs, delivered by staff that are knowledgeable and compassionate, in surroundings that provide comfort and dignity in partnership with communities". We were told that the main focus for the specialist palliative care team was to get patients at their end of life to their preferred place of care/death.
- Doctors and nurses told us end of life care awareness across the hospital had recently improved; they felt the specialist palliative care team was visible and provided patients with "excellent support".
- There were "key current priorities" clearly set for the specialist palliative care team which included implementation of the new individualised end of life plan across the trust, service development towards inpatient palliative care beds and an increased specialist palliative care workforce, rolling out of the gold standards framework and decreasing the time taken to 'fast track' patients out of hospital at the end of life.
- The end of life committee had drawn up an action plan in response to the national strategy and guidance to ensure that the trust had a clear action plan highlighting the progress against each requirement. Progress against this plan was monitored with target dates allocated to each of the actions listed.

**Governance, risk management and quality measurement**

- Senior managers were involved with the end of life committee which met regularly.

# End of life care

- Staff were clear about the role of the senior responsible clinician in specialist palliative care and their involvement in decision making.
- There were no specific risks indicated on the trust's risk register relating to ends of life care or the specialist palliative care team.
- The commissioning for quality and innovation (CQUIN) targets for 2013/2014 related to end of life care included; implementation of the Liverpool car pathway review findings training programme for all senior clinical staff; sharing findings of the review with a focus on nutrition/ hydration, advocacy, accountability, and syringe drivers, end of life medication and sedation and pain relief; continuous monitoring of fast-track discharge home for palliative patients; training for staff on twenty wards to increase staff awareness related to the 'preferred place of care'; and provision of a seven day face to face service.
- 65 consultants had attended a half-day seminar teaching session in end of life care in 2014 and the trust had achieved its targets and reported that audits showed an improvement in consultant communication for patients at the end of life and medication prescribing. This included increase in consultant led end of life discussions about nutrition and hydration. In addition documentation of preferred place of care had increased by 21%.

**Leadership of service**

- The Chief Nurse was the allocated executive lead responsible for overseeing the delivery the end of life service across the trust.
- The team leader for specialist palliative care and the clinical lead for the service were aware of issues relating to their specialities and had developed appropriate strategies and objectives to ensure continuous service improvement. There were systems in place to ensure this was communicated to all staff caring patients at the end of their life. For example there were end of life information boards on each of the wards containing information related to end of life principles and on recent developments within the area.
- There was good coordination across all divisions to ensure consistency of approach and that end of life training, when provided, was cascaded to all appropriate staff.

**Culture within the service**

- Staff on all wards we visited and members of the specialist palliative care team we spoke to were focused on providing a good experience for patients. They were patient-focused and aimed to provide the best possible care.
- Specialist palliative care team members felt well supported in their work. They told us they were encouraged, by their immediate line managers, to report any concerns they had and could discuss any issues with their manager.
- We observed that the specialist palliative care team worked well as a team. They spoke about supporting each other and helping out whenever required.
- The senior leaders told us they aimed to maximise staff involvement in all decisions made so they could own the changes made and help them to improve the service. The chief executive told us staff were very passionate and the trust focused on enabling them "to do what they do best" which was providing compassionate care at the patient's bedside.

**Public and staff engagement**

- The trust organised a bereaved families survey across 2013 and 2014 to gather relatives views related to end of life care received by the patients who died at the hospital. The response rate to this survey was low (35%) and findings, although positive, were not fully representative. Overall the family and carers stated that end of life care was good or excellent, doctors and nurses had shown the patient and their relatives respect and dignity. The results also indicated that the communication, advanced care planning and symptom management needed to be improved.
- The trust had organised a 'dying awareness week' in May 2014, it was held within the main atrium of the hospital with a view to engage public as well as the healthcare professionals. Discussions about wills, registering for organ donation and planning future care and support were held with staff who could provide advice on the subject.
- We were told that staff engagement with end of life care had improved in the months leading up to our inspection. Nurses we spoke with were aware of the end of life committee, they were also aware of the resources available to them, such as "end of life box" provided by the specialist palliative care team equipped with leaflets and information related to the subject.

# End of life care

- End of life training had started to be provided and we observed that this was well publicised among the staff working on individual wards.

**Innovation, improvement and sustainability**

- The specialist palliative care team was looking to recruit additional team members to improve level of care provided to patients at their end of life and promote training delivery.
- The trust was in the process of preparing long term strategies for the specialist palliative care team and end of life care to ensure service sustainability.

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Inadequate |
| Well-led | Requires improvement |
| Overall | Requires improvement |

## Information about the service

The department saw 335,121 patients in 2013/14. The highest attendances were for the following services: surgery, orthopaedics, trauma, ear nose and throat (ENT), ophthalmology, clinical haematology, cardiology, anti-coagulation and DVT, dermatology, and clinical oncology. There are five clinic areas, each with 16 consulting rooms. Radiology had facilities for computerised tomography (CT), ultrasound, (Magnetic resonance imaging) MRI and x-ray. Radiotherapy had three linear accelerator (linac) machines, a High Dose Rate Brachytherapy HDR and a superficial therapy and orthovoltage treatment machine. It also has access to an MRI a well.

Over four announced and one unannounced inspection days, we inspected all the clinic areas, clinic preparation, the booking and call centre office (which is based at King Georges Hospital) radiology, radiotherapy, the outpatient discharge lounge and the cancer day unit. We spoke with over 30 patients and their close family members or friends, over 90 members of staff, including doctors, nurses, administration staff, allied health professionals (such as pharmacists and therapists), as well as clinical, nursing, governance and managerial leads within each specialty. We also reviewed over 15 patient records and over 35 items of equipment.

## Summary of findings

The services had made some improvements in recent months as part of the trust's overall improvement plan. Improvements needed to continue and others areas identified during the inspection also required attention.

The services had not been organised to meet the need of the local population, however this had started to be addressed. There was a large backlog of patients that required appointments that had waited over 18 weeks. Radiology reporting timescales were only partly met. Cancer waits were variable depending on the pathway.

There were multiple capacity, scheduling, staffing and environmental concerns for patients using the radiology and phlebotomy services. Rates of patients that did not attend appointments, hospital cancellations and hospital changes were high.

Radiotherapy was one of the best five units in the country and there was positive outcomes for the Genito-Urinary Medicine (GUM) service and some other services.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Requires improvement

Incident learning was not always robust and actions were not always followed through. Equipment was not always where it was needed. Improvements had been made to the record management but further improvements were needed particularly with availability and filing. Mandatory training was not on target in some areas and not appropriate for some staff. Some staffing levels were below that needed to meet capacity, particularly in phlebotomy and radiology.

However medicines were managed, cleanliness and infection control procedures were adhered to and staff had appropriate safeguarding awareness.

### Incidents

- There had been 52 incidents in the support services directorate which includes outpatients since August 2014. Incidents noted included lack of staffing, poor patient record management (most frequent), and patients attending for cancelled clinics, with other incidents regarding equipment and IT systems. Most incidents had immediate actions taken and a few had individual learning such as performance management of staff. Duty of candour was highlighted on investigation reports if it applied. However, the reports did not highlight if actions recommended had been undertaken such as implementing the WHO surgery safety checklist for ophthalmology treatment.
- There were three serious incidents (SIs) recorded against radiology in 2014. A meeting was held after each SI and learning was disseminated in audit and staff meetings. However, there was varied awareness of what SIs had occurred in the department. We requested the root cause analysis investigations into these incidents but were not provided with the correct information. In addition, we reviewed the minutes of learning from a claim against the trust in radiology. Although this covered all the contributing factors to the incident, it did not specify specific learning or action to be taken in light of the incident.
- There had been 35 incidents in diagnostics in November, and 21 in December. There were five in phlebotomy mainly regarding the lack of a porter covering annual leave. There were 60 non accidental injuries in radiography in the last 18 months but audits showed the injuries that occurred were appropriate in the circumstances. Most incidents in radiotherapy were due to the couch position not being set accurately before a treatment.
- There was varied understanding of reporting procedures for incidents. Some staff in outpatient areas were unaware of the form which was completed for any incident. Some staff said they reported to their supervisor or completed a separate form such as a feedback sheet to medical records when patient records were unavailable for clinics which was in line with trust procedure but meant there was a risk incidents would not be logged or logged inaccurately. Some staff were unaware of what constituted an incident to report. There was also varied staff feedback on incidents with some saying they received feedback on just individual incidents whereas others said they received feedback on incidents from across the trust. When we observed a daily nursing huddle, a recent incident was discussed. Non-nursing staff, were not aware of the incident.
- Staff in radiotherapy had a good understanding of incidents and learning from incidents.
- Approximately half of all incidents reported were not investigated and closed within expected timescales.
- Mortality and Morbidity meetings took place in oncology.

### Cleanliness, infection control and hygiene

- Infection control audits were undertaken every month and showed 100% compliance in each clinic area.
- There had been previous concerns about the cleanliness of the outpatient toilets. In response a new rota had been set up with cleaning staff to improve this and we observed no concerns.
- When we observed clinical areas, they were clean and tidy. Daily checks of clinic areas were undertaken which were up to date. Equipment had daily cleaning stickers and we observed them to be clean. Scopes were appropriately decontaminated. We were told by some staff that cleanliness had been a problem up until our inspection and had been so for years but none of the records we saw corroborated this claim.
- There had been a leak in one of the outpatient areas which caused a flood and this had happened on

previous occasions. Staff closed the area and undertook a clean and check before the area was reopened. A plan of action had been developed to address the on-going problem.

- The cancer day unit staff raised concerns that bins were sometimes overflowing in the morning and it was not as clean as they wanted although housekeeping would come back to the unit to clean further if requested. Staff had raised this but cleaning staff were allocated a set time to clean the area and they were finding this was not enough time for an allocation although there was a plan for a deep clean at weekends. We requested the cleaning policy for the unit but the document did not outline the time needed for this task or what the standard of cleanliness should be, only how to decontaminate it. Staff adhered to infection control and prevention guidance. Staff cleaned their hands between clinical areas, were bare below the elbows and hair was tied when necessary. The majority of hand gels were stocked in the clinic and radiology areas.
- There had been previous concerns about the cleanliness of the outpatient toilets. The concerns had been addressed by a new rota with cleaning staff.

**Environment and equipment**

- Environment audits were carried out monthly in each clinic area. All these showed 100% compliance. However, we found curtains in radiology that were not labelled to show when they required replacing.
- Equipment was mostly in place and up to date in clinic areas including resuscitation trolleys in all areas. There were not enough bladder scanners, there were no hoists in one clinic area and we saw no risk assessment to show why this was the case. Ionising Radiation (Medical Exposure) Regulations (IRMER) checks took place in radiology and showed there were no issues with the equipment used.
- In radiology on one day of the inspection we found fire extinguishers were broken off the wall with no oxygen. We raised this and it was rectified by the end of the day although staff reported they continued to be knocked off the wall due to where they were situated as they were near double doors that were easily hit by porters with beds. We also found oxygen cylinders not mounted in radiology and the outpatient discharge lounge and these had not been remounted when we visited on another day.
- Appropriate single use items were in places such as proctoscopes and were disposed off correctly.
- Some safety signage in radiology was not complete such as who the radiation supervisor was for chest x-ray.
- The CT scanner in radiology kept breaking down. This was on the risk register to replace. In the meantime, when the CT required repair, patients had to transfer to King George's Hospital for a scan. A mobile scanner was due to be brought in for at least 22 days to ease the workload. This was causing problems with CT reporting timeliness.
- Lead aprons were in place for radiotherapists and radiologists and the service monitored staff exposure to radiation which included mini radiation counters that staff wore.

**Medicines**

- Medicines were appropriately stored, in date and prescribed. The responsible nurses had the controlled drugs keys. Medicine fridge temperatures were appropriately checked and correct apart from one in dermatology which was too high at nearly 12 centigrade. Quarterly medicine management audits were conducted to ensure medicines were appropriately stored.
- Some nurses prescribed (known as nurse prescribers) medicines in clinics.
- Sometimes chemotherapy was delayed arriving at the day unit from pharmacy, which was sometimes as late at 10.30am when patient appointments started at 9.00am.
- Pharmacists had access to GP summaries which meant prescribing errors were less likely.

**Records**

- We received varying audit information for missing medical records. One audit showed 24% of records were missing whereas others showed lower amounts.. The consistent theme from staff was around 10% of records were missing at clinic with higher missing records in specific clinics such as ENT, orthopaedics, urology and trauma. One of the issues raised was poor tracking of notes, particularly due to the tracking procedure with medical secretaries where notes were only recorded once medical secretaries had received them but there were occasions when notes were being taken to other places prior to the medical secretaries tracking them so they then became hard to find. In addition, notes were

only delivered from the off-site medical records four times a day which meant late requests for notes were sometimes difficult to obtain. However staff told us this was an improvement on previous performance, with less temporary notes used and better tracking though this was only slowly progressing. In the event notes were missing, clinicians had access to clinic letters and test results on their electronic patient information system.

- We found multiple records that were either in old folders or very large which raised the risk of records becoming loose. There was a 'rehousing' project where medical record staff at the off site library were to put old files into new folders and archive old files over two years old. However clinical preparation staff were unaware of the project. Clinical preparation staff were supposed to rehouse as well as preparing clinics but we were often told they were unable to do this as they did not have the time due to the tight deadlines for ensuring clinics were prepared.
- We checked patient records and they were appropriately completed with dating, signing by the clinician and legible notes.
- The mandatory training system locked staff out of the intranet if they had not passed their information governance training to ensure staff adhered to appropriate records management protocols.
- Records were stored appropriately in areas outside of public view in clinic preparation and we saw no files left in public view elsewhere. However a few staff told us there had previously been problems with records left on reception desks up to the weeks before our inspection.
- Patient notes in sexual health clinics and laser part of dermatology were kept separate to ensure they were confidential and easily accessible.

**Safeguarding**

- There was a varied staff awareness of safeguarding with some staff fully aware of how to report and who to report to whereas some others had no awareness of safeguarding.
- There were appropriate protocols and partnership working for safeguarding children in the sexual health clinic.
- Most staff were up to date with their safeguarding training including level two for children and adults.

**Mandatory training**

- Clinical staff were up to date with their mandatory training.
- Information showed not all administration staff were up to date with their mandatory training.
- Basic life support training was 84.9% in radiology and most mandatory training information we saw showed around 80% compliance.
- Staff completed on-line training in the hospital library as dedicated computers for this were available there.
- Although bank staff had local inductions, they were not required to complete e-learning although we were not told why this was the case. We were concerned they may not have the basic training for their roles.
- Study leave could not be taken unless you were up to date with your training to encourage staff to be up to date with their training. Managers sent alerts to staff if training was not kept up to date.

**Assessing and responding to patient risk**

- The service was not yet assured that patients had not come to harm whilst waiting for an appointment. The service had set up a process to assess whether patients had come to harm for those that were awaiting surgery, but the process had only just been set up for those awaiting outpatient appointments. The process was to check both the patient record and in speaking with the patient, whether they had come to harm using a standardised flow chart. We requested a copy of this process but we did not receive it. So far they had found two low harms on the non-admitted pathway.
- Some of the waiting areas were situated away from where staff were located and patients were not escorted for their diagnostic scans if they were on trolleys and we were not shown if this was risk assessed. Therefore it would have been difficult to identify a deteriorating patient in those situations.
- Patients were identified by their name, date of birth and first line of address before scanning to ensure it was the correct patient. An NRLS/NPSA approved WHO safety checklist was in place for interventional radiology which included sign in, timeout and sign out. The WHO checklist audits were conducted on 100 patients a month with compliance between 96 and 99%.
- Risk assessments took place in radiotherapy following evidence of over exposure with contact restrictions imposed on the patient depending on their exposure

level. Safety audits were also conducted which showed all appropriate measures were in place such as protective equipment, warning lights and emergency stops.
- Staff were aware what to do in the event of a patient deteriorating including how to call the crash team and where their resuscitation trolleys were located.
- Weight gain and loss was checked each time a patient attended radiotherapy to ensure their exposure was set at the correct amount and any equipment they needed to wear fitted correctly.

**Nursing staffing**

- 17 of 19 outpatient nursing vacancies had been filled by November 2014. There were no vacancies in the sexual health clinic However oncology and haematology clinics sometimes struggled to fill their establishment which meant their supernumerary nurse sometimes had to take on clinic work.
- Nursing staff levels were appropriate for the needs of the outpatient clinics in most areas with the overall service slightly over its full time equivalent establishment. However staff in the anticoagulation and DVT service nursing staff told us the service was under-resourced. All the staffing rotas we reviewed showed no staffing shortages.
- There were concerns regarding the workload of senior nurses. All matrons had to work across both sites where clinics were running concurrently with one also overseeing inpatient wards. There was a lack of charge nurses in place to reduce the matrons' workload as most clinics were run by either sisters or senior nurses (band 6).
- There was a high amount of sickness in phlebotomy with eight off out of 27 which meant staff were stretched especially considering there had been an 8% increase in activity. Management planned to competency train some specimen support workers to assist taking bloods and to appoint an additional senior phlebotomist. A business case had also been presented to appoint five more phlebotomists.

**Medical staffing**

- Medical staffing levels were due to be reviewed. However, this had not yet been done in the majority of specialities as capacity and demand modelling had not been completed and this meant these services were unable to evidence how many staff they needed. Those areas that these up to date showed in their business cases that they required additional consultants to meet the increased outpatient activity levels.
- Some clinics were being run by registrars rather than consultants and a number of clinics had to be run into the night and over weekends to deal with the workload. Service managers told us this was causing a huge strain on the medical staff workload. We were sent the consultant job plans showing how many hours outpatient activity each consultant was due to do but it did not show how these were mapped to clinic capacity planning so it was not clear how many doctors specialities required.
- There was one vacancy in histopathology being covered by a locum. There were no vacancies in radiotherapy although they were below the Institute of Physics and Engineering in Medicine (IPEM) recommended levels so two posts were on the local risk register to highlight this.
- When we spoke with medical staff, they told us staffing levels were not an issue for clinics but scheduling was causing them to work longer than contracted. Many consultants and registrars were working overtime and weekends to meet the demand and they were said this was not sustainable. Medical staff were also concerned that they were expected to see two clinics worth of patients if a registrar called in sick, rather than rebook the patients or bring in a locum. Some medical staff told us recruiting for vacancies was slow with one example of a post that had been approved to recruit in neurology over three months ago but no advert had gone out yet.
- There was a high vacancy rate in radiology for radiologists. Radiographer positions were being advertised during the time of our inspection. Five radiologists were on leave on one of the days we inspected which meant no one was available to report CTs. Most days of the week, radiology were below their establishment of radiologists. They said there had been five vacancies for over five months but interviews were being conducted the week after our inspection. At the time of our inspection there were four radiographer vacancies out of 45 for x-ray and two out of 18 for CT. A high amount of locums and agency were being used. There was a high use of agency sonographers due to six vacancies out of an establishment of 24. Ultrasound were short staffed with no manager and down a

sonographer and less overall staff than six months ago. They said this was a problem was the workload was increasing with over 40 scans a day which included one stop clinics for TIA, vascular and DVT plus inpatients.
- As physiology had an increase in workload, they were due to appoint another technician.

**Major incident awareness and training**

- An 'SOS' number was available for oncology patients to call if they required support which was always held by a cancer nurse. Patients who had used this told us advice was helpful and timely. This helped to reduce unnecessary admissions.
- There was a procedure in case of a radioactive incident. The room would be shut in radiology and an incident form completed. In radiotherapy, multiple barriers between the radiation source and staff access were in place that had been anti-terrorist approved. In the event of an incident with the source, patients were prioritised to be away from the source as much as possible and staff were time checked in the area to make sure they were not over exposed when trying to resolve any leak.
- We requested the business continuity plans for outpatients but what we were sent related to inpatients and we were not sent anything additional to this.
- Panic buttons were available to receptionists in the event of an emergency situation that required security.
- Staff were aware of the procedure in the event of a fire and testing was done regularly although no drill had been completed.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There was varying evidence about the effectiveness of outpatients, depending on the service. Outpatients was starting to obtain patient outcome information and radiotherapy had some of the best audit results for its service in the country. However radiology had concerns regarding its adherence to guidance, there were mixed results for oncology, and phlebotomy had a lack of information about their performance. Pain management was appropriate. Competency training was in place in all areas but phlebotomy. Nutrition was not always available. Multi-disciplinary working took place both internally and externally. Seven day working was partly in place although we were unsure how long this would continue in some clinics in outpatients due to weekends being used more to catch up on backlog than as a business as usual way of working. There was a long wait for some information, particularly clinic letters and there was a lack of staff to support the administrative side of the services. There was appropriate understanding of the Mental Capacity Act although we were concerned about the process for 16 to 18 year olds.

**Evidence-based care and treatment**

- The national institute for care and excellence (NICE - which contains medical guidelines for staff to follow) compliance overall was 76% with issues in radiology at below 70%. Radiologists said there was a lack of space and time to audit.
- The anticoagulant and DVT service did not meet NICE guidance as they were unable to review patients within 24 hours at weekends. We requested the COPD audit but this focused on inpatient treatment.
- Doctors in outpatients were able to show us that they were complying with best practice guidance. Radiotherapy's guidance was condensed national guidance and were easily accessible on their own database.
- Staff told us it was sometimes difficult to access policies and procedures on the intranet due to the slowness of the IT system.
- Radiology staff were able to explain their safety protocols and the local rules were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy. There was a concern regarding inappropriate referrals averaging five to six a day but radiology had a continuous learning loop for referrers when a referral was rejected.
- The hospital had conducted a non accidental injury (NAI) skeletal survey into using protocols outside of national guidance which showed 60% positive results.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective but safe scan for each body part and these showed appropriate exposure levels.
- Employee procedures were in place in radiology but were due for review.
- The laboratories had had full Clinical Pathology Accreditation (CPA).

- Haematology guidelines were in line with national guidance and up to date but staff commented that finding guidance was difficult due to an inaccessible search engine.

**Pain relief**

- Patients that required pain relief when either waiting for their appointment or during their appointment were given it. Patients were complementary about the pain relief they were given.

**Patient outcomes**

- Quality of care audits were performed in outpatients which audited information availability, cleanliness, staffing levels, medical records availability, equipment in working order, medicines management, and patient feedback. These were completed weekly and showed 100% compliance but were currently only being collected in 3/4 clinics although was due to be rolled out further. Patient feedback was summarised which was mostly positive.
- We saw examples of two clinic audits from August 2014 and January 2015. They showed there had been an improvement in patient note availability and patient waiting times. Audits were conducted over a 17 week timescale with different clinics audited each week and varied when they were audited every 17 weeks.
- Cancer peer review scored at least 80% or higher on self-assessment. However on peer review and validation in 2014, scores were lower particularly colorectal LM (0%), and multi disciplinary (MDT) (71%), acute oncology MDT (17%), general acute oncology MDT (45%), CUP MDT (38%). These were mainly due to a lack of a thoracic radiologist at lung MDT, lack of administrative support for pre-diagnostic MDT, lack of same day CT for 2 week wait, and lack of data manager. There were also concerns regarding the lack of a lead cancer nurse, and changes to lead clinician.
- Patient Reported Experience Measures (PREMS) showed issues with waiting times and workforce.
- Radiotherapy undertook both internal and external audits which were mostly positive and put it in the top five radiotherapy units in the country. These included system audits such as equipment calibration, image review process and BSI assessment as well as Royal College of Radiologists/Oncology audits such as anal cancer toxicity and outcomes of radical chemoradiotherapy and breast radiotherapy technique.
- IRMER audits were conducted in 2014 which showed 100% compliance. The last radiation protection review audit showed concerns regarding outdated procedures but the procedures we reviewed showed no issues.
- Phlebotomy staff were unaware of their blood error rate.
- Audits were conducted for clinic preparation to check its standard.
- The follow up to new ratio was better than the England average in the last 18 months at under two.
- Genito-Urinary Medicine (GUM) conducted audits which included whether they were meeting 48 hour access for patients and uptake of HIV testing (which was 80% against a target of 85%).
- We requested patient outcome information for outpatients such as physiotherapy audits but we did not receive any.

**Nutrition and hydration**

- Although phlebotomy was located in at the main entrance where there were food and drink shops and was near a water fountain, staff provided nothing additional despite patients waiting constantly over two hours for their appointment and the service being operated on a ticket system so it would be difficult for patients to move away from the area. However plans were in place to arrange drinks. No hot drinks were available in outpatient areas although patients could get a drink from shops on site if they were given a pager. Food and drink was only given for waiting patients in exceptional circumstances when long waits occurred.
- Patients were given food and drink when waiting in the outpatient discharge lounge and in the cancer day unit.

**Competent staff**

- Most staff told us they received supervision and appraisals. Nursing staff said they had learning and development goals and were able to pursue specific interests such as respiratory competence. Appraisal rates within clinical support services directorate for pathology were just over 91%, radiology was 87.5%, specialist medicine was just over 80% and therapies was just over 82%.
- Radiotherapy staff were trained to ensure they were competent and we saw certificates and copies of training conducted to show this such as Administration of Radioactive Substances Advisory Committee (ARSAC)

approvals for radiotherapists, and training for radiation protection supervisors. External weekend training was available for radiotherapists with time taken back in lieu and monthly MI training.
- Radiology had competency based training relating to the equipment they were using.
- Reception staff had started a customer experience course. The staff we spoke with who had attended the course said it was very helpful and gave them a better understanding and skill set for their role such as dealing with conflict, prioritisation and customer manner. They also had clinic outcome training to ensure the correct codes were used and patients could be processed on the computer system correctly.
- An induction checklist was in place for new and agency staff and we saw that this was completed.
- Link practitioners were in place for trainee radiographers.
- Although x-rays were able to be signed off by two radiographers, they had competency based training before they were allowed to do this and were still double checked by a radiologist and had 5% of their reports audited to ensure their reporting was accurate.
- There was no evidence of a training programme in phlebotomy.
- GUM nurses had specific sexual health training.
- Advanced practitioners were in place in pathology.
- Medical staff told us they had good access to study leave with in house and regional CMT days, and regular teaching.
- Cancer nurses had competency based training at a specialist cancer trust.

**Multidisciplinary working**

- Multi-disciplinary meetings occurred in oncology on a weekly basis which included specialist consultants, radiology, clinical nurse specialists, and histologists with external clinicians that were part of some pathways most weeks. Attendance for these was maintained and prioritised. Other support services for cancer were in place such as benefits officer, counsellor, psychotherapists, dietician, therapy and social worker. We requested the minutes of the cancer MDT meetings but were told they were not minuted and the information discussed could not be sent to us due to patient information.
- A GP Liaison Manager was due to be appointed.
- External resources were also used such as PET scans at other hospitals.
- Partnership working took place in GUM.
- External MRI scanners were being used.
- Clinicians told us access to physiotherapists for patients was slow although some medical specialties had specific physiotherapists dedicated to their service.
- Some staff felt there was not enough communication with other trusts.

**Seven-day services**

- The Trust currently routinely runs a 5 day service but has put in place a number of additional clinics in the evening and on weekends to reduce waiting times. However we were unsure how long this would continue as these clinics were either being run to reduce the appointments backlog or due to a lack of space to run clinics during the week although the trust said these additional clinics would run for the foreseeable future. In addition, seven day working was not the case with all specialities such as urology. However, six day working and evening clinics were standard in GUM. Urology only ran clinics during normal working hours though most clinics were run at King Georges Hospital as they were able to conduct procedures there.
- Out of hours GP access clinics ran till midnight some days but these were staffed using overtime and not as contracted hours.
- We saw Fridays were not currently being fully utilised for clinic bookings compared to other days but there was an expectation clinics would increase on this day to get through the backlog of appointments.
- The cancer day unit ran five days a week although there were plans to additionally run on a Saturday.
- ECGs were conducted externally at weekends with emergency cover by cardiology registrars.
- A radiologist and three radiographers were on-call at weekends and out of hours (8.00am to 8.00pm) covering radiology.
- Phlebotomy only currently ran Monday to Friday 7.00am to 4.30pm.
- The outpatient discharge lounge did not operate at weekends.
- Radiotherapy had the ability to work seven days a week and would review high risk patients such as spinal cord compressions with the oncall team. Time in lieu was given to those radiotherapists and radiographers that worked over the weekend.

# Outpatients and diagnostic imaging

### Access to information

- Clinic preparation had a target of ensuring patient notes were available for all patients at their appointments. However, we saw examples of clinics being prepared in the morning for an afternoon clinic. Most clinic preparation we saw was only the day before and in most instances, records were missing so had to be found. Although staff in medical records had been appointed to gather notes, this had only just been implemented so we could not determine if this had improved timeliness or patient record availability. Managers told us clinic preparation was understaffed due to the increasing clinic workloads but gaps were being filled by bank and vacancies were being advertised.
- Estimates on patient notes missing ranged from 24% to 8.4% depending on the clinic with around 10% quoted by most staff we spoke with. There was a target to have clinic preparation begin two to three days before a clinic to improve patient not availability but this was still aspirational for most clinics.
- No information about clinic performance was displayed in the waiting areas, such as surveys, number of falls, staffing numbers, average waits, did not attends (DNAs), or hospital cancellations. However, patients were kept updated on how long they would expect to wait that day depending on which clinic their appointment was for.
- Discharge letters took two to three weeks to reach GPs after a patient's appointment with some specialties higher than this such as nephrology and ENT. The trust had a target of 14 days and most specialities only achieved this a maximum of 50% of the time with some specialties not achieving it at all. This was due to a backlog with medical secretaries.
- Although extra clinics had been put on, no additional medical secretary staff had been arranged to draft and send the clinic letters.
- Test results were available electronically and clinicians told us they were always readily accessible at clinics.

### Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Most of the staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards including when to have a best interest meeting.
- Patient records showed and patients told us that consent was requested and obtained for any procedures, with any risks explained.
- We were concerned that part of the plan to reduce 'did not attend' was to write to parents of under 18s as 16 and 17 year olds could consent on their own behalf plus some clinics would be particularly sensitive such as Genito-Urinary Medicine (GUM), and gynaecology which children may not want their parents to know about. Staff said they would look into this.

## Are outpatient and diagnostic imaging services caring?

Good

Although some of the survey results showed average to poor patient experiences, more recent internal surveys and the majority of patients and family we spoke with described staff as caring. Staff respected patients privacy and dignity and explained things in a way people could understand. Appropriate emotional support was available.

### Compassionate care

- The cancer experience survey rated all but seven areas in the bottom 20% of trusts nationally. In response the hospital had conducted its own internal audits and they found that patient experience levels for cancer at the hospital were vastly more positive with feedback showing they would recommend the service constantly above 90%. The NHS Friends and Family Test score for February 2015 was 96% recommending the service. Twenty-five people had responded and the test had not been carried out across all outpatient clinics.
- Most of the patients we spoke with were very positive about the experience they had at the hospital and told us the staff were 'passionate'. Some patients told us they had been given last minute appointments after calling to book only two days ago. However a few patients felt staff in some clinic areas were abrupt.
- We observed patient consultations and they were friendly and compassionate with calm explanations.
- We observed most staff adhering to signs on consultation rooms to knock before entering.
- Curtains were drawn in phlebotomy if patients requested it or there was a concern but there were no signs regarding this and we observed no staff prompt

patients if they wanted them closed. We were told this was the case due to the time it took to draw the curtains all the time would affect the speed phlebotomists could see patients.
- Reception areas were configured so patients could not be overheard speaking to receptionists other than in phlebotomy and the eye clinic where waiting areas were near reception or where patient queued near the reception desks.
- Chaperones were available and staff were aware of offering them to patients. We observed them in use in the sexual health clinics and urology.

**Understanding and involvement of patients and those close to them**

- Most patients told us staff explained treatment and care in ways they could understand. However a few patients told us they struggled to understand some of the staff due to their accent or if the staff's first language was not English.
- Consultations we observed showed they were not rushed, with treatment risks and benefits explained and their understanding of this checked. Patients were informed about what would be next such as if they were being discharged or when their next appointment would be.
- Patients were kept updated on delays with whiteboards in all waiting areas and which consultant or doctor they would see when they booked in.
- However patients were not informed whether they would be seeing their named Consultant or a Registrar until they booked in with reception on the day of their appointment. They also said they had no continuity with the clinician they saw.
- Safeguarding information was displayed in waiting areas.

**Emotional support**

- Doctors explained and reassured patients in a way that was calm and considerate.
- Macmillan nurses were available for patients with cancer but we were told they rarely were used for any other patients that required emotional support and they had no access to a quiet room.
- Clinical nurse specialists (CNS's) provided emotional support to patients with cancer.
- There was a bereavement group coffee morning which met for families that were recently bereaved.
- Survivorship events were held for patients that were six months post cancer treatment that included support from dieticians, physiotherapists, personal training and CNS's.

## Are outpatient and diagnostic imaging services responsive?

Inadequate

The services had not been organised to meet the need of the local population, however this had started to be addressed.

There were multiple capacity, scheduling and environmental concerns for patients using the radiology and phlebotomy services. Rates of patients that did not attend appointments, hospital cancellations and hospital changes were high.

There was a large backlog of patients that required appointments that had waited over 18 weeks. Radiology reporting timescales were only partly met. Cancer waits were variable depending on the pathway. Some appropriate procedures were in place for vulnerable adults but these were not fully utilised and others were either not appropriate or not in place.

**Service planning and delivery to meet the needs of local people**

- Rapid access clinics were available for the medical receiving unit, care of the elderly and general surgery. Specific hot clinics were also available for follow up after an A&E attendance in ENT. These are clinics that can be booked at the last minute for patients who require an urgent review.
- 19% of clinics had been re profiled by March 2015. This had been delayed due to service managers needing to undertake an extensive piece of work comparing clinic profiles with consultant job plans and departmental business plans. The plan was to remove overbooking and ensure all clinics had a standard number of slots that were never exceeded as well as finish the profiling.
- 64% of Directory of Services had been reviewed as of March 2015 and was due to be completed by the end of March 2015. Most out of date were ENT, maxi facial,

dermatology and neurology. The progress for this had been escalated to senior leads. The directory of services being out of date meant patients were sometimes booked into inappropriate clinics.

- 13% of consultants had firebreak clinics which are clinics that are left empty to book in patients that have either been cancelled or have been waiting over 18 weeks or when demand requires them. We were told these allowed some patients to be arranged an appointment for the next day as some clinic slots could be left empty until the day before. On one day of our inspection, 17 patients were booked for a clinic this way.
- Appropriate booking processes were in place for outpatients and diagnostics. Patients who did not attend (DNAs) were risk assessed before being referred back to their GP, with particularly sensitivity with those waiting over 18 weeks and those that had been booked at the last minute. Those requiring follow ups over 12 months later required a new referral from their GP. Urgent diagnostics referrals were prioritised and triaged. Escalation if targets and timescales could not be met were in place with performance monitoring of these.
- If no choose and book appointments were available within the target time in oncology when a referral was made, they were reviewed and booked directly to ensure patients were booked within the target time if possible. Additional clinics were also made to cope with demand for two week wait pathways.
- Reception staff across the clinic areas were stretched. We saw two reception areas during our inspection that were below their establishment by at least one member of staff. We were told that bank and agency staff were rarely allowed at reception even in the event of sickness or annual leave. When staffing was below establishment, this sometimes created queues and bottlenecks when patients were booking in for appointments as the electronic booking system the hospital used to have had been removed as it did not link with the new computer system.
- The environment in most clinic areas was not responsive to patient needs. The eye clinic waiting area was constantly busy with all seats filled although patients were quickly transferred to smaller waiting areas near the consulting rooms. Some clinic areas had waiting chairs outside consulting rooms in corridors and the anticoagulation and DVT service saw up to 12 patients in one room at a time and did not maintain confidentiality. Staff told us there had been an incident where a patient collapsed and it difficult for the patient to be transferred through the corridor due to how narrow it was with the chairs.
- There was a lack of seating for the anticoagulation and DVT service and oncology/haematology clinics near the consultation rooms and radiology. Although there was a large waiting area for the phlebotomy service, it was constantly full with patients often standing. The whole area very congested.
- Some of the corridors and doorways were not accessible for a clinically obese wheelchair and there were no separate seats for those patients to wait. There were no separate children waiting areas in any of the clinics or diagnostic areas we saw that saw children as well as adults. There was a lack of space in clinic preparation so staff had multiple piles of notes on their desks and on the floor so it was difficult for them to keep in order which meant there was a risk for notes to go missing. Staff felt the cancer day unit and some of the clinic areas required additional space to cope with capacity.
- However, the consulting rooms were appropriate with separate treatment and consultation rooms that had a through door between them, with 16 clinic rooms per outpatient area.
- Reception staff raised with us concerns about reception areas. In all but the eye clinic, they told us the height and dividing walls meant they had to stand up to see if there were any patients waiting when part of their role required them to be sat at a computer. The dividing walls meant they could not easily refer to a colleague to help a patient. One reception had brought in glass as it was now the reception for the GP service out of hours where it was felt there was more of a risk of incidents but staff told us this did not improve things and actually made it hard to hear patients. The eye clinic reception had a small door and small area to go to reception. This created bottlenecks when patients were queuing so the door to the area quickly could become blocked. This also meant conversations at reception could not be kept confidential. The trust sent an action plan regarding refurbishment works that would take place regarding reception and waiting areas but these did not address the concerns we found.

# Outpatients and diagnostic imaging

- Staff told us there were issues with the venting filters and this had been raised with the health and safety team but nothing had happened in two years despite patients complaining about the unpleasant smells in the sexual health clinic.
- One stop and hot clinics were in place for ENT, cancer, allergy and pain but not echocardiography.
- There were no entertainment facilities in waiting areas other than in the cancer day unit. Magazines or newspapers were not available.
- Uniforms were standardised across clinical staff but not yet for administration staff, with colours and types depending on your role and grade. Some staff raised concerns regarding inappropriate referrals to radiology. Managers told us this was due to a lack of information on the referral so there was continuous feedback to the referring clinicians to ensure future referrals were appropriate.
- Staff raised concerns that private patients were being fast tracked ahead of NHS patients in radiology but we were assured that these patients were fast tracked only when they were acutely unwell.
- Phlebotomy had started opening at 7.00am to cope with demand but patients were turning up at 6.00am or earlier to ensure they were seen quickly. In addition, only it was one of only two sites that saw under three year olds and all under three's required an appointment whereas all other age groups had to be walk ins.
- The sexual health clinic required patients to book up to 48 hours in advance and this had reduced patients not attending as well as meant there were enough slots for patients.
- There was a shortage of parking places with staff and patients often queuing to park which sometimes blocked hospital transport.
- There was no IT access in the outpatient discharge lounge which meant staff could not help transport with patient information. There was also no link between different computer systems used.
- Radiotherapy could take most bariatric patients on site as machines could take people up to 32 stone.
- Some patients on admitted pathways told us they had not been kept up to date why their surgery was delayed, with one patient waiting 11 months for an ENT daycase slot.
- Procedures were in place to advise and support patients when clinics were delayed such as use of pagers, and when refreshments can be provided. However there was no aspect of the procedure regarding assessment or prioritising patients depending on their circumstances such as if transport is booked or they are vulnerable.

**Access and flow**

- In December 2014 the did not attend rate was 11.56% for new appointments and 12.09% for follow ups which is much worse than the England average. DNAs were in physiology with 14% in the pacing clinic although this is to be expected due to the elderly patient case mix. These rates had been consistent for several months. The service did have text reminders seven days and 24 hours before an appointment. they had recorded 40% of telephone numbers that could receive texts. Senior staff acknowledged the DNA rate needed to reduce by improving the text service and call centre even further. They had put multi lingual literature in GP services about DNAs and they were targeting the key DNA groups which were under 18s, and post code RM10 by also putting literature in schools. Partial bookings were also due to be introduced and patients were called at least twice to arrange an appointment before the hospital booked one for them. However some staff told us patients were being recorded as not attending on the system when the patient had booked in. This was due to some confusion with the different patient waiting areas.
- The cancellation rate (appointments cancelled by the hospital) was 17% with 37% clinics cancelled in September 2014 due to annual leave, study leave and staff on-call. Total cancellations were 2547, mostly in surgical specialties in 2014. Senior staff acknowledged that the six weeks before clinic cancellation policy had not been rigorously adhered to but this policy was now being fully utilised with senior management sign off if a clinic had to be cancelled within six weeks of its start date. Staff felt hospital cancellations had improved although we received a few comments from patients that their appointments had been cancelled multiple times, including one patient who had waited a year for a pain clinic appointment.
- The patient cancellation rate was 9%. 24% of appointments were first appointments and 43% were follow up appointments.
- Patient waiting over six weeks for diagnostics were better than the England average though had been worsening up to October 2014 at over 1% but were now back down to 0.4%.

# Outpatients and diagnostic imaging

- The referral to treatment time (RTT) rate was better than average up to November 2013 but no data was available from this date as the service had stopped reporting. The hospital was due to start reporting again in January 2015 but this had not occurred and was likely to be delayed until at least April 2015. This was due to an issue with transferring from their old patient information system to their new computer system where processes had been set up the same without reviewing whether they would work on the new system. When the new computer system started, it showed around 110,000 patients that required an appointment, 100,000 non-admitted, 10,000 admitted with 50,000 over 52 weeks. A validation project was therefore implemented to find how many patients actually required an appointment as some were flagging due to system or recording issues. Validators checked individual patient files and systems where they flagged on the system as requiring an appointment to check if this was actually the case. Where a clinical decision was required, these were reviewed by the relevant speciality consultant to ensure correct decisions were being made. Estimates were that around 8,000 of the non-admitted patients required an appointment although this had not been fully validated as not all files had been checked. As of January 2015, 53,236 non-admitted patient pathways required validating of which 18,057 were over 18 weeks and 893 over 52 weeks as the trust had focused on reducing the admitted pathway backlog first. The biggest issues were in general surgery, urology, orthopaedics, trauma, ENT, ophthalmology, maxillo-facial, pain, general medicine, gastroenterology, cardiology, dermatology, respiratory, neurology, and rheumatology. To reduce the backlog, 3,000 appointments had been outsourced to other hospitals. To prevent this in the future, a new upgrade of the system was due to remove the errors and training was being given to reception staff to ensure clinical outcomes were recorded.
- Four specialities were getting more referrals than they were treating. Particular capacity concerns were in pain, diabetes, dermatology, neurology, orthopaedics and gastroenterology where there was a recognised lack of consultants but these had not been evidenced in most areas due to clinic profiles requiring updating. Anti coagulation had a four to six week waiting list. We received information that referrals for eye casualty were being transferred to another trust. Audiology had waits of up to ten weeks for hearing aids. Some patients told us they had nearly a year wait for their appointment. The plan was to have all over 18 weeks completed by June 2015 by putting on an extra 200 clinics a month and additional booking staff and coordinators were expected post April 2015 on fixed term contracts to deal with the additional bookings that would be required post validation.
- Staff were measuring patients seen within nine weeks from referral for their first appointment until they could report on RTT. The last performance reported showed 71.7% of patients were seen within nine weeks for their first appointment which was consistent for the last few months. However there were concerns regarding follow up appointments with clinicians telling us these seemed to be very delayed and figures showed waits for follow ups were much worse than first time appointments.
- Waiting time performance was worse than the national average. 43% of patients wait more than 30 minutes to see a clinician but upper quartile and highest patient waits had only just started to be recorded. These were audited by checking the planned start time with the actual start time and the first appointment called in.
- Overrunning clinics were care of the elderly, pain, ophthalmology and urology due to overbookings and sheer patient volumes. We found overrunning clinics in most areas with ophthalmology and orthopaedic delays averaging 30 minutes and urology had delays of up to 90 minutes. We were told this was due to clinicians often being called away to emergencies.
- Doctors told us overbookings were a major problem as they constantly had multiple patients booked into the same time slot although nurses told us this was slowly improving. This meant waiting times increased and doctors were overstretched to meet the amount of patients. Clinical staff said there was an overall lack of clinic capacity.
- Follow up appointments could not always be booked in advance as the computer system would show no available slots so additional slots had to be approved by service managers.. This sometimes meant clinics were arranged at the last minute and patients were called to come in the same day to fill the clinic. Particular problems for this were in ENT. This was particularly leading to some patients waiting two to three weeks to have sutures, packs and splints removed causing infections.

# Outpatients and diagnostic imaging

- Two week wait for cancer had recently become in line with the national average after a long period being worse than the national average at 95.7%. 31 day waits for cancer were consistently worse than the national average though was improving to 87.3%. 62 day wait for cancer had been worse than the national average but were recently just better than the national average at just under 85%. Histopathology were 100% compliant with seeing cancer patients in seven and twenty day waits but at 80% for ten day waits where there was a large section.
- Call answering times in the call centre averaged at 42 seconds and 3.1% of calls were abandoned to the call centre. These had been consistently improving. The answer rate was 78.7% which was improving as it had been 42% This had been partly achieved by separating the staff that booked the appointments on the system from the staff that answered the calls. In addition, staff were flexed so that more staff answered calls at busier periods such as mornings and lunchtimes. However patients told us they were still experiencing some problems calling in despite calling at various times and reception staff said they still received calls directly from patients trying to book appointments.
- 661 patient appointment hospital changes occurred in December 2014. This was fairly consistent though had been over 2500 in April 2014. 10,552 patients had been affected by clinic changes in January and February 2015.
- Time from cancellation to first appointment was averaging at eight days and had been decreasing.
- For follow up appointments it was 57 days and this was increasing. The longest wait was 152 days.
- Three per cent of patients were referred to another clinician which had been steadily decreasing over the last six months.
- 50.92% of choose and book referrals were reviewed within the 72 hour target and this rate had been fairly steady over the last six months.
- CT scanning performance was poor with 26% of reports done within two weeks in January 2015 for oncology. For GP referrals, 18% of CTs were done in two weeks from referral and 43% were reported within three weeks. For MRI it was 14% and 21% respectively. Results were much better for A&E and inpatients though still low in most instances such as 31% of MRIs within 24 hours, and 25% within 4 hours, We were told part of the problem was the CT scanner was not located in A&E, an increase in workload by around 50% in five years, a broken scanner CT scanner which was being added to with currently a mobile scanner and a lack of reporting radiologists. Staff said the backlog had been escalated and some radiographers had been signed off to help reporting. However oncology said they were able to get CT scans the same day or very quickly and it was not often a problem plus there were no over six week breaches.
- X-ray performance was much better although medical staff told us reporting of x-rays for outpatients was not routine so consultants were having to keep paper lists of x-rays they had requested to ensure they reviewed the x-rays themselves. 75% of MRIs were done in 2 weeks and 84% of ultrasound MRIs. However, if the x-ray machine failed in A&E, patients had to go to the main radiology department for a scan. MR scans reported within three to four weeks. CT reporting was due within two to three weeks after scans.
- Ultrasound waits for outpatients were six to eight weeks when they had been four. We were told this was due to being short staffed with no manager and down a sonographer and an increasing workload.
- The respiratory physiology cancer service were not meeting the 62 day target as they were at 69% when they should be 81% but no appointments where waits were over 90 days. Their overall workload had increased in recent months. They were meeting their two week wait target by putting on four extra clinics a week including Saturdays. However they only had one room available two days a week which was leading to a five to six week delay.
- There were 37,000 chest x-rays outstanding from last year, 23,000 A&E urgent ones. The reporting rate had been declining from 94% in November 2014 to 64% in January 2015. They estimated 15 to 20% were unreported although it was estimated at 80% unreported last year. To deal with the backlog, two radiographers were now reporting.
- Hot reporting (report at same time at the patient's attendance) was in place in most x-rays other than chest and abdomens. The trust planned to train more radiologists to hot report and a business case for this had been agreed.
- The radiology service was not responsive to patient's needs. Doctors had to complete paper requests and spend time finding radiology staff to fulfil the requests.

# Outpatients and diagnostic imaging

- There was a lack of space and infrastructure in radiology. Radiologists were required to share desks and computers which meant there was sometimes no time to report. Radiology systems were different to outpatients and they did not interface fully. This meant most information on the computer system was not available in radiology.
- Pathology were meeting their one hour turn around time as their system showed when a specimen was due to breach the target so they could prioritise them.
- We received concerns that at night, the medical registrar on call in the A&E had to physically attend radiology to pass a CT referral which left the A&E without them on site. It was not clear from the referral guidelines whether this was agreed practice
- There were some concerns about communication between nursing staff and clinic preparation in one clinic area as notes were brought from clinic preparation to a holding room which was staffed by a member of reception in two hour shifts. This meant there was no direct communication between the nursing staff and clinic preparation so it was not always clear what patient records were ready. However, in other clinics, patient notes went straight from clinic preparation to the clinic they were due at. There was a plan to remove the holding area and make it a sub-waiting area.
- There was an outpatients discharge lounge where patients waiting for transport could wait. This had 90 to 130 patients a day and the average wait was 30 minutes.

**Meeting people's individual needs**

- A learning disability nurse was available and hospital passports were in operation for those patients that required additional support. Easy read information was available. Staff had training regarding learning disabilities as part of their mandatory training. A learning disability audit had recently been completed and each clinic area was due to appoint a nursing representative to attend a monthly meeting on learning disabilities. However we did not observe any of this in use as we did not identify any patients with learning disabilities on our inspection.
- A flag for patients that required additional support was on the system. However most reception staff were unaware of this and told us they would only be able to identify someone who required additional support if they had a carer.
- There was no fast-track system in place for vulnerable adults to be seen quickly in phlebotomy. We were told patients and their carers would need to approach the main desk to be fast-tracked, but this was inside the phlebotomy room, past the waiting area and the ticket dispenser and this policy was not highlighted in any way. In addition, none of the appointments in phlebotomy were able to be booked unless you were under three years old. Patients were required to go to another trust site for booked phlebotomy appointments.
- A fast-track system for vulnerable patients was in place in radiotherapy as flags were placed on their file at their initial appointment. Patients were then booked in appropriately depending on their needs such as time preference and if additional support was required.
- Patients waited a long time to get their medicines. medicines picked up at the hospital pharmacy were not timely as patients were often waiting over the target time of an hour to receive their medicines.
- A separate parking area for oncology patients was available and free. Car parking was made free if any outpatient clinic overran other than phlebotomy.
- Interpreters were available when patients required them including sign language and language line could be used if necessary. Staff were aware of how to book these.
- Oncology patients had an information pack that linked them to support groups and the network within the hospital if they needed any advice or information, where staff were on hand to answer questions over the phone.
- There were no bariatric facilities in outpatients such as wide seating or more accessible consulting rooms. The corridors and some of the door frames would not fit a wheelchair for clinically obese patients through them.
- A new outpatient's leaflet was being drafted which gave appropriate information about the service. However, there was no translation or easy read version at the time of our inspection
- Escorted discharge and care navigation were available to patients where patients could receive an at home assessment and provide initial support on discharge plus advise on helping manage a patient's own health.

**Learning from complaints and concerns**

- There had been 19 PALs enquiries and four formal complaints regarding outpatients between November

2014 and February 2015 relating to attitude of staff, patients being discharged, cancelling of appointments, delayed test results, delayed follow up appointments and incorrect clinic or consultant bookings.

- We reviewed five complaints responses and action plans. Although the response letters addressed the concerns of the complainant in an understandable way and included a summary explanation of actions to take place, the action plan documents were either not complete or did not have actions that would address the concerns raised and staff did not give any examples of a change or learning after a complaint.
- Complaints information was readily available. It was displayed on posters and leaflets were available in each clinic area.
- Complaints were not always linked with incidents when appropriate.
- Complaints were discussed with the specific individual, nursing team, clinical governance team, and management and were part of the agenda of department clinical governance meetings.
- In outpatients, most complaints were resolved informally.
- Most complaints in phlebotomy were patients who were fasting and waits in the morning. Complaints in anticoagulation included lack of space, lack of privacy and long wait delays. Most complaints in oncology and haematology was long waits.
- Patients we spoke with that had used the complaint process gave a good experience of it with appropriate responses in a timely manner.
- There had only been three complaints in GUM which related to staff attitude, incorrect website information and referral pathways. We saw evidence that all these had been learnt from and addressed.

## Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was inconsistencies in leadership of the services. Most of the operational leadership had visions and strategies, governance arrangements, performance monitoring and staff involvement with executive support that was visible. There was varying clinical leadership depending on the speciality with positive feedback in radiotherapy but particular issues in radiology. Risk management varied between specialties. Innovation was taking place but the pace the outpatient services were operating was not sustainable.

### Vision and strategy for this service

- The vision and strategy for outpatients focused on improvements to performance such as 18 week waits, DNAs, waits for appointments, data quality, patient note availability and hospital clinic cancellations. Most staff were aware of this vision and the strategies to achieve it and bought into the improvements being made and planned. This was due to a leadership understanding that in June 2014, the service was dysfunctional with lots of workarounds and a disenfranchised workforce.
- There was a plan to increase the hours of the phlebotomy service to include Saturdays as there was a decreasing amount of phlebotomy in other healthcare settings. They were also looking at increasing hours and centres in the community. However, they were aware additional hours may not be funded so a demand and capacity review was being undertaken to see if they could better utilise their staffing numbers across all the sites.
- Respiratory physiology had a vision to develop a local anaesthetic medical thorascopy.
- Pathology were due to centralise to the Queen's site and staff were aware of this.
- Radiotherapy had a vision to upgrade their current equipment to the latest versions.

### Governance, risk management and quality measurement

- There was an outpatient improvement plan which included developing a standard operating procedure (SOP) for scheduling template rules, develop process for updating Directory of Services, develop process to decrease DNAs and unnecessary appointments, optimise Medway functions, recruitment of appointments coordinator and C&B team, consolidate call centre and clinic prep staff, improve admin and customer service arrangements, improve sexual health clinic environment, rebuild appointment slots so patients not booked in same time slots, improve referrals process, improve information to oversee OPD, improve toilets, provide hot food, reduce surgery cancellations, and dedicated contact number post op. Only hot food and sexual health clinic had been

delivered as of November. Risks included communication between OPD and recruitment, information on Medway, actioning executive walk rounds, funding work stream, align resources to deliver milestones, and staffing.

- There was a cross trust improvement plan that also monitored outpatients on a monthly basis. Progress in December included work stream workshops, call centre answer rates improvement, Medway training, pilot Medway outcome form and electronic triage for Ophthalmology. KPIs were call centre answer rates, referral to another clinician, DNAs for new appointments, patients seen in less than 9 weeks, and patients with hospital change. A bulletin on this highlighted the progress plus a clinic cleaning programme, electronic referral triage for ophthalmology C&B, clinic outcome form for haematology and oncology, and standardisation of clinics. Next steps included review of issuing OPD letters, single contact number for call centre, standardised OPD uniforms, continuing clean of clinics, review DNAs, finish Directory of Services, shortlist GP liaison and continue refurbishment.
- There was a deep dive presentation into outpatients in an improvement plan oversight meeting. Solutions to concerns started by listening to patients and staff via various methods. Issues raised by patients included car parking, décor, cancelled clinics, contacting the call centre, missing notes, queues, not receiving letters and incorrect information. This showed there was a low recording rate by clinicians of when they arrived at clinic, when clinic started and when it ended. The plan was for clinic preparation to be three days in advance and this meant short notice cancellations had reduced by 87%. There was an identification that triaging of all GP referrals was not occurring leading to inappropriate appointment bookings. Using language line and interpreters. 16 of 43 milestones had been achieved by November 2014 of which 5 had been missed.
- There was an outpatients improvement plan risks and issues log. The plan included achieving the right work stream membership, staffing capacity, current updating of system, breaching 18 week RTT, restriction controls, communications with recruitment, actions from executive walk rounds, quality of information from, staff engagement to improvements and review of Directory of Services. Mitigations were in place including additional recruitment, networking with GPs, ICT updates, training in RTT processes, and communication between different staff members.
- Performance metrics including those from the improvement plan included number of patient hospital changes, DNA rates for follow up and first appointments, first appointments seen within nine weeks, percentage of patients seen by another clinician, choose and book referrals reviewed within 72 hours, time from cancellation to new and follow up appointments, percentage of patients receiving letters, urgent cases scheduled in three weeks, and refresher training on Medway. Actions taken included policies and procedures for case note tracking, and create outpatient user group meetings.
- Board minutes from February 2015 showed some progress on the workstream 'right appointment at right clinic' but identified there was still a lot of work to do. They reviewed start times, call centre, case notes, RTT, cancer waits, and capacity planning. Start times were being reviewed but there was work still to do. Call centre improved. Review of systems for letters and case notes.
- PTL was reviewed weekly which covered each speciality for both admitted and non-admitted. More focus on was admitted as all the patients on the backlog had been verified whereas focus on non-admitted was more on verification.
- There was appropriate leadership attendance at quality assurance meetings with the improvement manager and matron attending quality and risk committees.
- The risk register for support services was either out of date or not monitored and actioned appropriately. Most risks were from 2008 and were last reviewed in December 2013.
- The risks did identify many of the issues we identified during the inspection such as tracking of notes, clinic cancellations, loose patient records, and flooding, The outpatients risk register included three items, physical space in the cancer area, equipment in polyclinics and overcrowded waiting areas. There were no risks on either of these registers regarding RTT, DNA, radiology incidents, or waiting times.
- Radiology had a monthly dashboard which monitored each services activity, diagnostic targets performance, staffing levels, complaints and SIs.

- Service manager meetings took place in outpatients twice a month which reviewed staffing, operational issues and complaints.
- The monthly pathology directorate meeting minutes reviewed any operational changes, risks, staffing, finance, IT, audits, incidents, national guidance, performance, patient experience information such as complaints, and workforce information such as sickness. It was stated that there were over 250 risks in pathology. There had also been a review and audit of the phlebotomy service which found the environment appropriate but understaffed although later minutes showed staffing was appropriate to move to seven day working. This was contrary to our findings.
- Radiology directorate held meetings monthly. These discussed finance, and performance, with a high amount of continuing and any other business that involved staffing, equipment, and audits. There was an understanding and escalation of the equipment issues but the cultural and staffing issues we found had not been highlighted.
- Clinical governance meetings involving radiotherapy took place monthly where mortality and morbidities, risk registers and incidents were reviewed. Directorate meetings also took place for operational issues.
- The radiation protection group sat twice in 2014. There was no specific agenda but items discussed included IRMER training, referrals, risk assessments, emergency planning, procedures, radiation doses, incidents, policies, equipment and audits.

**Leadership of service**

- There was a mostly positive response to leadership within outpatients although there were examples of staff in specific areas feeling that leadership was not visible. When we spoke with the matrons, they covered a wide area where they were required at both sites of the trust plus polyclinics in the community. We were concerned about the leadership and governance of the phlebotomy service. There was no or little awareness of the problems we uncovered in the service. It had changed leadership teams on a number of occasions and some staff were still unsure if pathology was the right area for it to sit considering they felt it was more a nursing than a laboratory service.
- Staff were overwhelmingly positive about leadership in radiotherapy.
- Staff across the services said the executive leadership was visible; particularly the chief executive and the executive lead for outpatients and that they were supportive of any concerns raised.

**Culture within the service**

- Most staff we spoke with gave positive feedback about the culture in their area and within outpatients, pathology and radiotherapy with a low turnover of staff. Radiotherapy was awarded the trust team of the year in 2014. Although we received some comments from administration staff and the anticoagulation and DVT service that they did not feel valued or consulted on changes, most were positive about the team working within the departments.
- There was improving teamwork and communication between medical and nursing staff. Nurses told us medical staff were starting to be more responsive to concerns such as waiting times. However some medical staff felt the service was too operationally led and focused too much on targets rather than patient care.
- We received very poor feedback from radiology regarding the culture in the service with examples of consultants fighting and a lack of team working. Radiologists reported not feeling concerns were listened to and they were not supported as a workforce. Staff felt overworked and that job plans did not reflect the work they were undertaking in both skill and volume. Turnover in radiology was 7.7% and sickness was 3.7%.
- Sickness was high in phlebotomy and three staff had left in the last few months. Sickness was also high in anticoagulation where staff told us they were working extra hours which was causing stress.
- Instant recognition awards were in place for staff called 'Terrific tickets' which gave staff a free drink but none of the staff we spoke with told us they had received one.
- Staff had an awareness of the trust ‘PRIDE’ values although this was displayed in most areas of the hospital. Some staff had been on a PRIDE course.

**Public and staff engagement**

- There was a 5% response rate to the outpatients FFT although this was still at pilot stage. Quality audits were being undertaken which included getting views from patients and these were captured across all the clinics over a three to four month window.
- All the staff we spoke with felt engaged both within the department and within the trust and were aware of the

various changes and improvements being pursued in their areas. Outpatient nurses had a daily huddle each morning where nurses would pick up their clinic for the day and discuss any issues or concerns or changes. Monthly meetings took place for administrative staff. Radiotherapy had weekly staff groups and monthly meetings where incidents were discussed with team briefs every two weeks.

- There was an improving patient experience group (IPEG) patient experience which included volunteers.
- Most staff complained about the IT system. They told us it was slow and often froze or crashed. We were told a new set of computers with bigger capacity and a better set of servers was due in the next few weeks to improve things and staff told us IT were quick to fix problems.

**Innovation, improvement and sustainability**

- Short term solutions had been identified to improve the outpatient experience. This included ensuring call traffic went to the call centre rather than secretaries, training in Medway, and linking appointments. Other improvements identified were relocating the sexual health clinic, ensuring any moves are fully quality assessed, reprofile clinic templates to ensure right appointments at right times, review of the directory of services to ensure correct patients seen in correct clinics, revise the patient access policy, create a system for the review of choose and book referrals, have vacant clinics for patient rebooking's, recording of time patient seen, weekly performance data collection and monitoring, clear responsibilities for performance, meet the manager sessions every six weeks, two weekly senior management visits, outpatient surveys at consultant level, monthly survey of clinicians, have an outpatient coordinator, floor walkers for booking system issues, review printing workflows, training on tracker systems for medical records, rota for call handlers, text messages for appointments, improved toilet facilities, and provide cold food. Around half of these were not complete by September 2014.
- We received the outpatients improvement plan dated 25 September 2014 which was reviewed every two weeks. It was still a red risk, mainly due to booking of patient slots, and managing of the referral process. Clinics were due to be reprofiled by September 2014 but this target had been missed. Directory of Services was due to be reviewed by the same date but had also been missed. Clinics were due to be left vacant for appointment bookings by August 2014 using firebreak clinics but only a few consultants had started using these. FFT survey was due to be implemented by September 2014 and to get a score of at least 50% but piloting was still small. Time to answer calls was due to be less than a minute though no target date was set but this had been achieved. Call abandonment rate was due to be less than 10% but no target date was set although this had been achieved. Patients were due to be seen within 15 minutes of arrival but no target date had been set and current audits could not clarify if this was being met. No medical records should have been missing but no target date was set and this had not been met.
- Outpatients had a project plan to improve four areas of scope – 'right information and right decision' (which was to improve tracking of notes, structure of notes, reduce temporary notes, have fully prepared clinics, update directory of services, and improve choose and book triage), 'right patient, right doctor and seen on time' (which was to improve Medway use, reprofile clinics, reduce repeat cancellations, rebuild appointment slots, capacity plan, use partial booking, and performance review OPD) , 'communications' (improved call centre, letters are accurate, patient and staff feedback, and improved customer service standards), and 'clinical experience' (better information leaflets, better patient and staff boards, and patient pagers) . All were due to be delivered by the end of February 2015 at the latest.
- We were concerned about the sustainability of the current performance in reducing some of the backlog of appointments. We received feedback from service managers and doctors they were working at full capacity with evening and weekend clinics as well as full theatre lists. Staff in respiratory physiology cancer said they needed to continue with the extra clinics they were putting on just to keep up with demand. Leads knew they had overspent their budget with overtime spending which they expected to continue for at least the next six months due to having to arrange an additional 400 clinics.
- Pagers were being trialled, firstly in orthopaedics, then ophthalmology, for patients to take with them if there was over 30 minute delay or if a patient was visually or hearing impaired so they could leave the waiting area if they so wished. These were due to be rolled out across the clinics. However, although they were ready to be used, we saw none being used despite long waits in ophthalmology.

# Outpatients and diagnostic imaging

- Radiotherapy had a 3D training simulator for new staff to train to use the linac machines and for new patients to gain an understanding of how their treatment would be conducted. However they planned to introduce an ultrasound as currently patients had to attend radiology for these scans if they needed one. They also planned to introduce tablets.
- Capacity modelling for 2014/15 had been conducted for each speciality which included adding capacity to remove the estimated backlog for each service. The expectancy for each service was an increase in referrals and need for follow up appointments with some services expecting up to a 20% increase. However, we were not given any information on how this demand would be met.

# Outstanding practice and areas for improvement

## Outstanding practice

- The values of the trust - passion, responsibility, innovative, drive and empowerment (PRIDE) were well known and embedded in the culture of the people working at the trust.
- The new executive team were visible and engaged.
- There was lots of involvement from the local community and voluntary organisations. The foyers had lots of people giving information for patients and visitors about services in the local area. For example dementia care, stop smoking and healthy eating.
- Radiotherapy was one of the top five units in the country.
- The genitourinary medicine (GUM) clinic had an excellent service with appropriate protocols and processes and support for patients.
- There had been a number of initiatives to provide a responsive service for general surgery patients. The surgical assessment unit provided a timely service in emergencies and the 'hot clinic' reduced delays for patients.
- The hospital was a regional centre for upper gastro-intestinal conditions. Outcomes for patients receiving oesophago-gastric cancer services were good.
- There were good outcomes for stroke patients and the stroke service demonstrated good team work.
- Play specialists had developed a way to distract children awaiting MRI scans which involved joining other children and families on a 'train journey' from the outpatient's clinic down through the hospital corridors, using storytelling and positive reinforcement on the way. This had proved a good distraction for children and reduced their anxiety. We walked with one child and found them to be very engaged in the trail.
- Consultant paediatricians undertook short notice or 'HOT clinics', whereby GPs could make a consultant to consultant referral reach a joint decision on action including if needed early assessment. GP's reported positively to their commissioners on the success of this system.
- The consultant led critical care outreach team's seven day service had improved the outcome for patients through appropriate identification of deterioration and appropriate escalation.
- The critical care outreach team provided a 'critical care follow up outpatient clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their discharge.
- Neuro-intensive therapy unit encouraged diaries for patients who were staying for longer periods of time in the unit. Patient's families kept a record of daily activities such as visits, progress and treatments, items of news and the weather. A free newspaper was offered to patients in general critical care to help orientate them.
- The development of the Elders Receiving Unit had improved frail, elderly patient care.
- A dedicated team to support patients living with dementia . Wards could book a dementia trained health care assistant to support one or more patients in a bay on the ward. We were told this was, "A huge improvement" as they were dementia trained. Previously this role was done by a different bank nurse every day.
- The nurse led oral chemotherapy service was the first in the country.
- The hospital performed well in the National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme carried out in 2014.
- The end of life care service was patient focussed and end of life care needs was well understood by the majority of staff from all staff groups.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- Clear governance with integrated systems and processes to support staff to provide care and treatment safely.
- Serious incidents must be understood, investigated and lessons are learned promptly.
- Review systems for sharing good practice across the divisions and trust wide.
- Ensure compliance with all national guidelines and trust policies for medicines management.
- Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
- The IT systems are up to date and the IT strategy is implemented and supports clinical staff to carry out their duties.
- All services for neonates, children and young people are responsive to their needs.
- Ensure the radiology is fit for purpose and fulfils its reporting timescales, particularly for CT scans.
- Staffing levels are continued to be reviewed and acted on at all times of the day.
- Include a dietician as part of the critical care multidisciplinary team in line with the core standards for intensive care guidance.
- Comply with the Duty of Candour legislation.
- Comply with infection control code of practice in respect of hand hygiene audits, training and monitored improvement.
- Ensure locum and agency staff are competent and implement a formal induction process for all locum and agency staff in the relevant areas they care for patients.
- Ensure processes are in place for locum and agency staff in respect of accessing and using IT systems required for their role.
- Ensure patient risk assessments are acted upon.
- Review the general medicine on-call rota to ensure it meets the needs of patients.
- Meet the Emergency Care standards in the Elder's Receiving Unit.
- Audit and monitor the patient outcomes from the trust discharge strategies.
- Comply with the National Dementia Strategy.

### Action the hospital SHOULD take to improve

- Consider increasing the target rates for mandatory training.
- The effectiveness of the rota co-ordination for junior doctors
- Review the accessibility of the radiology services and consider a duty radiographer structure.
- Review the service level agreement for accessing therapies to ensure it meets patients needs promptly.
- Continue to improve patient record availability at outpatient clinics.
- The culture of staff within radiology and the anti-coagulation to ensure they feel part of the organisation.
- Review the environment in outpatients to improve the waiting and reception areas.
- Review the environment and the staffing levels of the day-care surgery unit.
- Review nurse staffing levels and skill mix on surgical wards, particularly out-of-hours.
- Review the availability and presence of consultant obstetricians and speciality registrar level doctors so that labour ward cover is in line with local and national recommendations.
- Consider an increase in establishment in the dementia team and the pain team.
- Review the audit programme in surgery so that internal audits are completed and implemented.
- Consider ways to increase multidisciplinary team working within critical care.
- Consider ways to make the overnight accommodation for visitor to patients in general intensive care less austere.
- Consider ways to engage patients in providing feedback specifically related to critical care services.
- Continue to increase the availability of medical records.
- Monitor the impact on patients from the reduction in Coronary Care Unit beds.

# Outstanding practice and areas for improvement

- Review the processes for medicines to take away on discharge.
- Consider undertaking a needs analysis in respect of those whose first language is not English.
- Improve engagement between junior doctors and management.