

Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Quality Report

Stadium Road
London
SE18 4QH
Tel: 0208836 6000

Website:
<https://www.lewishamandgreenwich.nhs.uk/>

Date of inspection visit: 7 - 10 March 2017
Date of publication: 17/08/2017

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 (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Requires improvement



End of life care

Inadequate



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook an announced inspection at the Queen Elizabeth Hospital as part of a planned comprehensive inspection of Lewisham and Greenwich NHS Trust from 7-10 March 2017.

Queen Elizabeth Hospital (QEH) is part of Lewisham and Greenwich NHS Trust. The trust was formed in October 2013 by the merger of Lewisham Healthcare Trust and the Queen Elizabeth Hospital Greenwich (following the dissolution of the South London Healthcare Trust by the Trust Special Administrator). The trust provides acute and community services for more than 526,000 people living in the boroughs of Lewisham, Greenwich and Bexley.

In February 2014 QEH had a planned inspection using our new comprehensive methodology and was rated overall as requires improvement.

Due to CQC receiving increased number of complaints and concerns being reported by patients, relatives and staff, we undertook a further inspection of the emergency department and medical services at the Queen Elizabeth Hospital in June 2016. We rated both services as requires improvement.

This most recent inspection was carried out to determine whether the hospital had made progress following their 2014 comprehensive inspection and 2016 focussed inspection.

We rated Queen Elizabeth Hospital as requires improvement overall. Initially some progress was made following the inspection in 2014, but since then the trust has found it hard to sustain any further improvements.

We rated safe, effective, caring, responsive and well-led as requires improvement.

Maternity and gynaecology and outpatients and diagnostic imaging services were rated as good.

Five services, urgent and emergency services, medical care, surgery, critical care and services for children and young people were rated as requires improvement and end of life care was rated as inadequate.

Our key findings were as follows:

- The hospital had systems for reporting incidents, but we found learning from incidents was variable and not fully embedded across all services.
- Medical and nursing staffing levels were not always in line with national guidance. There was a shortage of consultants on the critical care unit and in services for children and young people.
- Completion rates for mandatory training for both nursing and medical staff did not always meet the trust standard.
- In some services we observed non-compliance with infection prevention and control practices, hand hygiene, and the environment some patients were cared in had limited space and potentially compromised their safety.
- Medical patients who were cared for in surgical wards were not always reviewed by the medical team. Staff described significant difficulties in reaching the medical team responsible for these patients.
- The majority of the services we inspected were providing effective care. However, surgery was rated requires improvement and end of life care was rated inadequate.
- The hospital performed worse than the England average in some of the national surgical audits.
- The uptake of appraisals was variable and in surgery the uptake was low.
- We found many good examples of multidisciplinary working, but there were also poor interactions between some teams.

Summary of findings

- The majority of the services we inspected carried out audits, but in end of life care we found limited audit activity or benchmarking to assess the effectiveness of the service. The end of life care pathway was also inconsistently applied.
- In the majority of services we inspected we found staff were caring and compassionate. However, in medicine and end of life care we found that staff did not always demonstrate a caring approach to patients and did not always maintain patients' privacy and dignity. Feedback from patients in these services was variable.
- Patients described staff as 'friendly', 'helpful' and 'attentive', but patients on some medical wards described staff as 'rude' and 'abrupt' and said they experienced long waits for staff to respond to their call bells.
- In the majority of services patients were involved in discussions about their care and treatment. In medical care some patients told us they were not always provided with information or told why for example their medicines had been changed.
- Patients were not always treated in a timely manner and within national access standards.
- Some patients experienced long waits in the emergency department, had their surgery cancelled and were delayed in being discharged from critical care due to a lack of available beds.
- The hospital had a high 'did not attend' (DNA) rate for outpatient appointments, higher than the England average. It was also not meeting the operational standard of 93% for people being seen within two weeks of an urgent GP referral for suspected cancer.
- There were not always sufficient staff to meet the individual needs of patients, for example those requiring one to one support.
- Mixed sex breaches sometimes occurred in critical care and surgery and the location of the gynaecology clinics and early pregnancy unit was not sensitive to the needs of some women.
- Complaints were not always responded to within the agreed timescales. Additionally, oversight of agreed actions resulting from complaint investigations was limited.
- All of the services we inspected had systems to monitor the quality and safety of the care they provided, but we found they were not always effective or proactive. In some services there was low attendance at some of the meetings, sometimes due to insufficient staff.
- Services had risk registers, but not all of the risks identified during the inspection were recorded on the registers and some risks, critical care and services for children and young people, had been on the register for up to three years without any action being taken. We also found a lack of ownership of the registers in some services with no evidence that risks were regularly reviewed.
- Some staff did not feel involved in discussions or plans for their service and we received variable feedback on how well the hospital engaged with staff, the working culture and morale.
- Cross site working was happening to different degrees in each service, but was still at a relatively early stage.

However:

- Many staff we spoke with had attended safeguarding training for children and adults and knew the action to take if they suspected abuse.
- Emergency equipment, including resuscitation trolleys, were maintained and we saw evidence of regular safety checks.

Summary of findings

- We also found care and treatment was informed by evidence based guidance and staff could access guidelines via the intranet. .
- Nutritional risk and screening tools were used to assess and monitor patients' nutritional needs. Nursing staff had worked with the catering team to provide more flexible mealtime options for patients with dementia or reduced appetites. In maternity mothers received one to one and group support with breast feeding.
- Staff had a good understanding of consent process and recognised when the best interests of the patients had to be considered. Staff obtained consent from children and young people and parents involving both the child and the person with parental responsibility in obtaining consent where appropriate.
- Maternity service had a range of expertise and specialist support available for all women.
- Some progress had been made in meeting the needs of patients living with dementia including increased activities, improvements to the environment and the introduction of a team volunteers who were being trained in working with people with dementia, which included providing enhanced care.
- Translation services were available and a multi-faith spiritual team was available to provide support within the hospital.
- Staff were positive about the local managers and felt they were approachable and supportive.
- Staff told us there was an open culture and they felt able to report concerns.

We saw several areas of outstanding practice including:

- The uniquely designed door handles that had been installed on the doors to the neonatal and oncology units demonstrated the service was focused on reducing the risk of infections.
- Tiger ward had provided additional support to families and patients by introducing an informal coffee morning open to all patients on their case load and not just receiving treatment.
- The speech and language therapy manager had implemented a risk feeding protocol following a successful research pilot project. This resulted in demonstrable outcomes for patients, including a 10% reduction in the admission of patients with dysphagia through more effective feeding regimes. As part of the project new guidance was issued for patients and staff and a risk feeding register was implemented to help the multidisciplinary team track patients cared for under the new protocol.
- Staff in the Trafalgar Clinic provided care and treatment for patients in a nearby prison. Each patient's records were maintained on the service's electronic patient record system. This meant when a patient left the prison service, there was no disruption in care or treatment because clinical staff always had access to this. In addition, if the patient moved out of the area, the electronic records could easily be shared with pharmacists and health workers in the offender resettlement programme. This meant patients received continual care and were at reduced risk of developing health problems associated with an interruption to antiretroviral therapy.
- In the two years prior to our inspection, sexual health and HIV services recruited up to 50% of the participants for the trust's whole clinical trial and research portfolio. This resulted from a policy of proactive and early-adoption participation that was part of a two-year strategy to improve participation in research in other hospital departments and services.
- In critical care there was a dynamic programme of research and development enabled by the full time appointment of a research nurse working with doctors including consultants. Examples of research studies completed in the past year included a study exploring the relationship between family satisfaction and patient length of stay, and a pilot study looking at the improved physiotherapy outcome measure by the use of cycle ergometry in critical care patients. The trust recognised only a small sample size was used for each study.

Summary of findings

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

Importantly, the trust must:

- Review and improve the systems for monitoring and improving the quality and safety of care including attendance at key meetings in ED, surgery, critical care, services for children and young people and end of life care.
- It must ensure all risks are included on the risk register and are regularly reviewed and updated and carry out audits to monitor the effectiveness of treatment and care. ED, surgery, critical care, services for children and young people and end of life care.
- Ensure all risk assessments are carried out on patients in critical care.
- Ensure medical and nursing staffing levels are in line with national standards in services for children and young people, ED and end of life care, to provide safe continuity of care for patients.
- In surgery, ensure that patients are cared for in areas that are appropriate to their needs and have sufficient space to accommodate all equipment and does not compromise their safety and staff have the relevant skills and knowledge to care for them.
- The children's service should review the consultant cover provision to ensure it meets national standards and provide more continuity for patients in the neonatal unit.
- Ensure patients requiring end of life care receive appropriate and timely care.

In addition the hospital should:

- Work to share and embed learning from incidents in all services and across sites.
- Ensure staff comply with infection prevention and control policies and procedures.
- Ensure the ED has a separate room for the storage of medicines and medicines are stored safely in all areas.
- Ensure staff working on medical wards and in end of life care have the values and attitude necessary to treat patients, their relatives and visitors with dignity and respect. This includes staff treating them in a caring and compassionate way at all times.
- Ensure medical patients are appropriately reviewed when they are cared for on other wards and that all staff know who is responsible for them and they are contactable.
- Ensure that in surgery patient records are stored and held securely in one document.
- Ensure all patient records are complete and accurate including risk assessments.
- Ensure all patients have their pain assessed and receive analgesia in a timely manner
- Improve compliance with mandatory training completion rates for modules that are below the trust target in all staff groups.
- In critical care consider ways to introduce multidisciplinary meetings and ward rounds to review care and treatment of patients.
- Ensure there are ongoing arrangements for measuring and reporting patient satisfaction in critical care.
- Review the arrangements for bereavement services.
- In critical care, ensure formal arrangements for emotional and psychological support of patients and families including access to clinical psychologists are in place.

Summary of findings

- Review and update the operational policy for the critical care outreach team and ensure sufficient staff are deployed every day to provide an effective service.
- Review the environment and waiting times for women using the gynaecology service.
- Develop outcomes for gynaecology.
- Ensure staff working in HIV, GUM and sexual health services are informed and involved in any future plans for the service.
- Review the provision of care on Hippo Ward to ensure it is adequately staffed and is open long enough to support patient flow.
- Review the level of cover currently provided by play specialists to make sure that children are supported appropriately.
- In services for children and young people, encourage attendance at quality and safety board meetings so that information can be shared and discussed effectively.
- Complete two year follow ups of babies admitted to the neonatal unit as part of the national audit.
- Ensure patients who are at the end of their life, and their relatives, are ensured privacy.
- Improve cross site working in all services.
- Work to reduce the number of cancelled operations and improve referral to treatment times and reduce the 'did not attend' (DNA) rate for outpatient appointments.
- Continue to recruit to medical and nursing vacancies in outpatients and diagnostic imaging
- Respond to complaints within agreed timescales.
- Improve communication and working relationships between different staff groups.
- Provide sufficient staff to care for patients who need one to one care.
- Identify ways to empower and support staff to make improvements and take the lead in decisions and improvements in their services.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We rated urgent and emergency services requires improvement because the problems we found in previous inspections still existed. There were long waiting times for some patients to be seen by a doctor and for a bed once a decision to admit them had been made. The environment was sometimes very crowded and patients had to be cared for in public corridors albeit with screens around them. However, we also found staff provided kind, compassionate care and involved patients in discussions about their care and treatment. The majority of patients we spoke with were positive about the care they had received and described the staff as 'kind' and 'professional'. Both nurses and medical staff told us their received support from senior nurses and doctors and had opportunities for training and development. They were encouraged to raise concerns and staff we spoke with told us they were happy to work in the department.

Medical care (including older people's care)

Requires improvement



We rated medical care requires improvement because, although improved, systems for monitoring the quality and safety of care and reducing the risks to patients were not fully embedded. Staff did not consistently demonstrate a caring compassionate approach to patients. Patient dignity was not always maintained and patients were not always involved in discussions about their care. Staff were not always able to respond to patient's individual needs and sometimes found it difficult to obtain additional resources to support patients with complex needs. Many staff told us there had been an improvement in the leadership and most were positive about the local leadership and support they received from their managers. Some therapy staff felt they were not always recognised as key members of the team and were not always treated with respected or valued by other staff caring for patients. Care was informed by national guidance and patients were cared for by competent staff. Patients

Summary of findings

had their pain assessed and received appropriate analgesia. Nutritional assessments were carried out and the speech and language therapists had implemented a new feeding regime which had improved outcomes for patients.

Surgery

Requires improvement



We rated surgery requires improvement because we found many problems that were impacting/ or potentially impacting on the safety and quality of care that patients received.

Reporting and learning from incidents was not happening consistently and staff did not always comply with infection prevention and control policies. Patients were not always cared for in the most appropriate and safe environment and there was little evidence that risk assessments had been carried out and actions put in place to mitigate risks. Some of the risks we identified during the inspection were not reflected on the risk register. The results of some national audits found surgery performed worse than the England average e.g. national hip fracture audit. Some patients had their surgery cancelled on the same day and some prior to admission due to a lack of available beds. The number of patients who had their surgery cancelled and were not treated within 28 days was worse than the England average.

Staff felt supported by their immediate managers, but felt under constant pressure due to increasing demand and a lack of capacity. Staff across different groups and at different levels told us they did not feel they were involved in decisions about their service.

However, we found that despite working in difficult conditions staff strived to provide compassionate care to patients and involve them in decisions about their care. Patients told us they were aware that staff were busy, but said they were 'kind' and 'attentive'.

Critical care

Requires improvement



Critical care was rated requires improvement because we found the long standing problem of insufficient consultants had not been addressed and was having a significant impact on some aspects of the service.

The lack of consultants meant that the service was not meeting national guidance for patient staffing

Summary of findings

ratios, there were no regular meetings where all consultants discussed the care of patients, strategy regarding the bed base, patient caseload, recruitment and standards or guidelines. Although concern about the lack of consultants had been on the risk register since 2016 no action had been taken until an external peer review in 2017 when the trust had started the process to recruit more consultants. Staff were also not carrying out all necessary risk assessments on patients. In addition, the service had occupancy rates that were consistently greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. This could limit the unit's ability to take emergency admissions due to a lack of bed space availability. Flow and delayed discharges were a significant concern for the service and the unit had more non-clinical transfers than comparator units. However, we also found that many aspects of care were effective care and staff were kind and caring and treated patients with dignity and respect. Staff were positive about working on the unit and said the matron was open and approachable. They told us the matron was visible and very supportive.

Maternity and gynaecology

Good



Maternity and gynaecology were rated good because there were systems to monitor and improve the quality and safety of care provided. We saw evidence of reporting and learning from incidents and there were sufficient staff to care for women and their babies. Care was informed by national guidance and outcomes for women using maternity services were monitored. Staff were caring and responsive to the needs of women and had developed a range of services to meet the varied and complex needs of women who used the service. Women told us that staff answered their questions and were 'kind' and 'patient'. Women were able to choose where they gave birth. There was a good cohesive leadership team and which had established effective links with local and regional commissioners of services, local authorities, GPs and patients to coordinate care for women.

Summary of findings

However, the environment for women using gynaecology services was not always appropriate or sensitive to their needs and some women experienced long waiting times.

Services for children and young people

Requires improvement



Services for children and young people were rated requires improvement because of concerns about the number of nursing and medical staff in the neonatal unit (NNU). The service also did not meet national guidance for paediatric consultant cover. The number of play specialists had also been reduced which impacted on their availability to support children.

Children and young people who attended the Hippo unit, and had first attended the urgent care centre, sometimes experienced delays in having their observations carried out. Due to the times the service operated they sometimes had to attend the Emergency Department when it closed which prolonged their time in the hospital.

Since the last inspection in February 2014, there had been some improvement in cross site working and governance processes. However, some of the risks, increased number of cots in the NNU, identified during the inspection were not recorded on the risk register or little or no progress had been made. Medical cover was an example of this and discussions had been taking place for three year little progress had been made.

However, children and young people received effective care and staff were caring and competent to perform their roles and responsive to the individual needs of children.

End of life care

Inadequate



End of life care was rated inadequate. This was because there were insufficient staff to meet the needs of patients. Patients on the end of life care pathway received a variable standard of care, some medical staff were unsure how to initiate the end of life care pathway and there was little evidence of monitoring of the quality and safety of care provided to patients.

Attendance at meetings to monitor the quality of the service was variable and there was little or no action taken in response to problems identified. There was limited information on the wards about how staff could contact the end of life care team.

Summary of findings

We saw some positive caring interactions between ward staff and patients and the mortuary team and bereavement office staff. However, privacy and dignity were sometimes compromised and delayed communication between some hospital teams resulted in delayed or inappropriate care for some patients.

Although some action had been taken since the 2014 inspection we did not see evidence of sustained improvement in the service.

Outpatients and diagnostic imaging

Good



Outpatients and diagnostic imaging were rated as good because patients were receiving safe, effective care and the service was well-led. The service needed to improve how it responded to patients. We found a good culture of reporting incidents and the environment was safe and clean. Equipment had been cleaned and checked. Care and treatment was provided in line with national guidance and regulations. Patients told us staff were kind and said they felt involved in their care with staff providing explanations as needed.

Staff were positive about their immediate managers and said they supported them and they felt valued. Outpatients and diagnostic imaging had developed a five year strategy for improving the service

However, the service was not always meeting national referral to treatment times and the 'Did not attend' (DNA) rate was higher than the England average. Many of the clinics were observed were running late and there was no evidence that this was being monitored.

Queen Elizabeth Hospital

Detailed findings

Services we looked at

Urgent & 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 & Diagnostic Imaging

Detailed findings

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Background to Queen Elizabeth Hospital

Queen Elizabeth Hospital (QEH) is part of Lewisham and Greenwich NHS Trust ('the trust'). The trust was formed in October 2013 by the merger of Lewisham Healthcare Trust and the Queen Elizabeth Hospital Greenwich (following the dissolution of the South London Healthcare Trust by the Trust Special Administrator). The trust provides acute and community services for more than 526,000 people living in the boroughs of Lewisham, Greenwich and Bexley.

The trust serves an area of high deprivation and the health of people in Greenwich is varied compared to the England average. Deprivation is higher than average and about 25% (13,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

QEH is a district general hospital providing a full range of services including emergency department, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care. We inspected all of these services.

The main clinical commissioning groups (CCGs) for QEH are Greenwich CCG and Bexley CCG.

In February 2014 QEH had a planned inspection using our new comprehensive methodology and was rated overall as requires improvement.

Due to CQC receiving increased number of complaints and concerns being reported by patients, relatives and staff, we undertook a further inspection of the emergency department and medical services at the Queen Elizabeth Hospital in June 2016. We rated both services as requires improvement.

This most recent inspection was carried out to determine whether the hospital had made progress following their 2014 comprehensive inspection. We inspected each of the eight core services across QEH:

- Urgent and emergency services
- Medical (including older people's care)
- Surgery
- Critical care
- Maternity and Gynaecology
- Services for children and young people
- End of life care
- Outpatients & Diagnostic Imaging

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Nick Mulholland Care Quality Commission

The team included CQC inspectors, inspection managers, assistant inspectors, pharmacist inspectors, inspection planners and a variety of specialists.

The team of specialists comprised of a consultant in emergency medicine, consultant rheumatologist, general

and vascular surgeon, consultant in neuroanesthesia and critical care, consultant obstetrician, consultant clinical oncologist and a consultant in palliative care medicine. We were also supported by: senior sister for emergency care; general emergency nurse; infection prevention and control lead nurse; assistant chief nurse; major trauma and orthopaedic nurse specialist; theatre manager; intensive care nurse; head of midwifery; paediatric modern matron and paediatric staff nurse. We also had an Expert-by-Experience on the team and they are granted the same authority to enter registered persons' premises as the CQC inspectors.

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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about QEH. These included local clinical commissioning groups (CCGs);

local quality surveillance groups; NHS England; Health Education England (HEE) and Healthwatch

We carried out an announced visit from 7 - 10 March 2017 and unannounced visits were carried out on 12, 20 and 25 March 2017.

Both prior to and during the inspection we undertook a range of focus group meetings with staff from different roles and grades. We also facilitated focus groups with staff from black and ethnic minorities.

Whilst on site we interviewed more than 250 staff, which included senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services. We requested additional documentation in support of information provided where it had not previously been submitted. Additionally, we reviewed information on the trust's intranet and information displayed in various areas of the hospital.

We spoke with approximately 98 patients and relatives and reviewed a wide range of documentation submitted before, during and following the inspection. We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment were assessed.

Facts and data about Queen Elizabeth Hospital

At our last comprehensive inspection in February 2014 we rated the hospital as requires improvement overall. We inspected the same eight core services as this inspection.

Six of the eight core services were rated requires improvement, one service, urgent and emergency services was rated inadequate and maternity and gynaecology were rated good.

Detailed findings

QEH has 521 beds and in December 2016 it had 766 nursing staff WTE in post against an establishment of 949 WTE. It also had 576 WTE other clinical staff in post against an establishment of 537. As at December 2016 the overall vacancy rate, for nurses, at Queen Elizabeth Hospital was lower than at University Hospital Lewisham; 9% compared to 14% though rates for both sites were still below the overall trust rate of 15%. The highest vacancy rates reported at Queen Elizabeth Hospital were 14% within Critical care and 13% in both Outpatients and Surgery. Low rates were reported for Maternity (1%) and Medicine (6%).

In December 2016 the trust had 775 medical staff in post against an establishment of 930. The trust reported a vacancy rate of 11%; A&E and Outpatients reported high vacancy rates of 30% and 22% respectively. Maternity (16%) and Children's service (13%) both reported vacancy rates higher than the trust average. Critical care had the

lowest vacancy rate of 2%. Queen Elizabeth Hospital reported high vacancy rates in A&E (46%) and maternity (22%) while higher than average vacancy rates were reported in Medicine (16%) and Outpatients (16%).

From August 2015 to July 2016 QEH had 92,771 A&E attendances

From July 2015 to June 2016 QEH had 338,572 Outpatient appointments.

From April 2014 to March 2015 QEH had:

- 4,200 births
- 9,501 surgical spells.

Between January 2016 and December 2016 QEH reported one incident which was classified as a Never Event for Surgery. The incident involved an epidural pump that was wrongfully connected to an intravenous cannula surgery. Between December 2015 and November 2016 QEH reported seven serious incidents in maternity and gynaecology and two in medicine.

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at Queen Elizabeth Hospital (QEH) provides a 24-hour, seven days a week service.

Between March 2016 and February 2017, 196,947 patients attended the ED and 43% of these patients (85,147 patients) were seen at the Urgent Care Centre (UCC). The UCC provides treatment for minor injuries, illnesses and non-life threatening conditions. A separate healthcare provider manages the UCC and we did not inspect this unit during our inspection.

The main ED saw 111,800 patients between March 2016 and February 2017 and 22,010 (20%) of these patients were children and young people. Approximately 18% of ED attendances resulted in admission.

The ED consists of 20 major treatment trolleys, a five bedded resuscitation area with a paediatric resuscitation bay; a nine bedded blue area used for rapid assessment treatment (RAT), a green area for ambulatory care consisting of five rooms, and a paediatric emergency unit consisting of eight trolleys and a high dependency unit. The ED also has a clinical decision unit (CDU) consisting of two bays, two side rooms and six blue recliner chairs for patients. Each bay has five beds.

All walk-in patients including children above the age of one were streamed by a UCC nurse who determined if they were suitable for the UCC or needed to go to the main ED. Patients who are sent to the ED were then

triaged by an ED triage nurse to the relevant pathway. Children under the age of one, patients with referrals from their GP and patients undergoing chemotherapy were booked in directly to attend the ED.

We carried out an announced inspection on 7 – 9 March 2017 and then returned to the ED unannounced on Saturday 25 March 2017. We observed care and treatment, looked at 34 patient records, and spoke to 26 members of staff including nurses, doctors, consultants, administrative staff, domestic staff and ambulance crews. We also spoke with 19 patients and nine relatives who were using the service at the time of our inspection.

Urgent and emergency services

Summary of findings

We rated this service as requires improvement because:

- Many of the problems that we found during previous inspections still existed; there were long waiting times in the ED due to lack of available beds in the hospital, rapid assessment and treatment was suspended to accommodate patients who were waiting for beds, and patients were being cared for on public corridors during the inspection. Interim measures in place were insufficient to mitigate the problems with capacity in the ED.
- There was poor patient flow in the ED and waiting times were above the national average. Many patients were not being seen by a clinician within the 15-minute national target. There were ambulances queuing and the ambulance handover times were above the national average.
- The ED environment was sometimes overcrowded. There were patients on trolleys along the corridor and this constituted a barrier to evacuation in the event of an emergency.
- There was poor patient flow in the department. A significant number of patients with decision to admit remained in the ED, as there were no beds available on the wards. The average number of patients waiting between four and 12 hours from the decision to admit until admission was worse than the England average.
- Patients at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trust's four-hour target.
- Staff did not always complete illness specific proformas developed to prompt use of best practice guidelines. Our review of patients' notes showed that care plans and risk assessments were not always completed.
- There were fewer consultants than the recommended minimum of 10 in line with national guidelines. The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 14 hours a day, seven days a week.

- The department had a higher re-attendance rate compared with the national average.
- Although staff spoke highly of the local leadership within the ED, staff reported less support from senior management.
- Our review of the incident data showed there were significant numbers of incidents raised due to insufficient capacity in the ED; however, there has been no improvement in this area.

However:

- ED staff were caring, kind, and compassionate and involved patients in their care. We received numerous positive comments from patients. Patients' feedback was sought and the latest friend and family test results showed over 94% of patients would recommend the ED.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- Staff were supported in their role and had opportunities for training and development.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement because:

- Many patients who arrived in the ED were not seen by a clinician within 15 minutes of their arrival. This meant patients were at risk of deteriorating and experiencing poor outcomes.
- There were several ambulance queues and the ambulance handover times were worse than the national average.
- The ED environment was sometimes overcrowded. There were patients on trolleys along the corridor; this constituted a barrier to evacuation in the event of an emergency.
- There were fewer consultants than the recommended minimum of 10 in line with national guidelines.
- Hand hygiene compliance was still below the trust's target.

However:

- Incidents were appropriately reported and investigated, and lessons learned were communicated to staff. These included staff training to improve competency issues identified. There were effective arrangements in place for safeguarding vulnerable adults and children.
- The ED was visibly clean and equipment checks were up to date.

There was good compliance with mandatory training amongst nursing staff and allied health professionals.

Incidents

- There were no never events reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- Staff reported incidents on an electronic system and all the staff we spoke with during the inspection knew how to report an incident. Staff told us they received feedback and learning from incidents through emails, during handovers and at staff meetings.
- There were 1,538 incidents reported in the ED between November 2016 and February 2017. Of these incidents, 1,373 were reported as no harm, 125 as low harm, 18 as moderate harm and 22 as near misses. We reviewed the incident log and found the most common themes were pressure ulcers (25%), infrastructure (14%), access/admission/transition and discharge (13%) and security (9%).
- There were six serious incidents reported between March 2016 and February 2017. There were three incidents involving sub-optimal care of a deteriorating patient, two diagnostic incidents involved failure to act on test results and one incident was a safeguarding incident meeting serious incident criteria. We saw evidence that senior staff conducted appropriate investigations into serious incidents and made recommendations for improvement. We reviewed five serious incident investigation reports and each report was sufficiently detailed covering contributory factors, chronology, root cause, recommendations and lessons learnt.
- We observed that the ED routinely carried out training for staff following serious incidents in order to improve staff competencies and practices. For example, the department had recently carried out c-spine training following an incident in the previous year.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Nursing and medical staff were familiar with the duty of candour and were able to explain what this meant in practice. They identified the need to be honest about mistakes made, offer an apology and provide support to an affected patient. We saw examples of this being demonstrated in written letters to patients and their relatives.

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- Mortality and morbidity meetings were held at a trust wide level. We saw that findings from these meetings were incorporated into teaching sessions with medical staff in the ED.

Cleanliness, infection control and hygiene

- All areas of the ED were clean and tidy. Antibacterial hand gel was available in waiting areas, bays, entrances and exits. Basic personal protective equipment (PPE), such as gloves and aprons were available in each bay and we observed staff using them appropriately. In addition, the ED had adequate hand washing facilities and we observed staff washing their hands. The 'bare below the elbows' policy was observed by all staff. Disposable curtains were labelled with the date they were last changed. This date was within the last one month of our inspection.
- Equipment used in the unit, including commodes and bedpans were clean. Staff used "I am clean" labels to indicate that an item of equipment was clean and decontaminated. We saw cleaning staff adhered to a colour coding procedure for cleaning the department and for the disposal of waste. Waste was disposed in a secure area and there was a separate area for clinical and domestic waste.
- There was a lead nurse for infection prevention and control and staff carried out monthly hand hygiene audits. The ED conducted monthly hand hygiene compliance audits to assess compliance against three standards including hand hygiene before patient contact, hand hygiene after patient contact and whether staff were bare below the elbow. Between January 2016 and February 2017, overall compliance with the three standards was 83% against the trust's target of 95%. The audit showed that paediatric ED staff compliance with the bare below the elbow policy was low at 55%. The trust informed us they working to improve hand hygiene compliance. This includes sharing information about audit results with all teams across the hospital.
- Mandatory training records show that 96% of nursing staff, 98% of allied health professionals (AHPs) and 80% of medical staff had completed the infection

prevention and control (IPC) training against the trust's target of 85%. It also showed that 63% of administrative and clerical staff had completed the non-clinical infection control training.

Environment and equipment

- The ED had a separate emergency only entrance from the rest of the hospital. There was a streaming desk and two main triage cubicles in the reception area. There were two additional triage cubicles used for taking bloods and conducting investigation in the reception area. ED consisted of the majors' area, a green area for ambulatory care, the resuscitation area, a blue area used for rapid assessment treatment (RAT), a clinical decision unit (CDU) and a paediatric emergency unit.
- The paediatric ED had eight cubicles and one high dependency unit (HDU). A swipe access card restricted access to the paediatric ED and staff informed us the entrance was locked between 10pm and 7.30am.
- The ED had a wide range of specialist equipment, which was clean and maintained. Equipment checks in the unit were up to date. Equipment had maintenance stickers showing they had been serviced in the last year. Staff maintained a reliable and documented programme of safety checks. Staff maintained resuscitation equipment with daily documented checks. Most emergency drugs and consumables in the resuscitation trolley were in date. However, we found two expired items in a resuscitation trolley within the resuscitation area. We highlighted this to staff on duty and they immediately removed them.
- The resuscitation area had five bays. This included a paediatric resuscitation bay, which had the appropriate specialised equipment to resuscitate children. Staff told us they sometimes converted this space for adult use when available. The location of the resuscitation unit was conducive for the rapid transfer of patients from incoming ambulances to the care of the emergency team.
- The majors' area had limited space for the volume of patients seen in the department. It was divided into two by a toilet and sluice. There were twelve trolleys in the majors' area and eight trolleys on the other side of the area, called the 'majors' extension'.

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- During our inspection, rapid assessment and treatment (RAT) of patients arriving by ambulance was suspended in order to accommodate patients waiting for hospital beds in the blue area. As a result, we observed up to four ambulance crews waiting in the main hospital corridor to the ED on 9 March 2016. There were up to two ambulance crews waiting outside the main hospital corridor to the ED during our unannounced inspection on 25 March 2016.
- There was a specific room for patients with mental health conditions in the ED. The room adhered to national standards with two doors, no locks and soft heavy furniture. It was ligature free.
- The department was overcrowded during our announced inspection. An escalation area consisting of six trolleys had been created along the corridor within the majors' area. We noted trolleys on corridors could present a barrier to evacuation in the event of a fire safety incident. In addition, staff often "doubled up" the resuscitation bays in order to accommodate more patients. We noted one of the bays was "doubled up" in preparation for a patient's admission during our unannounced inspection.
- Staff monitored fridge temperatures on daily basis and recorded minimum and maximum temperatures. Records showed the temperatures were within normal range.
- We saw that the allergy statuses of patients were routinely recorded on medicines charts.
- The department conducted monthly medicine audits. Data provided by the trust showed that between July 2016 and January 2017, staff documented allergies in 96% of the patient records reviewed. Eighty-three per cent of all intended doses were given during the same period. The audit showed that there were 59 doses omitted out of 469 doses prescribed in the last 24 hours of each monthly review. Of these, four were doses of critical medicines.
- All nursing staff had completed the medicine management training by the time of our inspection. In addition, the practice development nurse (PDN) had organised critical medicines training for nursing staff in order to improve practice in this area.

Medicines

- Medicines were stored in drug cupboards within the resuscitation area. We observed the resuscitation area was always locked via keypad access. Senior staff explained they did not have a separate room for storing medicines due to limited space in the ED. The controlled drug (CD) cupboard was kept locked and when opened, we saw that the drugs inside were kept in an orderly fashion. We saw recorded evidence that daily checks were made and there were no gaps in the checks. Access to the drugs cupboard was via a keypad. However, we noted that cupboards containing intravenous medication were not always locked, although staff were always in the area.
- The CDU and paediatric ED had separate rooms for storing medicines and medicines were stored safely and securely. We saw that drugs were stored in an orderly fashion and we saw evidence that daily checks were made for controlled drugs.

Records

- We examined 34 sets of patients' notes including nursing assessments, medical assessments prescription charts and children records. Staff used paper records, and in most cases, we found written entries were legible, clear and concise. Staff had signed and dated most of the records reviewed. However, we found one instance where speciality staff did not record the time an assessment was carried out.
- We found inconsistencies in the documentation of clinical assessments. Staff recorded observations carried out, national early warning scores (NEWS), paediatric early warning scores (PEWS) and allergies. However, we noted that care plans for adults in the main ED including pressure ulcer prevention care plans, body maps; falls prevention assessment and nutritional assessments were either partially completed or not completed in 10 of the records reviewed.

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- Eighty-six per cent of nursing staff, 79% of allied health professionals (AHPs), 46% of medical staff and 63% of administrative and clerical staff had completed the information governance training against the trust's target of 85%.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Nursing staff were able to give examples of what would constitute a safeguarding concern and told us they would escalate safeguarding concerns to senior staff members and the trust safeguarding team.
- Staff in the paediatric ED reported they attended weekly safeguarding meetings to discuss incidents and referrals. Staff completed a safeguarding risk assessment for children who they felt were at risk. Information about children attending the department who had a social worker or a child protection plan was passed onto the safeguarding team to inform them of their attendance in the ED.
- Safeguarding training completion rates for nursing staff were above the trust's target of 85% for all four safeguarding modules. Ninety-five per cent (95%) of nursing staff had completed the safeguarding adults clinical level two training; 96% had completed the safeguarding children level two training; 100% had completed safeguarding children level three training (core); and 90% had completed safeguarding children level three – specialist training.
- Safeguarding training completion rates for medical staff were below the trust's target of 85% for all safeguarding modules. Eighty-three per cent of medical staff had completed the safeguarding adults' clinical level two training, 58% had completed the safeguarding children level two training and 73% had completed the safeguarding children and young people level three training (core).
- Completion rates for AHPs were above the trust's target with 100% of AHPs completing the safeguarding adults' clinical level two training and 98% completing the safeguarding children clinical level two training. All

administrative and clerical staff had completed safeguarding adults – non clinical level one training, safeguarding adults – clinical level two training and safeguarding children level one training.

- Staff also completed the prevent awareness training. PREVENT is a government scheme to safeguarding people and communities from the threat of terrorism. Completion rates for prevent training were lower than the trust's target of 85%. Forty-three per cent of nursing staff, 3% of medical staff and 71% of AHPs had completed the level three Workshop to Raise Awareness of Prevent (WRAP) training. Thirty-seven per cent of administrative and clerical staff had completed the prevent awareness level one and two training. Senior staff informed us staff had been booked to attend the PREVENT training in April 2017.

Mandatory training

- A practice development nurse (PDN) managed mandatory training and induction for new staff. Mandatory training included bullying and harassment, conflict resolution, equality and diversity, fire safety, health and safety, infection control, information governance, medicine management, patient manual handling, prevent training, resuscitation training, emergency planning and mental capacity act / consent to examination and treatment. Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice.
- Mandatory training completion rates for nursing staff were higher than the trust target for eight of the 14 training modules. However, training rates were lower than the trust's target for fire safety (48%), prevent (WRAP) level three (43%), adult and paediatric basic life support (74%), hospital life support (73%) and paediatric hospital life support (75%).
- Mandatory training completion rates for medical staff were lower than the trust targets for 11 of the 12 training modules. The highest completion rate for medical staff was in conflict resolution (87%), infection control (80%), and health and safety (76%). The lowest completion rates was for non-patient manual handling, prevent (WRAP) level three (3%), equality and diversity (25%), resuscitation training (41%) and information governance (46%).

Assessing and responding to patient risk

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- All walk-in patients including children above the age of one were seen by an urgent care centre (UCC) nurse who assessed if they were suitable for the UCC or needed to go to the main ED. A separate healthcare provider managed the UCC. Patients who are sent to the ED were then triaged by an ED triage nurse to the relevant pathway. The UCC saw 43% of the patients who attended the ED in the last one year.
- Children under the age of one, patients with referrals from their GP and patients undergoing chemotherapy were booked in directly to attend the ED. UCC staff streamed high-risk patients to the ED. These included patients with chest pains, heavy bleeding or difficulty in breathing.
- The national target is for patients to be triaged within 15 minutes of their arrival in the ED. Between September 2016 and February 2017, the average time to initial assessment or triage was 36 minutes. During our unannounced inspection on 25 March 2017, we observed that three people waiting to be triaged had been in the department for between 28 and 48 minutes.
- ED staff told us a number of patients were incorrectly streamed to the UCC and then sent back to the ED, thereby delaying the patient's treatment. Two children including a patient with sickle cell disease were streamed to the UCC during our unannounced inspection and re-triaged back to the ED after over two hours. The UCC referred 3133 patients to the ED between September 2016 and February 2017.
- We observed the ED triage process; it was appropriate and adhered to the national framework of the Manchester triage system. We observed triage nurses carrying out full assessments and recording presenting complaints, vital signs, past medical history, allergy and pain score. We observed triage nurses mitigating the risks to patients by reviewing the waiting list and picking out patients with high-risk symptoms such as chest pains.
- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Between February 2016 and January 2017, the median time to treatment was 50 minutes in line with RCEM recommendations.
- Children and young people had access to the paediatric assessment unit called the Hippo unit where children could go for further management or assessment.
- Staff used the National Early Warning Score (NEWS) to identify deteriorating patients and vital sign observations were recorded in patients' notes. The paediatric early warning scores (PEWS) was used to identify deterioration in children. Staff had received training to carry out observations as part of their induction and refresher training had been also be offered to established staff members.
- The department had a system of rapid assessment and treatment (RAT) for the immediate review of patients arriving by ambulance. Staff carried out RAT in an area called the blue area. This system is meant to ensure that staff received a clinical handover from the ambulance service, an early clinical diagnosis and early treatment. However, during our announced inspection, RAT was suspended and the blue area was being used as an escalation area for patients requiring inpatient admission. This meant effective clinical decision-making was being delayed which might lead to poorer outcomes for patients.
- Senior staff explained that the blue area was often used as a clinical decision unit (CDU) for patients requiring inpatient admission. However, whenever the area was not used as a CDU, RAT was immediately resumed. Data obtained from the trust covering a 32-week period between 10 July 2016 and 12 February 2017 showed that the ED did not undertake RAT for up to 16 weeks during the period. The department undertook RAT for an average of 11 hours per week against a target of 84 hours per week.
- Between January 2016 and December 2016, 52% of ambulance handovers were over 30 minutes. A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between January 2016 and December 2016, the ED reported 2,788 "black breaches".
- In the winter months from January to March 2016, the number of breaches increased month on month from 335 in January to 448 in March 2016. Performance

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improved from April 2016 to September 2016 when between 99 and 172 breaches were reported. The number of breaches increased once again in the lead up to the winter period, from 176 in October 2016 to 326 in December 2016.

- We observed up to four ambulance crews waiting on the public access corridor leading to the ED period of our announced inspection. We observed up to two ambulance crews waiting on the same corridor during our unannounced inspection on 25 March 2017.
- Completion rates for resuscitation training were lower than the trust's target of 85%. Eighty-one per cent of AHPs, 74% of nursing staff and 41% of medical staff had completed the adult and paediatric basic life support (BLS) training. Seventy-three per cent of nursing staff had completed the hospital life support (HLS) training and 75% of nursing staff had completed the paediatric hospital life support (PHLS) training. Forty-one per cent of medical staff had completed the management of resuscitation training.
- The ED had an escalation plan with trigger points for waiting times and capacity. The plan highlighted actions to be taken at each trigger point. We observed that staff routinely reported incidents regarding waiting times and capacity, however, we saw no evidence to indicate this alleviated the capacity problems in the ED.
- Our review of patient records showed that risk assessments including risks of falls and Waterlow (pressure ulcer) risk assessments were either not completed or partially completed in at least 10 of the 34 records reviewed. In one case, the Waterlow risk assessment was completed, a score of 16 was recorded which indicates the patient should be on a dynamic mattress. However, this patient was not on a pressure ulcer-relieving mattress. In another case, severe redness to the sacrum was noted in nursing records but no action was taken to address this.
- During our unannounced inspection on 25 March 2017, there were delays in obtaining beds and mattresses for patients. We observed up to five patients with "decision to admit" (DTA) waiting for

beds. Patients were lying on trolleys for significant periods of time putting them at risk of pressure ulcers. Between September 2016 and February 2017, the average monthly trolley wait over four hours was 393.

Nursing staffing

- A Band 8a Matron led the Nursing team. The department had 92 whole time equivalent (WTE) nursing staff against an established level of 92.4 WTE staff. There were seven nursing teams led by Band 7 senior sisters. There were five WTE additional staff in the CDU against an established level of 18.8 WTE staff.
- As at December 2016, staff vacancies were 7%, turnover rates were 9% and sickness rates were 3%. Between April 2016 and November 2016, the trust reported a bank and agency usage rate of 15% in the ED. Senior staff informed us that bank staff were mostly used in the main CDU which had low acuity patients. A formal induction process had been implemented for agency staff following our last inspection in June 2016.
- The daily allocation reflected the number of nurses for each area. The nurse to patient ratio was one to four patients in the majors' area and one to two patients in the resuscitation area. Two nurses were allocated to care for patients in the six bedded escalation area. A nurse was also allocated to care for patients arriving by ambulance and waiting to be allocated trolleys within the ED. These patients were often waiting with the ambulance crews by the main public corridor to the ED. Staff informed us there was no limit to the amount of patients that could be waiting there. However, the matron and PDN said they assisted nurses in the ED when the department was busy.
- There were sufficient number of staff on shift during the period of our inspection. This consisted of four nurses in the paediatric ED area during the period of our inspection. Three nurses were rostered to cover the night shift. We also observed that there were four nurses and a HCA rostered to cover the CDU during our inspection. There were 19 nurses, two escalation nurses and one winter pressure nurse in the adult ED during our unannounced inspection. Eighteen nurses and a twilight nurse were rostered for the night shift.

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- Between August 2016 and November 2016, the average shift fill rate for day staff was 99% for registered staff and 88% for unregistered staff. During the same period, the average fill rate for night staff was 99% for registered staff and 91% for unregistered staff.
- We observed a nursing handover and found it to be structured, detailed and relevant. Nursing staff discussed capacity in the department and allocated staff to each area of the ED.

Medical staffing

- There were 8.4 whole time equivalent (WTE) consultants in the ED against an established level of 11. This was less than the recommended minimum of 10 in line with national guidelines. The consultants were supported by one speciality doctor, 7 WTE middle grade doctors, 11.8 WTE senior house officer (SHO) level doctors and 13.6 WTE foundation year 2 (F2) doctors. There were 41.8 WTE medical staff in the ED against an established level of 58 WTE medical staff. This represented 30% vacancy rate by the time of our inspection.
- As at December 2016, the vacancy rate for medical staff was 46% and locum staff usage was at 36%. The ED at Queen Elizabeth Hospital had the highest vacancy rate of all services at the trust.
- Consultants provided cover between 8:00am and 22:00pm, seven days a week. An on-call consultant covered the night shift from 22:00pm to 8:00am. Other medical staff were rostered to provide cover for 24-hours a day, seven days a week. There was always an ED registrar on duty 24 hours a day, seven days a week. One medical staff covered the paediatric ED and the unit also had access to an on-call paediatric consultant. We saw copies of the medical staff rota and staff told us the cover was adequate.
- We observed a medical handover and found it to be structured, detailed and relevant. Medical staff discussed each patient in department. Medical staff were allocated to care for each patient in the ED and each medical staff received a handover from the night staff.

Major incident awareness and training

- There was a hospital wide major incident plan, which detailed what roles staff needed to take during an

incident. In addition, the ED had an emergency department business continuity plan with action cards in place for dealing with internal and external major incidents. These included procedures for dealing with hazardous materials incidents and chemical biological, radiological and nuclear defence (CBRN). It also included an evacuation risk assessment; a contact list and incident helpline; an escalation flow chart; lock down principles and evacuation flow chart; severe weather plan; and incident report forms. A hard copy of the major incident and ED business continuity plan was available at the nurse's station. Staff could also access the policies on the trust's intranet.

- A major incident cupboard was located within the majors' area. It was locked and the key was kept in a key cupboard within the staff office. CBRN equipment and all major incident stocks were regularly checked and labelled with the date they were last checked. Action cards for staff were stored in individual large plastic wallets with all relevant information regarding their area.
- Staff we spoke with told us they attended a major incident training as part of their induction. Staff were aware of whom to approach in the event of a major incident. We observed a morning handover and noted that a major incident lead was allocated for each area of the ED

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as requires good because:

- Policies and procedures were developed in line with national guidance and best practice. Guidelines were easily accessible on the trust intranet page and staff were able to demonstrate ease of access.
- Patients were cared for by appropriately qualified nursing and medical staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently.

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- The department carried out audits to monitor patient care. Recent audits showed evidence of improvement in patient care when compared with the outcomes during our last inspection.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.

However:

- The department had a higher re-attendance rate compared with the national average.
- The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 14 hours a day, seven days a week.

Local audits showed that pain relief was not provided in line with local and national guidelines.

Evidence-based care and treatment

- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies, such as the Royal College of Emergency Medicine (RCEM) and the National Institute for Health and Care Excellence (NICE).
- Guidelines were easily accessible on the trust intranet page and were up to date. Staff were able to demonstrate ease of access. Staff could also access hard copies of the guidelines in the event of a system failure.
- Adherence with guidelines was encouraged through the development of illness specific proforma's to prompt use of best practice guidelines. For example, we saw evidence of the sepsis screening tool and the ED adult triage and assessment form. However, our review of patient notes showed that care plans including pressure ulcer prevention care plans, body maps, falls prevention assessment and nutritional assessments were not always completed.
- Our review of patients' medical records showed that staff did not routinely complete the sepsis screening tool for all patients. However, we saw that staff adhered to the sepsis protocol and gave patients antibiotics within one hour of arrival, in line with NICE sepsis guidelines.
- There was a programme of local clinical audits based on the needs of the ED. These included pain in adults audit, fever in children audit and sepsis audit.
- We reviewed the fever in children audit from July 2016. The audit reviewed the records of 50 randomly selected children (aged one to five) presenting with fever to the ED between 11 April 2016 and 22 May 2016. The result of the audit showed that vital signs were completed 100% of the time except for respiratory rate (90%) and capillary refill time (52%). The audit found that 100% of discharged children in whom no diagnosis was found and with amber features were provided with an appropriate safety net.
- In addition, there was 100% compliance with the standard requiring that 90% of children with amber features and without an apparent source of infection should not be prescribed antibiotics. The department also met the standard requiring staff in the department to have access to the NICE guideline Traffic Light System.
- The learnings from the audit were shared at the ED clinical governance meeting in November 2016. In addition, the ED developed advice leaflet for parents and carers in line with the action plan. This was in use during our inspection. Education sessions were held with nurses during training days between July and October 2016. The audit recommended a re-audit by December 2017.
- We reviewed the severe sepsis/ sepsis shock clinical audit which was completed in December 2016. The data collection period was between May and June 2016. However, there was no indication of the number of patients or records reviewed. The result showed that vital signs were completed 100% of the time except for blood glucose measurement (83%). This showed significant improvements made from the last audit of 97% for vital signs and 41% for blood glucose measurements.
- Staff initiated high flow oxygen via a non-breath mask in 80% of the cases against a target of 100%. This was a significant improvement on the previous audit result

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of 46%. Serum lactate was measured in 100% of cases and blood cultures were obtained in 97% of cases against a target of 100%. This was an improvement on the previous audit of 95% and 66% respectively.

- Intravenous crystalloid fluid was given in 70% of cases within 1 hour of arrival against a target of 75%, and in 100% of cases before the patient left the ED. This was a significant improvement from the last audit of 51% and 86% respectively. Antibiotics were administered in 70% of cases within one hour of arrival and in 100% of cases before patients left the ED. This was an improvement on the last audit which showed that antibiotics were administered in 54% of cases within one hour of arrival. Urine output measurements were instituted before the patient left the ED in 43% of cases against a target of 100%.
- The audit recommended increased awareness through teaching sessions with nurses and doctors, and a re-audit every four to six months.

Pain relief

- Patients told us that they received pain relief when they required it. Our review of paediatric patient records showed that staff recorded pain scores and conducted pain reviews in line with local guidelines. However, our review of patient records in the main ED showed that staff did not always record pain scores in patient notes. In addition, staff did not always conduct pain reviews in line with local guidelines. We found inconsistencies in the documentation of pain assessments in seven patient records reviewed. Staff did not record a pain score in four of the records. Staff did not conduct a pain review for three other patients for over 10 to 14 hours after their arrival.
- The ED carried out an audit titled "Pain in Adults in ED" to evaluate how pain was managed in the ED in comparison to RCEM standards. According to the local guidelines and RCEM pain guidelines, 75% of patients with severe or moderate pain should receive appropriate analgesia within 30 minutes of arrival. In addition, 100% of these patients should receive analgesia within 60 minutes of arrival. Patients with severe or moderate pain should have documented

evidence of evaluation and action within 120 minutes of the first dose of analgesia. If analgesia is not prescribed and patient has moderate or severe pain, the reason should be documented in the notes.

- The audit reviewed the records of 64 randomly selected patients presenting to the ED between August and October 2016. The results showed that 75% of patients in severe pain had appropriate analgesia while 61% of patients in moderate pain had appropriate analgesia. It showed that 12% of patients in moderate or severe pain had analgesia within 30 minutes of arrival and 24% of these patients had analgesia within 60 minutes of arrival.
- Only 32% had re-evaluation of pain with only 9% having re-evaluation within two hours of initial analgesia. Patient Group Directions (PGD) were in place in the ED for nurse prescribing on arrival. Nine patients were documented to have severe or moderate pain but no analgesia was given with the reason documented in only three cases.
- The audit highlighted that delays in triage was a contributory factor to the delay in giving analgesia and recommended the need to reduce delays in triage. It also recommended education of doctors and nurses in pain management and an awareness campaign. The audit suggested a re-audit in April 2018.

Nutrition and hydration

- Staff completed nutrition assessments and fluid balance charts on patient's admission to the clinical decision unit (CDU) or for patients with long stays in the ED. However, we observed they were not always completed for all patients. For example, in one record we looked at, only part of the assessment was completed and it was not signed or dated. Staff did not document a body mass index score and they did not record the patient's weight.

Patient outcomes

- Between February 2016 and January 2017, the percentage of patients who returned to the ED within seven days of discharge from their last ED attendance (unplanned re-attendance) was 14%. This showed the department was performing worse than the national standard of 5% and the England average of 8%.

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- The department had undertaken specific audits managed by the RCEM around the areas of vital signs in children and procedural sedation in adults in 2015/16. We reviewed these audits in the course of our inspection in June 2016 and the ED performed below the RCEM standard of 100% in all areas.
 - The ED performed below the national average in three of five RCEM standards for vital signs in children. Only 14% of children had a full set of observations and capillary refill time recorded within 15 minutes of arrival or triage. Only 63% of records indicated that the clinician recognised abnormal vital signs. None of the children with abnormal vital signs had a further complete set of vital signs recorded within 60 minutes of their first set.
 - Following our inspection in June 2016, the department established an action plan to address the issues identified in the RCEM audits. The action plan for the vital signs in children clinical audit recommended that children presenting with medical illnesses should have a full set of vital signs taken and documented within 15 minutes of their arrival or triage. Children with abnormal vital signs should have a further complete set taken and documented within 60 minutes. The action plan also recommended adequate documentation of care plans, use of scoring system such as the paediatric early warning score (PEWS) and senior review of paediatric patients with persistently abnormal vital signs.
 - During our inspection, the use of PEWS was already in place and training in vital signs was part of the induction and teaching sessions for nurses and doctors. However, the department was not meeting target to document full vital within 15 minutes of the child's arrival. The action plan identified that the main problem was in delays due to streaming by the urgent care centre before patients went to the paediatric ED.
 - The ED performed above the national average in four of seven RCEM standards for procedural sedation in adults. It was the same with the national average in one standard and performed below national average in two standards. Only 8% of the records met the requirement that patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including ASA grading, prediction of difficulty in airway management and pre-procedural fasting status. None of the records met the requirement that monitoring during procedural sedation must be documented to have included non-invasive blood pressure, pulse oximetry, capnography and ECG.
 - Only 21% of patients were discharged after documented formal assessment of suitability in five areas. Although the ED performed above the average of 3%, this performance was below the CEM standard of 100%.
 - The action plan for the procedural sedation audit recommended a new guideline for sedations and training for staff. It also recommended that a pro-forma should be used for procedural sedation and analgesia as a checklist and as a record of the procedure. The recommendations had been completed by August 2016 and a re-audit was scheduled to take place in April 2016.
 - We reviewed the consultant sign off audit summary from January 2017. The audit reviewed 142 records between 30 December 2017 and 28 January 2017. Result of the audit showed that only 9% of patients were seen by a consultant, 16% were seen by middle grade doctors (ST4 or more senior doctor), 42% were seen by senior house officers or equivalent grade doctors, 11% were seen by ST1-2, 18% were seen by FY1-2 doctors and 3% were seen by non-medical practitioners.
- ## Competent staff
- A professional development nurse (PDN) monitored/recorded nurse competencies to make sure they were up to date with current practice based on national benchmark standards.
 - In addition to mandatory training, the PDN assessed the training needs within the ED and ensured staff were competent to do their job. For example, staff attended medical devices training following the purchases of new medical equipment.
 - New nurses undertook a two-week induction period with the PDN and received training and clinical supervision in all areas of the ED including triage, NEWS, incident reporting and safeguarding. Agency staff also undertook an induction before working in the department.

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- Only paediatric trained nurses worked in the paediatric emergency unit. Senior staff confirmed they did not use agency staff for the paediatric ED except for registered mental health nurses (RMN). We observed only permanent staff on shift during the period of our inspection.
- Data obtained from the trust indicated 95% of nursing staff had an appraisal in the last year. All nursing staff had completed their revalidation when due.
- Doctors who were new to the trust completed the trust induction prior to working in the ED. All new doctors were provided with a booklet outlining important points about working in the department including expectations relating to their role. Junior doctors confirmed they received an orientation and induction following their employment.
- We reviewed the training rosters and observed that each grade of doctors were allocated protected time for training.
- Data obtained from the trust indicated that all medical revalidations were completed within the year 2015/16. It also indicated 99 out of 101 medical staff within the acute and emergency division had had an appraisal during the same period.
- Patients presenting with mental health issues had access to mental health practitioners based on site 24-hours a day, seven days a week. Staff reported most mental health practitioners attended the ED within one hour of referral. Staff also had access to a substance misuse team to assess patients with drug or alcohol problems and related health issues.
- Staff highlighted the need for improvements in the relationship with speciality teams, in particular in the response time to see patients in the ED. Data provided by the trust showed that between July 2016 and February 2017, the average median speciality response time for medicine was 138 minutes against the trust's target of 60 minutes. The average median response time for general surgery was 107 minutes.
- The ED held multidisciplinary team huddle every morning. This was attended by the admission avoidance team, staff from the medical wards, mental health practitioners and staff from other speciality team. We observed a team huddle and saw that the nurse in charge discussed patients in the ED and their suitability for referral to each speciality team.

Multidisciplinary working

- Nurses reported that they worked well with medical staff to deliver care in the department.
- Staff in the ED reported they worked closely with the joint emergency team (JET) which included a team of physiotherapist that attended the department to access patients' mobility. The team included the social service team that assessed patients before they were discharged. They provided immediate social and therapy support for patients once discharged.
- The paediatric ED worked with other staff in other agencies to ensure patients received coordinated, specialist care. This included multidisciplinary working with health visitors, school nurses, social workers and the safeguarding team. We saw a copy of an information sharing form referring children to these agencies were appropriate. Staff attended weekly safeguarding meeting to discuss incidents and referrals with the safeguarding team.

Seven-day services

- Medical and nursing staff provided cover in the ED for 24-hours a day, seven days a week. The department had consultant presence from 8am to 10pm every day and on call overnight.
- Portable X-ray was available on request and there was one radiographer on duty between midnight and 8am. However, staff indicated they had no access to MRI scans out of hours.
- The JET team was available seven days a week from 7.30am to 8.30pm. A band 7 pharmacist covered the CDU from Monday to Friday and was available for referrals from the ED.
- The ED had access to 24 hours on call respiratory physiotherapy cover. Staff could also refer patients to the dietetic service from Monday to Friday.

Access to information

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- The department had a computer system that showed how long patients had been waiting and their location within the department. Our review of patient notes showed that all clinical staff recorded their care and treatment using the same document.
- Policies and guidelines were available on the trust intranet and were up to date.
- We observed that patients referred to the ED from the UCC were sent with a handover sheet containing the presenting symptoms and assessments made. ED staff informed us that UCC used a separate information system and they had to go the UCC if they required any further information about a patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were clear about their responsibilities in relation to gaining consent from people, including people who lacked capacity to consent to their care and treatment. We observed that documented consent forms were completed where required.
- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit.
- We spoke with mental health practitioners and they confirmed ED staff referred mental health patients appropriately.

Ninety-five per cent of nursing staff, 94% of AHPs and 23% of medical staff had completed the Mental Capacity Act (MCA) / consent to examination and treatment training.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- ED staff provided a caring, kind, and compassionate service, which involved patients in their care and we received numerous positive comments from patients.

- Staff were aware of people's individual needs and considered these when providing care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required.
- Patients' feedback was sought and the latest Friend and Family Test results showed 94% of patients would recommend the ED.

However:

Patients were often cared for in escalation areas, which compromised the privacy of patients.

Compassionate care

- We spoke to 19 patients and nine relatives and most of them provided positive feedback about their care. Patients said they were well looked after and had received good care. They said that staff were polite, courteous and professional and they were happy with their care. They said staff were kind and regularly asked if they were comfortable.
- We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw most staff maintained patient privacy and dignity by drawing the curtains around patient areas before completing care tasks.
- Most patients and their families in all areas of the ED including the paediatric ED area, majors and clinical decision unit were positive about their care. They said staff provided good care despite the fact that the ED was busy. They praised the professionalism and competence of staff. Staff displayed many "thank you" cards given by patients and relatives on the notice board within the paediatric ED area and in staff offices.
- However, one relative said they had to assist a nurse to deliver personal care to their partner, as other nurses were busy. One patient said they did not receive regular checks from nurses.
- We observed that patients were often cared for in the ED escalation area, which consisted of six beds within the corridor in the majors' area. There were privacy screens to protect the dignity of patients whilst being assessed; however, this area was the main access corridor within the major's area.

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- Patients arriving by ambulance often had to wait with the ambulance crews in the main access corridor to the ED. This was a public access corridor. We observed up to two ambulance crews waiting with patients during our unannounced inspection on 25 March 2017. We observed an ED doctor assessing a patient on this corridor.
- Between February 2016 and January 2017, the results of the NHS friends and family test showed that 94% of patients would recommend the ED. However, the average response rate during the period was low, at 9% against the trust's target of 20%.

Understanding and involvement of patients and those close to them

- Most patients and relatives reported they were involved in their care and given explanations about their treatment. Patients said staff introduced themselves before attending to them. They explained the procedure they were about to carry out and the risks were discussed. Patients said staff were patient and tried to understand them. All patients confirmed that staff obtained their consent before carrying out assessments.
- We spoke to the parents of a child with complex needs who frequently attended the paediatric ED. They confirmed that staff were always ready to listen to them and supported them. Staff drew up a care plan with input from the parents to care for the child. Staff also referred them to specialist services for ongoing care.

Emotional support

- The ED staff had a protocol on how to care for relatives who experienced bereavement. In the paediatric ED, staff provided families with "comfort" boxes containing a teddy, a card, a candle and a booklet. There was also a balloon included in each box to send a message to heaven. Each box contained an information pack with information about bereavement support, death review processes and finances for funeral. An appropriate box was also provided to families of adolescent patients.
- Emotional support was also provided by the multi-faith chaplain service within the trust and patients could access representatives from various faith groups.

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

Requires improvement



We rated responsive as requires improvement because:

- The ED was not meeting the national target to admit, transfer or discharge patients within four hours. ED compliance with the "four-hour" target was worse than the England average.
- There was poor patient flow in the department. A significant number of patients with decision to admit remained in the ED as there were no beds available on the wards. The average number of patients waiting between four and 12 hours from the decision to admit until admission was worse than the England average.
- Patients were not always transferred to a bed from a trolley within the trust's four-hour target.
- There were significant delays in investigating and responding to complaints.
- There were no special arrangements in place for patients living with dementia.

However:

- Staff had access to translation services when needed, giving patients the opportunity to make decisions about their care.
- Fewer patients left the ED without being seen when compared with the England average.

Service planning and delivery to meet the needs of local people

- The ED saw 111,800 patients between March 2016 and February 2017 and approximately 18% of ED attendances resulted in admission.
- Senior staff explained there had been a yearly increase in the number of attendances. This included an increase in the London ambulance service (LAS) blue light traffic. The trust cited the closure of several community services in the area as a factor affecting patient flow in the ED. For example, over 80

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community beds had been decommissioned in the area in the last year. Between December 2016 and February 2017, 30% of patients arrived via an ambulance. In addition, 15% of ambulances arrived via blue light traffic.

- To address these challenges, the trust established a silver command operational procedure, which was implemented as the capacity pressures within the ED build up. The trust had introduced the use of escalation areas to facilitate the release of some ED capacity. These included six trolleys on the corridor within the majors' area. In addition, the blue area which was an area designated for rapid assessment treatment (RAT) was often converted to a clinical decision unit (CDU) for patients awaiting beds on the ward.
- The trust requested ambulance diverts where necessary, but this was not always approved due to a lack of alternative care pathways in the area.

Meeting people's individual needs

- The main ED reception area had an information point where visitors could access information from various services via a telephone. These included the patient advice liaison service (PALS), voluntary services, NHS direct, blood and transplant and smoke free helpline. However, we observed there was no information in the ED waiting area about current waiting times.
- The ED waiting area was often overcrowded due to the volume of patients attending the department on daily basis. This was exacerbated by the use of escalation areas within the ED which meant that patients were cared for on corridors around the majors' area leading to poor patient experience.
- The paediatric ED was brightly decorated with child friendly motifs on walls. There were sufficient chairs in the paediatric ED waiting areas and children had access to toys and story books. The reception area was equipped with television and showed appropriate programmes for young children. We saw a range of information leaflets posted on the notice board about child safety, common illnesses, injuries, fever in children and infections.
- Apart from patients in the clinical decision unit (CDU) and the blue area, all patients were nursed on trolleys

in the ED. During our unannounced inspection on 25 March 2017, there were delays in obtaining beds and mattresses for patients. We observed up to five patients with "decision to admit" (DTA) waiting for beds. Between September 2016 and February 2017, the average monthly trolley waits over four hours was 393. There were 35 trolley waits over 12 hours during the six-month period.

- Patients and their relatives had access to a trolley stocked with tea and beverages. There was also provision for drinking water within the department. Patients and relatives also had access to the main hospital café. Patients confirmed they were offered food and drink following their admission to the ED. However, two patients said staff did not promptly offer them food following their admission. Patients in the CDU were offered food from a menu which included hot meals. Patients had different options for food including gluten free and kosher options.
- Staff reported they could access interpreter services for patients through a help line or face to face when required.
- Staff in the paediatric ED area told us all children with special needs had a passport in their record. They showed us a folder kept in the department used to record details of all children with special needs that had attended the department.
- Staff worked closely with substance misuse teams and psychiatric teams, who provided support to patients. Paediatric staff liaised with external organisations, such as charities who provide support to teenagers.
- There were prompts for staff to identify patients with learning disabilities and dementia whilst completing the triage assessment document. This included cognitive assessments for patients living with dementia. We saw a passport template for a patient with a learning disability. It was designed to be completed by patients or their relatives to identify information about the patient that staff needed to know.
- However, we observed there was no passport in place for a patient living with dementia despite this being highlighted within their clinical records. There were no

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special arrangements in place for patients living with dementia in the ED. For example, there were no dedicated cubicles or clocks on walls displaying date and time.

Access and flow

- The ED was not meeting the 4-hour performance target to admit, transfer or discharge patients during the period of our inspection.
- The Department of Health's standard for emergency department is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in ED. The department breached this standard between February 2016 and January 2017. Performance against this standard over the 12-month period was 85% compared with the England average of 90%.
- Staff indicated that patients breached the 4-hour target mainly due to a lack of beds on the wards and insufficient services in the community to facilitate discharge. Staff also expressed concerns about the triage system in place and its effect on waiting times.
- Staff said the UCC did not undertake blood tests and patients were referred back to the ED from the UCC for blood tests to be carried out. Data obtained from the trust showed that the UCC referred 3,133 patients to the ED between September 2016 and February 2017. This was an average of 522 patients monthly. Senior staff explained that this increased waiting time for patients within the department.
- The ED often referred children to the paediatric assessment unit called the Hippo unit for further assessment. The Hippo unit was managed under the children and young people's services. Children and young people referred to the Hippo paediatric assessment unit were sometimes sent back the ED when the Hippo unit closed at 10pm. Between 20 December 2016 and 4 March 2017, 39 children were sent to back to the paediatric ED from the Hippo unit. Thirty-eight of the children were discharged to go home and one was admitted to the paediatric ward. The average time spent on the Hippo unit was over 4 hours. The children spent an average time of two hours on their return to the paediatric ED before they were discharged or admitted.
- The ED performance dashboard showed that between February 2016 and January 2017, the average total time spent in the department for all patients was 17 hours. Total time spent in the ED for admitted patients was 25 hours and the total time spent in the ED for non-admitted patients was 9 hours.
- Between December 2015 and November 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit (DTA) until admission was worse than the England average. The overall average for this period showed that 17% of patients waited between 4 and 12 hours before being admitted whereas the England overall average for the period was 12%. During the same period, five patients waited more than 12 hours from decision to admit until being admitted.
- There was poor patient flow in the department. Several medical and surgical patients with DTAs remained in the ED as there were no beds available on the wards. During our announced inspection, at least 25 patients had a 'decision to admit' but were still in the ED. At least seven patients had been in the ED for over 19 hours and 13 patients had been in the department for over 12 hours. Seven of the patients were in the CDU, nine were in the blue area and nine were in the majors' area. Research has shown that these excessive delays in moving patients to specialist wards increases the risk of them receiving poorer outcomes.
- During our unannounced inspection on 25 March 2017, there were 69 patients in the department. These included 21 patients with DTAs. The longest wait in the ED was up to 56 hours. However, this involved a patient who did not want to go to the medical ward. Another patient had been in the department for over 33 hours. Eight other patients had been in the ED for more than 20 hours and the remaining patients were in the ED between 4.30 hours and 17 hours.
- Daily bed capacity meetings were held three times a day and involved ED managers and charge nurses to discuss patients requiring admission and update on capacity predications for the rest of the day.
- The percentage of patients who left the department before being seen was recognised by the Department of Health as an indicator that patients were

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dissatisfied with the length of time they had to wait. Between February 2016 and January 2017, 4.5% of patients left the ED without being seen against the target of 5% or less.

Learning from complaints and concerns

- There was an information point in the reception area with direct access to contact the patient advice liaison service (PALS).
- There were 96 complaints about the ED between December 2015 and November 2016. The majority of complaints received (28%) were in relation to medical and surgical treatment. Delays in patients being seen by a doctor accounted for 9%, nursing care (8%), communication with patients (8%), missed diagnosis (7%), wrong diagnosis (6%), attitude of medical staff (7%), attitude of nursing staff (3%), admission arrangements (4%) and delay in clinical investigation (4%).
- The department took an average of 71 days to investigate and respond to complaints. This was not in line with the trust's complaint policy which states complaints should be responded to within 25 working days.
- Staff told us they escalated complaints to the nurse in charge. They said they tried to resolve complaints at the time wherever possible and patients were encouraged to involve PALS where appropriate. They told us they received feedback about complaints and learning from them.

Are urgent and emergency services well-led?

Requires improvement



We rated well-led as requires improvement because:

- There were insufficient systems in place to manage the fundamental issues of capacity and flow within the ED. ED performance was below the objectives set out in the delivery plan.
- Although staff spoke highly of the local leadership within the ED, staff reported less support from the senior management team.

- Our review of the incident data showed there were significant numbers of incidents raised due to insufficient capacity in the ED; however, there has been no improvement in this area.

However:

- The ED had a vision and strategy to improve the service in the long term and staff were able to verbalise future plans.

Staff were supported in their role and had opportunities for training and development.

Leadership of service

- The ED was part of the acute and emergency medicine (AEM) division and led by a divisional director. The divisional director was supported by a head of nursing for the AEM. A matron led the nursing team in the ED and a clinical lead led the medical team in the ED.
- Nursing staff spoke highly of the matron and professional development nurse (PDN). Staff said they were approachable and visible within the department. Doctors also said they were supported by the consultants within the ED. We observed consultant interactions with junior doctors and saw that they provided leadership and direction when required. Black and minority ethnic (BME) staff confirmed they had equal opportunities in line with other staff.
- There were clear lines of responsibility in the department. There were seven nursing teams, and a Band 7 nurse led each team. Staff reported they received verbal recognition and compliments from senior staff within the ED.
- Although staff reported less support from the senior management, senior staff said the chief executive officer was approachable and visible.

Vision and strategy for this service

- The trust had established an emergency care redesign programme which was part of a trust wide transformation programme covering all aspects of emergency patient pathway across two ED sites.
- The key initiatives under the emergency care redesign programme included an improved pathway for all ED

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patients to the urgent care centre (UCC); expansion and refurbishment of the ambulatory care unit; improving patient flow in the acute medical unit (AMU); and delivering a frailty pathway.

- Staff we spoke with were aware of the emergency care redesign programme. They indicated that a new AMU was scheduled for completion by the next winter season. They looked forward to this, as they believed it would relieve the capacity pressures in the ED. In the interim, patients were cared for in escalation areas when the ED reached full capacity. We observed that these were insufficient to manage the fundamental issues of capacity and flow in the ED.

Governance, risk management and quality measurement

- The divisional director, head of nursing, consultants, senior matrons and senior non-clinical staff attended a monthly divisional governance meeting. The leadership team discussed the AEM performance scorecard, staffing, serious incidents, complaints, finance and quality improvement projects. Action points were raised following each meeting.
- Senior ED staff also attended monthly ED management team meeting and quarterly clinical governance meetings. Minutes of the meetings showed the meetings were well attended and staff discussed incidents, complaints and compliments, risks and audits.
- The ED held joint operational meetings with the urgent care centre (UCC). Minutes of the meetings showed that staff discussed the working environment, operational updates and pathways. Staff kept an action log to monitor progress against action plans.
- The ED maintained a risk register and an issues log. Staff used the risk register to identify potential risks and mitigating plans to address those risks. There were four risks on the risk register. We saw evidence risks were reviewed and mitigating plans were in place. Senior staff routinely discussed risks at clinical governance meetings and saw that the risks were identified in the AEM plan to improve the service. Staff recorded current issues in the department on the

issues log. There were 14 issues on the issues log. The issues log included three sections demonstrating actions taken including a resolution plan, an escalation route and progress/closing action.

- Risks identified on the risk register included delays due to the lack of community mental health beds including children and adolescent mental health services (CAMHS) beds. The trust had met with CAMHS commissioners to highlight the risk and their concerns. Staff indicated risks were escalated via daily conference calls with mental health trusts and local commissioners. In addition, two psychiatric liaison consultants meet monthly with commissioners to discuss and review relevant issues.
- The risk register also identified the risk to achieving the ED performance targets. The mitigating plan was to support the delivery of attendance avoidance programme in liaison with clinical commissioning groups (CCGs). However, the ED was not achieving its performance targets at the time of the inspection and it appeared the mitigating plans had no impact.
- The issues log highlighted specific issues regarding the risks in the ED. Issues highlighted on the log included lack of physical beds for patients staying over four hours in ED; insufficient capacity in the ED; and increase in speciality patients with decision to admit (DTAs) being nursed in the ED. The mitigating plan was to escalate capacity issues at silver command meetings and daily incident reports. ED staff had requested for additional beds which was still pending at the time of the inspection.
- Our review of the incident data showed significant numbers of incidents raised due to insufficient capacity in the ED, however, the issue persisted during our inspection and the escalation plans in place were insufficient to address it.

Culture within the service

- Staff told us there was a culture of support for continuing professional development and clinical supervision. Most staff told us that there was a positive culture within the department and they were happy to work in the ED. They confirmed they had good working

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relationships with other teams within the department. Medical staff said consultants were supportive and nursing staff felt supported by their managers and the matron.

- However, staff highlighted the capacity issues in the ED and space constraint to see patients. Staff reiterated the need for a quick solution to address these issues. Staff said the ED was often very busy but they still liked working there.
- Senior staff informed us there had been 17 resignations since August 2016. Some suggested this might be due to the pressures in the ED. Staff in the Paediatric ED highlighted the need to create opportunities for progression within the paediatric ED in order to retain good staff.
- Staff said they were encouraged to raise concerns with senior staff. For example, we saw evidence of concerns raised in relation to capacity and space constraints in the ED. However, it was not clear how the senior management engaged local staff to address these challenges.
- Staff indicated there was insufficient collaboration across sites. They felt they should be able to divert patients to a sister site when the ED had reached full capacity. We spoke to members of the senior management team about this and they confirmed that requests for blue light diversion were often rejected by external organisations.
- Staff we spoke with understood their responsibility under the duty of candour regulations and could articulate the process to follow. We reviewed incident reports, which highlighted training and support provided to staff following each incident.

Public engagement

- The department monitored patient satisfaction through patient surveys and feedback forms. Senior staff told us they met with patients and their relatives to resolve complaints and applied learnings to improve the service.







Staff engagement

- Nursing staff told us that each team had “away days” where they received training in aspects of their role and updates on the current trends within the department. Senior staff provided us with a schedule of nursing teams’ “away days” for the year.
- Results of the AEM staff survey in 2016 showed that 60% of staff would recommend the organisation as a place to work and 58% would recommend it to friends and relatives for treatment. Fifty-eight per cent (58%) of staff agreed or strongly agreed that feedback on service users was used to make informed decision within the directorate. Ninety-four (94%) of staff agreed their training had helped them do their job more effectively.

Innovation, improvement and sustainability

- In a document title “Delivering the Plan” dated 30 September 2016, the trust’s Acute and Emergency Medicine (AEM) divisional leads set out a strategic objective to deliver 90% emergency care 4-hour standard as an average for the year-end March 31, 2017. In order to achieve this, the division aimed to deliver 12 hours of rapid assessment treatment (RAT) per day, 7 days a week and ensure patients were triaged within 15 minutes of their arrival. It also aimed to reduce non-admitted breaches to 1% of total breaches and reduce the length of stay in the clinical decision unit to 24 hours or less. It aimed to ensure ambulance handover times were not more than 15 minutes, discharge 40% of patients ahead of 1pm every day and reduce the trust bed occupancy to 95%.
- The document identified risks to achieving the objectives, risk score and mitigation. Risks identified included capacity block in the ED caused by patients with decision to admit (DTAs) and the trust’s bed occupancy rate. However, there were no other mitigating plans in place than those covered in the emergency redesign programme. This meant that there were no interim measures to address capacity and flow in the ED other than the use of escalation areas for patients when the ED reached full capacity.
- Data provided by the trust shows that the ED had failed to achieve the objectives set out in the delivery plan and there has been no improvement in this area since the last inspection.

Medical care (including older people's care)

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

Information about the service

The acute and emergency medicine division and long term conditions and cancer division provide medical care services at the Queen Elizabeth Hospital. Acute medical services comprise 271 inpatient beds across nine inpatient wards, a 78-bedded acute medical unit, a cardiac care unit and a discharge lounge escalation area. Two wards are dedicated to healthcare for older people and there is a respiratory ward and ward dedicated to patients medically fit for discharge. A surgical ward also has beds available for medical patients when there is a lack of capacity elsewhere. The endoscopy unit has three procedure rooms, a four-bedded recovery bay and a consent room.

Medical services treated 30,525 patients between April 2015 and March 2016, of which 40% were day cases, 58% were emergency admissions and 2% were elective admissions. The most common treatment was for general medicine, medical oncology, clinical haematology, gastroenterology, care of the elderly medicine and diabetic medicine. During the same period trust endoscopy services performed 14,760 procedures.

During our inspection we visited all of the medical care areas, including a ward used for medical outliers and an escalation ward. To help us understand the quality and safety of medical care services, we spoke with the senior executive and leadership team responsible for this directorate as well as 14 doctors, five matrons, 15 nurses and healthcare assistants and 16 other healthcare

professionals. We also spoke with 14 patients, observed care in all clinical areas and looked at over 60 individual pieces of evidence including 20 prescription records and 20 care and treatment plans

Between April 2015 and April 2016 the average occupancy of medical care wards was between 96% and 100%.

We last inspected medical care services, not including endoscopy, in June 2016. At that inspection we rated the service as requires improvement. This reflected a lack of progress and improvement in leadership, capacity and clinical governance previously identified in February 2014. In addition there was room for improvement in how incidents were used as learning opportunities as well as in infection control, hazardous waste management, medicines management and the standards of patient records.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement because:

- There was limited evidence staff felt involved in the outcomes of incident reports and investigations.
- There was ongoing room for improvement in infection prevention and control practices amongst staff, particularly in relation to hand hygiene amongst consultants.
- There was poor adherence to the control of substances hazardous to health guidelines in numerous areas in relation to the safe storage of chemicals.
- Fire safety practice was inconsistent. For example, we found automatic fire doors wedged open in some areas and areas of the hospital where staff did not know what the fire and evacuation procedures were.
- There were inconsistencies in the completion of patient risk assessments and the regularity of reviews in some areas.
- Rates of mandatory training were highly variable and the medical team did not meet the minimum trust target of 85% in any mandatory training topic. Nursing and allied health professional teams met the minimum target in a minority of subjects.
- Medical patients cared for as outliers in surgical areas did not receive consistent medical review. This meant reviews were often delayed and patients deteriorated as a result. Staff described significant difficulties in reaching the medical team responsible for medical outliers.
- The hospital could not demonstrate a significant or sustained improvement in how patients were treated with dignity, kindness and respect in all areas.
- Although there were areas of demonstrable improvement in clinical governance, risk management and senior leadership, there were still significant gaps in communication between teams in some areas. This included staff who did not know about the trust's development plans and others who felt actively excluded or marginalised.

However:

- Staff demonstrated consistent knowledge of good safeguarding practice and policies and demonstrated how they put these into use.
- A specialist team had responded quickly to contain a potential outbreak of legionella by implementing water supply contingency plans.
- Medicines management processes ensured medicines were safely stored, tracked and destroyed when needed. This included controlled drugs and emergency medicine.
- Although nurse vacancy rates varied from wards between 6% and 24%, fill rates were consistent and the endoscopy unit was consistently well staffed.
- There had been significant improvements in the education and clinical competency development opportunities for nurses. This included a band five nurse development portfolio for respiratory nurses and improved competency training for nurses in non-invasive ventilation and cardiac care.
- There was evidence of effective multidisciplinary working in all areas we inspected. This included where patients had complex needs and multidisciplinary teams had to form at short notice. An established series of meetings involved all members of the team. Some staff highlighted areas for improvement in communication between different staff groups in the hospital.
- The clinical effectiveness team had registered 21 audits in the acute and emergency medicine division for inclusion in the 2016-2017 clinical audit programme.
- A carer's charter was in place in the hospital and staff had adopted the principles of the national John's Campaign to provide a more welcoming and flexible approach to carers visiting patients.
- Between April 2015 and March 2016 the average length of stay for medical elective patients was 4.2 days, which was similar to the national average of 3.9 days. For non-elective patients, the average length of stay was 6.7 days, which was similar to the national average of 6.6 days.

Medical care (including older people's care)

- A team of 30 volunteers had been recruited to help provide companionship and relieve boredom amongst patients. This team was being trained at the time of our inspection and staff had also significantly improved the activities available in the meantime.
- Tools were available to staff to help communication, including visual aids and access to translators.
- There was evidence of positive inter-departmental working to investigate and resolve complaints and we saw examples of learning from investigations.
- All of the staff we spoke with were positive about local leadership and there were areas of significant improvement, including in wards three and 18.

Are medical care services safe?

Requires improvement



We rated safe as requires improvement because:

- There was variable evidence the hospital acted on incident reports and findings from investigations. As a result some teams had stopped submitting incidents reports and others felt disempowered when doing so.
- Medical staff did not always adhere to good hand hygiene practices or the bare below the elbows policy. This team did not meet the trust's minimum target of completion for infection control training.
- Staff did not always follow safety procedures for the environment. This was because we found several areas of unrestricted access to chlorine tablets or other chemicals subject to the control of substances hazardous to health regulations. Fire safety procedures were also not consistently followed and we found areas where staff had propped open automatic fire doors.
- The completion of patient risk assessments on some wards was inconsistent, with missing or overdue reviews. This included for malnutrition and Waterlow scores.
- Although all of the staff we spoke with demonstrated appropriate knowledge of safeguarding protocols, levels of training were low amongst some teams. The medical team did not meet the trust's minimum target of 85% completion in any area of safeguarding and only 20% of this team had up to date 'PREVENT' training.
- Rates of mandatory training were variable and medical and nursing teams did not meet the minimum requirement target of 85% for up to date training in basic life support or resuscitation training, with the exception of the Trafalgar Clinic.
- Escalation processes were in place for patients who deteriorated but these were applied variably, although deteriorating patients were referred to the appropriate medical team. There were variations in how nurses used the national early warning scores system and a

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need for additional training in the use of assessment tools. There was evidence patients cared for as medical outliers did not always receive appropriate care when they became acutely unwell.

However:

- On each day of our inspection inpatient wards maintained a nurse to patient ratio of 1:7, with the exception of ward 18. The hospital used a safer staffing tool and some areas were able to be flexible in their planned staffing to meet demand, including the endoscopy unit.
- The hospital had recently improved its medical staffing provision overnight and at weekends. This included increased consultant presence and more foundation level doctors. However, junior doctors described low numbers of doctors out of hours as a risk to patient safety.
- Although some teams felt senior staff did not act on incident reports, others felt more positive and gave examples of improvements made. This included more secure equipment tracking in the endoscopy unit.
- Each ward or clinical area displayed up to date information in relation to the NHS Safety Thermometer, including rates of harm-free care and the number of diagnosed infections.
- Microbiology staff and the infection control lead nurse had investigated four cases of *Clostridium difficile* (C.Diff) in medical services. The investigations were comprehensive and led to improvements in practice, such as the provision of a light box to help improve staff training in hand hygiene practices.
- Staff demonstrated consistent knowledge of good safeguarding practice and policies and demonstrated how they put these into use.
- A specialist team had responded quickly to contain a potential outbreak of legionella by implementing water supply contingency plans. This included suspending the use of some taps and sinks and implementing chlorination and flushing procedures, which we saw were clearly documented.
- Emergency equipment, including resuscitation trolleys, were appropriately maintained with documented daily safety checks.

- Medicines management processes were in place that ensured prescriptions were made in line with local formulary guidance, including for antibiotics and the safe management of controlled drugs.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between December 2015 and November 2016, medical care and sexual health services did not report any Never Events.
- In accordance with the Serious Incident Framework 2015, medical care services reported two serious incidents between December 2015 and November 2016.
- Staff in the discharge lounge told us they felt incidents were acted upon and learned from. For example, following an incident in which a patient arrived in the discharge lounge with unsuitable clothing, staff reminded senior nurses on each ward to contact family members to bring suitable clothing for patients ready for discharge. Similarly, staff in the endoscopy unit told us they saw improvements after submitting incident reports. For example, the unit had cancelled procedures after another department borrowed an item of equipment and did not return it. As a result the team introduced an equipment log book that enabled named staff to track individual items. Since this had been introduced there were no further cases of cancelled procedures due to missing equipment..
- Some allied health professionals (AHPs) told us they had stopped submitting incident reports because they felt they did not receive feedback although the team said some matrons made a point of finding them and offering one-to-one feedback. However, other staff we spoke with felt more positively about the incident reporting procedure. For example, a healthcare assistant on the acute medical unit (AMU) said they felt "very confident" to submit incident reports and that the matron had followed up with them every time they had submitted a report.

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- Between December 2015 and November 2016 medical care services reported 2536 incidents, which included 81 'near miss' reports. No incidents resulted in death or severe harm, 2% resulted in moderate harm, 25% resulted in low harm and 70% resulted in no harm. Staff categorised incidents according to one of 11 categories. In this reporting period the most common category of incidents was slips, trips and falls, which made up 27% of the total. Pressure ulcers accounted for 19% of incidents and 5% of incidents were related to treatment or a clinical procedure. Of all incidents, 37% were reported on the AMU and 9% were reported on ward three. Lower levels of incidents were reported in all other wards and medical care areas, including 4% in the discharge lounge. From looking at the outcomes of incident investigations it was not evident that areas for improvement in practice were implemented and tracked. For example, incident investigations in relation to unwitnessed falls and a hospital-acquired pressure ulcer identified a need for improved staff training, awareness and proactive action. However there was no action plan or documented, tracked timeline to ensure this took place.
- Senior nurses demonstrated knowledge of the duty of candour in relation to patient incidents. For example, staff on ward 18 liaised with the safeguarding team and social worker to discuss a pressure ulcer with the relatives of a patient.
- A medical photography team were available as needed and staff used this team to photograph pressure ulcers or injuries from falls to help them document and investigate them as incidents.

Safety thermometer

- The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement on wards is used to focus attention on patient harm and their prevention.
- Each ward displayed an operations 'dashboard' to help patients, staff and visitors identify the safety track record for the previous month. The dashboard included NHS Safety Thermometer data including the percentage of harm-free care, infection control

measures such as instances of methicillin resistant *Staphylococcus aureus* (MRSA), the number of ward-acquired pressure ulcers and the results of the latest Friends and Family Test. The dashboard also included the average staffing level against the established need.

- We looked at the Safety Thermometer results for each medical inpatient area between April 2016 and April 2017. During this period ward 18 achieved a track record of 100% harm-free care, including no hospital-acquired pressure ulcers, falls with harm, VTEs or new urinary tract infections. Other areas performed consistently well. For example, in eight out of the previous 12 months, the AMU and ward 19 achieved 100% harm-free care. There were no instances in which harm-free care in a clinical area was lower than 88% in any month.

Cleanliness, infection control and hygiene

- In the 12 months prior to our inspection there were four reported cases of *Clostridium difficile* (C.Diff) in medical services. In each case a multidisciplinary team, including a consultant microbiologist and infection control lead nurse, conducted a post infection review in line with trust policy. The review included a retrospective assessment of each ward or department the patient was admitted to, their medical history and how the ward managed the infection after it was identified. The lead investigator also considered wider factors in the ward and hospital at the time, such as hand hygiene and environmental audit results. We looked at the reviews of each C.Diff infection in this period and found the reviews to be comprehensive and to consider each stage of the patient's journey through the hospital. Each review also indicated areas for learning and an action plan on what the investigation team and ward teams would do to mitigate future risks. For example, two of the reviews found that the latest hand hygiene audit results were lower than the trust's minimum 95% target. In response the ward manager and matron sourced a light box and used this to provide refresher training on correct hand washing techniques. All four reviews found that at the time of the incident the ward in which the infection was diagnosed had not achieved the trust's minimum target of 95% on the latest environmental audit. In response the

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investigation team mandated attendance at the next environmental audit for nurses and healthcare assistants (HCAs) so they could identify areas for improvement.

- Patients with confirmed C.Diff were admitted to side rooms and staff provided care with enhanced infection control strategies, including barrier nursing.
- Linen management and disposal in the acute medical unit (AMU) was effective, well-coordinated and ensured linen was protected from contamination and dust.
- The trust had a target of 85% for the completion of clinical infection control training. In January 2017 76% of medical staff and 99% of nursing staff had up to date training.
- Hand gel was available at the entrance to each ward or clinical area but not always readily available throughout. For example, there were very few bottles visible in the AMU. We observed variable use of this between wards as well as inconsistent hand washing amongst staff. For example, we observed a ward round in the AMU and saw the lead consultant did not use hand gel before seeing the first patient. In addition, we observed a ward round on ward three and saw a doctor was not bare below the elbows and was wearing a bracelet. This presented an infection control risk and was against hospital policy. The doctor removed their sleeves and jewellery when we joined the ward round but it was not clear this was normal practice.
- Staff in the discharge lounge were proactive in ensuring patients were protected from the risk of infection. For example, if a patient who was cared for in a ward side room was due to be transferred, the nurse in charge investigated the reason for the side room before accepting the transfer. This was because side rooms were often used to care for patients who presented an infection risk, which could not be safely mitigated in the discharge lounge.
- A team of technicians led decontamination procedures in the endoscopy unit, including ensuring the safe use of scope washers and driers. A lack of space in the unit meant a scope washer and drier were used in a corridor that was used by staff and patients. This presented a contamination risk but we saw

during observations that technicians managed the risk effectively although there was no formal risk assessment in place. The unit was due to be refurbished and expanded in April 2017, which would significantly improve space for equipment.

- Clinical areas contributed to the NHS Saving Lives initiative on a monthly basis. This included monthly audits of hand hygiene, intravenous fluid use, peripheral cannula safety and the decontamination of equipment. Staff in the endoscopy unit participated in a monthly dress code audit that included a check of fingernails and hair grooming to make sure staff adhered to personal infection control principles.
- Dedicated 'mediclean' workers were in place on the AMU. This team ensured all clinical and patient areas were cleaned to a specification and could perform a deep clean for areas that presented an infection control risk.
- We saw on AMU some hand wash basins were out of use due to positive tests for legionella. We spoke with the joint responsible person for water safety in the trust and found that legionella and other bacteria had been found across the hospital in various areas. The trust reflected this in the corporate risk register and all taps, sinks and thermostatic mixing valves affected had been cleaned, chlorinated and temporarily taken out of service. Risk management plans were effective and ensured the risk of the spread of bacteria had been contained. We saw evidence of this through reviewing flushing records and observing the practice of contracted mediclean staff.
- An annual review of flexible endoscope decontamination facilities in 2016 identified a number of areas for improvement in relation to infection control. Facilities issues such as the need for physical barriers between dirty and clean spaces were due to be in place by April 2017. In areas where the review found a need for improved staff training, this had been provided.

Environment and equipment

- Staff did not always follow safety procedures for the environment. For example, on one day of our inspection a disposal room adjacent to the endoscopy unit that contained hazardous and domestic waste was unattended with the door propped open. This

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room had a keypad that should be used to ensure it is always secure when not in use. In addition, a fire door used to access a medical gas storage area and fire doors at the entrance to the endoscopy and day surgery areas were both propped open. This meant in the event of a fire alarm the doors would not automatically close to prevent the spread of fire. During our inspection we also observed fire doors propped open in ward 18. We also saw cardboard boxes of disposable pulp items were stored on the floor of a disposal room, which presented a contamination risk from spilled fluids. This was also the case on ward 19 on one day of our inspection. On a care of the elderly ward, staff had posted a notice on the door of a storage room that stated it must be kept closed at all times for patient safety. However, this door was open and unmonitored on one day of our inspection. We spoke with a nurse who said they did not know why it was open and closed it immediately.

- Staff in clinical areas or wards were aware of their responsibilities in a fire alarm activation and could describe the evacuation procedure. This was not always the case in other areas. For example, reception staff who managed the waiting room for endoscopy and surgical day procedures said there was no specific fire and evacuation policy for this area and they did not know who was in charge or who would give them instructions. They said in a fire alarm they would start evacuating people from the waiting room.
- There were inconsistencies between clinical areas and wards in adherence to the control of substances hazardous to health (COSHH). For example, we saw an open container of chlorine tablets was stored on a cleaning trolley. In the AMU and ward three, chemicals subject to COSHH regulations were on display in an unlocked cupboard with unmonitored access. This included five containers of chlorine tablets.
- The discharge lounge had nine chairs and four beds in a bay that could be used as an escalation area for overnight accommodation during times of exceptional demand.
- We looked at 31 individual items of equipment during our inspection. Each item was labelled with an up to date electrical and safety service date.
- Security services were provided in the main hospital building. Although most staff said the security team had been responsive when they had been needed, some staff said there was a lack of understanding about the use of panic alarms. For example, reception staff located at the desk adjacent to the endoscopy unit told us they had operated a panic alarm at the desk to check it worked because they had received no training in its use. They said security staff had arrived 45 minutes after they operated the alarm and told them it was used so rarely they had debated whether to respond or to assume it was an accidental operation. This meant there was not a consistent understanding of the help staff could obtain in an urgent non-clinical situation.
- Between December 2015 and November 2016 staff reported 102 incidents relating to security, which accounted for 4% of incidents overall.
- Each patient in an inpatient ward had a bedside storage cabinet next to their bed. However, we saw in many cases a large yellow sticker with 'CONDEMNED' printed on it had been placed on the cabinet, in full site of the patient. This included nine cabinets in ward 19 and three cabinets in ward three, including one that had a label indicating it had been condemned in 2013. We asked staff about this who said the cabinets were leased from a third party who had identified they were overdue for replacement.
- Ward 21 was a specialist chemotherapy and haematology unit with 16 inpatient beds and an outpatient department. Eight of the beds were in private side rooms, two of which were equipped to provide negative pressure. Ward 14, which provided care in endocrinology, also had three negative pressure rooms prioritised for patients with tuberculosis.
- There was evidence of poor maintenance to the environment in ward 18. This included a torn fabric visitor's seat, which presented an infection control risk as well as damaged and chipped paintwork, dirty floor edges in two side rooms and evidence of surface-level dust on shelves and food and debris under a patient bed. Although televisions were installed in ward three and ward 18, they were not working.

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- Each ward or clinical area had a resuscitation trolley and oxygen available for emergency use. Resuscitation equipment should be checked daily for stock and serviceability. We looked at the safety logs for this equipment in every area we visited for a period of at least four weeks prior to our inspection and found staff had documented checks consistently.
- All inpatient wards we visited were compliant with the Department of Health (DH) Health Building Note (HBN) 00/10 part A in relation to the condition of flooring. In addition, all sinks complied with DH HBN 00/09 in relation to infection control in the built environment. This included in the provision of soap and hand towels although there were no hand washing technique posters on display in the areas we looked at.
- We observed waste management processes in clinical areas were mostly compliant with EU Waste Directive 2008/98/EC and Department of Health (DH) Health Technical Memoranda 07-01 (2013) in relation to the management and disposal of healthcare waste. However, there was an exception to this. The temporary closure function of sharps bins was not consistently used. For example, on the AMU we found most of the sharps bins on the unit had the lids open, even when not in use.
- Staff on the AMU introduced improved safety practices to meet the requirements of EU Directive 2010/32/EU in relation to the prevention of sharps injuries through a safer sharps system. We saw this in practice during our inspection and clinical staff we spoke with demonstrated a good level of knowledge.
- of the CD log on ward 18. However, all CDs were accounted for and the stock check list was accurate. We spoke with the nurse in charge about page numbering and he said he would speak with the nursing team to ensure this was rectified. On ward 14, a light in the main corridor lit up if the CD cupboard was unlocked, which provided additional safety and security for staff.
- As-needed medicine, such as pain relief, was stored in the discharge lounge in a locked medicine trolley and only the nurse in charge had access.
- Staff documented daily temperature recordings of medicine fridges to make sure medicine was stored within the safe range established by the manufacturer. We looked at the fridge temperature logs in every ward we visited, including the discharge lounge, and found them to be recorded consistently. Ambient cupboards were used to store medicine in each ward or clinical area. In each ward except for ward 18, staff documented daily temperature checks of the room to ensure it was maintained within the safe range identified by medicine manufacturers.
- Some wards and clinical areas, including ward three and the AMU had dedicated pharmacists based there. A pharmacist checked medicine administration records on each ward daily and completed a monthly antibiotic audit.
- Chemotherapy services were provided with the oversight of a Macmillan cancer lead nurse and oncology consultants. A dedicated pharmacy team managed chemotherapy medicines.

Medicines

- In the medical records of eight patients we looked at in the AMU, staff consistently documented the review of antibiotics in line with prescribing and local formulary guidance. We saw staff had signed and dated all prescriptions and that allergies and venous thromboembolism (VTE) prophylaxis was clearly documented.
- Controlled drugs (CDs) and resuscitation drugs were stored and managed appropriately in all wards in which they were stored. This included locked and controlled access, daily signed checks of stock and appropriate documentation when medicine was used. We found some discrepancies in the page numbering

Records

- We looked at the medical records of eight patients on the AMU, three records on ward 14 and two records on ward four. In all cases staff had completed risk assessments for malnutrition, VTE, falls and pressure ulcer risk within six hours of admission. In addition, there was evidence each patient had been seen on the post-take ward round by a doctor within 12 hours of admission and had a nursing care plan and diagnosis and management plan completed.
- We looked at the medical records of five patients on ward 18. We found staff had not always completed care plans consistently. For example, one care plan

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was undated and another was incomplete. We asked the nurse in charge about this who said the patient concerned had been transferred from another ward without a care plan. However, this meant there was not a process in place to ensure all patients had appropriate reviews undertaken if they were transferred from another ward without a care plan.

- We looked at the notes of two medical outlier patients on ward 15 during our unannounced weekend inspection. A consultant had documented a daily review in each case and both sets of medical notes were comprehensive with regular updates, evidence of multidisciplinary referrals and use of the 'alert, voice, pain, unresponsive' (AVPU) system to monitor risk. However, one set of notes did not include information on the patient's medical team, including no bleep number or contact details. In addition, neither patient had an individualised care plan. We also found a number of inconsistencies in the completion of regular risk assessments and monitoring tools. For example, one patient did not have a documented re-assessment of cognitive function within seven days, despite this need being established on admission. Although patients had hourly fluid balance documentation completed, one patient had not had a daily stool chart completed in ten days and erratic completion of comfort round documentation. One patient who had been admitted for over four weeks did not have a documented cognitive assessment or risk assessments for pressure ulcer prevention, Waterlow, nutrition, movement and handling, falls prevention or bowel care. We spoke with AHPs who told us completion of Waterlow scores and the malnutrition universal scoring tool (MUST) on wards was inconsistent. They said, "We regularly find these to not be completed or completed inaccurately. This means patients don't always get the care they need."
- We looked at the discharge summaries of three patients in the discharge lounge. A consultant had completed each summary and there was clear documentation of TTO medicines and post-discharge care.

- A medical records team provided a cross-site service in the trust. The team had very limited space and had implemented a feasibility study in September 2016 to look at creating an electronic records system that would use radio frequency tagging to track notes.
- Staff did not always adhere to the principles of information governance and we found discarded confidential patient records in two ward areas.
- Information governance formed part of the trust's mandatory training for all staff. We found a file discarded on a cupboard that contained a patient's confidential material in the AMU. During our unannounced inspection we also found a notes trolley with nine sets of patient notes ready to be archived and unsecured in the public area of a ward.

Safeguarding

- Medical staff in the acute and emergency medicine division had an overall compliance rate of 73% in safeguarding training. This included 82% of staff with up to date safeguarding adults clinical training, 54% of staff with up to date child safeguarding level two training and 83% with safeguarding children level three training. The trust's minimum target was 85%.
- The trust had a target of 85% for the completion of safeguarding and Home Office 'PREVENT' training. PREVENT is a national strategy that trains staff to identify the early signs of radicalisation and potential risk of terrorism. In January 2017 20% of medical staff and 64% of nursing staff had completed a workshop to raise awareness of PREVENT.
- A chaperone policy was clearly displayed in the endoscopy day unit and we saw evidence this was offered at the consent stage of each procedure from looking at patient records.
- All of the staff we spoke with demonstrated appropriate knowledge of their role and responsibilities in relation to safeguarding, including what to do if they observed suspicious behaviour, suspected abuse or found unexplained bruising on a patient.

Mandatory training

- The trust had a target of 85% for the completion of mandatory training, which included 11 modules for

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medical staff and 12 modules for nursing staff. Modules included health and safety, patient manual handling and information governance. In January 2017 medical staff did not meet the minimum training standard in any module. Overall, average training compliance was 54%. This reflected a range of between 20% compliance for fire safety training amongst clinical staff and 80% compliance in equality and diversity. Nursing staff achieved an average completion rate of 84% and exceeded the minimum target in six modules. Module completion rates ranged from 63% for hospital life support to 100% for equality and diversity.

- Agency nurses on ward 18 had completed theoretical fire safety training but there had not been a system in place to ensure all nurses had local training specific to the ward and hospital. The NHS nurse in charge on the ward had implemented a training programme with the estates department to provide fire safety training to nurses. At the time of our inspection, seven nurses had completed this.
- The adult therapies team had an overall mandatory training compliance rate of 85%. Rates ranged from 50% for adult and paediatric basic life support (BLS) to 100% for equality and diversity and bullying and harassment. .

Assessing and responding to patient risk

- The trust had a target of 85% for the completion of adult and child resuscitation training. In January 2017, 78% of medical staff and 75% of nursing staff were up to date with this training. In addition, 63% of nurses had up to date hospital life support training.
- We saw evidence clinical staff consistently escalated deteriorating patients to the on-call medical team or the critical care outreach team (CCOT). This included where medical patients were treated as outliers on ward 15. However, documentation of this was not always completed in line with trust guidance. For example, specific records were in place for staff to document use of the National Early Warning Score (NEWS) and the action taken, such as whether they called a peri-arrest to the resuscitation team. In one instance we saw staff had not completed the NEWS documentation but had noted this in the main medical notes. This meant it was not immediately

clear to medical and nursing staff what action had been taken. In the medical records of nine patients we looked at in the AMU and on ward 18, staff had documented the use of NEWS appropriately. In addition, the escalation process included the use of the Situation, Background, Assessment, Recommendation' tool (SBAR) to help identify the level of acuity of the patient. We spoke with a CCOT nurse who said there was a need for additional training on the use of SBAR as they frequently found it to be incomplete, which could delay treatment.

- The CCOT team conducted a daily ward round for patients with a tracheotomy who were being cared for as medical inpatients and not in the intensive care unit. This meant such patients had specialist input and monitoring.
- The allied health professionals team was involved with risk management and patient escalation in all medical areas and used this to ensure patients received appropriate reviews. For example, AHPs worked with doctors on the respiratory ward to ensure they had access to this information to conduct timely reviews.
- Staff used the visual infusion phlebitis (VIP) score to monitor risk to patients with an intravenous access device in place. This involved daily checks of the intravenous site to prevent avoidable phlebitis.
- Staff on ward 18 provided care for patients who were medically fit for discharge. There were clear guidelines in place to transfer a patient to a more appropriate ward in the event they deteriorated or became acutely unwell. This included defined roles for the duty senior house officer, the matron and bed manager. The nurses in charge on ward 18 told us this process was well established and they felt the senior site team were responsive when they needed to move a patient for their safety. However, some staff told us this system was not always followed. For example, four AHPs told us that in the week prior to our inspection two patient transfers from ward 18 had been blocked by doctors despite the patients' deterioration.
- During our previous inspection in June 2016, we found the site team did not always adhere to the admissions criteria for patients on ward 18. This meant staff sometimes cared for patients with complex needs without adequate training or support. At this

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inspection we found this situation had significantly improved and the NHS nurse in charge on the ward had developed a relationship with the site team that meant deteriorating patients were transferred to a more appropriate ward where they could receive more specialist care.

- There was a significant lack of structure in the management of risk to medical outlier patients cared for on ward 15, a surgical ward. This included a lack of accountability of patient outcomes and no dedicated medical nursing cover for these patients. For example, a senior member of the ward team described an incident in which a patient deteriorated and there was no medical doctor on the ward. They told us the doctor on the adjacent ward would not help due to a lack of experience and confidence and so they had to declare a peri-arrest to get the attention of the resuscitation team. The senior member of staff at the time e-mailed the consultant responsible for medical outlier patients and said they received no response.
- Staff used the 'sepsis six' tool to monitor patients who received chemotherapy for sepsis risk.
- The hospital introduced a new sepsis screening protocol in January 2017. We saw this in use on the AMU and ward three and the PDN had trained nurses in this through practical competency checks.
- A monthly audit of compliance with VTE risk assessment highlighted a consistent high standard of practice and documentation. Between April 2016 and March 2017 every medical inpatient area and the endoscopy unit achieved an overall average above the trust target of 95%. In addition each ward or department met or exceeded the minimum target in all cases except in December 2016 on ward 19, where the target was missed by 0.9%. The endoscopy unit and ward 18 and ward 19 achieved 100% compliance in every month.

Nursing staffing

- The hospital used the safer nursing care Shelford group tool to establish safe staffing levels. Within this framework the senior nursing team used an electronic tracking system to monitor staffing levels in relation to actual patient numbers and levels of acuity. This tool enabled the hospital to respond to increased activity and demands on capacity by sourcing additional

nurses, including from bank and agency. This tool also enabled the senior team to identify the skill mix of the nursing team on duty to ensure staff were deployed to the most appropriate areas.

- The hospital had established that 379 whole time equivalent (WTE) nurses were required to safely operate all inpatient medical areas in acute medicine and long-term care. At the time of our inspection there were 291 WTE nurses in post, which reflected a vacancy rate of 24%. Vacancy rates for individual wards and services varied from 6% on ward 16 to 24% on ward three.
- A senior matron and matron led the AMU, which was divided into two separate wards. Three band seven nurses provided day-to-day leadership and were each responsible for a team of staff nurses and healthcare assistants.
- Although agency nurses received a local induction before they could work in a ward, there were inconsistencies in how this was carried out. For example, senior staff we spoke with on ward 14 said agency staff received only a verbal induction and there was no written checklist or guidance for this. This meant the senior team could not be assured everyone working on the ward had a required baseline of knowledge and understanding of local procedures.
- The AMU had 10 WTE nurse vacancies and three healthcare assistant (HCA) WTE vacancies.
- Planned daily staffing for the discharge lounge was two registered nurses and two HCAs. This standard was met on each day of our inspection and overnight agency nurses provided care. A twice daily handover took place between the permanent staff and agency staff and the nurse in charge told us they felt this worked well and took place consistently.
- Ward 18 formed part of the trust's medical care provision and was staffed by an agency, with a hospital senior nurse present daily Monday to Friday. The hospital and agency jointly managed mandatory training and governance of the nursing team to ensure they delivered care in line with the hospital's policies.
- Nurse staffing levels were not always maintained in line with the NHS Improvement recommended safe standard of a nurse to patient ratio of 1:7. For example,

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on one day of our inspection three registered nurses were on shift in ward 18 to care for 28 patients. A nurse in charge and four healthcare assistants were also on shift. We undertook a sample of nurse to patient ratios during our inspection. On one day in ward 20, there was a ratio of 1:6.5 and four healthcare assistants were also available. On the nightshift this was reduced to a nurse to patient ratio of 1:8.6 with three HCAs.

- We observed handovers on wards 14, 18, 19 and the AMU during our inspection. On wards 14 and 19 we saw the senior nurse discussed each patient in depth and included their social status, involvement with social services, do not resuscitate status and their discharge plan. The discussion included risks of pressure ulcers and falls as well as details of the latest review and instructions from the multidisciplinary team.
- Nurse staffing coordination was not always effective. For example, on one day of our inspection on ward 19, an agency nurse arrived late for a handover but the nurse in charge had not expected them. Several minutes later a nurse from another ward arrived and said they have been sent by the escalation team. However, there had been no communication between this team and the ward senior staff and this meant the handover was interrupted whilst trying to resolve the situation.
- Daily staffing in the endoscopy unit typically included seven procedure nurses, five recovery nurses and two sterilisation and decontamination technicians. The daily team in this unit was flexible to meet planned procedures.

Medical staffing

- There were 13 junior doctor vacancies and three consultant vacancies in medical care services as at March 2017. The hospital participated in the medical training initiatives programme that enabled medical trainees to undertake rotational posts through the Royal Colleges alongside larger teaching hospitals. This was part of the hospital's recruitment strategy to reduce long-term vacancies.
- During our weekend unannounced inspection we reviewed the medical cover available in each area. Two specialist registrars were on-call to cover all medical wards, supported by a GP specialist trainee

and two FY2 doctors. An FY2 doctor held an on-call medical bleep 24-hours, seven days a week. In August 2016 an FY1 doctor was assigned to support the bleep-holder and at weekends a specialist registrar (SpR) was also available.

- At the weekend, two consultants were available on site between 9am and 5pm for acute medicine, including for a post-take ward round. Each consultant was supported by two FY doctors. One of the consultants was based on the AMU. Between 5pm and 10pm at weekends, the on-call SpR covered the AMU and a dedicated SpR was based on the AMU from 10pm to 9am. The consultants were also on-call to review sick or deteriorating patients at the weekend whilst they were on site.
- As part of the frailty pathway on the AMU, a care of the elderly consultant conducted a three hour review each weekend to ensure each patient had the appropriate care plan in place.
- A care of the elderly consultant had recently been introduced to provide care and treatment for medical outliers on ward 15. Ward 15 was a surgical ward that often admitted medical patients due to a lack of capacity elsewhere in the hospital. The hospital had implemented this post to reduce the length of stay of medical patients on ward 15 by facilitating transfer or discharge. However, staff we spoke with described significant gaps in communication and care on this ward with the medical team. For example, one member of clinical staff said they had dealt with cases where nurses had overridden care plans implemented by AHPs without any rationale or discussion and they had escalated this to a senior manager as they could not find a doctor who knew the patient.
- Consultants led twice-weekly ward rounds on care of the elderly wards.
- Procedures in the endoscopy unit were consultant-led and a nurse was also present for every treatment.
- The new frailty pathway had been under additional pressure due to short staffing, including the departure of the lead clinician. To ensure this pathway remained sustainable and patients had access to the care they needed, the medical director dedicated three days per week to patients care for on this pathway and a locum doctor was appointed.

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Major incident awareness and training

- The trust had a target of 85% for the completion of fire safety training. In January 2017 20% of medical staff and 74% of nursing staff were up to date with this.
- Staff we spoke with on the AMU could describe their role and responsibilities in a major incident and had undertaken a major incident demo to help put their training into practice.
- A fire marshal was in post on every inpatient ward and there were clear arrangements for who was in charge in the event of an emergency. During all of our discussions staff at all levels were aware of the arrangements in place specific to their shift.

Are medical care services effective?

Good



We rated effective as good because:

- Although rates of mandatory training were low in a number of areas, a dedicated team of practice development nurses had implemented a number of improvements in specialist training and clinical competency areas. This included in cardiac care and non-invasive ventilation.
- A band five nurse development portfolio was in place for nurses on the respiratory ward and could lead to a university degree programme.
- The speech and language therapy manager had implemented a risk feeding protocol following a successful research pilot project. This resulted in demonstrable outcomes for patients, including a 10% reduction in the admission of patients with dysphagia through more effective feeding regimes.
- The clinical effectiveness team had registered 21 audits in the acute and emergency medicine division for inclusion in the 2016-2017 clinical audit programme.
- During our mealtime observations we saw staff adapted their support to the needs of individual patients, including those with dysphagia and those who needed help to eat.

- The care of the elderly matron had delivered training and briefing sessions to enable staff to more effectively complete the 'This is me' booklet for patients living with dementia. .
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Between March 2015 and February 2016, patients had a lower than expected risk of readmission for the top two specialties for elective admissions; medical oncology and clinical haematology.
- Where staff took part in research activities, they undertook National Institute for Health Research good clinical practice research delivery training. This meant their work was in line with national ethical standards.
- Staff consistently recorded mental capacity and consent and there had been a significant improvement in the monitoring of the use of the Deprivation of Liberty Safeguards (DoLS).

However:

- The hospital performed variably in the 2015 Heart Failure Audit and the National Diabetes Inpatient Audit. This included performance better than national average in discharging patients following cardiac care but worse performance in ensuring patients received a specialist foot review within 24 hours of admission.
- Staff spoke of poor communication within some areas of the hospital that negatively affected patient outcomes. This included contradictory messages to patients by doctors and allied health professionals and a lack of understanding of the use of the rehabilitation care pathway.

Evidence-based care and treatment

- The speech and language therapy (SaLT) manager had completed an audit of risk-based feeding support and the management of dysphagia in older patients as part of a research project to improve overall nutrition for patients with complex needs. This had involved retrospectively auditing patient notes and then implementing training and support for staff on the importance of more timely nutrition assessments after admission. This led to significant improvement in risk feeding procedures. For example, a new information leaflet was provided for patients and relatives and the SaLT manager developed a risk feeding policy to guide clinical staff on appropriate levels of care. In addition, a risk alert system was introduced to the electronic

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patient records system to indicate risk feeding and a diet and fluid regime. A local risk feeding register was put in place that monitored 184 patients between 2014 and 2016. The research project and associated audits were conducted in line with national best practice guidance from the National Audit Office and in April 2016 the SaLT manager conducted a final audit that indicated 10% of patients had avoided unnecessary admission through effective risk feeding assessment and 90% of patients had a completed risk assessment within 48 hours of admission.

- Ward managers conducted audits of patient boards and samples of patient documentation on other wards to provide an impartial review of standards. The care of the elderly matron had used this system to improve the standards of the completion of 'This is me' documentation used for patients living with dementia.
- Care was delivered in line with National Institute of Health and Care Excellence (NICE) guidance in relation to their specific service, including in care of the elderly. However as there was no substantive audit programme, there was not a system in place to monitor compliance with this.
- Staff across wards and services in the acute and emergency medicine division had established an audit programme to produce clinical evidence they could be assured care and treatment was benchmarked against local and national standards. The clinical effectiveness team had registered 21 audits for 2016/17 in care of the elderly, general medicine and diabetes care. Local audits were linked with comparable national audits, such as a local delirium audit and delirium screening audit measuring service against NICE clinical guidance 103. In addition, four audits were planned to measure the quality of the acute medical take. This included intravenous fluid prescription on the acute medical take, the time taken to see patients post referral, timeliness of first consultant review and a handover audit.

Pain relief

- In a staff survey in January 2017, 100% of staff on ward 16 and 89% of staff on the AMU said their patients were never left in unwarranted levels of pain. In the same survey, 89% of patients in on ward 16 agreed with this and 79% of patients on the AMU agreed with this.

- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). This included regular pain assessments in line with the individual's condition and needs and consultant-led pain reviews or referral to a specialist pain team.
- In all of the patient records we looked at staff had included a pain score, which was reviewed regularly. However, where patients were cared for on ward 15 as a medical outlier, we did not find staff always had the skills necessary to assess and respond to pain.

Nutrition and hydration

- The speech and language therapists (SaLT) team had implemented guidance for ward staff on the completion of a post extubation dysphagia screen for patients who had experienced an endotracheal intubation. This included guidance where patients had multiple risk factors and for patients with pneumonia.
- We saw staff followed nutrition risk assessments and screening tools during our observations of the lunch service on three wards. For example, staff checked the consistency of food against patients' food charts and served food on red trays where necessary.
- Staff ensured patients cared for temporarily in the discharge lounge had access to appropriate food and drink, including hot meals and sandwiches.
- At the time of our inspection the SaLT team was implementing a trial of a 'puree petite meal' programme for elderly patients. We saw this introduced to the multidisciplinary team during a daily meeting in which the SaLT team highlighted the process for referring patients to them for food and diet reviews.
- The dementia lead and team had worked with the catering sub group to provide more flexible mealtime options for patients with dementia or reduced appetites. This included smaller portions, providing finger food and meals of different consistencies alongside advice from dieticians and the SaLT team.

Patient outcomes

- Between March 2015 and February 2016, patients had a lower than expected risk of readmission for the top two specialties for elective admissions; medical oncology and clinical haematology. For elective gastroenterology and all non-elective admissions, the risk of readmission was higher than expected.
- The hospital performed variably in the 2015 Heart Failure Audit. This included better than national average

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in one of the four standards and worse than national average in two of the four standards relating to in-hospital care. In the seven standards relating to discharge, the hospital performed better than the national average in four standards and worse than the national average in two standards.

- The hospital performed variably in the 2015 National Diabetes Inpatient Audit. For example, performance was better than the national average in eight metrics and worse than the national average in nine metrics. The largest variation was in the guidance that patients be seen by the multidisciplinary diabetic foot team within 24 hours of admission. In this metric the hospital performed at 42%, compared to the national average of 69%.
- Between June 2016 and November 2016, 71 patients experienced a transfer between the hours of 10pm and 7am. National guidance suggests overnight transfers are related to poor patient outcomes and should be avoided wherever possible. All overnight transfers in this period took place from the AMU.
- Senior clinical staff on ward 15, a surgical ward, described problems with communication in obtaining medical support for patients admitted there as outliers. For example, although a consultant and senior house officer were in place to review these patients, staff told us they had no means of contacting them. A senior member of staff said, "They [doctors for medical outliers] will only see patients if they're physically handed over. They don't carry bleeps, they have unconfirmed working hours and when we've left messages on their mobile phone they don't reply. They haven't been today and we don't know when or if they will come."
- Between April 2016 and April 2017 staff in the Trafalgar Clinic conducted eight audits, including two audits to establish care standards against national BASHH guidance.

Competent staff

- Nurses received specialist training appropriate to their ward and the needs of patients. For example, nurses on the AMU had completed specialist training to enable them to care for patients with chest drains, including practical training from a consultant and competency training on the use of the care pathway. Nurses on ward four, a cardiology ward, had received training in cardiology nursing. Senior nurses had undertaken

practical cardiac clinical competencies and the PDN was planning to introduce formal accreditation for this in the near future. On ward three, a respiratory ward, 80% of staff had completed training in non-invasive ventilation (NIV) and the management of tracheostomies with the support of the PDN. Staff on ward 21, which provided oncology services, received specialist training to care for patients who received chemotherapy and those on end of life care pathways.

- The PDN responsible for ward three had introduced study days for nurses that took place during scheduled work hours and gave nurses and HCAs access to the education centre. This PDN was also responsible for the AMU and wards three and four and had implemented a band five nurse development portfolio. This included a supported and structured programme of developmental competencies in infection control, pressure sore management and oxygen administration. Nurses received quarterly reviews and one-to-one opportunities for reflection on practice. Successful completion of the portfolio led to the opportunity to undertake a respiratory degree at a university.
- Foundation level doctors underwent a general trust induction followed by specific inductions for each ward, department or service they rotated through.
- The NHS nurse in charge on ward 18 had worked with the senior nurse provided by the agency that staffed with ward to improve the standard of patient documentation completed by nurses. This had particularly focused on discharge documentation and the senior team said the coaching provided had significantly improved this. The senior team had implemented a daily flowchart for nurses to follow to help them understand their responsibilities in relation to documentation depending on the shift they were on.
- Although established protocols were in place to ensure agency nurses had the appropriate skills and clinical competencies to provide adequate levels of care, some clinical staff raised concerns about this in practice. One doctor said, "The agency nurses I see on night shift often have low levels of clinical skills. I have seen nurses who can't cannulate and can't take bloods. It is not uncommon to get a call from a nurse who doesn't know what a NEWS score is and so hasn't taken one. You have to try and teach them while managing an extremely heavy workload and once you get five or six calls from

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nurses who don't have the skills they need, the whole shift falls apart." NEWS refers to the national early warning score and is discussed in more detail in the 'safe' section of this report.

- The endoscopy unit had a nursing team that included more than 50% new staff. This meant although nurses were qualified to be in post there was a lack of experience in the team. A senior nurse we spoke with said this was challenging because it meant they had to allocate the most experienced staff to patients known to be at risk for bleeding or other complications as more junior staff did not yet have the clinical competence to deal appropriately with this. A nurse educator was in post in the unit but did not have the capacity to complete practical competency checks on staff.
- Each member of staff should have received an appraisal each year. Staff in the endoscopy unit told us they had received at least one appraisal in the previous 12 months and they felt these were useful to speak to their senior team about training needs and identify areas of good work as well as areas to work on for improvement.
- In a January 2017 staff survey, 86% of staff on ward 16 said they felt sufficiently trained to carry out their job and 93% of staff on the AMU said the same.

Multidisciplinary working

- Twice weekly multidisciplinary team (MDT) meetings took place and were attended by a pharmacist, physiotherapists, occupational therapists and senior ward nurses. In addition, daily MDT huddles took place on each ward that staff used to review patients who were recently admitted, those with complex needs and patients with a planned discharge.
- An older adult's mental health team was available on-call. This team provided as-needed support to ward-based staff and reviews for patients with complex or deteriorating needs. Ward staff told us this team was always available and they had been particularly helpful in supporting patients whose confusion or reduced mental acuity continued despite the improvement of their medical condition.
- Some staff described ineffective communication in MDT working. For example, AHPs told us they made recommendations against transferring patients overnight because of the distress this could cause. However, they told us other staff often overrode this and transferred the patient without any communication or discussion of risk management. In addition, nurses were

not always given an adequate handover when patients were transferred overnight. For example, AHPs described having to complete ad-hoc handovers on ward 18 when patients had been transferred and nurses were unaware of their previous care from the dietician, physiotherapists and occupational therapists. AHPs told us they often had to visit wards to show ward staff where to access their notes, which duplicated work and took time away from seeing patients to deal with a problem that was avoidable. As part of this discussion, AHPs also identified the need for improved communication between clinical teams. For example, staff told us they had intervened in a situation where a doctor had told a patient they would be cared for on a rehabilitation pathway. However, they had not been assessed by an AHP and the occupational therapy team's subsequent assessment identified the patient was not suitable for rehabilitation. This meant the therapist had to have a difficult conversation with the patient that could have been avoided.

- A 30 minute multidisciplinary board round took place daily on the AMU to coordinate care, identify deteriorating patients and ensure appropriate access and flow through the hospital. We observed a board round during our inspection and saw it was attended by the AMU ward manager, nurses and the medical team, pharmacists, a radiologist and allied health professionals. A similar meeting took place on ward three, which we observed to include a detailed review of the needs of each patient.
- Members of the multidisciplinary team raised concerns that patients cared for as medical outliers on surgical wards did not always receive appropriate levels of care and assessment. For example, the AHP team said they did not always receive information or a handover of medical patients cared for on ward 15. This meant the team were only aware of patients if they proactively looked for them and this could mean patients experienced a failed discharge because medical staff had not involved the AHP team at an appropriate stage.

Seven-day services

- A SaLT therapist was available in the hospital on Saturdays from 9am to 12.30pm. The therapist reviewed newly referred patients as well as all those who were currently 'nil by mouth' and all patients on the AMU.
- Occupational therapy was available between 9am and 2pm at weekends but staff told us this was only

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provided if they agreed to work overtime. Physiotherapy was provided at weekends in the respiratory and orthopaedic services, again if staff agreed to work overtime.

- The discharge lounge was available 24-hours, seven days a week. It was used for planned discharge patients from 8am to 8pm weekdays and from 9am to 6pm at weekends. Overnight it could be staffed as an escalation area.
- The endoscopy unit offered a seven day service to increase capacity and meet demand. Bank staff operated the clinic on a weekend under the supervision of permanent consultants.
- The endoscopy team had identified unreliable out of hours radiology cover as a significant risk to the service. This was because there was a risk it could not meet the London Standards criteria and risked patients being transferred to another centre.

Access to information

- Consultants issued discharge summaries electronically to GPs. We looked at six discharge summaries on ward 18 and the AMU as part of our inspection. We saw they were comprehensive and included clear follow-up guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff used the abbreviated mental test (AMT) on admission for each patient and used the score to refer to specialised dementia services if needed. We saw the AMT in use in all of the inpatient records we looked at.
- The dementia lead monitored DoLS applications on a weekly basis at each hospital and circulated a list to the senior medical team each Friday. This meant there was always a record of inpatients with an active DoLS and staff working on a weekend had ready access to this information. The dementia and safeguarding lead had recently completed work with staff at the Queen Elizabeth Hospital to improve their reporting of DoLS applications to the trust's safeguarding team following an audit in July 2016 that indicated DoLS were inconsistently reported.
- We asked all of the patients we spoke with about consent to care and treatment. In each case patients told us staff always asked them before an examination or starting a treatment plan or procedure. We also spoke

with staff about this, who demonstrated knowledge of consent procedures. This was further evidenced through our check of patient records, which demonstrated consistent documentation of consent.

- Staff documented consent in the endoscopy unit on the day of the procedure and documented this in patient notes. We observed this process in practice and in five patient records we looked at consent had been documented.

Are medical care services caring?

Requires improvement

We rated caring as requires improvement because:

- There had not been a consistent and sustained improvement in the feedback we received about the attitude of and approach of some staff. This included a lack of compassion in some instances, such as when patients needed to use a commode.
- We observed care on ward 19 that did not maintain patient dignity and was likely to cause offence.
- Patients and relatives we spoke with gave variable feedback about their experiences of staff. Some patients described "excellent" care and said they felt well looked after. Other patients said staff had been rude to them and they felt unable to ask for help as a result.
- Patients did not always feel involved in their care or their medicine treatment plan. Some patients said staff spoke to them in medical terms and one patient said they felt staff treated them differently because of their age.
- Patients cared for as medical outliers on a surgical ward described difficulties in obtaining medical reviews. One patient had missed a diagnostics appointment as a result and another had self-referred to private care.

However:

- Overall the response rate in the NHS Friends and Family Test was significantly better than the national average and some wards received consistently high scores, including ward three.

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- A carer's charter was in place in the hospital and staff had adopted the principles of the national John's Campaign to provide a more welcoming and flexible approach to carers visiting patients.
- A 24-hour multi-faith chaplaincy service was available.

Compassionate care

- The trust participated in the NHS Friends and Family Test (FFT). Between December 2015 and November 2016 the response rate at this hospital was 42%, which was significantly better than the national average of 25%. In this period ward three and the Trafalgar Clinic scored consistently well, with results of 100% in seven out of 12 and eight out of 12 months respectively.
- We observed staff treat patients with care, respect and dignity during most of our observations. However, we saw some patients in the discharge lounge were waiting for patient transport and being sent home in a dressing gown or hospital bed clothes. On ward 20 we observed a patient in a side room had undressed themselves in view of the main ward area and staff responded quickly and gently helped them to re-orientate themselves and to dress.
- Some staff described ward staff as less than compassionate. For example, one allied health professional said they felt ward staff did not always have sufficient training to be able to provide appropriate care to patients living with dementia. For example they told us, "I have witnessed nurses calling patients 'rude' to their face, even when it was blatantly obvious the patients were confused and distressed. This makes the patient's behaviour escalate and the nurses raise their voices. I have intervened on a number of occasions when this has happened."
- One patient in ward three described staff as, "efficient and caring" and said there was always someone in their bed bay. Another patient on this ward said nurses and healthcare assistants had been "lovely" and "completely different" to their experiences elsewhere in the hospital. Another patient on ward three told us all of the nurses they had met were caring and they appreciated the time they took to provide personal care, including washing their hair. Another patient said staff were too busy to help them take a shower as often as they liked and told us nurses would sometimes use wet wipes instead for speed. Patients on this ward told us staff treated them with respect but said a lack of commodes made toileting difficult and they often had to wait up to 20 minutes when they needed a commode.
- We spoke with five patients in the discharge lounge, all of whom were positive about the standard of care they received there. One patient said, "The care is fantastic in here, I can't fault them." Two other patients said they felt treated with respect.
- We spoke with three patients on ward 19 who described variable experiences of care. One patient said they had complained to the ward sister about a "very rude" nurse during the night but did not know if anything had been followed up. Another patient said, "Some nurses are quite friendly but others are rude, abrupt and I feel bullied when I ask for help with a shower. The manner of some individuals is not at all friendly." All three patients spoke with us about a lack of understanding of their needs by some members of staff. Two patients said night times on the ward were noisy. For example, one individual said, "I can hear staff laughing and joking in the middle of the night and there's lots of banging of doors and equipment. I don't sleep well because of that." Another patient said, "They [staff] make me feel like last week's lunch. I've learned not to expect anything in a hurry. This morning I wet myself because I waited so long for a nurse to answer the buzzer, I was mortified."
- Three patients on ward 18 we spoke with said they were happy with the care provided by nurses. One patient said, "They are good at answering my call bell, night or day. Staff are kind and if I don't understand something they've always taken the time to explain." One patient said they were embarrassed to ask for staff help to use the toilet during the night and so a nurse had provided a commode. This meant they could remain in their side room and maintain some independence with toileting, which they said helped to make them feel more dignified.
- On one day of our inspection we observed a handover on ward 19 in a six-bedded bay. The member of staff stood in the middle of the room and pointed to each patient, addressing them as "this one." Some patients were awake and observing this, which was demeaning and disrespectful.

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- The environment in the endoscopy recovery area made it difficult to maintain privacy and dignity. This is because bed bays were close together and the area was crowded, which meant we easily overheard private conversations. Staff tried to mitigate this by closing privacy curtains and the service offered clinics daily on a single-gender basis.

Understanding and involvement of patients and those close to them

- A patient on ward three said they appreciated that staff had involved them in their discharge plan. In addition, ward staff had liaised with social services to urgently arrange respite care for a relative who was left alone at home following their unexpected hospital admission. Two other patients on this ward said staff had not discussed discharge with them and another patient said their discharge had been delayed but they had not been told why.
- We spoke with 12 patients about their understanding and involvement in medicine reviews and changes. Six patients said they felt involved in this area of their care, including one patient who said they felt there was good involvement from the pharmacy team. One patient said a respiratory nurse had changed the type of oxygen pump they used but hadn't told them why and said they were finding the new pump difficult to use. Another patient said they had their prescription changed several times and felt anxious because staff had not explained the reasons why. One patient in the discharge lounge said a member of staff had taken their asthma pump and had not told them where it was, which was causing some anxiety. The remaining three patients said staff had not discussed medicines with them.
- We spoke with two medical patients who were being cared for as outliers on a surgical ward. Both patients described delays in seeing doctors and nurses and confusion over their care and treatment plans. For example, one patient said they had been waiting for a CT scan for three days but staff told them these were prioritised only for outpatients. Another patient said they had booked an MRI scan with a private hospital after waiting five days in the ward for this. They said a doctor had told them a previous scan had missed "a big issue" but then gave conflicting information to them and their relatives. On one day of their inpatient

stay staff had given incorrect patient transport arrangements to the patient which meant they had a few minutes to get ready to be transferred to another hospital for tests, which they said meant they were "in pain" whilst nurses rushed to get them ready. They missed their booked appointment because of miscommunication between the ward and the transport service, leading to a further delay.

- Patients on ward 19 discussed variable experiences of being involved in their care. One patient said, "I feel like the nurses and doctors talk at you in medical terms. They don't check to see if I understand what they've told me." Another patient said a doctor had told them they were 'nil by mouth' and they were subsequently confused the next morning when a member of staff brought them breakfast. They told the member of staff about this who did not know about the situation.
- One patient on ward 18 showed us they were wearing a red wristband and had not been told what this was for. They said this made them feel anxious and said, "They [staff] treat me like I'm stupid because I'm old."
- It was not always evident that staff ensured patients understood their care plan or treatment needs. For example, allied health professionals told us it was common for them to meet patients who were confused because they had been transferred overnight, which meant that had been moved in the dark and staff had woken them up to do this.
- We observed a consultant ward round on the acute medical unit (AMU) and saw they involved each patient in a discussion of their care and treatment plan. The consultant also offered an explanation of anything patients wanted to know more about.

Emotional support

- A carer's charter was in place in the hospital and staff had adopted the principles of the national John's Campaign to provide a more welcoming and flexible approach to carers visiting patients. This included ensuring staff provided emotional support where needed and facilitated visiting hours to meet individual needs rather than the usual rules of the ward.

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In a January 2017 staff survey, 89% of staff on the AMU and 100% of staff on ward 16 stated they thought the emotional support provided to patients and relatives met their needs. In the same survey, only 60% of patients on ward 16 and 68% of patients on the AMU agreed with this.

Are medical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Senior ward staff described difficulties in sourcing enough staff to provide one-to-one care for patients with mental health needs.
- Staff in some clinical areas did not know about the dementia strategy or that there was a lead in post who could help them provide care.
- Although activities had improved overall, patients on some wards told us they were not offered the chance to take part or had not noticed any activities going on. They told us this resulted in boredom and they felt isolated as a result.
- Patients cared for as medical outliers on surgical wards were not always provided with the most appropriate care and treatment and this was reflected in the high proportion of complaints received relating to this.
- Although there were improvements to access and flow, patients in the emergency department still regularly waited up to 24 hours to be admitted due to delays in obtaining assessments from clinicians from medical specialties.

However:

- A new frailty pathway implemented in June 2016 was embedded in the acute medical unit and we saw this was responsive to the needs of elderly patients.
- Between April 2015 and March 2016 the average length of stay for medical non-elective was 6.7 days, which was similar to the national average of 6.6 days.
- There was a consistent focus on avoiding unnecessary inpatient admissions such as through the provision of additional multidisciplinary staff at a weekend and improved discharge planning.

- The average length of stay on ward 18 since our last inspection in June 2016 had significantly decreased. At that inspection we found patients stayed in the ward for up to four weeks. At this inspection the average length of stay was between two and five days.
- Between August 2015 and July 2016, 3540 patients experienced at least one bed move during their inpatient stay. This represented an 8% reduction from the previous year.
- There was a three year dementia strategy in place to improve care, resources and staff training for patients living with dementia. This included better multidisciplinary team working and the provision of resources such as large clocks and pictorial signs as well as training for security staff.
- Activities available to patients had been significantly improved, including through planned activities such as afternoon tea, doll therapy and visits from a choir. A team of 30 volunteers had been recruited and were being trained at the time of our inspection to provide safe and responsive support to patients and their relatives.
- Staff used tools such as an enhanced care bundle or hospital passport to structure care to patients with complex needs, including dementia or a learning disability. Translation services were readily available and staff in some areas had developed their own communication tools.
- There was evidence of positive inter-departmental working to investigate and resolve complaints and we saw examples of learning from investigations. This included improvements to practice.

Service planning and delivery to meet the needs of local people

- Senior staff on wards 19 and 20 described difficulties in sourcing enough staff to provide close supervision and care for patients with complex mental health needs. For example, the ward manager and matron said they had to budget to increase staffing as needed but there were rarely enough nurses or healthcare assistants available from the bank team or agency to provide additional staffing for patients who needed one-to-one care. For example, on one day of our inspection 23% of patients on ward 19 required an increased level of supervision but the ward manager had not been able to secure any additional staff. To mitigate the risk associated with this

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as far as possible, the ward manager ensured only one nurse in each bed bay worked behind a privacy curtain at any one time. This meant there was always one member of staff in the bay to supervise other patients.

- The tissue viability nurse had trained a number of ward staff in how to complete comfort rounds for patients admitted from nursing homes with poor tissue viability. Staff also had access to pressure-relieving equipment on demand.
- The hospital saw increasing numbers of patients with dementia and mental health needs. A mental health team was available in the hospital but specialist cover for dementia care was significantly short of demand.
- At our last inspection a new frailty pathway had been implemented in the acute medical unit (AMU) to increase capacity for elderly patients. We saw this was now embedded in the service and was working well.
- A joint emergency team worked with medical care wards to avoid hospital admissions and assist patients to access specialist community beds, including for rehabilitation.

Meeting people's individual needs

- Each inpatient ward or clinical area had a display with photographs of the permanent team and their job role as well as contact information. This was not always in an accessible format or location, which meant it could be difficult for patients with communication or mental health needs to access it.
- A dementia lead was in post who was responsible for the development and implementation of a three-year dementia strategy. This included increasing the provision of activities on wards and the implementation of a team of 30 volunteers. At the time of our inspection volunteers were being trained in working with people with dementia, which included providing enhanced care.
- Staff used a trust-wide dementia pathway that included onward referral to specialist support, a capacity assessment, assessment for the Deprivation of Liberty Safeguards and a risk feeding policy.
- The dementia lead worked with local care home forums to provide coordinated care for patients with dementia.
- Senior ward staff were able to accommodate the relatives of patients with dementia who were admitted as inpatients. This included providing unrestricted visiting hours and on-site overnight accommodation.

- A medical locum doctor led medical care for patients with dementia as part of a multidisciplinary team with physiotherapists and occupational therapists who had undertaken dementia competency training. This team had broadened the reach of dementia services by supplementing the support and care provided by nurses and healthcare assistants. The dementia lead told us this improved engagement with patients because if offered them more variety of activities and interaction with staff. It was not always evident that staff in every department understood the support available to them in providing care for patients with dementia. For example, staff in the endoscopy unit told us they were not aware of a link for dementia and they would rely on a relative or carer from a patient's care home in the event they were booked for a procedure and were living with dementia.
- The matron for acute and emergency medicine was working with the security team to raise awareness and understanding of patients living with dementia. This had improved the response of the security team to incidents on wards. For example, the team tracked which officer responded to an incident and where a similar incident occurred again they prioritised the same officer so they could build a rapport with the patient and try and reduce aggressive or violent behaviour.
- As part of the overall trust strategy to improve care and services for patients living with dementia, the dementia lead, matron for acute medicine and the dementia working group had worked together to provide improved activities for patients. This included visits from a violinist to provide music therapy, singers from a local university, hand massage and doll therapy. The team also arranged theme lunches at 'pop up' pubs that served non-alcoholic beer and afternoon tea services. Ward staff had access to personal DVD players and staff had sourced reminiscence programmes to help patients relax and reorientate them. AHPs and members of the local community ran a choir based in the hospital that organised singing events for patients.
- Some wards had implemented environmental improvements for patients living with dementia and those caring for them. For example, each bed bay in ward 18 had a large clock to help patients with reduced cognition or eyesight and toilets and bathrooms had pictorial signs at an appropriate height for patients to see them. Large pictorial signs were in place on ward 14 to help guide patients to toilets and showers. This was a

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useful tool for patients living with dementia or with reduced visual ability. In ward 14 and the AMU, staff had implemented dementia displays that included information for family members on how to cope with the condition as well as signposting to specialist support services.

- Staff provided large-print communication sheets for patients who found it difficult to communicate verbally. This included pictorial prompts and meant patients could communicate by indicating a mood, need or message without the need to speak. We observed this tool in use between a patient and healthcare assistant on a care of the elderly ward and saw it worked effectively and improved the empowerment of the patient.
- A pharmacy satellite unit was based on the AMU and was staffed by pharmacists, technicians and administration staff. This service had been implemented to ensure patients who were ready for discharge received their 'to take out' (TTO) medicine without a delay awaiting medicine from the central pharmacy. Out of hours, clinical staff had access to TTO medicine stored on the ward to ensure they could facilitate discharge when the pharmacy satellite unit closed.
- Staff used a discreet symbol on the information board above the bed of each patient with dementia. This helped staff to identify patients who needed more time to communicate and for whom they might need additional specialist help to care for. Another symbol was used for patients considered to be at high risk of falls.
- The NHS nurse in charge on ward 18 had implemented a daily activities programme for patients. This included daily group activities in each bed bay and the nurse adapted these to patient requests. We observed activities taking place on each day of our inspection. However, three patients we spoke with on this ward said they had not been offered the chance to take part in activities. One patient said, "There is nothing to do, it's like being in prison." On wards 19 and 20 HCAs had been trained to provide activities although this depended on them not having any clinical tasks waiting before they could begin.
- We spoke with ward staff in every area we visited about access to palliative care. In each case the nurse in charge demonstrated awareness of the process although there were differences in each individual's understanding of the role of the end of life clinical nurse specialist and the in-reach hospice team.
- Staff used an enhanced care bundle for patients who needed a higher level of supervision. This included a focused ward round by a nurse every 15 – 30 minutes to check on their condition and need and to update risk assessments and observations. We saw enhanced rounds in progress and we looked at the associated documentation, which indicated patients received more targeted care as a result.
- Staff used a hospital passport for patients with complex or additional needs, such as learning disabilities, dementia or reduced mental cognition.
- Some inpatient wards provided a printed information leaflet for patients and visitors that outlined the type of clinical care provided and other practical information such as visiting hours. For example, the leaflet for ward 20 included a colour-coded guide to staff uniforms and roles, the names of the senior team, facilities available on the ward and the values of the ward team.
- Patients described variable experiences with the standard of catering. For example, one patient on ward three had received the wrong meal during one day of admission and said the quality of food was variable. Two patients said their main meal and dessert were served at the same time, which meant frozen desserts had melted or hot desserts were cold by the time they started eating them. One patient said, "They [catering staff] offer odd combinations. I was given macaroni and cheese yesterday and they offered mashed potato with it." Three patients on ward 19 were critical of their experiences with the meal service. One patient described the food in the previous six days as, "unappetising, tasteless and cold" and another patient said their relatives brought in food secretly from home because they found the food "unpalatable".
- Patients on ward three had direct access to a communal garden. Eight patients we spoke with on this ward said they often felt bored and that there was a lack of activities or things to do. Televisions were fitted to most bed areas but this system was not working. One patient had borrowed a portable DVD player from a member of staff but there was not a stock of items such as this for all patients.
- A reminiscence room and facilities for social eating were available on ward 19 and an HCA had been trained to

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provide activities for patients living with dementia.

However, we did not see evidence of this during our inspection and on one day staff were using the reminiscence room for training. Three patients on this ward told us staff had not offered activities and they were not aware of anything available. One patient said a neighbour was being cared for elsewhere on the ward but staff had told them they were too busy to escort them to spend time together. Another patient said they appreciated a nurse who brought in newspapers every morning, which helped to relieve boredom.

- Staff on ward 20 played calming background music in bed bays to help patients feel relaxed in what was a busy environment. We found this worked well and patients we spoke with on this ward said they felt staff were present and attentive and that they felt the environment was relaxing and welcoming.
- Three female patients on wards 18 and 19 told us they were unhappy personal care had been provided by male staff without being asked first.
- Signage inside the hospital to help people navigate the site was not always clear or easily understandable. For example, there were no signs at any of the entrances to direct patients to the endoscopy day unit.
- A preparation leaflet was issued to each patient ahead of an endoscopy procedure to ensure staff were able to carry out their booked procedure. Where a patient was booked into a procedure from a ward, they did not always receive preparation information. For example, on one day of our inspection a patient had their procedure cancelled because they arrived without having prepared for their procedure. Staff spoke with them and found that their referring ward had not given them a printed information leaflet before they were discharged.
- Interpretation services were readily available in the hospital and staff in each area could access telephone translation support and could book interpreters to attend appointments with patients or visit them in inpatient areas.
- Each ward provided same-sex patient bays to avoid mixed sex breaches and all inpatient wards had private en-suite side rooms.

Access and flow

- Between April 2015 and March 2016 the average length of stay for medical non-elective patients was 6.7 days, which was similar to the national average of 6.6 days. For clinical haematology, the average length of stay was six days longer than the national average.
- There was a consistent focus on avoiding unnecessary inpatient admissions. For example, a speech and language therapy (SaLT) post had been introduced on a Saturday morning to review AMU patients and those seen in the emergency department. Using a risk feeding protocol, the SaLT therapist could implement a plan of care and avoid the need for an inpatient admission.
- Daily multidisciplinary team meetings included discharge planning, which we saw in practice from our observations of meetings.
- SaLT, physiotherapists and occupational therapists were available on site on Saturdays to assist in discharge planning. This involved working as part of a multidisciplinary team to review patients who were medically fit and to expedite their discharge home at the weekend.
- The hospital had introduced weekend matron shifts in December 2016 to support discharge planning and flow through the hospital. Weekend matrons also supported patient discharges into community beds and care homes, which was intended to reduce delays due to social or housing needs.
- Ward managers attended three daily bed meetings to coordinate patient care, access and flow. However, patients in the emergency department (ED) still experienced delays of up to 24 hours in undergoing a medical review to be admitted to a medical specialty in some cases. In response senior divisional teams had enforced agreed professional standards in medical specialties and implemented monitoring of referral times from the ED. As part of this initiative, a new chest pain pathway had been established that would enable clinical staff to transfer patients directly from the ED to the cardiology ward. Although this had been agreed in principle between clinical teams, it had not yet been implemented at the time of our inspection.
- The nurse in charge of the discharge lounge checked the hospital transport system at the start of each shift to identify patients expected to arrive in the lounge and liaised with each ward to coordinate their transfer. In

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In addition this member of staff attended each daily bed meeting to identify patients ready for discharge. A dedicated porter was assigned to the discharge lounge from 9am to 4pm on weekdays.

- The discharge lounge did not have written admission criteria but patients with mental health needs or those living with dementia and who wandered and patients on an end of life care pathway could not be cared for in the unit. However, we did not see from our observations that this was always adhered to. For example, we saw a patient living with dementia waiting in the discharge lounge who was confused and frequently moved around the unit. Although staff encouraged them to sit down they did not try and explain the situation to them or provide more than basic reassurance.
- Ward 18 was a pre-discharge ward for patients who were medically fit for discharge. This ward was intended for short-term patient stays. Due to a lack of capacity in the community, such as in care homes, patients often stayed in this ward for extended periods of time. However, the average length of stay since our last inspection in June 2016 had significantly decreased. At that inspection we found patients stayed in the ward for up to four weeks. At this inspection the average length of stay was between two and five days.
- A discharge coordinator and patient navigator formed a discharge team and we saw evidence of their planning and involvement with patients during our observations of nurse handovers and review of patient notes. Ward based staff said although the discharge team and older adult's mental health team worked hard to secure appropriate discharge placements for patients, it was increasingly difficult to find appropriate placements for patients who demonstrated violent behaviour or with needs relating to substance misuse.
- Between April 2016 to July 2016, 133 patients were cared for as medical outliers. A consultant and senior house officer provided dedicated care and medical reviews for these patients Monday to Friday. Overnight and at weekends the matron of the day reviewed them during a daily bed meeting. However, senior staff on ward 15, a surgical ward that accepted medical patients and AHPs described significant concerns about communication with this team.
- Between August 2015 and July 2016, 3540 patients experienced at least one bed move during their inpatient stay. This represented 25% of patients and included 2562 patients who experienced one bed move,

765 patients who experienced two bed moves, 169 patients with three bed moves and 44 patients with four or more bed moves. Overall bed moves had reduced by 8% when compared with the same period in 2014/15.

- Between March 2016 and March 2017, 466 endoscopy procedures were cancelled. This represented 3% of the service's total bookings and was a trust wide figure.

Learning from complaints and concerns

- Between December 2015 and July 2016, medical care services received 77 formal complaints, of which 43% related to the AMU. Complaints regarding medical outliers on surgical wards accounted for 16% of the complaints, which related to 10 wards or areas.
- Staff in the discharge lounge were able to demonstrate how learning from complaints was used to improve services. For example, a care card had been introduced to patient transfer forms that enabled staff to record temporary care notes to the transfer information sent from the ward.
- All ward managers had undertaken complaint training to help them manage local complaints more effectively. We saw this had a positive impact. For example, following the training, complaints received on ward 18 had been resolved with the first approach implemented by the ward manager with no escalation or continuation.
- There was evidence services worked together to resolve complaints. For example, staff in outpatients, the Trafalgar Clinic and the respiratory ward worked together when a patient inadvertently received an incorrect HIV test result sent by their GP. Investigating staff found this occurred due to a lack of communication protocol between the laboratories, the clinical team who ordered the test and the patient's GP. As a result all services involved declared a joint serious incident and worked with the laboratory to establish testing and communication protocols to ensure only final, accurate results were sent out. The investigating team involved the patient's GP in this to ensure knowledge was more widely shared.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

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- Although there was evidence of improved clinical governance and leadership since our last inspection in June 2016, there was not yet a coherent and stable track record of improvement across all clinical areas and teams.
- Staff representing different professional groups gave highly variable feedback on their engagement by the trust, working culture and morale. Some staff felt they were not included in the trust's future development strategy whilst others said they had been. Overall this represented a lack of consistency in how staff felt involved and valued.
- Junior doctors and allied health professionals did not always feel valued or able to cope with their workload. Individuals from both teams described instances of unsafe practice as a result of poor leadership or risk management.
- Senior staff in some areas described significant levels of clinical risk as a result of poor communication. This included the inability to contact consultants who would not carry a bleep and uncertainty around who was responsible for different patients.
- Services in the hospital were operated in divisions, each with a divisional director, divisional manager and divisional head of nursing. The divisions responsible for medical care services were the division of acute and emergency medicine, the division of long term conditions and cancer.
- A team of matrons led nursing care within medical specialties. This included an elderly care matron for wards 18, 19 and 20. Matrons held ward manager meetings on a monthly basis for their respective areas.
- An operations lead, delivery manager and eight trial coordinators led the research and development function of the hospital. This included management of contracts, finance and ethics and horizon-scanning for future opportunities. This team planned to expand the research function to incorporate other sites within the trust.
- Staff in the endoscopy unit spoke positively about leadership. One nurse said they often saw the nurse in charge and matron help out in recovery and procedure rooms and said this helped them in what was a very hectic department.
- Ward managers met together weekly as part of a 'diamond meeting' that enabled them to share leadership strategies, needs and experiences.

However:

- Staff in all wards and the endoscopy unit spoke highly of their local leadership. Staff on ward three told us local leadership had improved since our last inspection and this was reflected in a demonstrably more stable team.
- The dementia working group was working with the facilities and estates teams to improve the physical environment of the hospital to make it safer and more suitable for patients living with dementia.
- Clinical governance and risk management strategies were in place for research studies and clinical trials.
- We saw evidence of improved practice as a result of structured clinical governance processes, such as plans to improve nurse retention by the dementia steering group.
- Staff we spoke with could demonstrate how they applied the duty of candour in line with national guidance.

Leadership of service

Vision and strategy for this service

- The trust had included dementia as a corporate objective in 2017 to raise its profile in the organisation as part of a three-year dementia strategy.
- Staff we spoke with did not always feel involved in the trust's improvement strategy. For example, a senior nurse said, "I haven't been involved in the vision; we just get told what's happening. The chief nurse and chief executive seem hands-off; I don't feel that we're consulted on changes." We were also given positive examples; a senior nurse in the endoscopy unit who told us they had seen the plans and been given the opportunity to feed back to the senior team. They also said the trust released weekly updates, which they always took time to read.
- We spoke with the service leads for acute and emergency medicine. This team described positive improvements in the previous 12 months, including improved community discharge support and better support for doctors in providing complex care.

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Governance, risk management and quality measurement

- Senior matrons, matrons and ward managers led clinical ward services with additional responsibilities in specialist areas. For example, one matron responsible for four medical wards was also the hospital's dementia lead. An NHS matron had oversight of ward 18, which was staffed by agency nurses who reported to both the hospital matron and the agency matron. Clinical governance on this unit was jointly managed by the hospital and the agency through monthly joint meetings. A series of steering groups and working groups maintained oversight of clinical areas, clinical practice and patient outcomes.
- A dementia and cognitive steering group met on a bi-monthly basis and reported to the integrated governance trust board. A dementia working operational group contributed to this dementia governance structure.
- The dementia lead had identified risks to patients specific to the Queen Elizabeth Hospital. This included the lack of a secure garden that would allow patients to wander and a lack of information on admissions documentation. In addition, a think tank had conducted an environmental audit that highlighted risks such as the height of some walkways and the lack of communal space on some wards as further risks for patients with dementia. In response the dementia working group and dementia lead were identifying improvements to the hospital as part of the dementia strategy. This included a working relationship with the facilities and estates team who worked with the dementia lead to ensure any redecoration was completed with the needs of people living with dementia in mind. The team had also recognised short staffing and staff turnover on the care of the elderly wards as a significant risk to patients living with dementia. This was because it meant there was a lack of consistency for patients, which could be unsettling, as well as a lack of opportunities for activities.
- Ward managers from the AMU attended monthly clinical governance meetings with the multidisciplinary team to discuss local issues, incidents and learning outcomes from recent events. We looked at the minutes of

meetings in the three months prior to our visit and found them to be well attended and focused on the local issues of the ward, with discussion of trust-wide issues that affected the operation of the service.

- Senior teams used monthly directorate meetings to disseminate new information and national guidance to colleagues.
- Senior teams in each division managed risks to the service, patients and staff through the use of risk registers. This enabled the leadership team to assess the potential likelihood and impact of a risk and assign an appropriate member of staff to lead work to minimise or remove the risk. The hospital had an overall risk register and individual wards and services maintained versions that applied to their specific areas. Senior staff on individual wards demonstrated knowledge of the risks associated with their area, such as staffing on care of the elderly wards.
- Staff spoke variably of access to team meetings. For example, staff in the endoscopy unit said team meetings were monthly and were held at a time everyone could attend. This meant departmental and ward-based teams met to discuss risks on a regular basis. On ward four, the team met every quarter to discuss education needs, complaints and incidents and learning from these. This was supplemented with a daily safety huddle to plan the shift and identify any immediate concerns or risks, including deteriorating patients.

Culture within the service

- Foundation level doctors spoke variably of their workload and the working culture of the hospital. For example, doctors spoke about a specific on-call bleep that required them to cover the entire medical care provision in the hospital. One doctor said, "I've held that bleep and left work feeling broken." Another doctor said, "That bleep is pure and utter chaos. I started my first shift doing that with no idea what each ward was, no idea where they were and with no handover from anyone." Doctors who had held this bleep told us it was common to hold responsibility for up to 60 acutely unwell patients at once with bleeps every few minutes. One doctor said, "There is no way to see every patient who needs you when you're on that shift. I have held the bleep by myself for a whole weekend and it's scary. I don't know what the escalation procedures are and there is no way to tell which consultants are on site or who is on call."

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- AHPs we spoke with did not feel valued or respected by the senior team or by all colleagues on the wards. For example one AHP said, "I don't feel that we're seen as team members, just as 'the help' to reduce the workload. We end up doing a lot of nursing duties because we can't leave the patients in the state we sometimes find them in but we never get thanked."
- Most of the staff we spoke with described their line manager and senior team as supportive, including nurses in the AMU who said they felt the matrons and senior nurses were visible and accessible. Nurses we spoke with in the discharge lounge said they felt supported by their matron and felt the team worked well together. Nurses in care of the elderly wards told us their senior matron visited every day and was always accessible, which meant they felt supported.
- We spoke with a healthcare assistant who had worked in six different areas of the hospital. They said, "I have really been supported to gain all of this experience and think every team has been welcoming."
- Ward nurses and doctors demonstrated understanding of the duty of candour, including the circumstances in which it should be used.
- Staff we spoke with could demonstrate how they applied the duty of candour in line with national guidance. For example, staff in the discharge lounge had contacted the relatives of a patient who experienced a fall from a chair. We saw this had been documented in the patient's notes and a nurse had contacted a consultant for a review.
- Some staff we spoke with raised concerns about the impact of consistently operating wards that were short staffed. For example, some staff who were not nurses said they often had to complete nursing duties. They said, "There is acute pressure on wards and nurses are sometimes too busy to get a commode. We've seen patients ask three times for a commode and the nurses can't stop, so we do it ourselves. We also give personal care every day. Sometimes we see dried urine on bed sheets and so we change them ourselves."
- Staff in some areas described significant issues with communication between different teams. For example, three members of staff said a consultant on ward 14 refused to carry a bleep and it was therefore impossible to reach them. In addition, staff described difficulties in obtaining specialist support for medical patients with a learning disability and a patient with dysphagia who

was placed at "significant risk" because they could not convene a multidisciplinary review. These concerns related to medical patients cared for as outliers on ward 15, a surgical ward.

- Senior surgical nursing staff described concerns in the position they felt between consultants. For example, they said disagreements between the consultant team about how to manage medical outlier patients left patients unattended and at risk of deterioration. We spoke with the senior leadership team about this. One member of this team said, "We've escalated this problem to the site manager and the clinical director. Neither has taken action. Morale of our nurses is deteriorating and we feel that it's pointless escalating anymore as nothing gets done. There is no clear action plan for us, our nurses are not trained for medical care and we see highly inappropriate medical admissions. The care is unsafe and we bypass the CCOT team because of this and simply declare a peri-arrest."

Public engagement

- Each ward or clinical area had a 'You said, we did' board on display. Staff used this system to demonstrate to patients and visitors what action had been taken as a result of feedback from them. For example, the board on AMU highlighted that a compliments display had been put in place so staff could display the thank you cards and letters the unit received. As a result of feedback on ward three, staff had allocated a non-clinical room as a patient's day room with access to the garden.

Staff engagement







- Staff had taken part in the 2016 NHS national survey. The results for this are presented in our trust wide report as data was only available at trust level.
- Most of the staff we spoke with told us they felt listened to by their senior team. For example, one individual had raised concerns about the quality of agency nursing out of hours on a care of the elderly ward. They told us the matron responsible for the service had responded immediately to improve the situation. A nurse in the endoscopy unit said the chief nurse and their senior matron were visible and they felt well supported.
- Staff on ward 21 had quarterly away days that included the opportunity to feedback on hospital developments and plans as well as a chance to talk about incidents and complaints as part of the ward team.

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- Some staff told us they felt there were barriers to suggesting and implementing changes or improvements to working practices. For example, AHPs told us doctors and pharmacy staff were consistently positive about listening to them in relation to improving patient care, such as for patients living with dementia. However, they also said nurse staffing levels meant nurses were not able to engage with this and were more likely to label patients as “challenging” rather than engage in a multidisciplinary care approach.
- The service leads for acute and emergency medicine demonstrated an awareness of the impact consistent short staffing could have on staff morale. For example, they were focused on the ward three team following the departure of the ward manager. However, through engagement with staff and a focus on recruitment, the ward had successfully exited from ‘enhanced measures’ status and seen an increase of 50% in permanent nurses.
- A matron had been responsible for introducing the matron of the day role to supplement the daily existing matron cover.
- In January 2017 staff on the AMU and ward 16 had completed a survey about the standards of support they received at work. On the AMU 83% of staff said they were happy with the level of support they received from colleagues. On ward 16 93% of staff agreed with this. On both units 90% of staff said they felt able to make suggestions for improvements to their colleagues and senior team.
- Staff in some areas were able to undertake research to develop their work and improve services for patients. For example, the SaLT manager had successfully completed a research project into risk feeding as part of a multidisciplinary supportive framework of care.
- The AHP team was developing a new strategy to measure patient outcomes through the effective use of multidisciplinary notes. This was being designed to address issues with ward staff not reading AHP assessments and notes and therefore delaying care. For example, in one instance a patient had gone for over six hours without food despite a review from the speech and language therapist that stated they should be fed. This strategy had been implemented in the AMU where AHPs had provided training on rehabilitation referrals and pathways for junior doctors.
- The SaLT and dietetics team were trialling a ‘puree petite’ meal programme that offered patients with dysphagia new meal options with a 40% reduced portion size and an improved smooth consistency. Patients were issued with an easy-read information sheet and consent was obtained before they commenced the diet. The SaLT and dietetics team briefed ward staff where patients had agreed to take part.
- A development and refurbishment plan had been approved for the endoscopy unit and was due to begin in April 2017. This would include the installation of new decontamination equipment and a new treatment room to enable the service to offer fluoroscopy. The recovery bay would also be expanded to enable the service to offer procedures to males and females on the same day whilst offering segregated recovery bays.

Innovation, improvement and sustainability

Surgery

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

Information about the service

Queen Elizabeth Hospital is part of the Lewisham and Greenwich NHS Foundation Trust.

The hospital provides a 24 hour, seven days a week service for the population of the London Boroughs of Lewisham, Bexley, and The Royal London Borough of Greenwich.

The trust as a whole had 22,361 surgical admissions between April 2015 and March 2016. Emergency admission accounted for 7,685 (34%), 11,911 (53%) were day case admissions, and the remaining 2,765 (12%) were elective cases.

The hospital has seven operating theatres based in the main building, covering general surgery, gynaecology, obstetrics, orthopaedics, urology, and vascular surgery, with recovery areas based within the theatre department. There were three surgical wards identified as wards: 12, 15ab and 17 located on the first floor of the building with approximately 78 inpatient beds between them. A day care unit provided services for day surgery patients, and there was a pre-assessment department, where patients were assessed in advance of their surgery.

We carried out an announced inspection between 7 to 9 March 2017 and a further unannounced inspection on 22 March 2017. During our inspection we spoke with 18 patients, observed care and treatment and looked at 15 care records. We also spoke with approximately 30 staff members at different grades, including nurses, health care assistants, doctors of varying grades, consultants, ward

managers, matrons, anaesthetists, and members of the senior management team. In addition, we reviewed a number of documents such as meeting minutes, audits, and performance and quality data.

Surgery

Summary of findings

We rated this service as Requires improvement because:

- Overall, we identified a dedicated group of staff that were committed to providing quality patient care. However, staff felt frustrated and overworked. The morale of surgical staff was low due to the demands and pressures of the service.
- Surgery beds were not ring-fenced; therefore, medical outliers and patients escalated from the emergency department were placed in surgical wards. The lack of sufficient bed space meant operations were frequently cancelled.
- There was inappropriate placement of infectious patients, with patients allocated to rooms without any hand washing facilities. Further, there was evidence of poor in-hospital patient transfer practices, where patient's infectious status was not always handed over.
- The spinal trauma pathway was not always followed. Patients with spinal trauma injuries that could not be treated at the hospital were placed in inpatient wards. The hospital did not have the facilities or a neurosurgeon to treat these patients, and their transfer to the appropriate hospital was not arranged in a timely manner.
- We were not assured the placement of extra beds for patient escalation on ward 12, rooms five and six was safe. The rooms did not allow for a resuscitation trolley to pass by the extra bed, should staff need to access the patient to perform cardiac resuscitation.
- Patients were being placed in a recovery area of a decommissioned theatre. There were no bathroom facilities nearby and staff did not have the appropriate equipment to manage these patients.
- Staff did not always adhere to information governance practices. We found patient medical notes mixed with other patient's notes and patient records being left unattended throughout the surgical wards.
- Staff were not always following best practice in relation to infection prevention and control. We saw overfilled clinical waste bins, cluttered stock rooms, and infectious patient's side room doors were kept open, even when there were signs clearly stating that doors should be kept closed.

- Information reporting and sharing of information was not robust. Not all staff had access to the hospitals computer system and not all staff received feedback on incidents they had reported. We were, therefore, not assured the trust took action on all reported incidents.
- Nursing staff reported incidents, whereby due to staff shortages they were unable to provide the appropriate care and treatment to patients who required individualised attention.
- The trust was not meeting the national targets for patient outcomes, especially for those patients with bowel cancer and hip fractures. The trust was not meeting their fracture neck of femur standards of 24 hours due to theatre and bed capacity. There was evidence to show the management of medicines was not robust.
- Medical staff had a low rate of compliance for most mandatory training subjects. Nursing staff compliance rates were better, but still not meeting the trusts target rate for all safety related topics.
- The trust was worse than the England average for referral to treatment times (RTT). RTT was on the corporate risk register.
- There were ineffective working relationships with other teams, for example the site management team. Surgical staff felt undermined and felt their clinical opinions were not taken into consideration.

However:

- Staff responded compassionately when people needed help and support. They respected patient's privacy and confidentiality.
- Staff identified those patients vulnerable as a result of their medical condition, such as having needs associated with dementia. Staff took appropriate steps to ensure people were appropriately cared for.
- The service attended a daily safety huddle to enhance patient safety across the hospital.
- Staff were complimentary of their local leadership and felt well supported.
- There was good multidisciplinary input from physiotherapists, dietetic services, tissue viability nurses and the pain team.

Surgery

Are surgery services safe?

Inadequate



We rated safe as inadequate because:

- The reporting of incidents and the sharing of outcomes was not robust. Some staff did not have access to the trusts intranet system. Some staff told us they did not receive feedback from incidents they had reported.
- Infectious patients were not managed well with regard to minimising risks of cross contamination. There was evidence of poor in-house patient transfer practices.
- We observed a number of poor infection control practices within the surgical wards. Some clinical waste bins were overflowing in patient bays and stock rooms were dirty, cluttered, and disorganised. Procedures were not followed to stop the spread from infectious patients.
- The placement of extra beds in ward 12 meant limited access of essential lifesaving equipment if the patient required urgent medical attention.
- Spinal trauma patients with a category rating of four (they should not be seen by the hospital) were inappropriately placed in surgical wards from the emergency department. The hospital did not have a neurosurgeon to treat these patients.
- Patients were inappropriately placed in a recovery area of a decommissioned theatre. There were no immediate bathroom facilities and staff did not have the appropriate equipment to treat patients.
- There was evidence to show the management of medicines was not safe.
- There was some poor practice in relation to information governance. Patient notes were mixed with other patient records. Patient records were left unattended on nurse stations within the wards.
- Staff reported patient safety was compromised due to staff shortages. We were not assured those patients who required specialised attention received the appropriate care.
- Mandatory safety training rates for medical staff were low. Nursing staff compliance rates were better, but they still felt short on several subjects.

However:

- We saw evidence that duty of candour (DoC) was applied when a notifiable safety incident occurred.

- Resuscitation equipment in theatres and on the wards for use in an emergency was readily available.
- Staff we spoke with knew how to report safeguarding concerns.
- Theatre and nursing staff carried out routine observations of patients and recorded these appropriately in patient records.
- Results from the 'five steps to safer surgery' audit showed a consistent compliance rate of between 98-100%.

Incidents

- The trust reported serious incidents and never events to the Strategic Executive System (STEIS). STEIS is a system for collecting management information from the NHS. All serious incidents within the NHS should be recorded on STEIS.
- The trust had a policy for investigation of serious and adverse events. The trust completed root cause analysis investigations and subsequent action plans.
- Never events and serious incidents were discussed in the monthly surgical clinical governance meetings, monthly-integrated clinical governance meetings and at trust board level. We viewed a selection of minutes from each meeting and saw incidents and outcomes were discussed with proposed actions.
- The trust reported one never event for the surgical division on 24 November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The incident involved an epidural pump that was wrongfully connected to an intravenous cannula. The patient was to receive epidural medication post-surgery, and the epidural pump was connected to an intravenous cannula instead. The patient received one dose of local anaesthetic and opiate.
- We viewed the root cause analysis investigation for this incident. Lessons learnt included retraining for staff and a set of protocols shared across both hospital sites to ensure this did not happen again. The trust had applied the duty of candour with the patient and family and they had received a finalised version of the investigatory findings. The action plan was monitored at the surgical clinical governance meetings.

Surgery

- Between the periods of December 2015 to November 2016, the surgery division reported 875 incidents. One incident was rated as moderate in theatres and the others were rated as low, near miss or no harm. Slips, trips and falls accounted for the majority of reported incidents with 155, and acquired pressure ulcers with 108. Infrastructure (staffing, facilities) accounted for 87 reported incidents.
- The trust had an electronic system to report, investigate, and act upon incidents and adverse events. However, not all staff were able to use the system. Two healthcare assistants on the surgical wards told us they did not have a log in for the system and therefore relied on other members of staff to report incidents on their behalf. Bank and agency staff did not have access to the electronic system. They reported incidents, to a permanent member of the nursing staff.
- Most staff we spoke with told us they knew how to report an incident. We received a varied response from ward nursing staff on how they received feedback from incidents. Some said they did not receive feedback while others said they received feedback through the organisations e-mail system and one to one sessions with their line manager. Others said incident feedback was discussed in the daily ward handovers.
- We received a better response from staff who worked in theatres. They were able to tell us of occasions when they had reported an incident and had received feedback from their line manager and through their electronic e-mail. We saw incidents were discussed in theatre team meetings.
- We viewed the surgery clinical governance committee meeting minutes of November and December 2016, whereby incidents, outcomes, and learnings were shared during the meeting.
- Low harm incidents were investigated at a local level. We spoke with the surgery ward matron who described how they “closed the loop” on low rated incidents reported within the surgery wards. However, this meant the matron had to “close the loop” on their own reported incidents. For example, the matron had raised incidents relating to inappropriate placement of patients in the surgery ward. We were told, they would usually be expected to investigate and close the incident themselves, but because of their concerns, they now reported their incidents to the safety team who then escalated to the appropriate department. The matron said they never received feedback on these incidents. Therefore, we were not assured the appropriate action was taken when dealing with reported incidents of all severities.
- We viewed a selection of incidents reported on surgical wards and theatres between the months of September 2016 to November 2016. The range of incidents varied from slips, trips, and falls to pressure ulcers and shortage of staff. We did not see any outcomes or actions taken as a result of these reported incidents to assure us that there was a thorough process of investigation. However, the level of reported incidents demonstrated staff had a good understanding of the different types and levels of incidents.
- We noted some incidents reported as no harm were a cause for concern. For example, on 21 September 2016, the pharmacist contacted ward 15ab to state a patient had not been seen by a medical practitioner since 16 September 2016. This related to a medical outlier patient within the surgery wards. We did not see any evidence of actions taken.
- On 24 October 2016 and 26 October on ward 12, a patient with MRSA was being nursed in an open bay with two other surgical patients. This incident was rated as low. We did not see any information as to how this risk was being managed.
- On 17 January 2017, staff on ward 17 reported concerns for patient safety due to staff shortages. Staff reported that two patients required one to one monitoring, one patient required a ‘log roll’ (log roll or log rolling is a manoeuvre used to move a patient without flexing their spinal column), which required four members of staff to complete. There were five confused patients, one post-operative patient with a national early warning score (NEWS) score of 5. This meant the patient required closer one to one monitoring. No extra HCA had been booked for the night shift.
- Nursing staff we spoke with said, when there were nursing staff shortages, patients were cared for in accordance to their medical requirements, but this placed immense pressure on staff. For example, staff told us they were unable to answer call bells as quickly as they would have liked.
- On 31 December 2016, the incident record showed there were only two members of nursing staff for 28 patients.
- Mortality and morbidity reviews were discussed on a trust wide level. We saw notes from the mortality and morbidity meetings and the integrated clinical

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governance committee (IGC) meetings. We saw from the September 2016 meeting minutes reference was made which highlighted the hospital had received notification of outlier status for hip fracture mortality from the Hip Fracture Mortality Database. The hospital had taken action to review all patient notes and identified this as a data issue as the risk assessment had not been graded correctly. Further discussions were still taking place within the trust.

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The DoC formed part of the trusts incidents and serious incidents policy and procedure and complaints policy. Staff we spoke with had an understanding of the DoC. They gave us examples of when they applied the principle of the DoC by apologising and being open and transparent with patients and their families. The examples related to hospital acquired pressure ulcers and delays in treatment. We saw the DoC was applied for the never event which occurred in November 2016.

Safety thermometer

- The service participated in the national safety thermometer programme. This is an improvement tool for measuring, monitoring, and analysing patient harms and harm free care. The NHS safety thermometer recorded the presence or absence of four harms: pressure ulcers, harm from a fall, urinary tract infections in patients with a catheter and new venous thromboembolism (VTE).
- The focus of harm free care was designed to bring attention to the patients overall experience. Patients were assessed in their care setting. Measurement at the frontline was intended to focus attention on patient harms and their elimination. This data was collected on a monthly basis.
- Harm free care results were displayed at the entrance of all wards we visited and were easy to read. Results displayed for the month of February 2017, in each surgical ward showed there was 100% harm free care.
- The hospitals VTE screening target scorecard showed from April 2016 to January 2017 the hospital consistently scored 99% or above.

- Between December 2015 and December 2016, data from the patient safety thermometer showed surgery reported five pressure ulcers level 2, 3 and 4. Two pressure ulcers were reported in February 2016 and the remaining three were reported from September to November 2016 at a rate of one per month. Surgery reported four catheter urinary tract infections (C.UTI). No infections were reported from December 2015 to May 2016 after which one C.UTI was reported in June, two in August and one in November 2016.
- Each ward had both a registered nurse and health care assistant link nurse for the prevention of pressure ulcers who had received additional training and influenced nursing staff in adhering to best practice, through face to face discussions.

Cleanliness, infection control and hygiene

- Senior staff told us wards 12, 15ab were dedicated to elective surgery patients of different specialities. Ward 17 was dedicated to surgical orthopaedic patients. However, we found in all wards there was a mixture of medical care patients placed with orthopaedic patients and this posed a risk of exposing patients to infection and was not best practice.
- In the day care centre patients with infectious conditions, for example meticillin resistant Staphylococcus Aureus (MRSA) and C-Diff were kept in side rooms, which had no hand wash sinks. This meant staff had to block off communal bathrooms for patients to use. Staff reported these cases as incidents. Between March 2016 to March 2017, 20 patients with MRSA spent time in the day care unit as inpatients. Staff told us most of these patients were escalated to these areas by the site management team against the clinical advice of the nursing staff. Staff said, they had to 'block off' bathrooms solely for these patients to use, which meant other patients did not have full access to all bathrooms in the unit.
- The following incidents were reported by nursing staff. On 18 October 2016, a patient with C-Diff was sent to the day care unit. Staff were told the patient was not infectious, but the infection and prevention control team (IPC) confirmed the patient was. The patient remained at the unit for some hours before they were transferred to the appropriate isolation room.
- On 27 September 2016, a patient with gastroenteritis was admitted to ward 15b. Staff reported they were forced to move a patient with old MRSA symptoms (the

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patient had two confirmed negative swabs) out into the main bay of the ward. The infected patient was brought up to ward and spent an hour in the corridor, despite the site manager and emergency department being informed that the bed was not available. On 26 October 2016, a patient with MRSA was nursed in an open bay in Ward 12.

- On 20 February 2017, a patient was admitted in the escalation area of the day care unit from the emergency department. The patient was MRSA positive. No handover had been given to staff and the IPC team confirmed the patient required isolation.
- We did not see any actions taken or feedback, which had resulted from the reported incidents. Nursing staff we spoke with told us they did not receive feedback on all the incidents they had reported.
- Screening for MRSA and C-Diff of elective patients was done during pre-operative assessment. MRSA and C-diff infections information was displayed on the ward for staff and patients.
- Information received from the hospital indicated between April 2016 to February 2017 there were no cases of hospital acquired MRSA, four cases of C-Diff and three cases of methicillin-sensitive staphylococcus aureus (MSSA).
- During our visit, we observed several patients who were barrier nursed. This is when a patient is kept in a side room and extra precautions are implemented to prevent spread of infection. On three occasions, twice during our announced visit and once during our unannounced visit we observed the door to side rooms left open, even though there were signs indicating the door should be closed.
- Hand washbasins were available throughout the wards and theatres for staff to use. There was a variance in the availability of alcohol sanitizing gel. Some units were empty and had not been filled. We found this to be a common occurrence throughout the surgical wards.
- We observed surgeons, anaesthetists, and nurses washing their hands between patients on wards and in theatres.
- The trust conducted monthly hand hygiene audits to ensure staff were following The National Institute for Care and Excellence (NICE) QS61: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact and care. Information we reviewed from January 2016 to December 2016 showed a variance in compliance. Most departments achieved above the trusts 95% compliance rate; however, the day care unit was consistently below the trusts compliance with overall rates ranging from 65% to 80%. Ward 15a and 17 had a variance in their compliance rates throughout the year. Only Ward 12 and theatres achieved a consistently high rate.
- Hand hygiene audits were discussed in the IPC committee meetings with emphasis placed on the IPC leads to ensure staff adhered to hand hygiene protocols. The matron and ward managers to staff shared information during team meetings.
- Nursing and staff within theatres adhered to 'bare below the elbows'. Bare below the elbows is a term used to explain medical staff not having any clothing visible below the elbows, as this aids with preventing the spread of infection.
- We observed staff challenge in a respectful and professional manner a member of the medical staff who was not bare below the elbows in ward 15ab.
- We saw a few consultants complete ward rounds without long hair tied back and one had their handbag kept across their body.
- Theatre staff followed National Institute for NICE CG74 guidelines, which sets out explicit guidance based on best evidence in respect of the pre-operative, intra-operative, and post-operative phase of a patient's journey. Patients were provided with the appropriate theatre gowns and received information such as, bowel preparation and nasal decontamination. Staff wore the appropriate theatre scrub garments and shoes, covered their hair, and did not wear jewellery.
- Syringes and other disposable single use medical equipment was discarded appropriately in sharps bins, which were labelled and dated. All of the sharps bins we saw were within date and none were overfilled. However, some sharps bins were placed on the floor, which meant they could have been easily knocked over with the potential to cause a needle stick injury.
- The service used disposable curtains, which we saw were in date. This is in accordance with Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015).
- Not all equipment had "I am clean" stickers to indicate equipment was cleaned and ready for use. We found in ward 15ab, multiple commodes and drip stands without stickers.

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- There were IPC link nurses who worked in theatres and surgical wards, to re-enforce best practice and assist with audits. They completed competencies and received additional training to carry out their role. Nursing staff were able to tell us who their IPC link nurse was.
- Staff received IPC training as part of their mandatory training. 98% of nursing staff had completed mandatory training, which was above the trusts target of 85%. However only 72% of medical staff had completed their IPC mandatory training.
- Not all areas of the wards were visibly clean. The floor of the nursing stock room and medicine preparation area in ward 12 was dirty with debris lying on the floor. In ward 15ab and ward 17, the same rooms were messy and cluttered with stock.
- We saw a good supply of personal protective equipment available for staff to use. Throughout theatre and surgical wards, we saw a good supply of gloves and aprons stationed at various places for staff convenience.
- A domestic manager monitored cleaning. Domestic staff worked on a two-shift rota, which started at 7am and finished at 13.30pm. The second shift started at 5pm and finished at 9pm. All of the nurses we spoke with told us that cleaning staff were responsive and available. We spoke with domestic staff on wards who told us they felt very much part of the ward team. Housekeeping staff used the correct nationally recognised colour coded equipment when cleaning the surgical wards, bathrooms, and patient areas.
- Two operating theatres had higher levels of air filtration (laminar flow) in place, which was best practice for ventilation within operating theatres. This was important for joint surgery to reduce the risk of infection.
- We visited the decontamination service, which was operated, from the hospital. The service was able to fast track equipment for theatres within four to five hours. They also had a tracking system, which gave cycle number quality control. This meant any areas of concern related to equipment could be traced back to the cycle number and problems could be identified.
- The trust had an infection control policy and guidelines for staff. Staff were able to access this through the trusts intranet. Staff we spoke with were aware of the IPC policy.
- We saw resuscitation equipment was available in all clinical areas, with security tabs present and intact on each. Systems were followed for checking resuscitation equipment.
- Staff performed and recorded equipment safety checks at the start of each theatre session. This was in accordance with The Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines on checking anaesthetic equipment, which states, “A pre-use check to ensure the correct functioning of anaesthetic equipment is essential to patient safety”.
- Equipment in theatres, and recovery areas we checked were all safety tested and labelled to ensure they were safe to use. Equipment was also in date with regards to maintenance by the trusts in house Electro-Biomedical Engineering (EBME) department. The trust was in the process of implementing a trust wide medical devices management policy.
- In theatres, equipment was organised, clean, and available in trollies.
- The storerooms we checked had adequate stock of sterile instruments and consumables; however, some of the rooms in the surgical wards were cluttered and overfilled. Staff did not report any problems with the availability of equipment and stock.
- The general state of the fabric of theatres was good. Any repairs were reported to the in-house maintenance team.
- Each theatre had forced air warming blankets and fluid warming systems to keep patient warm during and after surgery.
- Ward space was limited. There was just enough sufficient space between inpatient beds to allow privacy and dignity, although in Ward 17 at some of the beds there was not enough room to allow for a bin for clinical and domestic waste. They were kept outside of the patient bay areas.
- Staff told us, in ward 12, rooms 5 and 6, (which were designed for one patient), were being used to board an extra patient. When the extra patient was boarded, the rooms became cramped. There was limited space to allow the for a patient to pass by the extra bed, as a hand wash sink was placed at the end of the bed. There was no space for an extra chair and patients had to share one call bell. There was no extra suction unit for the extra patient. The layout and design of the room did

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not allow for privacy and dignity for each patient. We asked the trust for information on how many times they have had to board an extra patient in these rooms, but did not receive this information.

- In ward 15ab, one shower had been out of action for approximately six months. This meant staff had to devise a rota and place patients on a list as to when they could use the shower.
- There were air vents above patient beds in ward 12, which became cooler at night. Staff said because the air temperature was within the accepted recommended range no actions were taken address their concerns.
- The decommissioned theatre recovery area, based near the day care unit was being used as an escalation and patient recovery area. The area had no bathroom facilities for patients or an electrocardiography (ECG) machine for staff to use.
- A designated waste management team collected waste and we saw staff using the correct disposal methods for clinical and domestic waste. However, in ward 15ab, we saw two overflowing clinical waste bins in the patient bay area. They had not been emptied appropriately and therefore this posed a risk of infection to patients, staff, and visitors.
- An external company tested generators at the hospital and a report showed there were no concerns.
- There were individuals within the hospital who were responsible for an area of compliance for the environment. This ranged from medical gases, water systems, asbestos, fire, lift servicing, and pressure systems. Regular tests and checks were undertaken to ensure the smooth running of all facilities.

Medicines

- Evidence seen during our inspection showed medicines relating to controlled drugs were not always managed appropriately.
- Our pharmacist inspector visited ward 15ab and checked the controlled drugs (CD) cabinet. We found that epidural and intravenous pain relief (morphine sulphate 250mg in 20ml IV and levobupivacaine 0.1% fentanyl 2mcg/ml INF 250ml used for epidural anaesthesia) were stocked on the same shelves in the CD cabinet. Our inspector asked the assistant ward manager why they were kept together and if they were aware of the National Patient Safety Alert (NPSA) epidural alert of 2007. The alert provided recommendations, which included providers having

effective controls in place to minimise the risk of incorrect selection as the two devices, looked similar in their appearance. The staff manager said they were aware of the NPSA alert, however thought that, as the bags were different colours, it was unlikely a mistake would happen. The manager was aware of the epidural significant event, which had taken place in the hospital in November 2016.

- In ward 12, we saw two CD books lying on top of a bin near the nurse station. They were not securely stored. Within the recordings, we noticed on 20 March 2017 the witness signature was missing from the patients CD recordings.
- Medicine/treatment rooms in the surgical wards were not always kept neat and tidy. We found one box of paracetamol suppositories on the floor in ward 15ab and the medicine trolley was overflowing with medicines.
- Pre-operative assessment clinics were used to identify patients with existing medications and to develop bridging plans when they were in hospital.
- All surgical wards had pharmacist input in reconciliation of patient's medicines and clinical screening of prescriptions.
- We saw medicines were given to patients by nursing staff in accordance with the prescription and that safety checks were carried out during the administration process. Medication prescriptions we saw were clearly written with the patient's allergy status.
- Medicine policies and resources were available on the trusts intranet. Medicine management was included in the trusts induction and mandatory training. Mandatory training compliance rates for nursing staff were 75% against a trust target of 85%.
- Two of the surgical wards we visited did not have fridges to store medication, as they were broken. We were told they had been broken for over two weeks and nursing staff had no indication of when they would be replaced. Staff were using other ward's fridges to store the medicines.
- Theatre staff completed daily temperature checks of the drug fridges and ambient room temperatures and we viewed the daily recordings.
- Senior pharmacists conducted medicines safety walkabouts and practice development nurses/midwives across the trust to collect data on several medicines management indicators.

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- We saw the collection of data for the month of January 2017 for wards 12, 15ab, 17 and the day care unit. The team looked at a random set of 10 patient records and found 100% compliance for all patients allergies documented. For the percentage of doses given in the last 24 hours, the figures ranged from 97% for ward 17 to 85% for ward 15ab.
- Other checks were made on fridge temperature checks and CD balance checks. There were satisfactory checks for all wards apart from 15ab, whereby they scored 93% for fridge temperature checks and documentation and were non-complaint for satisfactory CD balance checks and documentation.
- CD drug audits were undertaken by the trust. We viewed the Q3 2016-2017 audit. Areas monitored included, stock levels tally, CD checks completed every 24 hours, correct record of wastage, patient own CDs recorded and stored appropriately, unwanted/expired CD's returned correctly and keys kept securely. The audits were carried out across the two sites. We saw there was good compliance for CD's checked every 24 hours with 100% and 100% scored for unwanted drugs returned correctly, and keys kept securely. Surgery services scored worse than the trusts accepted compliance level for correct record of wastage. Theatre two and theatre recovery were signalled out in the audit as non-compliance for this area. However, it was noted that overall compliance had improved since the previous audit. Actions taken, involved sharing the report with each division so the information could be disseminated and fed back to staff.
- The trust carried out monthly anti-biotic care bundle audits to evaluate antimicrobial prescribing at ward level in order to identify areas of poor practice.
- Care bundles consist of a set of prescribing standards, which together produce better outcomes for patients. Standards used were, antibiotic indication, stop/review dates, appropriate route of administration, compliance with the trusts antimicrobial guidelines. The overall compliance rate for QEH was over 95%. For both November and December 2016, orthopaedics and general surgery were given an overall red rag rating.
- There was good compliance with appropriate antibiotic choice with orthopaedics and general surgery scoring 100%. However, the compliance in review/stop date documented, orthopaedics scored 38% and general surgery 37%.
- For December 2016, orthopaedics scored 0% for compliance in review/stop date documented and general surgery 50%.
- We saw actions had been taken, such as sharing results across relevant governance meetings and encouraging consultants to emphasise the importance of fulfilling all elements of the care bundle to their team, and prompt junior doctors to document required information during their ward rounds.
- A medication incident report was completed every three months and highlighted the trusts overall overview of medication incidents via their safeguarding incident reporting system.
- Staff had access to the British National Formulary (BNF) through the trusts intranet and hard copies kept within departments.
- We spoke with patients who had a good understanding of what medication they were taking and why. They told us staff explained what medication they were providing prior to administering.

Records

- Records were both paper based and electronic. Paper based patient records were mainly used in surgery wards.
- We were not assured patient notes were kept safely on surgical wards. For one set of patient records, we saw another patient notes had been placed inside, which meant, potentially patients were at risk of misdiagnoses and incorrect treatment. Not all patient notes were secured in each individual file. They were left loose, which was not in line with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We raised our concern with the head nurse and was told at the end of the shift someone would go through the notes to ensure they were in order.
- We saw a trolley in one ward that had been packed full with patient medical records. Upon investigation there were numerous loose notes that had no patient details, so it was very difficult to discover what record they came from. We were told these were discharged patient notes and that a staff member would be organising the records. However, some of the notes would not have been easily identified as to where they were meant to be placed. The trolley was not locked and was based near the nurse's station. This was not in line with the Data Protection Act 1998.

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- We saw on two separate occasions' patient notes, which had been left unattended, on the top of the nurse's station in the wards.
- We viewed 15 sets of patient records. Records showed where staff had completed patient risk assessments. These included risk assessments for falls, malnutrition, and pressure ulcers. All risk assessments completed followed national guidance. For example, all patients were risk assessed on admission for their risk of VTE. This was in line with NICE guidance.
- The trust had a statutory duty under the government's Prevent agenda to train their staff. Prevent is about safeguarding people and communities from the threat of terrorism. Prevent is one of the four elements of CONTEST, the governments counter-terrorism strategy. So far, 10% of medical staff and 33% of nursing staff had completed prevent training.
- Nursing staff we spoke with on the surgical wards said there had been a massive drive on safeguarding led by the matron and ward manager. They were confident in handling safeguarding concerns and would contact the safeguarding team within the hospital. There were safeguarding forms and social services folders within the wards for staff to view.
- During the daily ward huddle, safeguarding concerns were raised and we saw staff discuss a potential safeguarding concern and the actions they were taking to help the patient when they were discharged from the hospital.
- There were quarterly safeguarding meetings with local commissioning bodies whereby, safeguarding strategies and updates were discussed.
- The organisation produced an annual safeguarding children and adult report. The purpose of the report was to provide assurance to the local borough local safeguarding boards and clinical commissioning groups that the statutory and local requirements regarding safeguarding and protection of children were being met.
- The report discussed topics such as female genital mutilation (FGM), child sexual exploitation (CSE), domestic abuse, and child protection information sharing system.
- The report described how the trust had set up a domestic abuse service within the hospital. The service offered domestic abuse support to anyone coming into the hospital, irrespective of their residential address. Staff were able to describe the service and the escalation processes during our visit.
- In all wards, we visited the safeguarding lead name and contact details were displayed for staff and public.

QS3 – statement one.

- Records we viewed contained good multi-disciplinary input from consultants, anaesthetists, and physiotherapists. Nurse's observations were recorded clearly and each record we viewed contained patient signed consent.
- Patient 'bedside' records were kept in folders on a table in patient bays. Any visitor could easily have viewed each file as there were chairs placed around the tables, whereby visitors sat. In one bay, the patient folders were laid on a table with half-filled cups of tea and finished food trays waiting to be collected.
- Eighty nine percent of nursing staff had completed information governance training against a trust compliance rate of 85%. However, only 57% of medical staff had completed information governance within their mandatory training.

Safeguarding

- The staff we spoke to were able to explain their understanding of safeguarding and the principles of safeguarding for children and adults. They were clear about the trust's safeguarding escalation process.
- There were children's and adults safeguarding policies available to staff and these could be accessed through the organisations intranet.
- Nursing staff had a 98% safeguarding training completion rate. Both Safeguarding Adults Clinical Level 2 and Safeguarding Children & Young People Level 2 had a completion rate above the trust target.
- For medical staff the completion rate for safeguarding level 2 for children was 78% and for safeguarding level 2 adults was 74% which was below the trust target. However, for level 3 safeguarding children & young people the completion rate was 89%, which exceeded the trust target of 85%.

Mandatory training

- Staff were required to complete mandatory safety training either through e-learning modules or face to face learning. There were systems in place to monitor attendance. Most staff we with told us they were up to date with their mandatory training.

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- The trust set a target of 85% for completion of mandatory training.
- Surgical nursing staff at the hospital had an overall mandatory training completion rate of 78%, which was worse than the trusts expected target. Eight of the 13 mandatory training modules exceeded the 85% trust target.
- Bullying and harassment, resuscitation for both adults, and paediatric both had a 100% completion rate.
- Fire safety, clinical and Prevent Level 3 had a completion rate below 50%.
- Surgical medical staff at the hospital had a 54% mandatory training completion rate and the trust target of 85% completion was not met for any of the mandatory training modules.
- Conflict resolution (81%), Infection control clinical (72%), health, and safety training (70%) had the highest completion rates.
- Prevent level 3 (10%) and equality and diversity training (45%) had the lowest completion rates. The remaining modules all had a training completion rate below 60%.
- The practice development nurse and ward manager worked together to ensure nursing staff were up to date with their training. An e-mail to remind staff when their training was due was sent to individual staff members.

Assessing and responding to patient risk

- At pre-assessment appointments, the pre-assessment nurses would assess the suitability of patients for surgery. They carried out health assessments such as an electrocardiogram (ECG), and discussed the procedure. If the discussions (at either a telephone or face-to-face) pre-assessment highlighted a potential safety concern, staff told us they would escalate this to the anaesthetist.
- Patients who were seen at the pre-operative assessment unit were assessed using the ASA American Society of Anaesthesiologists (ASA) classification. The hospital ensured that appropriate pre-operative assessment was recorded. We reviewed three sets of notes and could see that preoperative assessments were well documented. All patients were assessed using the ASA classification, which was documented in the anaesthetic record sheet. The score was reviewed in line with the national ASA Classification System. For those with ASA II or higher the

patient was reviewed by a senior anaesthetist. Staff in the pre-admission unit told us that if necessary patients would be referred back to their GP for further follow up and/or treatment.

- The hospital used the National Early Warning Score (NEWS), and escalation flow charts. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. If a patient's score increased, staff responded by increasing the frequency of observations. Staff were able to request urgent review by the consultant. In all of the five patient records we reviewed, all patients had frequency observations and NEWS recorded and escalated where appropriate.
- In October 2016, the NEWS audit showed a good compliance of 95% and above with all aspects monitored, except for observations dated which scored 82% and a qualified staff initials were present scored 88%. The Department of Health; Care of the Acutely Ill Patient in Hospital-Competency Framework 2009, highlights the role of the 'recorder' who takes designated measurements, records observations and the 'recogniser' who then interprets the measurements. The trust recognised more work was needed for the two aspects of the audit and information was shared with staff to reinforce the message.
- The percentage of patients screened for VTE was above the trusts compliance target of, 95% between December 2015 to November 2016. This is in accordance with the National Institute for Health and Care Excellence (NICE) Quality Standard Three.
- The theatre team used the 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in surgery, by carrying out a number of safety checks before, during, and after surgery. The hospital audited the use and completion of the WHO surgical checklist. We saw the observational audit of the checklist showed 100% compliance between December 2015 to November 2016, except for March 2016, which indicated two patients were sent before the team brief.
- During our inspection, we observed the theatre team undertake the WHO checklist correctly. We also reviewed eight sets of notes and found fully completed WHO checklists.
- We reviewed fifteen sets of patient notes across the different surgical wards and all of them had a pressure ulcer risk assessment recorded (Waterlow score) on

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admission. Staff reassessed the patient's risk daily. This allowed the service to manage the pressure ulcer risk for patients at high risk. For example, by helping patients to change position regularly.

- Nursing staff told us they were able to contact a doctor via a bleep if the patient deteriorated. However, we saw an incident reported by staff on 13 January 2016, which related to no availability of an orthopaedic, orthogeriatric or urology doctor on call from Friday night, all day Saturday and all day Sunday. The nursing staff member stated nobody answered the bleep.
- Surgical staff, told us of their concerns with the escalation of spinal trauma patients. There was an agreed pathway of care for these patients to be seen at another trust who had the appropriate facilities and consultants to deliver care and treatment for these patients. The agreed pathway suggested patients who were sent to the emergency department had the appropriate MRI scan. The scan was then categorised to the severity of the patient's condition. If the scan was rated a number four, the patient was to be directly transferred to the appropriate trust for treatment. This was not happening.
- Patients graded four were sent to the surgical wards. The reason given was there no available beds at the other trust. However, this was a cause for concern as the appropriate consultants and facilities were not available at QEH. Sometimes patients were transferred straight to the surgical wards without having the MRI scan which was not in line with the pathway of care. Nursing staff and leaders expressed their concerns for patient safety. Sometimes it took the matron most of their working day to ensure the patient was safely transported to the appropriate trust.
- Nursing staff told us of one incident, whereby a spinal trauma patient graded four was placed in ward 15ab at the weekend. The matron and other nursing staff told us ward 15ab did not have trained staff to 'log roll' patients. The matron logged these as incidents, and escalated these concerns to the safety team. So far, they had no feedback or actions taken because of the reported incidents.
- Two rooms in ward 12 were being used as escalation areas and extra beds were placed to board patients when necessary. The rooms were not suitable to accommodate extra patients. We asked the trust for their risk assessment information with regards to the rooms, but did not receive the sufficient data. We were

told a risk assessment had been undertaken, however we were not assured the placement of an extra bed was safe for patients. An incident had previously occurred whereby staff were unable to get the 'crash' trolley pass the extra bed to treat a patient in cardiac arrest. After the incident, a decision was taken to not use the rooms to board extra patients, however we were told this decision was reversed after a risk assessment was completed.

- Nursing staff told us patients placed in the rooms were not meant to be acute high-risk patients; however, they said this was not happening. We were told of incidents whereby nurses were unable to get a hoist into the room to accommodate patients at the far end of the room. For those patients at the far end of the room who required the assistance of two nurses to aid with mobilisation, it was difficult to get pass the extra bed to exit the room.
- We viewed the room and saw if an extra bed was placed it was difficult for patients and staff to pass the bed to get access to the other patient. A hand washbasin was positioned at the foot of the extra bed which limited access to pass through. Staff expressed their concerns for the safety of patients when two beds were placed in the rooms. Nursing staff said their clinical decisions were not taken into account.
- On the day before our inspection, nursing staff told us about a decision taken by the Director of Operations to board a patient in ward 12 and that the escalation policy was not followed. When the concerns were raised with the Assistant Director of Operations, staff said they passed the responsibility onto the director and took no action.
- Staff had access to a mental health nurse if they were concerned about risks associated with a patient's mental health; staff knew who this was and how to contact them.
- The trust followed NICE guidelines NG51: Sepsis: recognition, diagnosis, and early management. There was a sepsis screening and action tool for staff to use.
- The trust conducted sepsis screening. Results showed between October 2016 to December 2016 100% of patients met the criteria for local protocol for sepsis screening and were screened for sepsis. The screening involved auditing a random set of 30 patient records to see if sepsis clinical codes were used in the assessment and treatment of patient care.
- For patients who presented with severe sepsis, red flag sepsis, or sepsis shock were administered intravenous

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antibiotics within 90 minutes of being an inpatient and had an antibiotic review carried out by a competent decision maker by day three of them being prescribed, the trust scored 100% for October 2016, 85.7% for November, and 100% for December.

- Staff we spoke with were able to explain the sepsis-screening tool and what actions they would take to manage patients with sepsis.

Nursing staffing

- For December 2016, the trust as a whole had 24.42 (17%) less Whole Time Equivalent (WTE) nursing staff in place than what was determined by the trust to provide effective and safe care. The hospital had 170.03 WTE staff in place and a vacancy rate of 13%.
- Surgical wards at the hospital had the highest vacancy rate of 24% followed by theatres (17%).
- As at December 2016, the hospital reported a turnover rate of 12% in surgical care.
- Surgical wards at the hospital had the highest turnover rate of 29% and trauma and orthopaedics had the second highest rate of 22%. Theatres had the lowest turnover rate of 0%.
- Surgical services used an evidence based acuity tool to assess patient's acuity and dependency and ensured the establishment reflected patient needs. However, we observed this did not always happen. During the inspection we were told by staff that sometimes, patients placed in theatre recovery area on level three ventilation, were not cared for by an appropriately trained intensive care nurse. Furthermore, trainee anaesthetists had raised this concern in the Health Education England of October 2016 report we viewed.
- The service relied on bank and agency staff to fill gaps and we saw the trust tried to use regular bank staff where possible. This meant staff were familiar with the environment, policies and ways of working. Between April 2016 and November 2016, the hospital reported a bank and agency usage rate of 26% in surgical care, higher than the trust average of 13%. General surgery had an average usage of 31% while theatres and wards had an average usage of 21%. General surgery reported the highest agency and bank usage in September 2016 (41%), while the lowest usage was in July 2016 (26%). For the remaining six months, agency and bank usage remained between 30% and 33%. Theatres and wards

had the highest agency and bank usage in April 2016 (29%) and the lowest in May 2016 (15%). For the remaining six months, agency and bank use remained between 19% and 22%.

- In November 2016, the trust took the decision to reduce registered nurse staffing levels in ward 17 from five in the day to four and four during the night to three, by replacing them with an extra HCA. Nursing staff, they had felt the impact of this on their workload since the change as registered nurses had more accountability within the scope of their role.
- We saw 16 incidents reported by nursing staff between September 2016 and February 2017 regarding staff shortages. The incidents highlighted that due to staff shortages or lack of additional nurses for one to one care, they could not provide the appropriate care and treatment for patients.
- The wards used a standardised trust handover sheet containing information about each patient. A copy was given to each member of nursing staff. Nurses communicated important information on patients care and treatment and individualised needs. Nurses also conducted bedside handovers on a one to one basis.

Surgical staffing

- Trust data showed from December 2016, within general surgery there was a vacancy rate of -2%, resulting in the hospital having 6.7 WTE more staff in place. The vacancy rate was -17%. Trauma and Orthopaedics had a vacancy rate of 9% (3 WTE) while Anaesthetics reported a vacancy rate of 4% (1.6 WTE). As from December 2016, the hospital reported a turnover rate of 5% in surgical care.
- Anaesthetics reported the highest turnover rate of 8% and trauma and orthopaedic had a turnover rate of 4%. General surgery at this site had the lowest turnover rate of 2%.
- The service used bank staff to ensure the service ran effectively at times of staff shortages. Between May 2016 and November 2016, the trust reported a bank and locum usage rate of 17% in surgical care. The Anaesthetics department reported the highest bank and locum use of 13% in July 2016 while the lowest usage of 4% was reported in September 2016. For the remaining six months a usage of between 6% and 9% was reported consistently.

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- Between 1st of September and September 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average by 6% and the proportion of junior (foundation year 1-2) staff was about the same.
- On call and out of hours cover was provided by junior doctors to consultants 24 hours a day, seven days a week. Consultants were on site daily and non-resident out of hours. On call, consultants attended the hospital out of hours when there was an emergency.
- We saw a report of a review undertaken by Health Education England of the anaesthetic department in October 2016 regarding concerns raised by trainee anaesthetists. Concerns covered the gaps in rotas and the report explained they had heard from anaesthetic trainees, that despite all consultants being available on the phone, there had been incidents when a consultant who was on call had refused to attend out of hours, when asked to come into the trust by the trainee. In one case, it had taken a significant number of hours to convince the consultant to attend. At the time of inspection the trust were in the process of reviewing their escalation policy and setting plans in place to ensure on call consultants attended emergency calls.
- Furthermore, trainees reported they did not always have intensive care trained nurses available with them whilst caring for patients in recovery, who were ventilated awaiting an intensive care unit bed.
- For the 2015/16 financial year, the hospital reported a sickness rate of 0.09% in surgical care.
- We observed a morning handover meeting which was well attended and started promptly at scheduled time. Staff discussed clinical cases and evidence of multidisciplinary corroboration between different specialities. Junior doctors were included in these meetings.

Major incident awareness and training

- There was an emergency, preparedness, resilience, and response (EPPR) policy, which had been updated in December 2016.
- The plan covered roles and responsibilities in the event of a major incident, such as fire.
- A minimum of 30 minutes training in emergency preparedness was provided during induction, which was refreshed every three years.

- 98% of registered nurses had completed mandatory training of major incident training (emergency Planning) against a trust target of 85%. 43% of medical staff had completed the training.
- The trust had gold, silver, and bronze commander controllers, staff who were responsible for using commands and taking leadership control during an emergency. They had the power to temporarily create extra staff capacity. For example, in an emergency, which required extra surgical activity, staff redeployment was actioned through, suspending or cancelling pre-booked leave, increasing staffs contractual hours, altering shift patterns and working hours in excess of 48 hours.
- Nursing and medical staff were aware of the new EPPR policy and were able to describe their roles and responsibilities during a major incident.

The trust also had a business continuity plan which gave details of how the organisation would continue to function in the event of a major event.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- The hip fracture audit and National Bowel Cancer Audit results showed surgical services performed worse than the England average.
- The trust was not meeting their fracture of neck of femur surgery standards of 24 hours, due to theatre and bed capacity.
- There was a low completion rate for staff appraisals.
- Multidisciplinary team (MDT) collaborative working was varied across surgical services. We saw examples of good MDT working but also saw poor interaction regarding respectful communication between professionals.

However:

- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies and were available on the hospital's intranet.

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- Pre-assessment care plans were comprehensive and covered health and social care needs.
- Patient's pain was assessed and managed well.
- Junior doctors across different surgical specialities were complimentary about their training and support from peers.
- Staff we spoke with demonstrated good understanding of their responsibilities under The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- Generally, care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and the National Institute for Health and Care Excellence (NICE) guidelines.
- In theatres, and in patient notes, we saw evidence that care and treatment was provided in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic liquid.
- The hospital used the National Early Warning Score (NEWS) to assess and respond to any change in a patient's condition. This was in accordance with NICE guideline CG50: Acutely ill adults in hospital; recognising and responding to deterioration.
- Staff assessed patients for venous thromboembolism and took steps to minimise the risk where appropriate, in line with NICE guideline CG92: venous thromboembolism: reducing the risk for patients in hospital.
- Patient notes showed pre-assessment nurses performed pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions. This is in line with NICE guideline NCG45: Routine preoperative tests for elective surgery.
- The hospital followed NICE guidance CG65 for hypothermia: prevention and management in adults having surgery, staff monitored the patient's temperature before anaesthetic, and then every 10 minutes afterwards.
- The trust followed NICE NG51 Sepsis: recognition, diagnosis, and early management. Staff used a sepsis screening and action tool. Sepsis audits were undertaken to ensure staff followed local protocols.
- Nurses completed the water flow and malnutrition screening tool (MUST) scores for patients and used the scores appropriately to guide care planning. The Waterlow risk assessment score gives an estimated risk for the development of a pressure sore in a given patient.
- We were not assured the hospital followed the appropriate protocols to keep patients safe from infection. Patients with MRSA were not always kept in an isolated room and medical outlier patients were placed with surgical patients.
- There was a clinical audit programme governed by the quality, governance assurance department. The programme was formulated to comply with local and national priorities. Local audits completed included the WHO checklist. We saw from surgical governance meeting minutes from April 2016 to December 2016, how improvements in the team briefing had been made due to actions taken. These included sending every member of surgical staff an accountability letter on the WHO checklist process.
- The clinical effectiveness team reviewed all new published NICE guidance. They requested the appropriate clinical leads complete a compliance assessment across the trust to ascertain if current services were in line with recommendations made by NICE.
- The clinical effectiveness team met with audit leads and discussed local audit topics to be included in the audit programme.
- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance.
- The trust participated in national audits such as The National Bowel Cancer and National Emergency Laparotomy audits. There were local audit plans to monitor quality and performance when providing care and treatment, such as sepsis screening, VTE assessment, pain assessments and IPC monitoring.

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- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant legislative guidelines, for example Health and Safety at Work Act 1974, Reporting of Incidents Diseases and dangerous Occurrences (RIDDOR), 1995.
- Staff could access updated policies and guidance on the trust's intranet. There were numerous computer terminals throughout the wards and theatre areas staff were able to use.

Pain relief

- There was an onsite pain team, which was available from 9am to 5pm Monday to Friday, outside of these hours an on call service operated.
- Two consultants and two registered nurses covered the pain team.
- We were told all registered nurses completed a pain management study day, which was updated every two years. We did not see evidence to see the compliance rates.
- There were effective processes in place to ensure patients pain relief needs were met. However, nursing staff told us due to staff shortages, on occasions they were concerned they did not always attend patients in a timely manner to treat their pain.
- There was an assessment pain tool within the NEWS chart used within the hospital. Nurses asked patients to rate their level of pain on a score from one to 10, with 10 being the worse. In patient notes, we reviewed pain scores had been completed for each patient.
- There were pictures of happy to sad faces, for those patients who were unable to describe their pain. They were able to point to the appropriate face, so staff could identify their level of discomfort.
- Surgical services carried out pain audits. Pain scores were monitored for comparisons between day one and day two of a patients stay in hospital. The audit for the end of 2016, showed overall the pain team and nursing staff were effectively managing patient's pain. For example, 18 patients who had hip and knee surgery, and who had a pain score of 10 (the highest pain score recorded) on day one, was lowered to eight patients on day two.
- Four patients told us the pain relief they had received worked quickly and nursing staff asked them frequently if they were in pain. They knew they could use their call bell if they needed to. They told us they and not needed to use the call bell for any pain requirements.

- Staff on wards did intentional rounds every couple of hours to ask patients about their comfort.
- For those patients unable to take medication by mouth, pain relief also included patient controlled analgesia (PCA) and epidural infusion. Service leaders reported sufficient pain management equipment including dedicated epidural pumps.
- A pain list service was operated in the day surgery care unit. Staff told us patients only had standard chairs to sit in when having their pain assessed or treated and sometimes this was not adequate for their needs. There were no beds or chairs, which could be altered to take patients more comfortable when having their pain needs assessed and treated.

Nutrition and hydration

- Patient advice followed the Royal College of Anaesthetists guidance on fasting prior to surgery. It recommends patients can eat food up to six hours and drink clear fluids up to two hours before surgery. Pre-operative information included information on fasting times.
- One inpatient told us they had their planned surgery cancelled for three consecutive days, which meant they had not eaten. We were not assured the patient had received the appropriate care and treatment. The patient said fasting for three consecutive days had caused distress and discomfort.
- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk from malnutrition. The role of MUST is to aid the identification of patients who are malnourished in order they may be referred for further assessment or nutritional intervention.
- In 2015, the trust found poor compliance with the nutritional screening tool. A re-audit in 2016 identified improvements had been made. For example, compliance with the recording of the patients weight was 47% in 2015. For 2016, this showed as 71%. In total, there had been a 53% increase over the previous year. However, the calculation of body mass index (BMI) was poor with a low completion (below 50%). The action plan showed further training would take place with ongoing study days for nurses and dietetic presentations at nurses and HCA training days.
- There were water coolers throughout the wards.

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- Staff assessed and recorded patients' nausea and vomiting score and all records we reviewed had completed checks.
- The trust offered dietetic advice and speech therapist support when required. Patient's dietary requirements could be tailored to suit their medical needs. For example, patients who could not swallow easily would be given a diet, which contained less solid foods, to make patients feel more comfortable.

Patient outcomes

- The hospital took part in national audits focussing on patient outcomes.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10.7%, which was worse than expected. The 2015 figure was 4.51%.
- The proportion of patients having surgery on the day of or day after admission was 71.7%, which did not meet the national standard of 85%. The 2015 figure was 81.1%. The perioperative surgical assessment rate was 97.5%, which did not meet the national standard of 100%. The 2015 figure was 89.3%.
- The proportion of patients not developing pressure ulcers was 87.2%, which fell in the worst 25% of trusts. The 2015 figure was 99.2%.
- The proportion of patients having surgery on the day of or day after admission was 71.7%, which placed the site in the lower quartile nationally. The case ascertainment rate for the site was 80.1%, compared to a national average of 90.7%.
- The length of stay was 19.8, which fell in the middle 50% of trusts. The 2015 figure was 23.5%.
- We reviewed actions (currently being implemented at the time of our inspection) taken as a result of the audit findings. These included developing protocols to assess and monitor patients, so there was a better understanding of the nature and management of dementia to help prevent delirium, which was the most common complication of hip fracture. This included adopting standardised protocols and approaches to anaesthetic and surgical care.
- Consideration whether theatre capacity, orthogeriatrician, and therapist staffing was aligned to the times of day at which hip fractures commonly presented. Actions to ensure processes were in place to collect accurate data on hip fractures was due to be fully met once they recruited a second orthogeriatric nurse. This was planned for April 2017
- In the 2015 Bowel Cancer Audit, 79% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average and had risen from 69% in 2014. The risk-adjusted 90-day post-operative mortality rate was 6.1, which was within the expected range. The 2014 figure was zero. The risk-adjusted 2-year post-operative mortality rate was 17.7%, which fell within the expected range. The 2014 figure was 30%.
- The risk-adjusted 90-day unplanned readmission rate was 17.9%, which fell within the expected range. The 2014 figure was 12.0%. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 47%, which again fell within the expected range. The 2014 figure was 55%.
- Additionally patients undergoing a major resection had a post-operative length of stay greater than five days of 79%, compared to a national average of 69%. The case ascertainment rate of 103% was better than the national average of 94%, which indicated good quality of audit participation.
- We reviewed action plans which included auditing the percentage of rectal cancer patients who still had a temporary stoma 18 months after surgery. This was to be finalised in August 2017. Other actions included the trust regularly reviewing the audit data to increase data completeness, particularly for those patients who did not undergo major resection. This was to be discussed at the yearly audit annual general meeting.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 7%. This placed the trust within the middle 50% of all trusts for this measure.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 42%, significantly higher than the national aggregate.
- The case ascertainment rate was between 81%- 90% better than the national average of 79%, although the trusts' case ascertainment rate had decreased from >90% in 2015 to 81%-90% in 2016.
- Recommendations from the audit included actions such as, GP teaching sessions on NICE referral guidelines, which were presented to the local commissioning group. New referral forms had been introduced, to ensure measures were in place for early referral from primary care.

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- In the 2016 National Emergency Laparotomy Audit (NELA), the hospital achieved an amber (50-69%) rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 111 cases. Consistent documentation of an accurate estimate of risk of death is central to both providing informed consent for the patient and for ensuring that peri and post-operative care needs are anticipated and met.
- Recommendations and actions taken because of the audit, included reminding clinical staff to assess and record risks of complications after surgery, which needed to be shared with all of the MDT.
- The Queen Elizabeth Hospital achieved an amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 88 cases.
- The Queen Elizabeth Hospital achieved an amber (50-79%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 75 cases.
- The Queen Elizabeth Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 50 cases.
- The risk adjusted 30-day mortality for the hospital was within expectations based on 143 cases.
- The case ascertainment rate was 74% better than the national average of 70%. Therefore, the quality of hospital participation in this audit was good.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, indicators showed fewer patients' health improving and more patients' health worsening than the England averages.
- Between September 2015 and August 2016, patients at the hospital had a slightly higher than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. The non-elective specialties trauma, orthopaedics and urology had the largest relative risk of readmission.
- We were told by the head of nursing the hospital was not meeting their fracture neck of femur (NOF) standards of 24 hours due to theatre capacity. We saw two incidents reported by nursing ward staff in October 2016, whereby two patients had their NOF surgery cancelled due to the overrunning of the surgical list. We did not see any details as to whether the patients had been re-scheduled.

Competent staff

- Between April and August 2016, the hospital surgical appraisal completion rate was 59.6%.
- There was a medical appraisal and revalidation policy where roles and responsibilities were clearly outlined.
- The revalidation department monitored appraisal and revalidation. As of March 2016, the trust had an appraisal/revalidation rate of 99%. For surgery services, 131 appraisals had been completed out of 136. There were valid reasons for remaining five that had not been completed.
- For the overall trust, 673 nurses were due to revalidate between April 2016 to 31 March 2017. The revalidation team commenced a monthly rolling programme in December 2015, and to date 100% of nurses have submitted on time.
- All nurses were contacted prior to their revalidation deadline asking them to contact the revalidation officer with the name of their confirmer. Reminders and escalation procedures were in place for those who did not engage.
- The senior and learning development facilitator ran revalidation workshops and to date 120 nurses, both registrants and confirmers had been educated in the process.
- A standard operating procedure had been drafted and shared with matrons, as support lied with matrons and heads of nursing.
- Newly appointed staff attended the trust's induction programme and received local induction to their relevant area. Staff remained supernumerary for six weeks until their competencies were signed off.
- Staff were able to apply for courses and nursing staff they had to write an essay as to why they wanted to attend the course.
- Staff were complimentary on the trusts support for attending courses and furthering their development. We spoke with a HCA who had received additional training on phlebotomy and most staff said they had been able to attend the course they had shown a preference to.
- The university linked to the anaesthetic training, insisted nursing staff had six months of anaesthetic training before they were able to start the course. This meant Band 5 trainee staff had their supernumerary period

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extended, as they were unable to work in the anaesthetic department without a formal course. Staff told us this was not a standard approach across all universities and was cause of frustration.

- However two anaesthetics trainees and intensive care medicine (ICM) trainees reported that the training experience they received was of an extremely high quality and better in comparison to some other trusts in which they had previously worked. They stated they were exposed to a wide range of conditions and cases and a number of trainees confirmed they would like to return to work at the trust in the future.
- The Health Education England, postgraduate medical and quality management overview of May 2016, found students in theatres were well supported. They had a wide range of multi-professional learning and mentors who were keen to share their skills.
- Nursing students always worked on a one to one basis, received a formal orientation package prior to a placement, and had a structured learning programme.
- In Ward 12, they found post-graduate students were keen and motivated members of staff and were well supported.
- The NHS England, anaesthetics urgent concern review in 2016 found trainee anaesthetists felt well supported and stated they had sufficient clinical supervision. Furthermore, trainees had commented they welcomed the intensive care unit (ICU) shadowing system that was in place, which ensured novice trainees felt comfortable working on the ward out of hours. Anaesthetic trainees commented that they felt extremely well supported by their college tutors and all trainees confirmed they knew who to turn to for support. Theatre staff told us a level three ventilated patient was placed in theatre recovery due to the lack of bed space in the intensive care unit. The patient was cared for by a recovery nurse and anaesthetist, but there was no intensive care trained nurse to care for the patient.

Multidisciplinary working

- Multidisciplinary team (MDT) collaborative working was varied across surgical services. We saw examples of good MDT working but also saw poor interaction regarding respectful communication between professionals.
- Pre-assessment nurses liaised with anaesthetists and surgeons to co-ordinate pre-operative investigations.

- Patients reported good levels of support from physiotherapists and told us their input had helped with recovery after their procedure. We saw evidence of MDT in all patient records we reviewed including input from consultants, nursing staff, physiotherapists, and pharmacy.
- Consultants and nursing staff undertook daily ward rounds and ward staff liaised with district nurses to arrange ongoing care for patients post-discharge.
- However, there were many medical outliers in the surgical wards and staff told us of the difficulty in contacting medical consultants to review the patient. Nurses told us nobody wanted to take responsibility for medical outliers and often patients were not seen particularly at the weekends. An incident reported on 21 September 2016 by the pharmacist indicated a medical outlier patient based in Ward 15b, had not been seen by a senior clinician since 16 September 2016.
- There were tensions between the site management team and ward managers. We observed a bed meeting, whereby clinical concerns of ward staff were not considered. The discussion did not demonstrate mutual respect and acknowledgement of each other's challenges.
- There were fractious relationships between the surgical and medical divisions; many staff including senior surgical staff felt the trust placed less priority and importance on the surgical division.
- The surgical wards had recently introduced daily midday huddle meetings, managed by the matron and attended by the respective managers of each ward. Topics discussed were current staffing issues, patients receiving end of life care, unwell patients, DoLS, IPC, incidents, and safeguarding. There was good communication between each staff member and the matron was kept up to date on current issues within each ward.
- There were daily bedside handovers by the nursing team. We observed good interaction and communication by staff members.
- A daily ward MDT took place attended by the nurse in charge, a physiotherapist, an occupational therapist (OT), the ward clerk, and the discharge co-ordinator. However, the meetings were conducted in the ward by the nurse station and were often interrupted with other staff members and patients walking through the meeting. The environment was noisy and we were unable to clearly understand what was being said.

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- We observed good MDT working in operating theatres. Staff communicated effectively and there was good teamwork.
- There was critical care outreach service (CCOT) at the hospital; however, they did not cover all shifts. An NHS England urgent review report relating to anaesthetist support found the site team could allocate CCOT nurses to other areas, which they found seriously diminished their effectiveness. The hospital were still in discussion with NHS England regarding how often nurses were relocated to other areas and whether this was a frequent occurrence at the time of our inspection.
- Patients completed pre-admission medical information, which included past medical history, allergies and current medical history.
- Most permanent staff members had access to policies and procedures via the trusts intranet and hard copies, which were kept in theatre and ward departments.
- Newsletters kept staff updated on clinical issues. However, a few HCA told us they did not have access to the trusts intranet system.
- There were information posters on the walls by the workstations and staff rooms for staff reference. These included copies of the trusts policies and outcomes of recent audits.
- The matron told us ward meetings were not recorded, so there was no access of information for those that did not attend. However, any concerns were raised in daily MDT meetings and on a one to one basis with staff members.

Seven-day services

- There were two designated theatres for emergencies, which operated on 24 hours a day seven days a week.
- Nursing staff told us weekends were not very well covered and junior doctors were placed under a great deal of pressure. An incident reported by a member of nursing staff on 13 January 2017 provided details of how there were no orthopaedic/orthogeriatric or urology junior doctors on call on the Friday evening and all of the weekend. Nobody answered the on call bleep.
- Arrangements were in place to ensure out of hours medical cover consultant surgeons were on call, rather than resident within the hospital. Nursing staff we spoke with said they were able to contact consultants if they needed to.
- The trust was in the process of reviewing their seven-day pharmacy service, to provide a more clinically focused weekend service across both sites.
- An out of hours on call pharmacist was available at all times. Access was via the switchboard. Currently the pharmacy department was open Monday to Friday from 9.30am to 5.15pm and Saturday and Sundays from 10am to 1pm.
- Investigations, such as blood tests, CT scans, x-rays could be accessed 24 hours a day seven days a week.

Access to information

- There were pathway records available to staff that contained all information staff needed to deliver effective care and treatment. Records included risk assessment for VTE, falls and nutrition and medical notes. We saw completed VTE assessments for 10 records we viewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with said treatment and care was explained, and staff sought consent before treatment. Patients told us, risks to their treatment had been explained and they had been provided with information on the benefits and risks of their surgery before they signed the consent form. In patient records, we saw completed consent forms with risks recorded by doctors. Interpreters were booked to assist with taking consent if patients needed this.
- Staff had a good understanding of the importance of consent. They knew the importance of gaining patient consent before treatment. We observed theatre staff gained consent prior to patients undergoing surgical treatment and found it to be in line with the trust's policy.
- All records we viewed contained signed consent forms, prior to surgery and were signed and legible.
- We saw mental capacity assessments were completed in five patient's records we viewed.
- We saw the therapeutic restraint policy of adults under the MCA 2005 Deprivation of Liberty Safeguards (DoLS) and procedures for DoLS authorisation. Staff were aware of the policy and how they could access this through the organisations intranet.
- A nurse was able to explain a recent DoLS application where a decision was made in the patient's best interest to have enhanced care on a one to one basis.

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- There was a dementia team and a dementia nurse worked on ward 12. Patients were assessed and an extra member of staff was recruited to provide one to one support. We saw nursing staff provide one to one care for those patients with mental health concerns.
- There was mandatory training for all staff in the Mental Capacity Act (MCA) and consent to examination/treatment. As of December 2016, training had been completed by 47% of medical staff within surgery. Nursing staff had a completion rate of 98%.
- The clinical documentation audit of 2016/17 for the surgery division found for orthopaedic patient records the trust scored 100% for the DNACPR form being fully completed by the consultant, legible, evidence of involving next of kin when the patient lacked capacity and the placing of the DNACPR proforma at the front of the patient records. Evidence of a review of the DNACPR order during ward rounds scored 100%.
- However the 'Not for resuscitation' status recorded in the text of the main doctors notes and recorded next to the nurses notes scored low with 14% and 33% respectively.

Are surgery services caring?

Good



We rated caring as good because:

- During the inspection, we observed the majority of staff treating patients with kindness and compassion.
- Patients told us that, despite pressures, staff were “very attentive and kind” and “couldn’t do enough for you”. Patients’ positive attitude towards staff was consistent across all the surgical wards.
- Patients provided positive feedback on the staff caring for them in clinical audits.

Compassionate care

- Staff on the surgical wards knew what good care looked like and could provide many examples of how to achieve this. For example, one nurse said providing good care was taking the time to understand the patient and understanding their likes and dislikes.
- Staff treated patients with dignity and respect. For example, we observed patients fully wrapped/covered

when taken to and from the shower and toilet facilities. Staff reassured patients when giving personal care and maintained their privacy by using curtains and screens consistently in wards.

- However, due to staffing issues and surgical demand, their ability to achieve a good standard of care was compromised. Staff told us they did not have enough time to spend with patients when they were short of staff, especially those who required more individual attention.
- On ward 17, a patient described often having to wait for help and could tell staff on the ward were stressed. They also mentioned staff had been “too busy” to move a disruptive patient, even though they had also been asked by several other patients.
- Patients told us that, despite pressures, staff were “very attentive and kind” and “couldn’t do enough for you”. Patients’ positive attitude towards staff was consistent across all the surgical wards.
- A patient gave us an example of when a staff member from another healthcare provider had been rude to them, and the staff on ward 17 had been “very caring” and “attentive” and helped them raise a complaint.
- However, although patients widely agreed that staff were very caring on the surgical wards, several patients stated that non-permanent staff were sometimes less attentive and could even be “rude”. A patient on ward 17 gave an example of a staff member being rude, however they said the ward sister dealt with the issue immediately and this reassured them.
- In the discharge lounge, which was also used as an escalation area, staff left some patients on beds with their legs uncovered and curtains open. These patients were visible to all other patients in the discharge lounge and to the public from a window on the door.
- In wards 15ab, the ward coordinator would make staff aware if a gynaecological patient had suffered a miscarriage to ensure they were treated sensitively and given extra support if needed.
- Results of the Friends and Family Test (FFT) for the hospital the percentage of friends and family that would recommend surgery wards was between 88% and 100%. The FFT information displayed on the information board on ward 17 showed the FFT score was 96.2% for the month prior to inspection.
- The response rate for FFT was low at 8%, and worse than the England average.

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- The trust provided examples of patient satisfaction audits, two of which included patients in urology clinics and urology inpatient service users.
- We observed thank you cards displayed in the surgical wards from patients expressing their gratitude to the nursing staff. During the inspection, we observed a member from the housekeeping/cleaning services speak to a member of staff with learning difficulties in a rude manner. This was unacceptable behaviour and we fed this back to the trust during our corroboration.
- On two separate occasions, we saw two members of nursing staff using their mobile phones while sitting in the patient bays of ward 15ab.

Understanding and involvement of patients and those close to them

- The surgical wards at the hospital provided patient information leaflets, for example on ward 12 the trust provided preoperative information booklets.
- The trust sent patients at the hospital surgical pre-assessment questionnaires, which had been site, developed.
- Patients we spoke with generally praised the staff for involving them in their care. In ward 17, staff told orthopaedic patients their treatment plan and one patient praised their consultant as “fantastic” with “good explanation” of their care.
- Other questions asked patients if they felt their further treatment/plan was explained well. Responses showed patients felt satisfied or very satisfied with this aspect of their care. The questionnaire also asked patients if they felt informed regarding their follow up by urology services and the responses were positive with 80% of patients very satisfied, 15% satisfied and no patients unsatisfied with this area of the service.
- Some positive comments made by patients included “very thorough examination and explained everything clearly” and “the treatment plan was explained well, more so than ever before”.
- The trust-identified areas of improvement for the urology clinic in terms of patient understanding and involvement, which included making sure notes, were available on time for appointments, ensuring appointment letters are more informative regarding length of stay and ensuring patients are given clear directions to the clinic.

- The urology inpatient service patient satisfaction audit asked patients if they felt their doctor explained their condition clearly to them, which also had a positive response with 87% of patients feeling satisfied or very satisfied with this aspect of their care.
- Negative comments made by patients included doctors’ should “listen more to the patient, sometimes all the doctors talk to each other” and there had been “an initial communication problem where I outlined my discontent to the team”. This second issue had been dealt with the trust effectively, however, “they apologised for their lack of time due to being busy, and they were very professional with the rest of my dealings with them”.

Emotional support

- Some patients told us they received emotional support from the staff caring for them; however, others said there was no emotional support as staff were too busy.
- The hospital had a multi-faith room for reflection, which provided a quiet and private space for patients, and visitor’s emotional and spiritual needs. Staff also told us patients could request a chaplaincy service if they wished.
- Nursing staff showed awareness of patients suffering from anxiety or depression. We saw the service made appropriate referrals for psychiatric support for patients at risk of self-harm.

Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The trust was not meeting the England average for the length of stay for surgical elective patients.
- From December 2016 to March 2017, 167 surgical operations were cancelled, on the same day, some prior to admission, mainly due to lack of bed availability.
- The percentage of patients whose operations were cancelled and not treated within 28 days was worse than the England average.

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- Staff told us out of hours discharges occasionally happened due to the lack of available patient transport. Frequent delays in discharge happened due to patients waiting for their medication.
- There were medical outlier patients on surgical wards, which meant bed management became an issue.

However:

- Surgical wards used care plans and assessments to ensure those patients who required specialist help received this.
- Nursing staff endeavoured to resolve complaints locally before they escalated.

Service planning and delivery to meet the needs of local people

- The trust had a sustainability and transformation plan (STP). **The purpose of STPs is to help ensure health and social care services in England are built around the needs of local populations.** The plans are place based, whole system plans. Under national guidance, the trust had established a leadership team of four individuals from across each part of their system, which included local commissioner's members of the local council and a member of another NHS trust.
- An initial STP submission was made in June 2016, which was reviewed by NHS England, and a final STP was submitted in October 2016, which recognised that the detail would continue to evolve through public engagement and discussion with stakeholders. Some elements of the STP, such as their proposal to develop two elective orthopaedic centres and potentially changes to specialised commissioning, required formal public consultation. Having dedicated centres meant offering more procedures and patients spending less time in the hospital as there would be fewer cancelled operations.
- Between October 2015 and September 2016 the average length of stay for surgical elective patients at QEH was 4.7 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.7 days, compared to 5.1 for the England average.

- The length of stay for trauma and orthopaedics, general surgery and urology for elective patients at QEH were all longer than the England average. General surgery, trauma, and orthopaedics had the longest stay for non-elective patients.
- Trauma and Orthopaedic elective patients at QEH had a stay of 4.6 days, longer than the England average of 3.4 days. Elective patients in general surgery stayed 4.7 days compared to an England average of 3.3 days. General surgery had a stay of 5.3 days for non-elective patients, which was longer than the England average of 4.0 days.
- From December 2016 to March 2017, 167 surgical operations were cancelled at QEH on the day, some prior to admission with the overwhelming reason being lack of bed availability. This was a massive source of frustration within surgical services. Most staff we spoke with felt the reason of lack of bed space was due to accident and emergency escalated patient and medical outliers, taking priority over surgical patients. Staff said surgical services were the last on the list of priorities within the trust.
- The trust's surgery plan set out ways of reducing their RTT figures by reopening a decommissioned theatre to create sufficient theatre capacity at the hospital. The proposals would create 10 new theatre sessions for urology, gynaecology, and general surgery. This was due to be operational by April 2017.

Meeting people's individual needs

- Staff assessed patient individual needs at the pre-assessment unit. This included any physical, mental, or cultural needs. Staff told us that, where an interpreter was required, this was identified and arrangements would be made in advance of the patient.
- Support for patients with limited mobility was provided as required and requested. Patients told us that nursing staff offered to help with personal care but respected their independence and dignity.
- We saw a dementia friendly area for patients in ward 17, which contained sensory materials for patients to use. There were red trays for meals, and patients had assessment and enhanced care plans for one to one care. We viewed three patients living with dementia records and found care plans and assessments had been made.

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- The wards were accessible to patients or relatives with wheelchairs, however space between patient beds was sometimes less spacious to allow for this access. The trust was able to meet patient's special dietary requirements either due to the medical, cultural, or religious beliefs. Patients were able to have a choice of meal. Most of the patients we spoke were very pleased with the availability, choice, and quality of food during their stay. They reported adequate sized meal portions and regular refills of water, tea, and coffee. We observed most patients with a cold water or juice jug beside their bed. We observed staff ask patients if they needed a drink. There were regular protected meal times on surgical wards and we saw staff and visitors respected these. This meant staff were able to assist those patients that required help during their meal times.
- The day surgery unit offered hot drinks, water, and biscuits to patients before discharge home. Ward 17 had a family and friends room which contained books, magazines, puzzles, and facilities for drawing, which were used by both patients and relatives. Staff also told us, when they had time, they would paint patients nails.
- There was a multi-faith chaplaincy which patients and relatives were able to use. The temperature in parts of wards 12 and 17 was cold. Nursing staff told us they sometimes provided blankets to relatives and used the warming blankets from theatres to help keep patients comfortable. Patients in certain parts of Ward 12 had air vents directly above their beds. Staff logged their concerns with the maintenance team. Staff were told there was not a problem as the temperature was within the accepted temperature range, however during the inspection, parts of ward 17 felt cooler than expected.
- Most patients we spoke with said staff responded swiftly to call bells. We observed staff attend call bells promptly during our inspection. Bariatric services were provided at University Hospital Lewisham.
- Some patients told us, nights were uncomfortable due to other patients being either disruptive or noisy. The surgical wards had many confused patients who required one to one nursing attention. In the day care unit, the recovery area which was being used as an escalation area had no convenient bathroom facilities for patients to use. There were no television or radio services. Patients with infections were not always being placed in appropriate rooms. In the day care unit, side rooms had no separate wash or bathroom facilities for patients to use. In ward, 15ab one shower room had been inoperable for several weeks, which meant there were not enough washing facilities for patients to use. Patients were being placed on a list to use the remaining working shower.
- There were no separate children and young people's recovery area within theatres. A curtain was used as a division area. Patients were sent to the discharge area wearing their hospital gowns. We saw mixed sexed patients sitting next to each other wearing hospital gowns. This was not dignified for the patient.
- In the day care unit, nursing staff reported on occasions there were not enough seats for the number of patients. Therefore, some patients had to stand while they waited for their appointment.
- On 27 October 2016, staff reported an incident that the day care unit had no space available to pre-assess the patients for surgery.
- We reviewed various incidents reported by nursing staff on the shortage of staff in the surgical wards when caring for patients who required additional support. Additional support ranged from patients with dementia and those who were vulnerable as a result of their medical condition. For example, one incident reported on 27 September 2016 regarding shortage of staff on ward 17. Two HCA had not been booked for additional support for those patients that required one to one support. In total, there were 11 confused patients out of a total of 28 patients on the ward who required close or one to one monitoring. There were only four registered nurses and two health care assistants. It was stated that bay three of the ward required at least three nurses to assist with the five patients based in the bay. The staff member reported it was very unsafe for patients and staff members. There were at least another 13 incidents reported on ward 17 since September 2016 to February 2017, which mentioned shortage of staffing and lack of sufficient nurses to provide appropriate care for patients who were vulnerable as a result of their medical condition. Therefore, we were not assured patients had received the appropriate care and attention they required. This was not deliberate neglect from staff or lack of competence within the scope of their role, but purely through the lack of staff numbers. This was either through additional staff not being booked or bank staff

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who had failed to turn up for the shift. Many nursing staff said they were concerned they were unable to provide the appropriate safe care and treatment due to the lack of sufficient nursing staff.

- Equality and diversity training was part of mandatory training. Latest figures showed 99% of nursing staff had completed the relevant training. Only 45% of medical staff had completed this mandatory training.
- Patients were kept in single sex bays wherever possible. However, staff told us sometimes orthopaedic patients were placed in mixed bays when the ward was busy. We also observed in the discharge lounge/escalation area there were mixed sex patients placed next to each other in bays.
- On wards 15ab staff would, wherever possible, allow partners of gynaecological patients to stay overnight if patients requested.

Access and flow

- NHS England data (December 2015 to November 2016) for the referral to treatment time (RTT) indicated, the trust was worse than the England overall performance.
- The latest figures for November 2016 showed 61% of this group of patients were treated within 18 weeks versus the England average of 71%. From December 15 to April 16, the variance between the trust average and the England average was between 1% and 9%. From May 2016 to September 2016, the variance between trust and England averages increased to between 15% and 22%.
- The worst referral to treatment times at the trust was in June, July, August and September 2016 when on average only 52% of patients were referred for treatment within 18 weeks. The percentage of patients referred for treatment within 18 weeks decreased by 15% over the twelve month period.
- The following surgical specialties were better than the England average for admitted RTT. Plastic surgery result was 90% against the England average of 82.6%, general surgery with 83.1% against the England average of 75.9% and urology with 80.7% against the England average of 79.8%.
- The following surgical specialties were worse than the England average for admitted RTT, with ophthalmology at 16.7% against the England average of 78.2%, ears, nose and throat procedures was 34% against and England average of 69.9% and trauma and orthopaedics being 35.7% against an England average of 66.5%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period, Q3 2014/15 to Q2 2016/17 Lewisham and Greenwich NHS Trust cancelled 653 surgeries. Of the 653 cancellations, 4% were not treated within 28 days.
- The trust utilised the nationally recognised Interim Management and Support Tool (IMAS) model to complete the demand and capacity review for theatres. The outcome of this modelling showed there was a capacity shortfall of over two theatres across the trust, with the assumption that the trust is delivering optimum productivity in line with national benchmarks. Currently the trust had 95, four-hour sessions per week, which provided insufficient theatre capacity to meet the demand to deliver RTT activity, specifically in orthopaedics, gynaecology, and ENT. In order for the trust to deliver their surgery plan, the model showed that there was a capacity gap of 37 sessions, resulting in non-compliance with RTT, increased waiting times for treatment and a poor patient experience.
- During our inspection, we found a high number of medical patients on the surgical wards. Surgical ward beds were not ring fenced and senior staff told us that the trust was more focused on not breaching the waiting times in the emergency department. Nursing staff told us that on average the surgical wards had eight or more medical 'outliers' each day. Nursing staff and senior members of staff said the bed management team clinically and managerially led surgery.
- Medical 'outlier' patients did not receive prompt care and attention from medical consultants, as they were busy conducting ward rounds on designated medical wards. Patients had to wait for consultants to complete their ward visits before they were seen. Nursing and senior clinical staff told us they often had to chase for a medical consultant to come and review the patient. It sometimes took staff several attempts to contact a medical consultant and on most occasions, nobody would take responsibility or ownership for the patient. During our inspection, there were approximately 12 medical outlier patients across the three surgical wards we visited.

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- Several weeks before our inspection a medical consultant had been employed by the trust to take responsibility for medical outlier patients and staff said they had seen a slight improvement since they had started.
- From quarter one Q1 2015/16 to Q1 2016/17 bed occupancy rates at the trust were higher than the England average with the exception of Q4 2015/16 when occupancy rates were equal to the England average. In Q2 2016/17, occupancy rates were lower than the England average. The overall trend shows slight variations from Q1 2015/16 to Q1 2016/17 though occupancy rates have declined to below the England average in Q2 2016/17.
- At the time of our inspection the trust were undertaking a theatre transformation programme, which will enable them to establish and agreed methodology, process, and calculation for theatre utilisation data. We therefore had no information on theatre utilisation.
- Theatre staff prioritised different patient groups on the operating lists, with priority given to elderly patients, children and young adults and patients with learning disabilities. Staff told us these patients were placed first on the list.
- Bed management meetings were held on a daily basis and attended by nurses and managers. However, we were told that the lack of beds on wards meant patients were occasionally held in the recovery ward overnight, when they would normally spend a minimum amount of time in recovery. On occasion patients were recovered inside the theatre itself, which meant the daily surgery operating list was affected and cancellations were made.
- There was no separate space for children to recover, a curtain was used to separate adults from children.
- Patients were delayed with their discharge. Nursing staff and senior surgical staff told us patients who were ready to be discharged in the morning often waited until late afternoon for completion of their notes. This had an impact on the access and flow of patients through the surgical division, as beds were unavailable which affected daily theatre operating lists. During our inspection we saw four patients whose discharge had been delayed. They were ready to be discharged in the morning, but were still waiting in the afternoon for their notes to be completed. Nursing staff and a senior consultant said there were solutions in resolving delayed discharge, but this meant better corroboration

from doctors in completing notes and perhaps delegating some duties to junior members of staff. One consultant told us it was possible for senior clinical staff to start discharge procedures for patients before treatment began, enabling the discharge process to speed up, but this meant consultants fully engaging in the process.

- From November 2015 to November 2016, the hospital did not meet its own target of 50% for fractured neck of femur patients seen within 24 hours every month with the exception of December 2015 and January 2016.
- Surgical wards had separate bays for male and female patients. Data provided by the trust showed there were no mixed sex breaches reported on surgical wards.

Learning from complaints and concerns

- Between December 2015 and November 2016, there were 45 complaints. Medical and surgical treatment was the subject that received the most complaints (20%). Communication and information provided to patients as well as discharge arrangement accounted for a further 14% and 11% respectively.
- Ward 17 received the most complaints, (27%) while theatres were responsible for 24%. Ward 15A (18%) and Ward 15B (16%) accounted for a further 33% of all complaints received.
- There was information displayed throughout the wards, explaining to patients and relatives how to make a complaint and what the investigatory processes would be made.
- A complaint satisfaction survey was conducted and showed 137 complainants from across the trust were contacted in December 2016. A total of 43 complainants were asked questions related to the trusts complaints process. 67% of complainants found staff helpful when raising a complaint whilst 14% found staff unhelpful.
- 74% of complainants found the process of making a complaint easy and 55% of complainants considered their complaint resolved satisfactorily.
- Staff told us they tried to resolve complaints locally, with either the nurse or matron. Patients could complain formally to the dedicated team in the trust, which managed complaints for all clinical directorates. The hospital provided a Patient Advice and Liaison Service (PALS) to deal with concerns from complaints.

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- Medical staff discussed complaints during monthly clinical governance meeting. We reviewed minutes and saw evidence that complaints frequently featured on the agenda.

Are surgery services well-led?

Requires improvement



We rated well-led as requires improvement because:

- Staff had a good understanding of the surgery plan, but did not have a good understanding of the trust's overall vision, strategy, and corporate goals.
- Staff did not feel included in clinical plans and decisions made by the senior management team.
- Staff felt pressured with the constant demands placed on them and did not feel they had the appropriate support. For example, staff shortages meant patients care and treatment was compromised, as staff did not have the time to provide the necessary care.
- All staff we spoke with felt supported by their immediate line managers, but they did not know much about senior management of the service.

However:

- Staff felt well supported by their line managers and local leadership.
- Staff knew their role and function within the hospital and we found them to be committed to the hospital.
- Surgery services reviewed innovations and had several projects ongoing to improve patient care.

Leadership of the service

- Clinical leads said the divisional director was supportive of their needs and understood the difficulties the surgery division faced. However, they felt surgery services was placed at the bottom of the executive team's priorities. There was a shared belief the emergency department and medical division were given priority, for example bed space, to the detriment of surgical division. Senior surgical staff said they had raised their concerns to the divisional leads, who in turn had let the executive team know, but they had not seen any action taken.
- Nursing staff we spoke with on the surgical, wards and in theatres valued their line managers and felt supported

by them. There was high praise for the matron of surgical wards. Staff told us they were treated fairly and there was an open door policy where they were able to discuss concerns.

- Nursing staff told us about ongoing issues that were not addressed. They said the matron would raise concerns on their behalf but nothing further was done at a higher level. For example, staff shortages and medical outlier patient concerns were never dealt with. Staff said they sometimes felt they were 'firefighting' within their role.
- Some of the clinical directors of surgical specialities told us they felt undermined and not involved in higher decision making. As they still operated clinical theatre lists, they had limited time to fully engage in non-clinical aspects of the role.
- There was a disconnect between the executive team and frontline staff. Staff from all levels within surgery services told us they did not see the executive team and felt their voice was not heard. Nursing staff commented they did not see the director of nursing.

Vision and strategy for this service

- Since the Trust was formed in 2013, theatre capacity has remained a challenge. The division of surgery, theatres, anaesthetics and critical care developed a vision to: "provide safe and caring surgical services across our two sites to our population by one, cohesive well led multi-disciplinary team that are responsive to our patients and populations needs yet effective through utilising our facilities and workforce across both site, producing positive outcomes and value for money".
- The division had completed a review of its services and a demand and capacity model for theatres to identify what capacity was needed to deliver this vision. The review developed some key objectives for the division, which included the aims of delivering one service across two sites, improving delivery of RTT and cancer national standards, and delivering its financial plan.
- To deliver these aims, the division had established the surgery plan. The surgery plan aimed to close the demand and capacity gap as well as improving productivity.
- The surgery plan had three phases to it: to rearrange the theatre template to align capacity based on specialties demand. This included funding 17 theatre sessions. The creation of 10 new theatre sessions for orthopaedics by building a modular laminar flow theatre at their Lewisham Hospital site for orthopaedics. The creation of

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10 new theatre sessions for urology, gynaecology, and general surgery by commissioning the currently decommissioned day surgery theatre at the hospital. This was due to be operational from April 2017.

- Surgery staff we spoke with were aware of the surgery plan and timelines of the plan, however they were not aware of the trusts overall strategy and vision.
- The trusts overall vision of “one trust, serving our local communities” was to be a consistently high performing and financially sustainable trust by 2020.
- Objectives included making improvements in quality and safety across the whole organisation. For surgery services, this involved, maintaining their performance in meeting the 18 week referral to treatment standard.

Governance, risk management and quality measurement

- The hospital had a clinical governance structure in place, which gave accountability and information flow pathways. The divisional manager had overall responsibility for surgical services. Surgical services was split into eight specialties, each had a clinical director, governance lead and service manager managing them.
- Surgery services held monthly surgical clinical governance meetings, with representation from across both sites. Policy approvals, service area delivery, divisional risk registers, incidents, patient’s stories, and business continuity were reviewed at each meeting.
- Integrated governance committee meeting were held on a monthly basis. We reviewed the minutes of meetings and saw there was good cross site attendance from the multidisciplinary teams. Clinical effectiveness, adverse incidents, patient safety, mortality, guideline compliance, and innovations were reviewed.
- We reviewed a selection of the trust board meeting minutes and found clinical topics discussed were in line with similar discussions, which had taken place in integrated governance committee meetings.
- Performance and risk sharing was good amongst surgery services. Many of the service leaders had good informal links with other areas on improving the quality of the service and the sharing of information. However, there was recognition that this type of sharing of information should be more formal.
- There was a clinical quality review group, which reviewed clinical quality improvements across the whole of the trust.
- A monthly clinical scorecard was shared with surgery leaders, which provided snapshots of quality performance indicators.
- The hospital had core service risk registers, which fed into a corporate risk register. The risk register allowed the hospital to record any risks to the service with actions and plans to mitigate these risks. Risks were rated with a rag system of red, amber or green, with red being the highest risk. We viewed the surgery risk register and found senior house officer (SHO) shortages was placed as a high risk. However, we did not see nursing staff shortages or the high use of temporary nursing staff as a risk, although this was a risk on the trusts corporate risk register. Nursing staff we spoke with during our inspection expressed this as a top risk.
- Medical outlier patients were not on the surgery risk register neither was the inappropriate placing of high risk spinal trauma patients. We were, therefore, not assured risks were being effectively captured at a local level.
- It was apparent surgery services had a number of ongoing issues, which needed resolving. The lack of ring-fenced beds for orthopaedic patients, high cancellation of theatre lists rates due to lack of sufficient bed space and inappropriate placement of medical outliers and escalated patients from emergency department needed urgent attention. We saw these concerns and the risk register were discussed at the surgical governance meetings.
- Staff told us they did not have confidence that all issues were being dealt with. We were told there were plans for future refurbishment of the hospital but there were no formal plans in place.
- Access and flow remained a high challenge. Late discharges meant lack of bed availability and cancellation of theatre lists. Staff told us emergency department had priority for bed space within the hospital. Nursing staff, consultants, junior doctors, and senior surgical leaders expressed the same concerns. Although this was a risk on the surgery and corporate risk register, we did not see any action plan in place.
- The hospital had an audit timetable, which showed a rolling programme of national, corporate, and local audits. The audit committee managed oversight.
- Surgery services held team meetings in each department, including theatres and wards. Staff told us

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they used these meetings for a two-way information sharing. Most of these meetings were not recorded so we were unable to see shared information and learning as a result.

Culture of the service

- Overall, we identified a dedicated group of staff that were committed to providing quality patient care. However, staff felt frustrated and overworked.
- There was low morale amongst some of the nursing and consulting staff. They told us they were “exhausted”, from the constant pressures and demands of the service. A few staff members said they felt they were “firefighting”, that is, they were constantly trying to deal with problems as they arose, rather than planning strategically to avoid them.
- Some nursing and senior staff said the site management team were sometimes intimidating and felt bullied. They told us their clinical advice was ignored by the team and felt their position was undermined. Situations they were not happy with were forced upon them.
- Staff at all levels said there was a cultural divide between the two sites.
- As from December 2016, the hospital reported a sickness rate of 5% in surgical care. Trauma and orthopaedics had the highest sickness rate of 9% followed by theatres (7%). Surgery (other) had the lowest sickness rate of 1%.

Public engagement

- The trust ran a programme of corporate engagement events such as healthy eating and weight management, dementia awareness.
- The trust had a patient experience committee, which was a meeting with staff and external bodies such as Healthwatch, to discuss local patient initiatives. We reviewed minutes from September 2016. Patient user group feedback was discussed; Healthwatch reports, complaints, and future workshops were reviewed.
- A surgery patient improvement action plan was in place, which discussed themes and feedback from Friends and Family Test, NHS choices, patient groups and forums. Discussions on feedback for surgical wards were reviewed. For example, for ward 17 a patient complaint was discussed and updates actioned.

- There were feedback forms for patients and relatives to complete if they wanted to provide feedback. We saw information provided on surgical wards, providing details of how a patient could leave feedback.







Staff engagement

- The trust held staff awards every year to recognise good care and practice.
- We reviewed the summary analysis of the staff survey results for surgery 2015.
- There were 200 responses out of a possible 1014. The average response rate for the hospital was 21%.
- The trust performed better than the previous year for questions such as staff recommendation of the organisation as a place to work and effective teamwork.
- The top three ranking areas for the division were under the ‘provide staff with clear responsibilities’ sector. The worst ranking areas were within ‘health and wellbeing’ sectors, violence, and harassment.
- Key improvement areas included, improving the response rate, promoting zero tolerance in clinical areas, through conflict resolution training, improving dignity at work, and reducing the vacancy rates. Staff from the day care unit and surgical wards felt they had not been able to contribute to improvements, as they had not been included in discussions on change. For example, the ward manager of the day care unit was not involved in any discussions involving the opening of the decommissioned theatre based next to the day care unit. This will have a direct impact on the day care unit and the trust had missed an opportunity of involving frontline staff who may have made valuable contributions to the planning.

Innovation, improvement and sustainability

- The surgery division governance and risk group produced an innovation report.
- A report we reviewed showed there were nine innovations. Such innovations included the use of ‘optiflow thrive’ system in perioperative care. This system provided high flow heated and humidified oxygen via dedicated nasal cannulas for short term intravenous in perioperative settings. The advantage was it provided continuous positive airway pressure, which improved oxygenated following extubation in the immediate hours after major abdominal surgery.
- There were other innovations, which involved abdominal wall reconstruction.

Critical care

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

Information about the service

The critical care unit provides general critical care support for the local population. There are 19 beds on the unit which are arranged into ten beds for patients requiring level three care (advanced respiratory support alone or basic respiratory support with support of two other organ systems), and eight beds for patients requiring level two care (more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure). There is an additional unfunded bed for additional bed capacity. Patients requiring level 3 care have one-to-one nursing and those requiring level 2 have a ratio of one nurse to two patients. There is a Critical Care Outreach Team (CCOT) who assist in the management of critically ill patients across the hospital.

We visited all areas of critical care over the course of our announced inspection. During our inspection, we spoke with 32 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team, three patients and seven relatives. We reviewed four patient records and many pieces of equipment.

Summary of findings

We rated this service as requires improvement because:

- The service was not meeting national guidance for consultant cover and there were long standing consultant vacancies.
- The environment was not meeting national building guidance. Insufficient space was identified as an issue at the previous inspection and had not been acted upon and we saw that, bed numbers had subsequently increased.
- The Critical care outreach service was not managed by the critical care service and the operational policy was past its review date. Staff on the wards were not always sure what the function of the outreach team was.
- Intensive Care National Audit and Research Centre (ICNARC) data demonstrated readmission and non-clinical transfer rates were worse when compared to other similar services.
- There were no regular multidisciplinary meetings where the team could review patient care and goals of treatment.
- Due to the shortage of consultants there was no regular training for junior doctors.
- There was no overnight accommodation available for visitors.

Critical care

- There were high numbers of delayed discharges due to problems with access and flow within the hospital. Bed occupancy was also higher than the national average, which could limit the service's ability to provide a bed in the event of an emergency.
- A recent peer review had highlighted a number of concerns around the medical leadership, number of consultants and governance arrangements. Due to the lack of medical staffing there was little time to develop a strategy for the service.
- The trust had not previously developed any action plans on how to address these concerns. Whilst we were told plans were now moving forward, we identified unresolved concerns during our inspection.

However:

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion.
- In general, we observed good infection prevention and control practices. Patients and relatives were happy with the cleanliness of the environment.
- Suitable processes and training opportunities were in place to ensure nursing staff were competent such as regular access to learning and development.
- There were good examples of team working within the service, such as between the nursing team and the therapy team.
- Interactions between staff and patients were individual and delivered in a caring and compassionate way. Staff treated patients with dignity and respect, and patients said staff were reassuring.
- Staff involved patients and their relatives in the delivery of care and treatment and tailored their help to meet the needs of the patient.
- Staff reported a positive culture within the service and worked well together as a team. Staff were happy with the support they received from their manager, and reported an open door policy.

Are critical care services safe?

Requires improvement



We rated safe as requires improvement because:

- Morbidity and mortality (M&M) meetings were not held on a regular basis and the service was not discussing every patient.
- Consultant to patient staffing ratios did not meet national guidance.
- The environment was and not in line with national guidance. This had been highlighted as an issue at our previous inspection, yet the hospital had increased the bed numbers. We saw no examples of risk assessments to mitigate the risks.
- The critical care outreach team had a high number of shifts where only one nurse was working instead of two. Staff within the hospital were not always sure of the purpose of the outreach team and there was no up to date operational policy available for staff.
- Compliance with fire safety training was below the trust target.

However:

- Staff had a good understanding of incident reporting and we saw evidence of cross-site learning from incidents.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- The environment was visibly clean and we saw staff were following appropriate infection prevention and control processes.

Incidents

- The trust reported Serious Incidents (SIs) and Never Events to the Strategic Executive Information System (STEIS).
- The service reported no never events for the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare

Critical care

providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- Incidents were reported via an electronic reporting system that could be accessed by all staff and completed on any trust computer.
- Between December 2015 and November 2016 the Critical Care Unit (CCU) reported 260 incidents and an average of 22 per month.
- Of the 260 incidents 168 (64.6%) were reported as no harm, 87 (33.5%) low harm and five (1.9%) were near miss. There had been no incidents reported as moderate harm, severe harm or death within the reporting period. We reviewed the incidents log and found the most common themes were pressure ulcers (37%), medication incidents (13%) and access/admission/transition and discharge (11%).
- The surgical divisional governance team and pressure ulcer working group aimed to reduce the number of pressure ulcers. An action plan was developed by the units matron, senior nurses and tissue viability nurses. This included improving identification of lesions, auditing risk scoring, appropriate mattresses, staff education and skin checks during every handover.
- Serious incidents (SI) are those that require investigation. Between January 2016 and December 2016, the service reported no SIs..
- Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.
- Staff told us they received feedback and learning points from incidents, including those that occurred in other units within the hospital and other sites within the trust. Learning was shared via a range of methods including directly via email or in staff meetings.
- Staff were able to describe action points from incidents and cross-site learning. For example, staff told us there had been a never event at Lewisham Hospital which involved a medication error. The investigation report was shared with staff at QEH and all nursing staff wrote a reflective account about appropriate management of controlled drugs.

- Morbidity and mortality (M&M) meetings were not occurring on a regular basis. Managers told us M&M meetings were held based on any unexpected deaths highlighted in the service's Intensive Care National Audit and Research (ICNARC) report. These deaths represented only a small proportion of the overall mortality. The delay of ICNARC report publication could mean M&Ms were not held in a timely manner. Senior leaders told us there were plans going forward to ensure all deaths were discussed.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.

Safety thermometer

- The CCU participated in the NHS Safety Thermometer scheme. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. This was intended to focus attention on patient harms and their elimination.
- We were told there were no unit acquired pressure ulcers reported by the service between January 2016 and December 2016. However, the trust provided a document called 'Pressure Ulcer Reduction – Getting it Right'. Within this document it stated there were a number of unit acquired pressure ulcers between January 2016 and February 2017. Therefore, we received conflicting information.
- During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow pressure ulcer prevention score. There were pressure ulcer prevention link nurses across the CCU who were available to provide support to their colleagues. Tissue viability nurses were available Monday to Friday from 9am to 5pm to provide specialist advice in this area.

Critical care

- There were no falls reported between January 2016 and December 2016. We saw documentary evidence of patient mobility assessments undertaken by physiotherapists and patient risk assessments completed when appropriate.
- Catheter care bundles were used by staff throughout critical care. There were no reported catheter associated urinary tract infections (CUTI) between January 2016 and December 2016.
- Venous Thromboembolism (VTE) risk assessments were recorded on the patients' record and completed on a daily basis. Hospital audit data showed compliance with this assessment between April 2016 and January 2017 varied between 85% and 97%. There was a VTE link nurses within CCU who was auditing VTE to improve compliance.
- We saw dried blood on the arterial blood gas machine. On two occasions, we saw a syringe filled with blood left on top of the sharps bin next to the machine. We raised this concern with the matron who took immediate corrective action.
- We inspected various pieces of equipment such as commodes and found a good level of cleanliness including under the seats and on the commode legs.
- Infection prevention and control (IPC) was part of mandatory training and had been completed by 98% of nursing staff. This was in line with the trust's target of 85%. However medical staffing was 67%, which was below the target.
- There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and saw all staff used PPE as required.

Cleanliness, infection control and hygiene

- The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the department of health Code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of spillage of body fluids.
- All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.
- There were dedicated housekeeping staff for cleaning the CCU. Housekeepers worked from 7.30am to 2.30pm and 6pm to 8pm. Out of hours a team was available on call. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.
- We reviewed patient areas on the CCU as well as dirty utility areas and treatment rooms. All areas were visibly clean and free from dust. Patients and relatives were satisfied with the level of cleanliness on the wards.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned and observed staff replacing stickers once they returned the clean equipment.
- Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.
- Where patients had a known or suspected infection they were nursed in single rooms. There were signs displaying presence of infection which meant staff and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed the majority of the time. However, on one occasion we saw a side room door was left open despite the sign saying it should remain closed.
- Isolation rooms had negative airflow.
- There were disability accessible patient toilets available on the unit. The unit shared a shower room with the surgical ward next to CCU.
- Hand sanitisers were readily available at the entrances to the CCU and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- We observed bed space curtains were labelled and dated when they were last changed.
- CCU audited catheter care, cleaning and decontamination of equipment, and hand hygiene. These audits took place on a monthly basis.

Critical care

- Between December 2015 and December 2016 cleaning and decontamination of equipment audit data showed an average compliance of 99%.
- Hand hygiene data between January 2016 and January 2017 showed compliance was on average 91%.
- Trust information showed it had been more than four years since the last unit acquired case of methicillin-resistant staphylococcus aureus (MRSA) and 385 days since the last case of Clostridium Difficile (C Diff). MRSA and C.Diff are both healthcare-associated infections (HCAIs) that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the rate of unit acquired blood infections for the CCU better (0.3) than comparator units (1.9) and the average for unit acquired infections in the blood (1.6).
- The unit has designated infection control and prevention (IPC) link nurse Who staff could access for support.
- There were two isolation rooms which fulfilled requirements for an isolation facility as per HBN Note 00-09. The rooms had lobbies, special ventilation and hand wash basins. The doors were tight fitting and sealed.
- Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommends there must be a programme in place for the routine replacement of capital equipment. The matron told us it was difficult to participate in bids for new capital equipment due to the busy nature of the ward.
- During our inspection a number of staff highlighted the fact the hospital only had one optiflow system. This is a high oxygen delivery system and it is used to avert ventilation, and support a patient who is critically ill. It is a rescue oxygen therapy for patients. High flow oxygen therapy can be used as well as or instead of non-invasive ventilation, with the advantage that it is more easily tolerated by patients. Not having sufficient optiflow systems means non-invasive ventilation is the only option, which is often difficult for patients to tolerate. Hence on occasion these patients will subsequently require invasive ventilation. Avoiding invasive ventilation is desirable as this automatically deems the patient level three, and at risk of aspiration and requiring sedation, this can increase mortality. Any device that reduces the need for full ventilation is desirable. Staff told us the hospital had recently ordered four more optiflow systems but we were not sure how this number had been calculated and if this would be sufficient to meet the needs of the hospital.

Environment and equipment

- Health Building Note 04-02 (HBN 04-02) for critical care units gives best practice guidance on the design and planning of healthcare buildings. The environment did not comply with national standards. There was a general lack of space and the unit looked cramped. Space around the beds in the open bay was limited and filled with equipment. There were a limited number of high backed chairs available, which had to be shared between patients and clinical wash-hand basins had to be shared between beds. The unit had only recently added this to the risk register and therefore no risk assessments had taken place.
- Patients and visitors shared the same entrance. This was against recommendation in the HBN 04-02 to prevent visitors from observing patients coming in and out of the critical care unit. There was an electronic swipe card entry system for staff and a buzzer entry system at the entrance to the CCU which was used by visitors. This meant staff could control who accessed the CCU when the door was secured.
- At the time of the inspection the service did not have access to a Magnetic Resonance Imaging (MRI) scanner that could accommodate ventilated patients. If patients required this, the service had to organise a transfer to a different hospital. Between March 2016 and February 2017 there were four patients who had to be transferred to other locations for an MRI. This was sometimes causing delays in accessing MRI scans for patients who needed them. For example, one patient had been waiting days to be sent to another hospital for the scan. We were told by the senior management that a new MRI had been ordered and had arrived at the hospital. However, this was not available for use at the time of the inspection.

Critical care

- The CCU had access to a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The content of the trolley met recommendations from the Difficult Airway Society (DAS) 2013. However, the trolley should be checked by staff on a daily basis. We reviewed the record book and found the trolley had only been checked four times between January 2017 and February 2017.
- Resuscitation trollies were located at appropriate intervals throughout the CCU. We saw the contents of the trollies were checked daily by nursing staff and were tagged and sealed.
- Needle sharp bins were available at each bed space and within the medication preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line. All bins had yellow lids and there were no separate blue lidded bins for medication. There was a sharps contamination injury first aid kit available for staff which gave details on what to do in the event of a sharps injury.
- Dirty utility rooms contained facilities for disposing of clinical waste and cleaning equipment.
- Staff told us they were able to access equipment required to care for patients and access to computer terminals to allow access to pathology and imaging results for example as well as policies and guidelines.
- There were lists available which showed staff the exact shelf location of various pieces of equipment. This meant staff could access equipment in a timely manner.
- We checked a range of equipment during our inspection and found it all to be safety tested. We reviewed service records and found them to be up to date.
- Oxygen cylinders throughout the CCU were appropriately stored in designated racks and were in date.
- The service was conducting mattress audits in which mattresses were checked for holes, tears, odours and stains. There was 100% compliance for all areas.
- There were systems in place to ensure the safe supply and administration of medicines in accordance with National Institute for Health and Care Excellence (NICE) NG5 Medicines optimisation: the safe and effective use of medicines.
- Information provided by the hospital indicated that there were 1.5 WTE CCU pharmacists in post to cover the CCU. Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (FICM) recommend there should be at least 0.1 WTE specialist clinical pharmacists for each single level 3 bed and for every two Level 2 beds. The service was able to meet this standard when it had ten level 3 patients. However, at the time of the inspection there were 13 level three patients and 6 level two patients, which meant the service was not meeting the recommended standard.
- The unit was also not meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations around pharmacy technical support. There was no technical support available on the CCU.
- Pharmacists attended ward rounds five days a week (Monday to Friday).
- Medication management was part of mandatory training. Compliance was 67%, which was below the trust target of 85%.
- We observed staff on each unit preparing and administering intravenous and oral medicines. They followed correct procedures, including checking the dosage, the expiry dates, patient identification and any allergies.
- Medicines were stored in locked units across the CCU. Controlled drugs (CDs), which are medicines requiring additional security, were stored in lockable, wall-mounted cupboards. On each unit, the keys for these cupboards were held by the nurse in charge of the area unless being used by ward staff. Registers containing details of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked the CD stock levels collaboratively on a daily basis. During our inspection, the CD stock levels documented in the stock books were checked and were accurate.

Medicines

Critical care

- We reviewed nine prescription charts and saw they were fully completed. Allergies were clearly documented and allergy stickers were applied to patients' records.
- All staff had access to the British National Formulary (BNF) as well as policies and information relating to medicines management, including the Trust antimicrobial formulary.
- We observed the medicines reconciliation process which meant that when patients were admitted to hospital the medicines they were prescribed on admission corresponded to those they were taking before admission.
- Patients' own medicines were stored in individual drawers at the head of each bed space.
- Medicines requiring refrigeration were stored in designated and lockable medicine fridges. Staff checked the temperature of the fridges on a daily basis and we saw no gaps in recording.
- In area A, we found one of the fridges was overstocked and some medication had been pushed to the back of the fridge resulting in wet packaging. We saw no documented action for two occasions in the first week of March 2017 where the fridge was above the optimal temperature range.
- Records for a fridge in area B showed the fridge was sometimes exceeding the maximum temperature and staff were resetting the fridge on each occasion. Records showed this had been reported to maintenance but no corrective action had happened as a result.
- We found three pre-prepared medications, two noradrenaline and one antrapid. Noradrenaline is given to treat life-threatening decreased in blood pressure and antrapid is used to reduce high blood sugar levels. It is not good practice to pre-prepare medications due to infection risk and also there is a risk the medications could be used incorrectly or in error. We raised our concerns with the matron who informed us the medications had been pre-prepared to be used on the day they were prepared and staff should have disposed of them.
- We saw intravenous fluid and dialysis fluid stored in the corridor at the entrance to the unit. The matron told us

this was stored there due to a lack of space within the hospital. This was not in line with trust policy and there was a risk it could be tampered with. This had been added to the service risk register.

Records

- Paper based medical notes were used to record medical interventions and involvement from the multidisciplinary team. These notes were kept at the end of each patient's bed for easy access. We reviewed four sets of patients' records and found they were legible, signed and fully completed.
- Patient observations and assessments were recorded on the daily record sheet which was kept at the end of each patients' bed. Nursing documents were clear and concise and care plans fully completed. This included information such as regular observations, fluid balance and pain scores.
- We reviewed nine prescription charts and found there was good completion. VTE prophylaxis regimes were consistently prescribed and administered.
- Ninety three per cent of CCU nursing staff had completed information governance training, against a trust target of 85%. However only 42% of medical staff had completed this training, which was below the trust target.
- CCU conducted a monthly documentation audit where performance was rated either green (100%), amber (85% to 99%) or red (less than 84%). Between January 2016 and July 2016 the service achieved green and amber for in all areas which were audited including recording of patient identification, nursing assessment and evaluation, drug delays or omission. CCU had only started auditing nutrition screening, clinical risk assessment and National Early Warning Scores (EWS) scores in January 2017 and compliance was 100% for this month.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy.
- Nursing staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.

Critical care

- All staff we spoke with knew the safeguarding team and could identify where to find their contact details if required.
- Safeguarding adults training was completed by staff as part of the trust's mandatory training. All staff were required to attend this training. For safeguarding adults and children compliance for nursing staff was above the trust target of 85%. However, medical staff were below the trust target for both safeguarding adults (58%) and safeguarding children (50%).
- The CCU used the 'Richmond Agitation-Sedation Scale' (RASS) to score the level of sedation for each patient receiving sedative medicines. We found evidence this assessment was being completed in patients' records.
- Staff were not regular using the Confusion Assessment Method for ITU (CAM_ICU) flowchart to determine whether delirium was evident, in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The matron told us the service was developing guidance for use of the tool, which needed to be approved by the trust.

Mandatory training

- Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Ongoing mandatory training was undertaken as e-learning modules and further classroom based sessions. The matron told us staff had been allocated into teams which included at least one band seven. Team development days were arranged throughout the year in order for staff to keep up to date with mandatory training.
- Senior staff told us a trust wide compliance target of 85% was set for mandatory topics.
- For nursing staff the service was meeting the trust target for information governance, conflict resolution, health and safety, manual handling and infection prevention and control.
- However, nursing staff were not meeting the trust target for Medication Management (67%), Fire Safety (40%) and Prevent WRAP Level 3 (60%).
- Medical staffing were below the trust target in all mandatory training modules. Medical and dental staff at Queen Elizabeth Hospital had an average training completion rate of 52%. We were not told about any action plan to increase mandatory training figures. Basic life support training was completed by all staff and compliance was 100%, which was in line with the trust target of 85%.
- Hospital Life Support (HLS) compliance was 99%, which was also in line with the trust target of 85%.
- Compliance with management of resuscitation training was 75%; this was below the trust target of 85%.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient.
- There was access to liaison psychiatry and/or other specialist mental health support if there were concerns about risks associated with a patient's mental health. Staff knew how to access these services. However, the service was not conducting any risk assessments for mental health.
- There was no up to date written escalation procedure that identified the criteria for the management of emergency admissions to CCU. However, we were told all patients requiring emergency admission were referred to the critical care consultant on duty.
- The critical care outreach team (CCOT) was not managed by the critical care service and did not fall under the surgical directorate. The CCOT was part of the hospital management team and provided 24 hour seven day a week cover. The trust stated the purpose of the CCOT team was to deliver level zero to level three critical care to non-critical care areas to patients at risk of deteriorating. The trust said CCOT was staffed by two nurses during the day and two nurses during the night. We were told a critical care doctor was also assigned to the CCOT, however staff told us this had only happened two weeks before our inspection.
- During the inspection we reviewed CCOT staffing rotas between January 2017 and March 2017 and saw there were numerous shifts with only one nurse working. CCOT told us they expected this to improve once the team were fully staffed.

Assessing and responding to patient risk

Critical care

- The National Early Warning Scores (NEWS) was used throughout the hospital wards to enable early identification of deteriorating patients. This was in line with guidance from the Royal College of Physicians and compliant with NICE 50 guideline. Hospital documentation identified that a referral to CCOT should be made when the NEWS reached a score of five or above or if a person had any single score of three. However, feedback from staff within other wards in the hospital identified that staff did not always understand what the purpose of CCOT was and therefore they did not always know when they should be escalating patients.
- The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCODN) and had recently had a peer review. The peer review raised concerns regarding the outreach team and ward staff not escalating patients appropriately.
- We asked a range of nursing staff to show us the CCOT operational policy and no one was able to show us this. When we spoke to the CCOT manager we were shown an operational policy dated 2013 which was before the service was part of the hospital management team. Therefore, we found no up to date guidance to explain the purpose of CCOT and when staff should be escalating patients.
- Staff showed us the sepsis pathway which helped them identify sepsis at an early stage. The screening and management proforma allowed staff to follow a clear process when a patient was deteriorating. This incorporated the sepsis six which are six things staff should be monitoring with patients who are at risk.
- Patients requiring surgical tracheostomy were required to be transferred to University Hospital Lewisham because the Ear, Nose and Throat (ENT) team, were based there. The critical care network peer review raised this as a concern because it was potentially hazardous to transfer patients with an unsafe airway. We were told going forward ENT staff would attend patients at the Queen Elizabeth Hospital site.
- There were 92 whole time equivalent (WTE) members of qualified nursing staff including 15 WTE vacancies (16%), as of February 2017. The vacancy rate of 16% was higher than the average nursing staff vacancy rate at this hospital site (9%).
- Band six critical care nurses had the highest vacancy rate (9%). At the time of our inspection we were told 11 band five nurses were undertaking the specialist critical care qualification. Once completed in December 2017, these nurses would be able to apply for band six posts. We were told the service planned to over recruit band five nurses in order to train and develop them.
- As of December 2016, the staff turnover rate was 9% on the CCU, which equated to 6.5 WTE staff leaving the trust.
- Between April 2015 and March 2016, the sickness rate for critical care was 4% (878.27 days). This was lower than the trust average (6%).
- There was a nursing handover at the start of each shift. This handover was brief and was followed by a more detailed bedside handover once staff were allocated patients. The shift leaders also held a separate more detailed handover for all patients. This gave them the opportunity to discuss if any patients were unstable and incorporated a skin inspection for pressure ulcers.
- The trust used the Shelford Safer Nursing Care Tool (SNCT) to assess levels of acuity and dependency of inpatients and help determine optimal nurse staffing levels. Staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a minimum registered nurse to patient ratio of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated the service complied with the required staffing levels. Patients with additional care needs were nursed by two nurses. CCU were meeting the recommended standard.
- Best practice guidance suggests no more than 20% agency usage per shift. Nursing staff rotas we reviewed and our observation of nursing staff during our inspection demonstrated the service was not always compliant with this standard. Data provided by the trust indicated between April 2016 and November 2016 the CCU bank and agency rate was 20%. The CCU reported

Nursing staffing

Critical care

an average agency and bank usage rate higher than the trust average of 13%. At Queen Elizabeth Hospital the highest usage rate was reported in April 2016 (29%), and again in June 2016 (22%). Lower agency and bank usage was reported in August 2016 (16%) although usage increased again from 18% in September 2016 to 20% in November 2016.

- The Critical Care Outreach Team CCOT worked 24 hours a day, seven days a week. This was led by two critical care nurses during the day and two during the night. We reviewed the outreach rota and saw there were numerous shifts between January 2017 and March 2017 which only had one outreach nurse working.
- The unit had one WTE practice development nurse responsible for coordinating education, training and the continuing professional development framework.
- Bank and agency staff received a local orientation and induction on their first shift. Agency staff we spoke with were positive about their induction process. We saw evidence of completed agency staff induction checklists in CCU.

Medical staffing

- A total of 3.5 WTE consultants were in post across the critical care unit at the QEH. In line with recommendations from the Faculty of Intensive Care Medical Core Standards for Intensive Care Units, 100% of consultants were Faculty of Intensive Care Medicine accredited or had suitable equivalent qualifications
- Consultant cover was not always in line with the Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommendations that the consultant to patient ratio was between 1:8 and 1:15. During the day, CCU had two consultants but at night there was only one consultant. In order to meet the recommended level for the number of patients the unit would require two consultants 24 hours a day. The consultants were both substantive and locums.
- One of the two consultants was allocated to the outreach service. Faculty of Intensive Care Medicine Core Standards (FICM) guidelines state that consultant intensivists must be available at all times to offer consultant level care to patients as necessary. Consultants participating in the duty rota must not be responsible for delivering other services whilst covering

the critical care unit and must be able to attend within 30 minutes. The service was not meeting this standard as should the consultants be required to attend outreach and critical care services at the same time, it would mean one of the services would not have access to a consultant within time and would potentially leave patients at risk.

- The South London Adult Critical Care Operational Delivery Network (SLACCODN) peer review of the service was conducted in February 2017 found a number of concerns regarding medical staffing. These included the patient to consultant ratio, long term consultant vacancies and a lack of medical leadership. Senior leaders told us the service was recruiting four new consultants to work across both Queen Elizabeth Hospital and University Hospital Lewisham.. We were told this would ensure the service was meeting the FICM guidelines around consultant cover. We looked online at the consultant advertisements and saw they were for locum posts. These posts were only for six months and therefore we were not assured the trust had put together a long-term solution for this issue. Following the inspection the trust informed us that the locum posts have been approved by FICM to be permanent posts.
- There were nine junior doctors working on the CCU plus one foundation year doctor. During the day three to four junior doctors were allocated to work, and this was reduced to two for the night.
- Junior doctors told us they felt well supported and reported good access to clinical supervision.
- One of the consultants had organised a 'group chat' on a mobile phone app, which included over 80 doctors. This was used to help fill vacant shifts.
- There was a detailed medical handover every morning at 8:30am which included discussions of all patients on the CCU. However, at the time of our inspection the doctors used the nursing handover sheet as a prompt and record and were not using a medical handover document.
- Medical staff performed ward rounds twice daily, meeting the Intensive Care Society Standards. However, feedback from staff was that the night ward rounds were a recent addition.

Critical care

- As from December 2016, Queen Elizabeth Hospital reported a turnover rate of 0% and sickness rate of 0% for medical staff in CCU.
- Between April 2016 and November 2016, Queen Elizabeth hospital reported a bank and locum usage rate of 18% in CCU. Bank and locum staff usage at Queen Elizabeth Hospital was higher than the overall trust average, 18% compared to 13%. From April to July 2016 usage rates have increased month on month from 13% to 24%. From August to November 2016 usage rates decreased from 20% in August to 16% in November 2016. The combined effect of higher than average agency and bank staff use (20%) and bank and locum use (18%) might have a compromising effect on quality of care provided.

Major incident awareness and training

- There was a hospital wide major incident plan, which detailed what roles staff needed to take during an incident. The matron and band seven nurses had received training on major incidents. They were clear on their roles and responsibilities in the event of a major incident.
- The major incident and fire safety policies were kept in the nurse's station on each ward. Staff we spoke with could identify where this was kept.

The fire safety policy gave staff information about the protocol to follow in the event of a fire. We reviewed training records and only 41% of staff had received fire safety training.

Are critical care services effective?

Good



We rated effective as good because:

- Patients were provided with care and treatment based on a range of best practice guidance.
- There was a programme of clinical audit which included measurements of patient outcomes.
- Critical care had recently participated in a peer review to highlight areas of good practice and areas of improvement.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently.
- Nurses told us they were supported to attend training and courses for professional development. We found examples of courses being funded by the trust.
- There was good access to dieticians, speech and language and physiotherapy services. Physiotherapy was available seven days a week and patients had appropriate access to rehabilitation.
- Pain levels were consistently scored and patients said their pain was effectively managed.

However:

- Intensive Care National Audit and Research centre (ICNARC) data demonstrated that readmission rates were worse than other similar units.
- Multidisciplinary meetings were not happening on a regular basis and numerous staff highlighted this as a gap.

Evidence-based care and treatment

- Policies and procedures were available on the trust intranet and shared drive. Policies and procedures were up to date and referenced to current best practice from a combination of national and international guidance. This included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.
- New doctors to the unit were provided with a detailed information handbook which contained guidelines including intubation guidelines, cardiovascular management and sepsis, for example.
- The Critical Care Unit (CCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units across the UK.
- There was a local audit programme in place to ensure certain audits were completed monthly such as Saving Lives and Safety Thermometer.

Critical care

- An evidenced-based ventilator-associated pneumonia (VAP) prevention care bundle was in use throughout critical care. Hospital audit data between December 2015 and December 2016 showed compliance with care bundle on critical care unit (CCU) was 98%.
- We observed patients were risk assessed for VTE at appropriate intervals (on admission and after 24 hours) and that suitable VTE prophylaxis was in place. This was in line with NICE quality standard 3.
- Patients undergoing rehabilitation received regular sessions of physiotherapy which met the Faculty of Intensive Care Medicine Core Standards for Intensive Care Medicine. This recommends a minimum of 45 minutes of each active therapy, for a minimum of five days a week.
- We observed nursing handovers and saw staff discussed whether patients had pre-existing mental health needs.
- CCU participated in quality improvement projects to ensure compliance with national guidance. For example, an audit looked at compliance with Intensive Care Society (ICS) standards for handover and step down to other wards. Compliance was poor for discharge documentation (44%) and hand-over (21%) and verbal handovers to the members of accepting teams were not always being completed. An action plan had been put in place to address the issues identified which included educating staff and modification of the discharge proforma.
- The hospital used a sepsis screening tool and sepsis care pathway based on the 'sepsis six', which is a national screening tool for sepsis. However, this was not audited.
- Patients were not assessed daily for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines.
- The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCODN). This is an NHS operational delivery network provides clinical advice and expertise through clinical collaboration. It helps identify any gaps or issues in service provision. The CCU had recently participated in a peer review process. The peer review report highlighted a number of

concerns including issues with consultants, MDT working, clinical governance, escalation pathways, delayed discharged and clinical ownership of the risk register.

Pain relief

- Pain was assessed on an hourly basis as part of observations using a formal patient reported scoring system. Patients were asked to score their pain on a scale of one to 10. If a patient was unconscious, staff used the Face, Legs, Activity, Cry and Consolability (FLACC) scale which was a measurement to assess pain in those unable to communicate. Staff told us they would look for signs of things such as grimacing and restlessness.
- Some patients had Patient Controlled Analgesia (PCA) devices, which is a method of pain control that allows patients the power to control their pain.
- Patients told us staff asked them about their pain on a regular basis. All patients we spoke with were happy with their access to pain relief medication and said it was managed well.
- Support for patients with pain issues could be obtained from the hospital pain team who were available via a bleep system. The pain team were available from 9am to 5pm Monday to Friday, outside of these hours an on-call service operated. Most staff were able to tell us how to access the pain team. However, one member of the CCOT team was unsure if there was a pain team or not.

Nutrition and hydration

- There was one whole time equivalent (WTE) dietician available for the critical care unit. This provision was compliant with the British Dietetic Association recommended numbers of WTE dieticians for the number of critical care beds available. The trust reported that because this was at the lower end of the recommended level, it significantly impacted the potential to carry out audit and developmental work.
- We reviewed four patient records and saw evidence of comprehensive fluid balance monitoring on the daily care charts.
- The CCU had an enteral feeding protocol in place for initiating enteral nutrition out hours. This incorporated

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guidance for identifying and managing patients at risk of refeeding syndrome. The nurses implemented the feeding protocol when patients were admitted to the unit. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.

- Parenteral nutrition (PN) was started upon agreement of the CCU medical team. PN could be started out of hours or at weekends by critical care staff. Parenteral nutrition (PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals. Dieticians were not available over the weekend, so if a patient was admitted they would be seen by the dietician nutrition team the following week. All patients requiring PN feeding were referred to the hospital PN team.

Patient outcomes

- The critical care service contributed data to the Intensive Care National Audit Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units across the UK. We reviewed data from the 2016 Annual Report.
- Annual report data showed the CCU at Queen Elizabeth Hospital had a risk adjusted hospital mortality ratio of 1.13. This was within the expected range. The figure in the 2015 annual report was 1.07.
- For the CCU, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.53. This was within the expected range. The figure in the 2015 annual report was 1.16.
- We reviewed more recent quarterly data between April 2016 and September 2016. ICNARC data quoted below relates to this data period.
- ICNARC data from April to September 2016 showed there were 88 deaths. This represented a mortality rate of 20.7%, which was just above expected mortality rate.
- The mean length of stay on CCU report by ICNARC was seven days which was more than the average for comparable units (5.7 days) and all units (4.5 days).

- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated the CCU was performing about the same (2.7%) as other similar units (2.2%).
- ICNARC data showed there were seven unplanned readmissions to the HDU within 48 hours of discharge, which represented 2.7% of patients admitted to the unit in this period. This was slightly worse when compared to other similar units (1.4%). More recent ICNARC data between October 2016 and December 2016 showed the unit had no unplanned readmissions.
- Patients suspected as having brain stem death or with a plan to withdraw life-sustaining treatment were referred to the specialist nurses in organ donation. There was a written protocol for the identification and referral of potential organ donors.

Competent staff

Nursing Staff

- The CCU employed a practice development nurse that supported staff and facilitated a continuing professional development programme.
- New staff attended the trust induction prior to started work on CCU, where they then received a local induction and were allocated to a mentor. Staff were supernumerary for a period of up to six weeks while their competencies were reviewed and signed off as appropriate. Staff told us they had plenty of time to settle into the unit and get to know ways of working before looking after patients independently.
- Once staff completed the induction programme, they progressed to the National Competency Framework for Critical Care Nurses – Step one. This is a competency-based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. Staff were very positive about the learning and level of support they received during this.
- Self-assessment competency documents were in use for certain items of specialist equipment, for example the cardiac output monitors and specific types of ventilators and nasogastric feeding pumps.
- The FICM core standards for Intensive Care Units recommends 50% of critical care nurses should be in

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possession of a post registration award in critical care nursing. At Queen Elizabeth Hospital 51% of critical care staff had achieved this award. The trust reported that this should increase to 66% by May 2017.

- We spoke with numerous members of staff who told us there was good access to training for professional development. Staff were able to access charitable funds from within the organisation to help fund courses. For example, one nurse was studying for a masters' degree and had received charitable funding from the organ donation team.
- Appraisals had been completed within the previous 12 months for 94% of nursing staff.
- The Critical Care Outreach Team (CCOT) were not part of the same directorate as critical care. The nurses who were part of CCOT were separate from the nursing team on the CCU. Nurses from CCU were unable to rotate onto the outreach service which limited developmental opportunities.
- Members of the outreach team were not provided with formal teaching on sepsis.

Medical Staffing

- Doctors who were new to the trust completed the generic trust induction prior to working on the unit.
- All new doctors were provided with a comprehensive booklet outlining various important points about working on the unit, including timing of key activities and expectations relating to their role.
- Medical staff told us they had received full formal inductions to the unit which included local orientation.
- Appraisals had been completed within the previous 12 months for 100% of medical staff.
- All junior doctors we spoke with told us there was no formal teaching happening. Due to a lack of medical staffing teaching had not been happening and there was no formal timetable in place. There was also no cross-site teaching between Queen Elizabeth and UHL critical care units.

Multidisciplinary working

- The critical care outreach team (CCOT) was responsible for reviewing patients in other areas of the hospital to determine their need for admission to critical care.

There were no up to date written guidelines which advised when patients should be escalated to the CCOT. Staff within the hospital were not always sure of the purpose of the outreach team.

- The recent peer review by the SLACCODN found there was a lack of multidisciplinary (MDT) meetings.
- There were no formal multidisciplinary meetings or 'rehabilitation group' to discuss patients admitted to the CCU. This group should be attended by consultants, follow up nurses, critical care liaison nurses and other members of the multidisciplinary team, such as physiotherapists. This provides staff the opportunity to discuss short-term or long-term goal setting. The CCU was not compliant with NICE clinical guideline 83 in this instance. Staff recognised the need to set up a formal MDT meeting for patients who were longer term and complex needs.
- There was a hospital wide tracheostomy group which involved the CCU consultant, outreach team and physiotherapists. We saw them visit patients and document interventions in their notes.
- There was a clinical lead and specialist nurse responsible for organ donation. However, as the hospital was not a trauma centre there were very few potential organ donors. A multi-professional organ donation committee met every quarter, chaired by the hospital chaplain. CCU staff reported good links with the specialist nurses in the organ donation team.
- All staff we spoke with said there was good MDT working between nursing, doctors and therapists. Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.
- Intensive Care Society (ICS) recommendations state that there should be a minimum ratio of one physiotherapist to four patients. The CCU was funded for 2.5 WTE physiotherapists and was just meeting this recommendation. However, physiotherapy staff could not always attend the daily ward rounds due to staffing numbers.
- Staff told us patients received physiotherapy input from early on in their admission, to support airway clearance

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where needed and for early instigation of rehabilitation. In patient records, we saw evidence supporting this, however compliance with NICE clinical guideline 83 had not been audited.

- The CCU was funded for 0.5 WTE Speech and Language Therapist (SALT). Recommendations from the Faculty of Intensive Care Medicine (FICM) state that patients should have access to SALT staff with critical care experience, therefore the recommendation was being met.
- According to ICS standards all Tracheostomy patients should have a communication and swallow assessment by SALT when the decision to wean from vent has been made. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help patients breathe. The SALT service reported that they did not receive referrals for all patients who come under this criteria and the service would not meet the demand with the current establishment of staff.
- There were no dedicated occupational therapists (OT) which does not meet the ICS recommendation of 0.22 WTE OT per level three bed.

Seven-day services

- Consultants completed twice daily ward rounds, including during the weekends, which was in line with recommendations from the Guidelines for the Provision of Intensive Care Services. However, pharmacy staff attended ward rounds from Monday to Friday only, which was not compliant with these guidelines. Physiotherapy staff were unable to attend ward rounds on a daily basis due to workload pressures, this was not in line with recommendations.
- The trust offered a clinical pharmacy service on Saturdays and a dispensary based service on Sundays. Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations state pharmacy services ideally should be available seven days a week, with a minimum of five days per week. The service was meeting this recommendation.
- Physiotherapy staff worked across seven days and the unit could access emergency respiratory physiotherapy support 24 hours a day, seven days per week.

- Speech and Language Therapy (SALT) was available five days a week (Monday to Friday) and also for a morning service on Sundays. This was to help pick up patients who had been admitted Friday evening.
- Direct access to an ICU trained dietician was available five days a week.
- Access to an ICU trained pharmacist was available five days per week. Only generic pharmaceutical support could be obtained over the weekend, unless an ICU trained staff member was working.
- Patients could access investigations such as blood tests, x-rays and CT scans 24 hours per day, seven days per week. Staff reported there was no difficulties for accessing this type of support services and told us urgent investigations for critical care patients were prioritised.
- However, at the time of the inspection patients were transferred to other hospitals if they were ventilated and required an MRI scan. Senior leaders told us a new MRI machine had been ordered and would be available soon.

Access to information

- Staff obtained most of their in-house information via the hospital's intranet and shared drive. This included policies and procedures, mandatory training, and emails from colleagues. Computer terminals were available in patient bed spaces, which allowed access to information.
- There were folders by each patient's bedside which included a range of protocols including feeding and sedation.
- When patients were admitted to CCU, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically.
- Staff said some of the computers were quite old and sometimes accessing information was difficult as the computers were slow.

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- There was a critical care unit information leaflet available for relatives, friends and carers. This leaflet gave detailed information about the critical care unit and relatives said they found it useful.
- Discharge summaries were sent to general practitioners (GPs) when patients were discharged from the unit. We reviewed some discharge summaries and saw they were detailed and contained all key information.
- The CCU and CCOT used different computer systems and were unable to access each other's, this limited information sharing between the two services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood the need to obtain consent from patients before performing care, investigations, and giving medicines.. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patients best interests.
- We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind each procedure being performed. We observed staff explaining what they were doing to unconscious patients.
- We reviewed four patient records and could not find any completed consent forms.
- Staff completed Mental Capacity Assessments for people who they believed may lack the capacity to consent. Key information about mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) were available on the shared drive. There was also information about DoLS displayed on a notice board in the staff room.
- Staff knowledge of DoLS was good. Staff explained the principles behind DoLS and were clear how this was applicable in a critical care setting. For example, staff knew to use hand mittens and that a DoLS assessment needed to be completed. We reviewed some patients' records and found evidence of a DoLS checklist which was in place for a patient requiring mittens. This checklist was appropriately completed.
- Mental capacity training was 92% and the CCU had recently introduced DoLS training, however this had not yet been completed by all staff.

- Staff were aware when a patient might need to use independent mental capacity advocates (IMCAs) and told us they would seek support from the matrons.

Are critical care services caring?

Good



We rated caring as good because:

- The critical care unit provided a caring, kind and compassionate service, which involved patients and their relatives in their care.
- Staff at all levels demonstrated dignity and respect when speaking with patients, their relatives and visitors.
- Patients and relatives said they felt involved in the treatment decision making process.

Staff provided good emotional support to patients and there was access to a chaplaincy service.

Compassionate care

- All patients we spoke with were positive about the care and treatment they had received on the unit. Patients said things like: "The nurses are great here", "The staff do a good job", "The staff are very compassionate and caring".
- All the relatives we spoke with were positive about the unit and the staff and said things like: "The care here is fantastic and second to none", "every nurse here treats my relative like they know them personally", "The staff are unbelievable, the job they are going is amazing", "You couldn't pay for better care". During the inspection we observed a relative stop the matron to say thank you for the job the team were doing for their relative.
- Compassion was one of the trust's values that staff worked with and they embedded this in all areas of practice, from treating patients clinically to engaging with friends, relatives and carers.
- All observations of care we saw were positive, showing kind and compassionate care. We observed nurses assisting patients to make them more comfortable, such as offering them pillows to rest.

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- We observed staff interactions with patients and relatives. Staff were courteous, professional and engaging. Staff spoke with patients in a calm and reassuring manner, and listened to what patients had to say.
- We saw staff maintaining patient's privacy and dignity by drawing curtains around the patient areas before completing tasks and covering patients with blankets.
- We observed many thank you cards expressing gratitude and compliments from previous patient and relatives about the care received.
- We asked the service for Friends and Family Test (FFT) data and were told CCU did not collect this data. We were told patient surveys were part of the quality round process which was implemented in November 2016. This took place every two weeks and asked patients questions around confidentiality, interaction with staff and staff compassion. We were provided with data for two weeks in December and compliance was 100%. However, we were not provided with information on how many patients were involved in this and also no more recent data.

Understanding and involvement of patients and those close to them

- We observed doctors on ward rounds offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of. Patients said they were given opportunities to ask questions and these were answered by staff. Patients and relatives told us staff would always explain things in a language they could understand.
- Patients and relatives told us they were always kept informed of the treatment plans and staff explained any test they were due to have.
- We observed staff interacting with patients and involving them in decisions about their care, for example one patient discussed dietary requirements.
- Staff ensured patients were fully informed before completing any intervention. For example, we saw doctors explaining examinations before completing them.
- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, the possibility of organ donation was discussed with the patient's next of kin. The CCU and the specialist nurse for organ donation did this collaboratively where possible.

- Photographs of some of the nursing and therapy team were displayed at the entrance of the unit. This provided information for patients and relatives on who they could contact for support, such as the matron.

Emotional support

- Feedback from patients and relatives was positive and they told us staff were supportive and had been reassuring and comforting during difficult times.
- There was a bereavement booklet for relatives, friends and carers following the death of a patient. This provided them with key information and told them how to access the bereavement service within the hospital.
- There was no access to a psychologist on the unit. Staff told us if a patient required psychological support they would refer the patient to the psychiatric liaison team.
- Staff could not tell us about any external support organisations that they could signpost people to.

Are critical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There was no overnight accommodation available for relatives to stay in, and no arrangements in place for nearby hotels.
- Occupancy rates were consistently greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. This could limit the unit's ability to take emergency admissions due to a lack of bed space availability.
- Flow and delayed discharges were a significant concern for the service and we were not assured the trust had taken action to mitigate this. Staff told us the emergency department took priority when it came to allocation of medical beds.
- The unit had more non-clinical transfers than comparator units; in January 2017 there were 15 in total.
- The service was not reporting mixed sex breaches appropriately.
- There was no counselling service or psychological service available to patients..

However:

- The service used a range of methods to communicate with patients including visual aids and alphabet boards.

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- We saw detailed discharge summaries which were sent to patients local doctors.
- We saw complaints had been appropriately investigated and changes made as a result of relative feedback.
- There was a follow up clinic for patients to attend following discharge.

Service planning and delivery to meet the needs of local people

- We reviewed the services admission guidelines and found it was out of date and did not include up to date bed numbers. Critical Care Unit (CCU) admitted patients after elective or emergency operations or if they became acutely unwell, either in the community or on the hospital wards.
- ICNARC data from April 2016 to September 2016 showed the CCU primarily admitted non-surgical admissions (82.7%). Emergency surgical admissions represented 14.9% of admissions and elective surgery represented 2.4%. Non-surgical admissions meant patients came from emergency departments, other wards or hospitals and other critical care units.
- The CCU was funded for level two and level three beds. Staff told us this was for 10 level three beds and 9 level two beds. However we were told the number of patients cared for at each level could be flexed to meet the needs of patients. For example, at the time of our inspection there were 13 level three patients.
- Patients who required planned postoperative admissions to critical care were identified by a booking in procedure. This involved phoning the CCU to book a bed. However, the matron told us this was not a regular occurrence.
- Between February 2016 and February 2017 there were five patients who were booked into critical care following their surgery. Of these, only one patient was not able to access the bed on time. There were no cancellations of elective surgery due to a CCU bed being unavailable.
- Unplanned admissions to CCU were referred to the consultant on duty during working hours.
- A follow up clinic was available for patients to attend after they were discharged from the unit. The follow-up clinic was run by two nurses. Staff told us this gave

patients the opportunity to discuss their experience on the CCU and clinical investigations. For example, discussions around what happened when the patients were unconscious.

- Discharge summaries were sent to the patient's GP.
- There was a confidential conversation room available for visitors where doctors could discuss confidential information. There was also a relatives' room for relatives to use which had sofas.
- HBN 04-02 recommends services should provide access to overnight accommodation or have arrangements with a nearby hotel. The service was not meeting this guideline. Staff told us they would try to accommodate visitors staying over by offering them a high backed chair to sleep on or sleep in the confidential discussions room.

Meeting people's individual needs

- Staff used a patient diary for each patient who was ventilated on the unit. Nurses, doctors, relatives and visitors could contribute to the diary and include details of the patient's progress and treatment. After the patient was discharged, staff in the follow-up clinic used the diary to discuss the patient's stay with them. This was a useful tool, which helped people to remember some of their time and to reduce anxiety around missing memory or delusions that can occur after a critical care admission.
- Visiting times on the CCU were between 12pm to 5pm and 6pm to 7.30pm each day. For next of kin there were open visiting times so they could visit 24 hours day. Staff across the CCU told us there was flexibility with visiting times if needed, which relatives confirmed.
- An interpreter service was available for patients and their visitors. Staff told us they could book both telephone and face-to-face consultations and told us services were available in a range of different languages.
- Relatives and patients had access to a multi-faith chaplaincy service and we saw information on how to access this was displayed.
- Staff (including non-clinical) were not offered 'awareness' training to help them identify and respond to patients with mental health learning disabilities/autism or dementia diagnoses.

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- At the time of the inspection there were no patients on the ward with a learning disability. Staff told us if there was a patient with a learning disability, they would link with the safeguarding team and specialist learning disability nurse within the trust. The unit could access agency carers for additional support. Learning disability passports were in use.
- Staff used a range of communication aids to communicate with those who could not express their needs verbally. This included a pictorial guide for patients to point to express their needs. There were a number of key statements alongside pictures for things such as 'I am in pain', 'I feel sick', 'I am hot', 'I am cold'.
- The speech and language therapist had conducted an audit looking at communication needs of patients. As a result, the unit had purchased a communication trolley. However, this was not in place at the time of the inspection.
- It was not clear how patients living with dementia were identified. Staff told us if they suspected a patient of having dementia they would contact the dementia nurse within the hospital.
- All patients were reviewed by a critical care consultant within 12 hours of admission. This met the guidance of the Faculty of Intensive Care Medicine.
- We saw two patients had televisions brought to their beds so they could watch TV and movies.
- Food menus offered a range of options including healthy option, softer choices, vegetarian, kosher, halal. If a patients had any specialist dietary requirements staff would record this.
- Patients who were able to eat told us they were happy with the food choices available on the unit. We observed patient meal times. Patients were enabled to eat independently and drinks were places within their reach. We observed nurses assisting patients when required.
- A multi-faith spiritual team was available to provide support within the hospital. There was a chaplaincy rota which gave details of who could be contacted 24 hours a day, seven days a week.

- There was no counselling or psychological team available on the unit. Staff told us if they thought a patient had mental health needs they would refer the patient to the psychiatric liaison team.

Access and flow

- The critical care unit had clear admission guidelines. Admission to critical care was usually agreed by the consultant on shift. However, the guidelines were out of date as the bed numbers documented were incorrect. These were guidelines and not a formal policy with review date.
- We reviewed four patient records and found unplanned admissions were admitted within four hours of the decision to admit being made.
- Between March 2016 and March 2017 the average bed occupancy for critical care was 97.4%. There were three months where bed occupancy was over 100% including April 2016 (101.6%) and January 2017 (103%). These occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency. If a unit is at higher occupancy it may be unable to respond to emergency admissions and may be required to step down patients too early. Delay of critical care admission was on the risk register.
- Bed occupancy levels at CCU at Queen Elizabeth (97.4%) were higher than the bed occupancy levels at UHL (88.5%).
- Between February 2016 and March 2017 there were 46 incidents raised due to a lack of bed availability on critical care.
- Recommendations from the Faculty of Intensive Care medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data from April 2016 to September 2016 showed there were six patients transfers out of the unit for non-clinical reasons which was worse than (1.3) other similar units (0.5%). During the inspection we were told that in January 2017 the unit had had 16 non-clinical transfers, which was a significant issue.
- For the Critical Care Unit at Queen Elizabeth hospital, there were 6,570 available bed days. The percentage of

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bed days occupied by patients with discharge delayed more than 8 hours was 9.37%. This compares to the national aggregate of 5.16%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2015 annual report was not available.

- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes. ICNARC data from April 2016 and September 2016 showed that seven patients were discharged between 10pm and 7am (2.7%) which was in line with national performance (2.0%).
- Data from the trust showed there were 349 delayed discharges between April 2016 and November 2016 out of 603 admissions, 481 discharges and 120 deaths. Patient flow was on the services risk register.
- All staff identified delayed discharges as a significant issue. This was because once patients were ready to be discharged from CCU the unit struggled to find them a bed within the hospital. Staff said a number of patients were discharged directly from CCU to their homes in the community, Trust data showed between March 2016 and March 2017 there were 45 discharges directly to the patients home. Staff said the generally feeling was that the emergency department (ED) got priority for beds in order to meet ED targets. This in turn meant critical care struggled to discharge patients in a timely manner.
- The unit reported no mixed-sex accommodation breaches during the 12 months before our inspection. A mixed-sex accommodation breach occurs in a critical care unit when there are male and female patients in the same unit and one or more of them no longer needs that level of critical care and becomes ready to be transferred to a level one unit, but there is no available bed for transfer. We were told a mixed sex breach was only reported after 24 hours. NHS England states that it is not acceptable to set a time limit before recording a breach as the breach occurs the moment the patient is placed in the mixed-sex accommodation. Once the patient no longer needs that level of critical care, they become an unjustified breach and should be recorded both locally and nationally. The service was not doing this.

Learning from complaints and concerns

- Between December 2015 and November 2016 there were eight complaints about critical care. The trust took

an average of 44 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be responded to within 25 working days. It should be noted that the date on which complaints were received were only provided for one of the eight complaints received.

- Site-specific data was not provided for Critical Care service. Four of the eight complaints received were in relation to communication with family (2) and communication/Info to patients (2). delay in clinical investigation, loss of personal property, medical/ surgical treatment and nursing care received one complaint each. The CCU received four and the Neonatal Intensive care Unit four complaints.
- Information about how to make a complaint was available in the CCU reception. Staff told us they tried to manage complaints at a local level to try offer an immediate solution.
- Information on the hospitals Patient Advice and Liaison Service (PALS) was readily available on the unit.

In response to a complaint regarding visiting times there was now open visiting times for next of kin.

Are critical care services well-led?

Requires improvement



We rated well-led as requires important because:

- The leadership team did not have a long term vision and strategy in place at the time of the inspection. Senior leaders told us the lack of consultants meant there had not been sufficient time to develop a formal strategy for the service.
- A recent peer review had highlighted concerns with the governance structure and number of consultants.
- Morbidity and mortality meetings were not happening on a regular basis due to the lack of consultants.
- There were plans in place to make improvements, such as the recruitment of new consultants, but the issues were still current during the inspection.
- The leadership team had not been demonstrating appropriate responses to issues identified until very recently. There were a number of long standing

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concerns such as consultant recruitment and the environment. Concerns about consultant cover was on the risk register, however it had not been reviewed since November 2016.

- Senior critical care staff, including the clinical director were responsible for overseeing risk management, including the maintenance of the risk register. There was no clinical ownership of the unit risk register, which sat within the surgical directorate risk register. There was no documentary evidence it was regularly reviewed.
- Other than feedback forms, we did not see evidence of engagement with patient or the public to develop and improve critical care services.
- We found conflicting information around pressure ulcers and were not assured the trust had good oversight of pressure ulcers.

However:

- We saw excellent nursing leadership within the unit and staff reflected this in conversations with us. Staff were positive about the levels of support they received from the matron and each other. Patients and relatives told us the staff worked together as a team and well together.
- The culture on the unit was very open and all staff felt comfortable approaching the matron with any issues or ideas. Engagement with nursing staff was continuous and they were able to develop their leadership skills through professional and clinical development.

Leadership of service

- Clinical leadership was the responsibility of the divisional director and directorate clinical lead (cross-site) who worked closely with the lead nurse and matrons for critical care who were site specific. Critical care was part of the surgical directorate within the trust.
- During the inspection it was highlighted that previously there was an absence of clinical leadership due to the lack of consultants. Since the peer review accountability and responsibility was improving and staff said the trust and executive board were now listening. However, this was still a very recent development and action plans were still under development.
- During our inspection we found that senior staff were visible on the wards and knew staff across the service.

- All staff spoke positively about the matron, praising the matron's supportive attitude and open approach to management. We were told the matron was readily available and approachable and involved in the unit both clinically and managerially. Staff said the matron would stand in for nurses when they needed to take breaks and help with patients if required.
- Relatives and patients also pointed out that the matron was very present on the CCU, and they knew who they needed to go to with any issues or concerns.
- Staff at all levels, including senior nurses and ward clerks, told us their roles were valued and they felt the local management team cared about them and their well-being.
- In terms of nursing, lines of accountability and responsibility in the unit were clear and staff understood their roles and how to escalate problems. Nurses told us the matron kept them up to date with any serious incidents and fed back the results and learning to the team.
- Junior doctors told us they received good access to supervision, however, the lack of consultant cover meant training was not happening.
- Outreach did not fall under the leadership of critical care and was a separate team. This limited joint working and developmental opportunities for nursing staff as there was no rotation available.

Vision and strategy for this service

- At the time of the inspection, there was no formal documented strategy for the CCU. We were told this was because the lack of consultants along with the busy nature of the ward had left little time to strategize. We were told once the consultants were in post a strategy would be developed and the action plan would be addressed.
- The CCU had recently participated in a peer review with the South London Critical Care Network. The findings highlighted a number of key concerns that the service needed to address. Senior leaders told us as a result of this report the vision for CCU was to move forward from this and make the improvements that were suggested.

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The trust had developed an action plan to address the issues highlighted. However, we were not assured the service had put together a long term solution for consultant cover at the Queen Elizabeth Site.

- We asked staff about the vision for critical care and they were unsure what this was. Some staff were able to tell us the trust values, however some staff did not know what these were.

Governance, risk management and quality measurement

- Senior critical care staff, including the clinical director were responsible for overseeing risk management, including the maintenance of the relevant risk register. The recent peer review had identified the risk register as an issue. The report said the risk register was not robust, there was no clinical ownership of the risk register and it was not regularly reviewed. Senior leaders said they were working to making the risk register more robust.
- We requested to see the services risk register and were provided with the surgical division risk register. The risk register we were shown identified five risks. These included consultant vacancies, non-compliance with the Health and Building Note 04-02, transferring ventilated patients and two fluid storage risks. Three of the risks had been added two weeks before our inspection following the critical care network review. One of the risks, consultant vacancies had not been updated to include information about the new posts being advertised. Therefore, we were not assured this was being regularly reviewed.
- There were clinical governance arrangements in place. We were told every six to eight weeks there were cross-site clinical governance meetings which were chaired by the medical director. We reviewed two sets of minutes for these and saw evidence a variety of quality, risk and safety topics were discussed. Senior staff told us key information from these meetings was disseminated to ward staff via handovers and in the communication book.
- The service also fed into the surgical division governance meeting which took place on a monthly basis. Once every quarter the meeting focused on critical care. The matrons from both hospitals critical care units prepared a joint report of performance for this meeting.
- Every eight weeks there was a site-specific governance meeting which involved the unit's matron and band seven nurses. The band seven nurses also held their own meeting every six to eight weeks to discuss any key challenges on the unit. We reviewed two sets of the band seven minutes and saw things like delayed discharges and changes in practice were discussed.
- The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCODN). The peer review reported the services governance structure as a concern. The report highlighted inconsistent attendance and contribution from consultants as an issue. Morbidity and mortality (M&M) meetings occurred every three months and only discussed outliers highlighted by the quarterly ICNARC report.
- The peer review reported consultant leadership was also a concern. There were no regular meetings where all consultants discussed the care of patients, strategy regarding the bed base, patient caseload, recruitment and standards or guidelines.
- It was apparent that the CCU had some long-standing issues including the environment and consultant time. Staff told us the trust had not been responsive in dealing with issues. Prior to the critical care network peer review there had been no plans for improvement. In response to the peer review the senior leaders were developing an action plan.
- The environment was identified as a major challenge on several occasions throughout our inspection. Staff reported the bed numbers had increased since our last inspection, yet the space remained the same. We were told during a trust presentation that there were plans to do a refurbishment in the future. However, this was a recent development and no formal plans were in place.
- Access and flow was a key challenge for the CCU. On a regular basis patients were ready for discharge but a lack of access to medical beds meant discharge was delayed. Staff told us the emergency department seemed to get priority for beds within the hospital. This issue was highlighted by a range of different staff

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including the senior leaders within the surgical directorate. However, we found no plan or strategy in place detailing how the service was going to mitigate this.

- Despite the cross-site clinical governance meeting, feedback from staff suggested there was still work to do on harmonising, where appropriate, policies and guidelines across the two CCUs. There were many examples of practice being different at the two sites including the timing of parental nutrition (PN) infusion resting time and nursing intensive care charts.
- The critical care outreach service (CCOT) was not part of the surgical directorate and therefore not part of the critical care unit. Several members of staff said this service would be better in critical care. At the time of the inspection, the senior leaders of critical care could not access the CCOT system and had no oversight of the CCOT risk register or incidents records and vice versa. This limited sharing and learning between the two teams.
- Staff were unable to identify who the sepsis lead within the hospital was and we were unable to establish who had oversight of sepsis management.
- We found conflicting information around pressure ulcers. We were told there were no unit acquired pressure ulcers reported by the service between January 2016 and December 2016. However, the trust provided a document called 'Pressure Ulcer Reduction – Getting it Right' stated there were a number of unit acquired pressure ulcers between January 2016 and February 2017. We were not assured the trust had good oversight of pressure ulcers.

Culture within the service

- An open door culture was encouraged and staff told us they felt comfortable raising any issues with the CCU matron.
- Staff commented there was a culture of 'no blame' should things go wrong. Everyone was encouraged to learn from incidents that occurred both within the CCU and across the trust.
- Nursing staff told us there were good levels of support and opportunities to develop. There were good

arrangements for mentoring and staff training. We saw staff were keen to share their knowledge with each other and observed staff asking questions and seeking guidance

- Staff at all levels told us they were proud to work in the service and told us they had good working relationships with each other and morale was good. We observed staff work together to complete tasks and ensure suitable patient care took place. Staff told us they organised social events for outside work.
- Staff understood the importance of being open and honest when things went wrong and understood the principles of duty of candour.
- There had been a recent unexpected death on the unit and all staff involved were offered a debrief. Staff told us they found the debrief helpful and we observed the team reassuring and supporting one another.

Public engagement

- There were regular team development days held on the unit to develop staff skills, knowledge and improve teamwork.
- The CCU encouraged patients and relatives to give feedback and there were feedback forms available on the unit for them to complete. There was a 'you said, we did' board on the unit which gave details of any changes made because of feedback. For example, changes to the relative room to improve access.

Staff engagement

- Staff told us the trust held awards every year to celebrate good practice. Staff who won awards were given vouchers.
- The matron had developed a system to collect feedback from staff on every shift. Staff were asked to rate the shift as either green, amber or red and asked to explain why they chose that rating. Any issues identified were discussed with the matron and areas for improvements highlighted. We reviewed the records and saw 95% of shifts were rated as green.
- A newsletter called 'Spotlight' was shared with staff throughout the ward via the communication book.







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- Other than feedback questionnaires, we did not see evidence of engagement with patients or their relatives in terms of developing services to meet patient needs.

Innovation, improvement and sustainability

- The trust carried out a pilot looking at the improved physiotherapy outcome measure by the use of cycle ergometry in critical care patients. Patients who developed critical care-acquired weakness were at a higher risk of mortality, longer duration of mechanical ventilation, longer critical care length of stay and higher hospital costs. Cycle ergometry is an early intervention for muscle strengthening in critical care patients including those who are mechanically ventilated. It is a statutory piece of equipment used to enable cyclical rotation and can be used to perform passive, active and resisted exercise. The pilot found there was notable improvements in the treatment group in all three outcome measures (grip strength, quadriceps strength and critical care physical assessment tool CPAx). However, the trust recognised only a small sample size was used. Senior leaders told us the trust planned to purchase this equipment for critical care.
- Every Tuesday and Friday ward rounds were nurse led rather than medically led. This helped give nurses ownership over their patients and improved multidisciplinary working between nurses and consultants.

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

Information about the service

In addition to the maternity and gynaecology service, we have included information about sexual health, genitourinary medicine and HIV services, which are provided from the Trafalgar Clinic and are within the women's and sexual health division.

Only the maternity and gynaecology service contributes to the ratings.

From April 2014 to March 2015, there were 4200 deliveries at Queen Elizabeth Hospital and this increased to 4736 babies born between February 2016 and January 2017.

The unit consists of an obstetric consultant-led delivery suite consisting of 11 delivery rooms and a new midwifery-led birth centre, opened in 2015, with four birthing suites.

Ten of the delivery suites are single rooms and one is a three bedded room. There is a birthing pool in one of the delivery suites and further portable birthing pools available if required.

The midwifery-led birth centre is for women whose pregnancies have been assessed as 'low risk'. Birthing suites all have their own birthing pool and en-suite facilities.

There were approximately 50-60 deliveries a month at the birth centre during 2016. This accounts for approximately 14% of all births delivered during this period. Over 80% of deliveries in the birth centre were water births during the last three months of 2016.

Women with low risk pregnancies can also choose to have a home birth, supported by the community midwife team. Approximately 2% of births in 2014/15 were home births, falling to 1% in the year to January 2017.

Obstetric-led births outnumber midwife-led births by more than five to one. There are two dedicated obstetric theatres, one for elective procedures, the other for emergencies, and a recovery area.

There are six additional rooms in the delivery suite and five in the birth centre that can be used flexibly as additional antenatal or postnatal rooms.

There is a 31 bedded ward for antenatal and postnatal care, consisting of four bedded bays and single rooms. These beds are for antenatal women whose pregnancies have been assessed as high risk and for women and babies requiring additional support in the form of transitional care before going home.

There is a separate self-contained room adjacent to the delivery suite, the Jade room, for bereaved families with double bed and seating area, tea and coffee making facilities and an en-suite shower. There is also smaller room, the Dove room, where bereaved parents can spend time with their baby.

Antenatal clinics are held in the hospital and in local GP surgeries, health centres and children centres.

There are seven teams of community midwives providing antenatal clinics, support for home births and postnatal care. Community midwives visit women immediately after they return home with their babies.

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There is a fetal screening service for women between 11 and 13 weeks of pregnancy and opportunities for later scans if required. A seven bedded maternity day assessment for women with abdominal pain, raised blood pressure or reduced fetal movements, for example is also available. This is open from 8am-8pm Monday to Friday and 10am-4pm at weekends.

The early pregnancy unit provides specialist scanning and support for women experiencing problems in early pregnancy. This clinic currently accepts walk-in referrals up until 12 noon from the emergency department and up until 11.00 from primary care and community clinics. Women who need to return are seen in the afternoon. Outside of these hours the gynaecology on call doctor is available via the emergency department. There are gynaecological clinics offering specialist services such as hysteroscopy, colposcopy and urodynamic assessment in addition to management of other gynaecological conditions.

There is no dedicated ward for gynaecological inpatients and these women are cared for on general surgical wards. This includes women who have had a medical termination of pregnancy due to fetal abnormality, although they may be cared for in rooms in the maternity unit at times of high capacity.

We visited all areas of maternity and gynaecology services and spoke with more than 70 members of staff, some on an individual basis and others in joint meetings, handover sessions and focus groups. This included staff of all grades including midwives, doctors, consultant obstetricians, maternity care assistants, coordinators, ward managers, matrons and members of the senior management team.

We spoke with 10 patients from both gynaecology and maternity and we looked in detail at four sets of patient notes. We made observations in respect to of the provision of care, staff interactions, the availability of equipment and the environment. We reviewed written material such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements.

We visited the Trafalgar Clinic where, between March 2016 and March 2017 14,021 clinical consultations were carried out.

Summary of findings

Overall we rated the service at Queen Elizabeth Hospital as good because:

- The service provided safe and effective care in accordance with national guidance. Staff monitored outcomes for women and took action where improvements were necessary.
- Resources, including equipment and staffing, were sufficient to meet women's needs. Staffing levels were appropriate on ward areas and there were contingency plans when the maternity unit became busy. Additional midwives had been recruited and there were specialist midwives to support vulnerable women and those who had particular medical needs.
- Staff understood how to report incidents and emergencies, and there were systems for reviewing these and sharing lessons learnt with colleagues.
- Staff had the correct skills, knowledge and experience to do their job.
- There was good evidence of multidisciplinary working within the maternity unit, across trust sites and in the community.
- Staff took women's individual needs and choices in to account when planning the level of support they needed throughout their pregnancy.
- Staff treated women with kindness, dignity and respect. There was good support for those who had suffered bereavement.
- The service took account of complaints and concerns and took action to improve the quality of care. There were mechanisms and initiatives to capture the patient experience and respond effectively.
- Governance arrangements at all levels enabled managers to identify and monitor risks effectively and review progress on action plans. Engagement with patients and staff was strong.
- There was evidence of innovation and a proactive approach to managing performance improvement.
- Staff at all levels were positive about working at the service and proud to be part of the team.

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- The Trafalgar Clinic had improved the patient records system to ensure that if a patient known to them was admitted to the hospital, the clinical team had immediate access to their HIV care records.
- Staff in the Trafalgar Clinic had adapted to a period of significant change due to new commissioning intentions and adapted the service to meet the complex needs of the local population. This included working with highly vulnerable people to reduce HIV risk and to reduce stigma around the condition.
- Staff in the speech and language therapy and Trafalgar Clinic teams had developed a significant research portfolio that reflected the services provided and aimed to improve patient care.

However:

- There was no separate provision for gynaecology inpatients and these women were cared for on general surgery wards.
- The early pregnancy unit and gynaecology clinics were not always able to provide sensitive support as they were located next to antenatal services and pregnant inpatients patients may be cared for alongside those who had suffered a pregnancy loss. Staff and patients in the early pregnancy unit reported long waiting times in clinics due to demands on the service.
- There was evidence of some cross site working but this needed to be developed further.
- The trust had not acted on escalation from staff in the Trafalgar Clinic that fabric curtains in treatment rooms needed replacing. Along with fabric chairs and carpeted areas, this unit did not meet best practice infection control guidance. However, after our inspection we received evidence that fabric items had begun to be replaced.

Are maternity and gynaecology services safe?

Good



We rated safe as good. This was because:

- There were effective systems for reporting, investigating and acting on incidents and serious adverse events. The service routinely reviewed incidents and shared any learning and outcomes with staff.
- There were sufficient maternity staff, and there were plans to increase the number of medical staff. There were systems to monitor staffing levels and provide flexibility and contingencies when demand increased.
- Staff planned and provided care and treatment in a way that ensured women's safety and welfare.
- The service managed medicines safely.
- Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed.
- There were clear safeguarding processes in place: staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- The environment in which women received care was suitably safe and clean.
- The service had obtained funding from the Sign Up to Safety campaign to employ a dedicated fetal wellbeing midwife in addition to established staff.
- Mandatory training rates for nursing and midwifery staff had met targets set by the trust in most training modules.
- Staff in the Trafalgar clinic were up to date with their mandatory training.
- Patient risk in the Trafalgar Clinic was managed in line with sexual risk behaviour and staff could arrange for urgent access to specialist teams in drug and alcohol use when a patient presented with an immediate risk.

However:

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- Compliance rates for medical staff, in maternity and gynaecology, in mandatory training were below target for the majority of modules, with some modules achieving compliance rates less than 50%. This issue had been included on the risk register for the service.

Incidents

- In the 12 month period between December 2015 and November 2016 no never events were reported occurring in the maternity and gynaecology services.
- There were 1117 incidents reported in the maternity service from December 2015 to November 2016, of which 667 resulted in no harm, nine resulted in moderate harm and 364 in a low level of harm and 77 were near misses.
- There were 20 reported incidents for gynaecology of which almost all resulted in no harm.
- There was a robust system for reporting and investigating serious incidents. This included the requirement for a basic synopsis of the incident and report within 72 hours. The deputy chief executive and quality leads were informed and a lead investigator appointed with an internal panel review. Debriefs to staff and family were provided as necessary, with an expected 60 day turnaround for investigation and report. Escalation was made to the safeguarding lead as necessary.
- We saw the protocol for managing and reporting a maternal death which was in line with the London NHS Network and with appropriate notification requirements clearly outlined and a requirement for an external consultant to oversee the investigation.
- A serious incident occurred during our visit and we saw that this was handled promptly and sympathetically in accordance with the protocols in place with debrief sessions for all staff.
- The trust discussed outcomes from serious case reviews at operational and governance meetings throughout the directorate, and weekly risk meetings.
- We looked in detail at four of the seven serious incident investigation reports. All were reported appropriately and fully investigated. All reports indicated an independent multidisciplinary panel had collected evidence with appropriate leads appointed to oversee the investigation and produce the report, such as the patient safety midwife and consultant obstetrician. We saw that in each case a comprehensive investigation had taken place with a view to analysing the root cause of the incident, identify contributory factors, learn lessons and take appropriate action as required.
- In each case there was a description of the incident and summary of findings along with a detailed chronology of events highlighting any contributory factors, and consideration of possible actions that may have mitigated the risk. There were risk assessment scores allocated for different aspects of the incident and a clear summary and conclusion. We saw that the duty of candour requirement had been addressed in each case with a record of communication with the patient and family members as appropriate. Care had been taken to preserve the anonymity of patients and babies.
- There were summaries of lessons learnt from each incident and arrangements for shared learning, for example at the daily 'Just Take 5' handover meetings. In each case there was a detailed action plan with responsibilities and timelines clearly defined. For example in one case it was recommended that high risk patients should not be left alone for extended periods of time when in labour and that the obstetricians on duty should always be aware of the heightened risk of uterine rupture in patients undergoing vaginal birth after a previous caesarean section. This demonstrated that the trust had sound systems to analyse serious incidents and take effective actions to prevent reoccurrence.
- We spoke with four midwives who were able to explain the process for reporting and recording an incident. There were arrangements for sharing learning from incidents with staff including briefing sessions at handovers, monthly newsletters and learning from experience fed into mandatory training sessions. Staff told us that incidents were reported via the unit coordinator or manager and that feedback was provided by email. They reported that the department had done a lot of work to improve mechanisms for feeding back information to staff when things go wrong.
- Staff were aware of the duty of candour requirement.
- One member of staff told us "The risk team are really good at letting you know the follow up on incidents and when they're closed".

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- We observed discussion of service developments at the daily morning team handovers, 'Just Take 5', at which staff were briefed on current patients and new guidelines on fetal monitoring.
- We read the minutes of some of the risk group meetings and saw that multidisciplinary staff were fully engaged in the analysis of incidents and identification of any trends.
- Some staff we spoke with said they did not feel incident reports were appropriately acted on. For example, staff in the Trafalgar Clinic had submitted incident reports after staff fell ill due to excessive heat in the laboratory. Although fans had been provided, the problem had not been resolved and staff told us they continued to experience symptoms in the summer.
- Clinical staff in the Trafalgar Clinic attended bi-annual morbidity and mortality meetings that involved a cross-site multidisciplinary team to review the treatment and outcomes of patients with complex conditions.

Safety thermometer

- The service used the maternity safety thermometer dashboard and a maternity scorecard to monitor patient safety, activity within the service, patient experience, workforce and screening information. This allows maternity teams to measure the performance of the department and the proportion of mothers who have experienced complications or harm as well as providing a snapshot audit of activity on a rolling monthly basis. The dashboard collected monthly data on certain measures which could be compared to other units throughout the country, such as the proportion of women developing infection after labour and the proportion of women that had concerns about safety during labour and birth that were not taken seriously. The dashboard also measured combined 'harm-free' care which combined physical safety measures with women's concerns. We saw the dashboard for 2016 which showed that a median of 70.9% of women at the trust overall experienced harm free care during 2016.
- A maternity scorecard spread sheet was produced showing monthly results over the previous 12 months. Each section of the scorecard showed a wide range of measures including for example total births and antenatal bookings, emergency and elective caesarean

section rates, number of home births, premature birth rates, the number of serious incidents, percentage of women suffering tears during deliveries and post-partum haemorrhage.

- The scorecard also recorded the midwife, birth ratio, percentage of 1:1 care during labour and information on complaints. There was a green, amber and red colour coded system to indicate whether performance was within target ranges, with a red alert to flag those results that required action. This prompted a performance escalation report to address all those areas of the scorecard.
- We saw the scorecard results for the 12 months up to January 2017 and the most recent performance escalation report, which was clear and addressed each area showing a red indicator with commentary on response. We saw for example that early access for women to maternity services and caesarean rates were both below target levels. These were being addressed by streamlining the referral process for women in early pregnancy and there was a separate detailed action plan for reducing the caesarean rate.
- There was an additional scorecard for the birth centre which recorded the number of births at the birth centre as well as transfer rates, the frequency of water births and breastfeeding rates.

Cleanliness, infection control and hygiene

- We observed all areas of the hospital providing maternity services including the obstetric theatres. We found the standard of cleanliness to be good and there was evidence of domestic staff following guidance in regard to the required cleaning standards, practices and frequency of cleaning.
- Appropriate signage was on display regarding hand washing for staff and visitors, and there was adequate numbers of hand gel dispensers around the department.
- Data reviewed from the last infection prevention and control audit in February 2017 showed 100% compliance, with five separate audits conducted per month. This demonstrated a good level of cleanliness and hygiene

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- We saw the results of recent monthly hand hygiene audits which showed a very high level of compliance. We saw the cleaning schedule for theatres which was comprehensive and clear outlining methodologies and responsibilities.
- We reviewed data which showed 93% of nursing and midwifery staff had completed infection prevention and control training. However, this figure fell to 42% for medical staff
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when necessary, and followed 'bare below the elbow' guidance, in line with national good hygiene practice. We saw there were daily cleaning and equipment checks in all the rooms. We found stickers on items of equipment indicating they were clean and ready for use although we found that a few equipment trolleys were dusty despite stickers indicating that they had been inspected as clean.
- Systems were in place to identify women for Hepatitis B and HIV at booking to ensure care provided followed the correct care pathways and there were specialist clinics to oversee care for these women. The maternity scorecard showed that 99.9% of women had antenatal screening for HIV.
- There were no reported cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) from February 2016-January 2017.
- Hand hygiene and infection control audit results were consistently above the trust's target of 95% in the Trafalgar Clinic. Between April 2016 and April 2017 staff achieved 100% in each audit, including in the correct use of personal protective equipment.
- The Trafalgar Clinic did not have a named infection control lead and not all areas of the clinical environment had appropriate infection controls in place. For example, clinical rooms had fabric privacy curtains and fabric chairs in them. One clinical room was carpeted although staff told us this was only used when the unit was full to capacity during high demand at walk-in sessions. This presented a cross-infection risk due to the potential for bacteria to build up on the fabric. The senior clinical team had escalated this issue to the trust but disposable curtains and plastic chairs had not been provided. However, staff completed

monthly hand hygiene audits and monthly bare below the elbow audits to ensure their practice was in line with trust policy. After our inspection we asked the trust for more information on this. We were told that the fabric chairs in the unit had been condemned and replaced and that fabric curtains had been replaced with disposable ones.

Environment and equipment

- The design of the maternity unit helped to ensure women and babies were safe. The opening of the new midwife-led birth centre in 2015 increased capacity in the maternity service. It provided a calm and well equipped environment for women with low risk pregnancies to give birth assisted by midwives but with medical and surgical support close at hand if needed. Each of the four delivery suites in the birth centre was large and spacious with a birthing pool, large bed and en-suite shower and toilet. The obstetric consultant-led delivery suite provided an additional 11 delivery rooms (one of which was three bedded), one of which had a birthing pool. There were additional portable birthing pools that could be used if required.
- There were two dedicated obstetric theatres, one for elective procedures, the other for emergencies, and a recovery area.
- There was a 31 bed ward for antenatal and postnatal care, consisting of four bed bays and single rooms. There were six additional rooms in the delivery suite and five on the birth centre that could be used flexibly as additional antenatal or postnatal rooms. There were adequate shower and toilet facilities on the ward.
- The maternity unit could only be accessed by staff and other authorised personnel. There was a security guard at the entrance to the maternity ward to monitor visitors entering and leaving the ward and visitors were asked to log in and out. Two patients we spoke to complained about the attitude of the security guard said he was rude and inconsistent about the number of visitors that were admitted to the postnatal ward.
- There was adequate equipment on the wards to ensure safe care specifically, cardiotocograph machines (CTG) which monitor a fetal heart rate over a period of time and resuscitation equipment for both adults and babies. A new electronic system of CTG central monitoring had been installed so that staff on the maternity unit could

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monitor the CTG output from any of the delivery rooms on a central screen which was located in one of the staff rooms. This enabled more continuous management and meant that staff were alerted to any changes. Staff confirmed they had enough equipment to meet patients' needs.

- Daily quality control and safety checks were carried out on equipment such as resuscitation equipment, blood pressure monitoring equipment and CTGs. These were all up to date and 100% compliant. However, in a few cases we saw that there were a few gaps in recording during January and February for resuscitaires, fridge temperatures and an adult resuscitation trolley, although these were small in number. Drugs and IV fluids on equipment trolleys were not always locked away securely and we found that in two cases blood bottles were out of date. One blood pressure monitoring machine did not display a safety testing label and we saw two suction catheter bags that were unsealed. When informed, staff removed the unsealed bags and the blood pressure machine was marked for checking.
- Utility rooms which were used for cleaning equipment and materials were locked and could only be accessed via a secure keypad. Staff in the Trafalgar Clinic told us the security team had been "very responsive" when a patient became aggressive and they were removed to protect other patients and staff from harm.
- In sexual health it was not always evident that local clinical teams had support from the trust senior team to replace ageing equipment. For example, complex level three genitourinary medicine (GUM) services were reliant on working microscopes for the microscopy service. However, the microscopes in the Trafalgar Clinic had exceeded their life cycle and the trust had declined an application from the team for funding to obtain new microscopes. This presented a risk of interruption to the service.

Medicines

- Medicines were stored in locked cupboards and trolleys in all clinical areas. Medicines that required storage at a low temperature were stored in a specific medicines fridge. All fridge temperatures were checked and recorded daily, although there were some gaps in recording. Nurses and midwives told us they received support from the on-site pharmacist, when necessary.

- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Records showed controlled drugs were checked in line with hospital policy. Controlled drugs were stored in a separate locked CD cupboard. This cupboard was clean and tidy and all drugs were within expiry dates.
- We saw recent results from the monthly medication safety walkabout audit from November 2016 to February 2017. The audit had not been completed for December. One of the criteria monitored was safe storage of medication and we saw that this was non-compliant for February 2017.
- We found on the delivery ward that some drugs and IV fluids were stored on an emergency trolley which was stored in an unlocked cupboard which meant that these items were not secured. We brought this to the attention of ward managers and saw that this had been corrected on the next day of our visit with trolleys securely locked away.
- The Trafalgar Clinic had dedicated pharmacists based there. A pharmacist checked medicine administration records on each ward daily and completed a monthly antibiotic audit.
- A full time pharmacist and full time pharmacy technician worked in the Trafalgar Clinic and led the operation of the HIV home care service. This provided patients with a home delivery service for their regular antiretroviral medicine.

Records

- Staff kept clinical records in line with trust standards. We reviewed four sets of clinical records from the maternity and gynaecology service. All contained a clear pathway of care for each stage of pregnancy with records of regular review of care and re-assessment of any identified risk or safeguarding issues. There was good documentation of screening, blood test results, intrapartum care, CTG monitoring during labour, medication and any allergies. Records also documented any risks identified and used the modified early obstetric warning system (MEOWS) to chart the level of risk for patients.

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- There was good evidence of MDT input as required and a holistic approach to care, with clear records of communication with patients and their involvement in decision making.
 - We were informed by the Head of Midwifery (HOM) that the trust now used a mixture of paper based records and a new on-line electronic system of hospital notes. Women kept a set of hand-held notes throughout their pregnancy and the unit used a colour coded system of paper notes to differentiate between antenatal, postnatal, neonatal and mainstream hospital care.
 - We were told that there had been some issues of compatibility between the new electronic records system and the old IT system, which was now obsolete, and there was a risk that historic clinical information may be lost or difficult to access. This issue had been placed on the risk register for the service and there were plans to ensure that an appropriate system of archiving was put in place to address this risk.
 - The service used symbols on patient notes to indicate particular risks or circumstances, for example a gold star was used to flag a safeguarding concern.
 - Clinical notes in gynaecology clinics and early pregnancy unit were still paper based but scanned onto the IT system.
 - Some midwives said the electronic system was not always user friendly and felt that it was still a work in progress. Some community midwives reported that it was not always easy to access the system to obtain results and other documentation.
 - Staff in the Trafalgar Clinic had improved the HIV test recording procedure to ensure each patient test was completed under a hospital number and name so that if they needed to be admitted, ward staff could access critical information immediately.
- Safeguarding**
- There were effective processes for safeguarding mothers and babies and the trust was in the process of strengthening the risk management system for sharing information about children and young people presenting at the service. The service had a dedicated midwife responsible for safeguarding with strong links to other safeguarding leads within the trust and the community. Each of the community midwifery teams had a midwife allocated to safeguarding.
 - Women were assessed for any safeguarding or social risks at their first booking appointment. The records we reviewed showed evidence that these risks were reviewed on a regular basis throughout pregnancy. Women were offered the opportunity to be seen alone without family members so that they could discuss any sensitive matters confidentially if they wished. This meant that safeguarding concerns could be identified at any stage throughout pregnancy with appropriate support on hand. For example the safeguarding lead told us that there would be extra vigilance where a woman booked late in her pregnancy, if she missed appointments or was reluctant to agree to an advised plan of care.
 - We saw the safeguarding maternity pathway policies on the trust intranet and the trust wide safeguarding policy which mirrored the London-wide Multi Agency policy. There was a new pathway to ensure that women who self-referred (on line) had access to a midwife within four days. There was a poster displaying the safeguarding maternity pathway clearly displayed in the antenatal clinic reception area.
 - The service had a specialist midwife team, the Best Beginnings team, to oversee the safeguarding of vulnerable women. This team was responsible for high risk cases, such as women suffering from domestic violence and teenage pregnancies, to provide support in the community and at hospital and advise other midwifery colleagues. Where risk factors were identified either at initial booking or at any point throughout pregnancy and post-natal care, a referral would be made to this team with clear pathways and support from specialist midwives. Referrals could be made from other points in the service such as triage, the early pregnancy unit or from other health professionals such as GPs, social workers or health visitors.
 - There was a multi-disciplinary risk and safeguarding meeting every week, the maternity concerns meeting, which included members of the Best Beginnings team discuss safeguarding issues and high risk cases.

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- There was a trust wide safeguarding committee which included senior staff and safeguarding leads from the trust as well as representatives from local CCGs, to discuss broader policy based issues in relation to safeguarding. There was a Children and Young Persons' Safeguarding Assurance Group which met monthly and included representatives from the service as well as safeguarding leads to discuss local issues such as training, performance reports and action plans. We saw the minutes of these meetings which were thorough with action points and time frames. This demonstrated careful reporting and monitoring of safeguarding was continuing in the maternity service.
- Senior staff acknowledged that the electronic record system was still a work in progress but said that they were working to ensure that safeguarding information was fully captured in discharge summaries so that GPs and other community services would be fully informed of current safeguarding issues for on-going postnatal support.
- In addition there was a team to support those with mental health issues, the Time team, and specialist clinics for women with alcohol and substance misuse problems.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of the practice. We were told that FGM was a significant problem in the boroughs covered by the trust. We saw the trust policy on FGM and saw that guidelines and procedures were in place to assist staff. Patients at risk or who have had FGM require a full risk assessment, with the provision of information and counselling, and referral to a consultant and the safeguarding team where appropriate.
- A recent CQC report on safeguarding in the local area noted that the service had effective systems for multi-agency liaison for vulnerable patients during the antenatal period so that information could be shared between maternity services, health visitors and GPs. The report recommended that risk assessments should be reviewed at regular intervals during pregnancy and we saw evidence of this in patient records. The recommendation that all pregnant women should be offered the choice to be seen alone at any point to discuss sensitive issues (such as domestic violence) had been addressed and women now received this information in appointment letters during their pregnancy.
- We saw the child abduction policy for the service which was used across the trust and had been created from the Child and Young Person Abduction Policy 2016 and the New-born Security Policy 2015. There were laminated sheets titled 'Response to abduction of a baby' kept at the nurses' station which outlines key actions to be taken in the event of an abduction.
- The trust set a target of 85% for completion of safeguarding training, which included several modules – Emergency Planning, Mental Capacity Act and Consent, Safeguarding Adults Clinical Level 2, Safeguarding Children and Young People Level 2 and Level 3 and Safeguarding Children and Young People Level 3 – specialist. The 85% compliance target was achieved by nursing and midwifery staff in four of five modules. Safeguarding Children and Young People Level 2 training achieved rates of 78%. Medical staff met compliance targets in two of five modules although rates were above 80% in all except Emergency Planning which had a compliance score of 13%.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. All staff we spoke with said they were happy to call the lead nurse if they had concerns and were aware that there were leads for those with particular vulnerabilities such as teenage pregnancy or those suffering from domestic abuse or alcohol or substance misuse.
- A senior nurse in the Trafalgar Clinic was the safeguarding lead and all clinical staff had up to date safeguarding adults and children level three training. This was a mandatory requirement to work in this clinical service. This team had additional training to care

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for vulnerable and at-risk patients, including those who disclosed underage sexual activity, those who had experienced female genital mutilation and those experiencing domestic violence or sexual coercion.

- All staff in the Trafalgar Clinic had completed chaperone training and each patient was routinely offered this option before being seen. Staff proactively ensured a chaperone was present where a patient presented with inappropriate behaviour.
- All of the staff we spoke with demonstrated appropriate knowledge of their role and responsibilities in relation to safeguarding, including what to do if they observed suspicious behaviour, suspected abuse or found unexplained bruising on a patient.

Mandatory training

- Midwifery, nursing and medical staff were required to attend mandatory training courses including manual handling, infection control, medicines management, health and safety, resuscitation, conflict resolution, fire safety, information governance, equality and diversity and PREVENT training. The trust set a target of 85% for completion of mandatory training within the maternity and gynaecology services.
- We reviewed the latest trust data for February 2017 which showed an overall compliance rate of 77%. Training for nursing and midwifery staff exceeded the target in 11 out of 17 modules while a further three modules just below target (75% or above), although fire safety and PREVENT training only achieved rates of 33% and no staff had received training on bullying and harassment.
- However compliance rates for medical staff fell below target for all except three of 15 modules. Five modules had compliance rates of 50% or less. We were told that this issue had been included on the risk register for the service.
- Staff we spoke with reported regular mandatory training updates.
- All staff in the Trafalgar Clinic had up to date basic life support and anaphylaxis training.

Assessing and responding to patient risk

- Midwifery staff identified women as high risk by using an early warning assessment tool, known as the modified

early obstetric warning system (MEOWS), to chart the level of risk and assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We saw evidence of this in the four records we reviewed which contained appropriate MEOWS charting and other risk assessments, which were reviewed throughout the care pathway.

- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion of a World Health Organization's safe surgical safety checklist in obstetric theatres.
- Women had a full risk assessment at their first antenatal appointment which was longer than subsequent appointments so that a full medical and social history could be taken. Risk assessments were used to determine if a pregnancy and labour were likely to be low or high risk and whether a home birth or midwife-led birth was appropriate in all the circumstances. Risks considered included maternity history, multiple birth, previous caesarean section, weight, age, blood pressure and conditions such as diabetes.
- Risks were clearly documented in the electronic records reviewed and the IT system and paper notes used indicators or flags to denote certain risks or medical concerns. Examples of risks included a gold star to indicate a safeguarding risk, a sunflower to indicate HIV infection and a teardrop symbol to indicate previous loss/bereavement.
- There were consultant led antenatal clinics, principally for higher risk pregnancies and midwife-led clinics. There were a range of specialist midwifery services and clinics to provide support to women who were at medical or other risk, such as obesity, diabetes, previous complications in pregnancy, smokers, teenage pregnancy, women at risk of domestic violence, alcohol and substance misuse or other safeguarding concerns.
- Maternity triage operated via a telephone line that is available 24 hours a day, seven days a week for urgent queries. Women could telephone for an assessment, advice and reassurance. There were two rooms available for triage if further examination or monitoring

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was needed on site. There was also a maternity helpline available from 10am to 5pm, Monday – Friday, and an on-line email system ‘Edie’ for general questions and information.

- There was a Pregnancy Plus clinic for women with a high BMI which was supplemented by an Active Mothers program and run by community midwives. There were also various specialist clinics and midwives to support women with particular need such as diabetes, those who had previously had a caesarean section (VBAC – vaginal birth after caesarean), those with blood disorders such as sickle cell anaemia, teenage women and those who had suffered bereavement. The Best Beginnings team managed risks for those identified as vulnerable and the Time team held specialist clinics for women with mental health problems.
- Consultant midwives and obstetric-led care was provided for women with more complex medical problems or where additional input was required. This included women whose birth preferences were outside recommended guidelines which would represent additional risk such as those who wished to deliver twins at home or those who chose not to have induction of labour when medically indicated. We saw the trust guidelines for managing such cases which were comprehensive and covered referral to consultant midwives and obstetricians, offering informed choice and providing continued care through pregnancy.
- The service had obtained funding from the Sign Up to Safety campaign to employ a dedicated fetal wellbeing midwife in addition to established staff, whose remit was to facilitate training on CTG and fetal monitoring. This had led to the development and launch of new fetal monitoring guidelines and classification tables which were distributed to all staff. A copy was seen on the staff noticeboard and we saw that midwives were given self-help sheets for easy reference.
- The unit used the ‘fresh eyes’ approach, a system which required two members of staff to review fetal heart tracings. We observed that a fresh eyes review was carried out every hour, which indicated a proactive approach in the management of obstetric risks. A new central monitoring fetal monitoring screen was located in the staff so that staff on the maternity unit could monitor the CTG output from any of the delivery rooms on a central screen which was located in one of the staff rooms. This enabled more continuous management and meant that staff were alerted to any changes or deterioration so they could respond to increased risk swiftly.
- We observed the Just Take 5 handover meeting which was attended by midwifery and medical staff. All current patients on the labour ward were discussed along with any women in the unit where there were risks or concerns. The consultant-led handover was thorough and covered any additional information, monitoring or interventions required. Gynaecology inpatients were also discussed at daily handover sessions.
- We were told about other initiatives and training to manage and reduce risk during pregnancy. The trust maternity service across both hospital sites was working on a jointly funded project with Lewisham Public Health, ‘Better Births’ run by a research group, the ‘Poppie’ team. This project had received funding for two years to monitor women who were at risk of pre-term birth and the correlation with continuity of care throughout the pathway.
- The community matron informed us that all community and birth centre midwives received ‘Drills and Skills’ training sessions where they worked on case scenarios to manage obstetric emergencies.
- The community matron informed us that all community and birth centre midwives received ‘Drills and Skills’ training sessions where they worked on case scenarios to manage obstetric emergencies.
- Staff in the Trafalgar Clinic conducted a daily safety briefing prior to the start of the service. We attended a meeting during our inspection and saw it included a review of booked patients, staffing levels, a check of equipment and any research participants due to be seen.
- Staff in the Trafalgar Clinic assessed patients’ level of risk in line with their sexual behaviour and factors such as drug and alcohol use. In particular, the service was able to address immediate risk in relation to chemically-enhanced sexual activity (‘chemsex’) that presented significant risks to patients by sourcing a specialist drug use support worker to visit the clinic.

Nursing and Midwifery staffing

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- Staffing levels were set and reviewed using nationally recognised tools and guidance. The service was using the principles set out in the Birth Rate Plus acuity tool and the safer staffing framework to provide guidance on staffing levels. There were safer staffing reviews every six months and the trust had increased baseline staffing levels since the 2014 CQC report to reflect the increase in birth rate.
- The ratio of midwifery staff to births within the service at the time of our visit was one midwife to every 31 births. This ratio had fallen during 2016 due to the increase in demand on the service.
- The trust reported a vacancy rate of 12% for nursing and midwifery staff for January 2017 and we were told that recruitment was currently underway and funding had been secured to increase staff numbers due to the increase in demand.
- We saw staffing rosters for the previous week which reflected the stated staffing levels and skill mix. We also saw a monitor of planned versus actual staffing hours within the service and saw that maternity figures showed that actual performance represented less than 100% of planned hours but consistently over 90%. Gynaecology staffing was just under 100% of planned levels.
- The maternity scorecard recorded between 98-99% of women in labour received one to one care from a midwife during 2016. We observed that during our visit there were enough midwives to provide one to one care for all women in the delivery ward and birth centre. There was a range of specialist midwives to provide support, for example fetal wellbeing, infant feeding, screening, safeguarding, mental health as well as ward managers, a consultant midwife and a supervisor of midwives.
- There were 24 hour staffing levels with five midwives on duty to attend to women on the postnatal ward, nine on the delivery suite and four in the birth centre. In addition there were specialist midwives, such as the fetal wellbeing midwife and ward managers, coordinators and consultant midwives who could 'act up' if required as well as Supervisors of Midwives. There were additional administrative staff and a bereavement midwife so that other midwives could focus on clinical duties.
- Staff reported that there were generally enough staff to meet patient needs and agreed that the department was very efficient at redeploying staff when demand increased. However most agreed that the department was often stretched as demand was increasing and staff vacancies due to maternity leave had left gaps in staffing levels. Midwives could be brought in from the other hospital in the trust (University Hospital Lewisham) or from the community at times of high demand. Midwives told us that senior staff and managers were always willing to help out when needed and that there was a very strong ethos of team work.
- The service used a 'live' capacity document which was updated every eight hours to reflect the workload and staffing levels in each area. We saw the capacity document on the day of our visit. This showed the assessment, plan of care and risk level for each of the rooms in the delivery suite and birth centre along with required staff and the named midwife allocated to each room. The document also recorded staffing levels throughout the department with patient information for each area including the postnatal ward, triage area and day assessment unit. There were details of staff on call, home births and women who were located elsewhere in the hospital. On call clinical staff were also detailed in the document.
- The capacity document showed a colour coded overall status for the department (green on the day of our visit) and a contingency plan showing changes or redeployment of staff where needed. We saw for example that the fetal wellbeing midwife was providing clinical support on that shift and that two patients were being transferred to the other site in the trust. This demonstrated that the department had continuous oversight over workload in the department so that they could respond effectively to changes in demand and ensure that adequate staff were available to meet the needs of the service.
- Patients reported that they had received one to one care during delivery and said that midwives were always on hand and were unrushed. A few commented that the postnatal ward was more stretched and that midwives seemed very busy with less time to attend, although all were very positive about the availability of support for breast feeding.

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- Gynaecology inpatients were cared for by staff in surgical wards although nurses with gynaecology training were allocated to care for them and staff reported that there were enough staff to meet the needs of patients.
- The trust reported a high level of turnover with rates of 15% for midwifery and nursing staff and 23% for medical staff. Staff sickness rates were reported at 6%. The service had recently introduced a preceptorship (mentoring) program for student nurses and other staff focussed initiatives to encourage retention of trained midwives and reduce staff turnover.
- The early pregnancy assessment unit was staffed by three nurses and a sonographer. We were told that demand had increased and that there were often long waits for patients to be seen, although recruitment would be increased. Staff on this unit confirmed that lack of staffing often caused delays including those with ectopic pregnancies who had to wait several hours in some cases for medical attention, which had been reported to senior management. We saw from the risk register that the service were aware of these shortfalls and there were plans to increase staffing levels in this area with an additional sonographer as well as an additional health care assistant to meet and greet patients at the clinic.
- There were seven teams of community midwives covering two local authority boroughs, each with 4-5 full time equivalent midwives. There were community team leaders who linked with specialist midwives at the hospital to provide support for a range of needs, for example one team leader ran a weekly clinic, the River Clinic, for women at risk due to substance abuse. We spoke with the community matron who told us they were a committed and well-functioning team who worked effectively and flexibly with their hospital based colleagues. Community midwives supported women at antenatal clinics, home births, the birth centre and could provide extra capacity on-site at the hospital unit when necessary.
- The Trafalgar Clinic operated a separate nurse staffing model that ensured there was a 100% fill rate of shifts and agency nurses were not used.
- A head of nursing led nursing care in acute medicine and a head of nursing for genitourinary medicine (GUM)

and sexual health and the matron for GUM and HIV led nursing care in the Trafalgar Clinic. Daily staffing in this unit typically consisted of three clinical nurse specialists, one registered nurse and a healthcare assistant.

Medical staffing

- The trust reported a vacancy rate of 29% for medical staff for January 2017. Between January 2015 and June 2016 the trust reported that there were 68 hours of medical cover per month on the labour ward at the hospital which was planned to increase to 87.5 hours from 1 April 2017 as there would be funding for an additional consultant post.
- We were informed that there was only one junior doctor to cover the day assessment unit which was currently on the risk register. This caused delays as the unit often had to wait for medical support from the labour wards when needed.
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours work when they were on call for the obstetrics and gynaecology units. There was a dedicated anaesthetist to provide epidural pain relief and anaesthesia in theatre for caesarean sections and other surgical procedures.
- Multidisciplinary ward rounds took place each morning and evening for all women and review of critical care women as their condition dictated. Gynaecology and maternity patients were discussed at shift handovers led by the consultant obstetrician on duty. We were told by staff on the surgical ward that gynaecology inpatients often had to wait a long time to be seen as they were seen after the maternity ward round which were often interrupted by delays or emergencies.
- Consultants worked on a team basis, and provided cover within the team for sickness and leave. This helped to ensure that women received consistent care.
- A clinical director and clinical lead led sexual health and HIV services. Daily medical cover in the Trafalgar Clinic was typically provided by up to two consultants and up to three foundation year (FY) doctors. This included one full time FY2 doctor, a part time FY1 doctor and a GP trainee. Overall two consultants led the complex HIV service

Major incident awareness and training

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- We spoke to service managers about preparations in the service for major incidents. They told us there was a business continuity plan with escalation and closure policies. They said there was also an annual assurance visit from NHS England to check on the level of emergency preparedness for periods of disruption.
- The service had been closed on two occasions in the last two years. The last closure was due to a power failure at the hospital. Contingency plans had been put into place and patients, with their midwives, were transferred to the other hospital in the trust to provide continuity of care.
- Care in the Trafalgar Clinic was delivered in line with British Association for Sexual Health and HIV and British HIV Association guidance. Staff benchmarked this through local audits and research. Care pathways for HIV positive patients were embedded and comprehensive and included access to specialists within the wider multidisciplinary team.
- In sexual health there was extensive evidence of positive multidisciplinary working. This included daily board rounds on each ward, daily briefings in the Trafalgar Clinic and ad-hoc specialist multidisciplinary working for patients with complex needs.

Are maternity and gynaecology services effective?

Good



We rated effective as good. This was because:

- We found good multidisciplinary working between hospital and community services. Support from allied healthcare professionals and specialist expertise was available to women using these services.
- The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits.
- Patient outcomes were routinely monitored through a rolling maternity scorecard system and action taken to make improvements.
- Staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision. Women reported that staff were competent and professional.
- Women reported having their pain effectively managed and there were choices for managing pain. An anaesthetist was on duty to administer epidurals.
- Women were offered support to feed their babies.
- Junior doctors in the Trafalgar Clinic had substantial opportunities for specialist development and research participation.
- There were no clinical indicators for gynaecology patients
- There was a lack of agreed pathways for the management of some gynaecological conditions.

Evidence-based care and treatment

- We found the care of women using the services was in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- There was evidence available to demonstrate women using these services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). We could see from records and through discussion with staff that care was in line with (NICE) Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32. For example we saw evidence of a discussion with a consultant before an elective caesarean and a debrief after birth.
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were

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available on the trust's intranet and were approved by the obstetric group. Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.

- We saw a range of other evidence based guidelines used by the trust including intrapartum care, post-partum haemorrhage, new-born feeding, postnatal care and intrapartum fetal monitoring. These guidelines were all up to date.
- The service used an alternative system of cardiotocography (CTG) interpretation called FICO rather than NICE (2014) guidelines. This had been introduced recently after analysis of available data and on-going evidence was being collated by the fetal wellbeing midwife to validate the decision in line with the Sign up to Safety project.
- We saw the protocol for the management and reporting of maternal death and guidelines for supporting women who were at risk, for example women whose birth preferences fell outside recommended guidance. This included women who had previously had a caesarean section who wished to have a vaginal delivery or a home birth. Staff had been briefed on this protocol and were well informed.
- The service produced an audit programme spreadsheet which was comprehensive with national and local audits, detailing project leads and proposed finish dates. There were 14 audits registered and 10 had been completed with four on-going. These included management of women with severe pre-eclampsia, operative vaginal deliveries, audit of consent, readmission after labour, electronic fetal monitoring and post-partum haemorrhage. There was documentation outlining audit results and recommendations.
- We reviewed results of the audit on post-natal readmission rates which were above expected rates and this showed the most common causes for readmission to be pre-eclampsia and sepsis. An audit of cases of pre-eclampsia in January 2017 showed that identification and escalation could be improved with recommendation for a trigger list to improve diagnosis. We saw the reports on an audit of the antibiotic care bundle in line with MEOWS during the end of 2016.

- The review carried out in January and February 2017 by the Royal College of Obstetricians and Gynaecologists found there was no 'adequate agreement on guidelines and their implementation' or common pathways for women who may be experiencing abnormal uterine bleeding, biopsy or hysteroscopy.
- Staff in the Trafalgar Clinic completed a rolling local audit of gonorrhoea microscopy slides that enabled the service to ensure microscopy services were effective and detected infectious cultures. This contributed to national surveillance to identify antimicrobial resistant infections.
- Patients in the Trafalgar Clinic received HIV testing and care in line with national guidance from the British Association for Sexual Health and HIV and NICE guidance 60.

Local audits in the Trafalgar Clinic included participation in a national British HIV Association syphilis audit, checking cardiovascular disease competencies for HIV positive patients and a qualitative audit of patient attitudes to their medicine plan in preparation for a presentation at a national conference.

Pain relief

- Women received appropriate pain relief promptly and according to their needs and wishes. There was a leaflet with detailed information on the pain relief options available to them, this included Entonox piped directly into all delivery rooms, and pharmacological methods such as Diamorphine and Pethidine as well as epidurals.
- Anaesthetic cover was based on the labour ward and in the birth centre 24 hours a day and included an epidural service. There was a dedicated anaesthetist available to the maternity service and midwives told us an anaesthetist was always available for epidurals within the target time of 30 minutes but usually more rapidly.
- Women on the unit told us that they had received effective pain relief in a timely manner. They felt they had been well informed and reassured by midwives and anaesthetists. One woman said she requested an epidural after being given a leaflet to reassure her. She reported that she felt well informed to take this decision and give consent. She said the epidural was given when required and she was given effective pain relief afterwards on the ward.

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- The service did not yet actively promote alternative therapies such as aromatherapy and hypnobirthing. However training in hypnobirthing was currently being provided for groups of midwives in the community and in the birth centre with plans to expand so this could be offered more confidently in future.
- We spoke to a patient on the gynaecology ward who had surgery the previous day. She reported that she had received suitable pain relief post-surgery and that staff were available to help if there were any issues with pain.

We reviewed an audit of epidural delivery during 2016 and saw that wait times for epidural were 25 minutes on average with 9% of women having to wait for more than one hour.

Nutrition and hydration

- The service had specialist midwife advisors to provide one to one and group support for breast feeding babies after birth. There was information on the trust's website about breast feeding and weaning, with links to the NHS choices website and United Nations Children's Fund (UNICEF) as well as breast feeding support groups in the area.
- The trust had implemented the UNICEF Baby Friendly Initiative standards. The maternity unit has been awarded full UNICEF baby friendly Level 3 accreditation.
- The service provided leaflets on breastfeeding and weaning and there were posters displayed throughout the department offering advice and support and advertising daily drop in sessions. There was information on the trust website on breast and infant feeding and within pregnancy booklets.
- The maternity scorecard recorded between 76-86% of women initiated breast feeding before discharge.
- Patients cared for in the Trafalgar Clinic for HIV and related conditions had their care coordinated by HIV staff and dieticians in the hospital where appropriate. This meant a dietician conducted a nutritional review in the specialist clinic and staff there could administer supplements or related medicine with periodic reviews by the dietician

Patient outcomes

- Information about the outcomes of patients' care and treatment were routinely collected and monitored by

the service through the governance and risk management processes, the maternity scorecard and the monthly clinical quality review and governance reports. The maternity scorecard was colour coded to flag outcomes that fell outside the target range and prompted an escalation report if the code changed to red (which meant action was required).

- Nationally published data for April 2016 to January 2017 reported an overall caesarean section rate for the hospital of 28.6%, slightly higher than the England rate of 27.3%. The emergency caesarean section rate was higher than the England average (17.5% compared to 15.4%). The elective caesarean section rate was slightly lower than the England average (11.1% compared to 11.9%).
- We saw the action report to reduce unnecessary caesarean sections, which detailed a variety of planned measures incorporating staff training, normalisation of birth programs and encouraging vaginal delivery after previous caesarean sections. The service was continuing to monitor this closely and take appropriate action
- The service had a target of over 50% of women presenting for antenatal booking within 10 weeks gestation and 90% within 12 weeks and six days. The 50% target had been achieved in seven out of 12 months in the period from February 2016 to January 2017 but the 90% target had not been reached in any month during the same period. The service had introduced a 'Call the Midwife' mobile number which women could use to register their pregnancy without having to see a GP and there was an on-line self-referral form on the trust's maternity website.
- The service achieved a normal vaginal delivery rate of just under 60% in eight of the 12 months to January 2017 although this rate did not fall below 58% and was therefore comparable with the national average of 60%.
- The maternity scorecard indicated a target of less than or equal to 3% for 3rd or 4th perineal degree tears occurring during vaginal delivery. It was noted the target was exceeded in 8 months out of 12 from February 2016 to January 2017 although rates were generally not a level requiring action.

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- Assisted delivery rates ranged from 7.7% up to 14.9% from February 2016 to January 2017 and were above the target of less than 10% in 11 out of 12 months. The dashboard did not distinguish the type of assistance needed, such as forceps.
- The indicator for post-partum haemorrhage (PPH) of equal to or greater than 1500 mls, met the target of less than or equal to 3.5% of deliveries in 2 of the 5 months to January 2017 with rates between 4.3% and 4.7% for the other three months.
- Stillbirths were measured on a quarterly basis with a target of less than or equal to 5.3 per 1000 births. This rate was 5.2, 2.5, 2.5 and 7.4 in the four quarters to January 2017. There were eight neonatal deaths after 22 weeks gestation during the 12 months to January 2017. An average of 21 babies of over 37 weeks gestation per month were unexpectedly admitted to the neonatal unit.
- A recent review (January and February 2017) of maternity and gynaecology services by the Royal College of Obstetricians and Gynaecologists found the hospital did not have a dashboard of standard outcomes for gynaecology.
- Staff in the Trafalgar Clinic used a structured template in the electronic patient records system as part of a standard operating procedure to track patients who did not attend booked appointments and did not contact the service. This was in place to reduce the risks associated with untreated HIV and ensure patients received coordinated care when they may be experiencing mental health problems or have complex needs. This included the capacity to contact their GP, departments in NHS hospitals and known family contacts to trace them. Staff also liaised with the Home Office in the event a patient had been removed from the UK and needed essential health and treatment information.
- Clinical staff in the Trafalgar Clinic worked to implement NICE national guidance 60 in relation to reducing undiagnosed HIV by improving uptake of testing by encouraging more intradepartmental working in the hospital. For example, by working with colleagues to

improve knowledge of HIV risks and symptoms, staff had identified previously undiagnosed HIV in patients referred from the emergency department and urology services.

- Staff had access to nine HIV care pathways, including a specialised pathway for HIV positive patients with neuro-cognitive degradation, including dementia that enabled them to access services at an HIV community hospital.
- Between April 2016 and April 2017 staff in the Trafalgar Clinic conducted eight audits, including two audits to establish care standards against national BASHH guidance.

Competent staff

- At the time of our inspection the ratio of midwives to supervisors of midwives was 1:14, which was better than the recommended ratio of 1:15. There was also a full-time supervisor of midwives. Midwives said they were well supported by their supervisors particularly in relation to safety, assisting junior staff and in advising on issues related to risk.
- From 1 April 2017 the hospital was planning to introduce a new model of midwifery supervision with Professional Midwifery Advocates replacing the old title of Supervisor of Midwives. It is anticipated that the role would remain similar with responsibilities for clinical supervision, professional advice and support, appraisal and revalidation processes.
- The service had introduced a preceptorship (mentoring) program with a new preceptorship midwife in post since January 2017 to mentor student and newly qualified midwives to ensure that they were competent to provide care at different levels. During the period of 'preceptorship', they received additional support and supervision, went through a programme of competencies and rotation through the service including the community. Staff and managers told us that this new role had been very successful and students felt they provided valuable support. Newly qualified staff and students said that supervising staff were always careful to allocate them to cases which were within their levels of competency.
- Staff working in both maternity and gynaecology confirmed they had an annual performance review or

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were expecting to have one in the immediate future. Staff we spoke with informed us the review offered a chance to discuss their performance and development needs, and that this was a valuable and positive opportunity. There were opportunities for further one to one review if requested and additional training was commissioned each year to enhance professional skills such as mentorship training or alternative skills such as hypnobirthing. We were told that an email was sent to staff each year asking what training they were interested in.

- We spoke with the fetal wellbeing midwife who was undertaking work as part of the maternity unit's 'Sign Up to Safety' project. This project had the aim of improving birth outcomes by enhancing the competence in fetal monitoring of midwives and doctors. New guidelines had been introduced and staff had received training via a series of master classes and briefing at handover sessions with supporting materials such as posters and reference sheets.
- We observed that the Just Take 5 handover session was also used as an informal training session with quizzing on current topics such as post-partum haemorrhage, with reviews of data and information on new guidelines. Clinical handover was also used to discuss and refresh knowledge on particular complications and patient situations.
- Revalidation was part of appraisal process for medical staff and was coordinated within the directorate. Staff we spoke with reported no difficulty in getting an appraisal done.
- All nurses in the Trafalgar Clinic had completed BHIVA Sexually Transmitted Infection Foundation training to a level appropriate to their role and responsibilities. Doctors in this clinic held a minimum of intermediate-level Sexually Transmitted Infections Foundation (STIF) certification from The STI Foundation. In addition, nurse training was provided in line with national Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists standards.
- Staff in the Trafalgar Clinic told us they had access to additional specialist training whenever they asked for it and a PDN was in post. For example, a healthcare assistant (HCA) said they had developed clinically by

undertaking training in phlebotomy and microscopy. They described the clinic as a good environment to learn in and said they received hands-on practical support from clinical nurse specialists to help them put their training into practice, particularly when interpreting test results. However, some staff told us funding was no longer available for them to take advanced practitioner training, which could affect future career plans. In addition, one member of staff said they could not access training from other clinical teams in the main hospital and felt there should be a mechanism for staff in this unit to be able to find out about training opportunities. However, nurses had access to enhanced clinical skills training, which meant they were able to provide a wider range of services to patients.

- Foundation level two (FY2) doctors who spent time on a rotation in the Trafalgar Clinic received weekly protected teaching time with a consultant. When an FY2 doctor first started a rotation, a consultant reviewed each patient's notes with them before the appointment to ensure appropriate care was planned. As the FY2 doctor became more experienced, a consultant would review a sample of five consultation notes at the end of each shift as a strategy to ensure there was evidence of clinical competence. We spoke with an FY2 doctor in a rotation in this service. They said, "My portfolio has doubled in the four months I've been here and I'm involved with research, audits and posters. The consultants couldn't be more supportive, this is a good learning environment."
- HIV consultants had identified a need for more consistent and in-depth training for junior doctors to enable them to confidently deliver HIV test results to patients on inpatient wards. This followed instances where junior doctors had given a positive test result but needed a doctor from the Trafalgar Clinic to then attend the ward and support them. Although this training had not been established hospital-wide, it was available on an on-demand basis and junior doctors who completed a rotation in the Trafalgar Clinic completed it.
- All staff in the Trafalgar Clinic involved in research and clinical trials had completed National Institute for Health Research good clinical practice research delivery training. This meant they could work as part of a multidisciplinary research team within ethical and clinical boundaries.

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- Nurses and junior doctors in the Trafalgar Clinic took part in a monthly peer review and learning session that enabled them to present case studies and research to each other in a supportive environment for learning.
- Staff in the Trafalgar Clinic told us they had received at least one appraisal in the previous 12 months and they felt these were useful to speak to their senior team about training needs and identify areas of good work as well as areas to work on for improvement.

Multidisciplinary working

- There was very good multidisciplinary working in the Maternity directorate. All staff including those in different teams and services, for example consultant, nursing and midwifery staff members, worked collaboratively to ensure the best care was provided to their patients and good communication was maintained. Staff worked together to assess, plan and deliver women's care and treatment.
- There was good evidence of multidisciplinary working to assess and respond to risks and to work on service planning. This was apparent in minutes of meetings at senior trust level as well as departmental meetings.
- There was access to medical care for women who had other conditions, for example, specialist medical antenatal clinics for women with comorbidities. This included women with diabetes, obesity, hypertension, as well as specialist support from the Time team, for those with mental health issues, and also from the paediatric and neonatal nursing specialists.
- Midwives at the hospital and in the community worked closely with the Best Beginnings risk team, GPs and social care services while dealing with safeguarding concerns or child protection risks. Risks were notified to health visitors, and GPs and community midwives had access to pathways about vulnerable women.
- The community midwife team worked collaboratively with hospital based midwives when attending the birth centre to support their patients and provided extra resource. Community midwifery teams were linked to an obstetrician at the hospital site so there was a contact point if they need to raise any issues or queries that needed medical input.
- The trust was working towards an integrated care model for the future with more cross-site and community working with new initiatives for multi-disciplinary working. We were told of a recent pilot study day organised with local ambulance services with multi-disciplinary attendance to assess how health care professionals worked together with different skills levels, using different case scenarios.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals, such as pharmacists, social workers and bereavement counsellors. Midwives in focus groups reported that there was a good working relationship with community staff, good interaction and shared training as well as good communication channels and regular emails with updates and alerts.
- We attended a morning multidisciplinary handover meeting on the delivery ward. It was well attended meeting with the governance lead, ward managers, matrons, obstetric medical staff, midwives and students. The meeting was respectful and inclusive and demonstrated good collaborative working. The meeting was used as an opportunity for updates, for example on the use of anti-coagulant and antibiotic therapy. It was also used for reminders about a new community jaundice clinic and new fetal monitoring guidelines, as well as an informal teaching and review session.
- The medical handover was led by the consultant obstetrician on duty and included knowledge checks and challenges for each doctor as they reviewed each patient.
- We were also informed that staff from different disciplines trained together. For example medical and midwifery staff attended Practical Obstetric MultiProfessional Training (PROMPT) which was part of their regular mandatory training. This training has been associated with improvements in perinatal outcomes and has been proven to improve knowledge, clinical skills and team working.
- We saw effective MDT working in the Trafalgar Clinic, such as when a patient attended with a complex kidney condition.
- Clinical nurse specialists provided a sexual health screening service in a community clinic in Greenwich on

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a weekly basis. The Trafalgar Clinic's clinical director maintained oversight of this and nurses provided a seamless pathway from the community clinic to the hospital service if patients presented with an HIV risk.

- Sexual health, HIV and contraception staff held a monthly MDT meeting that included all sites in the trust. Where a patient was admitted as a medical inpatient and HIV was the primary cause, they could be cared for in this hospital through multidisciplinary relationships between consultants. This team also maintained close relationships with colleagues at another NHS trust, which would accept patients transfers if more specialist HIV inpatient care was needed

Seven-day services

- The delivery suite, midwife-led birth centre and the wards were open 24 hours a day seven days a week. There was medical staff presence on the labour ward 24 hours a day, with consultant presence 68 hours per week with plans to increase this to 87.5 hours following funding for another consultant from 1 April 2017.
- The day assessment unit was open seven days a week, from 8am to 8pm Monday to Friday and 10am to 4pm at weekends. Nurse prescribers on this unit could prescribe some medicines such as antibiotics or adjust anti-hypertensive medication so that women did not have to wait for a medical referral.
- The early pregnancy unit was open from 8.30am to 5pm Monday to Friday excluding bank holidays, when emergency scan clinics were provided.
- The area used for antenatal clinics during the week was used for some postnatal follow up appointments at the weekend or pregnancy booking appointments.
- The maternity triage service operated 24 hours a day, seven days a week. There were on-call community midwives on the evenings and weekends.
- An HIV/GUM consultant was on call 24-hours a day, seven days a week and available to all departments and medical services in the hospital. This included for emergency prescriptions of post-exposure prophylaxis (PEP), a course of medicine that can prevent HIV seroconversion if taken within 24 hours of exposure to the virus.

Access to information

- We found that professional guidance and policies were freely available to staff on the trust intranet. We also saw displays of pathways, such as the safeguarding pathway, and also posters with information on guidelines and updates on display.
- Information was communicated to staff via specific meetings, Just Take 5 and other handovers, emails and newsletters.
- Women carried their own hand-held notes during their pregnancy although information was also recorded in IT records.
- Some community midwives in focus groups told us that they did not always have good computer access to results although they said that the IT department were very supportive.
- Staff in the Trafalgar Clinic provided care and treatment for patients in a nearby prison. Each patient's records were maintained on the service's electronic patient record system. This meant when a patient left the prison service, there was no disruption in care or treatment because clinical staff always had access to this. In addition, if the patient moved out of the area, the electronic records could easily be shared with pharmacists and health workers in the offender resettlement programme. This meant patients received continual care and were at reduced risk of developing health problems associated with an interruption to antiretroviral therapy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help them make decisions and choices about their care and the delivery of their babies.
- We saw evidence of consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines. Staff had access to a trust-wide policy for guidance on consent.
- Training on consent and the Mental Capacity Act (MCA) was incorporated into safeguarding training as a discrete module. Seventy-nine per cent of nursing and midwifery staff and 64% of medical staff were up to date with this training. There was minimal awareness of the

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- Staff documented consent for research participants in the Trafalgar Clinic prior to the start of a project or clinical trial and re-consented the participant at each visit. Specific consent documentation was in place in this clinic for patients who attended alone and who were under the age of 18. A named nurse was in post for this group of patients and all clinical staff had training in the Fraser guidelines and Gillick competencies.

Are maternity and gynaecology services caring?

Good



We rated caring as good. This was because:

- Staff took into account the individual needs of women and their partners and ensured appropriate support was provided to them.
- Feedback through the Friends and Family survey indicated that women had a good experience of the service.
- There was good support for those who had suffered bereavement with a separate, suitable furnished room and a specialist midwife.
- Women using the maternity service reported that staff were kind and caring and provided sympathetic support particularly during labour and birth.
- We observed that staff took steps to ensure that they protected the dignity and privacy of women in all areas.

Compassionate care

- Women we spoke with were positive about their experiences and the standard of care they had received, which indicated kind and caring staff.
- Women told us they had a named midwife. They felt well supported and cared for by staff and said their care was delivered in a professional way. One said that she had received a lot of emotional support when she was anxious or upset.
- Comments from women included “The nurse at triage... and the doctors were absolutely fantastic” and “I felt really well looked after. The consultant took my history into account and I had confidence in the team”. Other

comments were “The staff are brilliant and answer all your questions – or will come back to you with an answer. Pain relief is provided as needed and the midwives address you by name” and “I felt fully supported throughout my pregnancy. Ante-natal appointments were on time and the care here (in hospital) was excellent and the delivery room was really spacious. I’ve had a really good experience”. One partner of a patient stated “She felt respected and no-one is abrupt”.

- Women were very complimentary about the breast feeding midwives who were described as helpful, patient and supportive. They reported that they spent a lot of one to one time with them and were patient when teaching and explaining things to patients, which was reassuring and helpful.
- A few women felt that staff on the postnatal ward were often very busy and had limited time to attend to individual patients although they were apologetic and helpful if they were delayed. One woman commented “They’re nice when they’re there”, while another said, “The midwives are supportive but busy – they do their best”.
- A patient on the gynaecology ward told us the care and treatment received had been very good with sensitive and supportive care. She said the consultant had explained her procedure clearly and outlined the risks involved.
- Women told us that staff took time to ensure they protected the dignity and privacy of women in all areas of the service, including gynaecology inpatients and this was confirmed by observation. We observed midwives, nurses and doctors protecting the privacy of women by knocking before they entered rooms and not opening doors and curtains any wider than necessary. When we asked to speak to a gynaecological patient on the surgical ward the attending junior doctor sought the consent of women first.
- Results of the trust’s Maternity Friends and Family Test for the 12 months to November 2016 showed that an average of 98% of women would recommend the antenatal care provided by the trust which was the same as the national average. The figure for birth

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performance was 97%, the postnatal ward experience figure was 96%, and postnatal community performance figure was 98% (with a national average of 98% for all these three measures).

- The CQC patient survey for maternity services published in December 2015 indicated that the trust performed about the same as other trusts across all 16 indicators, including being kind and understanding, being treated with respect and dignity and for having confidence and trust in the staff caring for them during labour and birth.
- We saw a recent survey of 246 colposcopy clinic patients and 84% reported that their overall experience of the clinic was good or excellent. The trust's Maternity Friends and Family Test results for gynaecology patients over the six months to March 2017 showed that 89% of women would recommend the care received by the trust.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. This was especially the case for women who had a complicated pregnancy, for example those who had diabetes, hypertension or were at risk of pre-term birth. Women we spoke with said they were well informed and involved in their care; they understood the choices open to them and were given options of where and when to have their baby safely.
- Staff said that they discussed birth options at booking and during the antenatal period. Supervisors of Midwives and the consultant team were involved in agreeing plans of care for women making choices outside of recommended guidance, for example requesting homebirth with either a current or previous high risk pregnancy. The team focused on supporting women's choices of birth while ensuring they were making fully informed choices.

Emotional support

- There were effective arrangements in the service for supporting those who had suffered bereavement due to fetal loss at any stage in pregnancy. There was a dedicated bereavement midwife who helped women and their families with emotional and practical support in the period following the loss. The service did not have

a counselling service but the bereavement midwife provided information on local counselling services and helped to make initial appointments. The bereavement midwife also provided emotional support for patients from the early pregnancy unit who had suffered a loss and those who had had a late miscarriage or termination of pregnancy.

- An HIV specialist psychologist was available and a cognitive behavioural therapist provided one-to-one support for patients as well as training for nurses to enable them to provide emotional and psychological support.

Are maternity and gynaecology services responsive?

Good



We rated responsive as good. This was because:

- In most respects the maternity service was responsive to the needs of women and their families, with access to investigation, assessment, treatment and care throughout their pregnancy.
- Where women had additional healthcare-related needs, there was access to specialist support and expertise. Specialist teams supported vulnerable or young pregnant women, those with alcohol and drug addictions and women with mental health issues.
- We found excellent partnership working between hospital and community services to support women and improve care pathways.
- The maternity service monitored staffing and bed capacity on a continuous basis and had a system which could respond effectively to fluctuations in demand.
- The service was working to maximise the use of the birth centre, increase opportunities for home birth and decrease the rate of caesarean sections through care planning and risk identification.
- People could raise concerns and complaints and be confident these would be investigated and responded to appropriately.
- Staff in the Trafalgar Clinic provided 'fast track' services for certain patients, including those under the age of 18

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and those at risk of Hepatitis C. This service also provided a wide range of health promotion and risk reduction support and strategies to meet the needs of the local population.

- Each patient booked for an appointment in the Trafalgar Clinic received a text message reminder in advance that also offered them the opportunity to reschedule if this was no longer convenient.
- Staff in the Trafalgar Clinic demonstrated how they actively worked to reduce stigma around HIV to help improve the experience of their patients and provide a holistic service that met social needs as well as clinical needs.
- The location of gynaecology clinics, inpatients and the early pregnancy unit were not sensitive to the needs of some patients, such as those suffering miscarriage or termination of pregnancy as they were next to areas providing antenatal care.
- Some women in the early pregnancy unit reported that they experienced long waits to be seen.

Service planning and delivery to meet the needs of local people

- The Queen Elizabeth Hospital is located in an area of high deprivation. Staff in focus groups reported that people using the service came from a diverse community with many women who were vulnerable or with complex needs.
- The service had strong links with local and regional commissioners of services, local authorities, GPs and patients to coordinate and integrate pathways of care that met the needs of the total population. There was evidence of developing cross site working with the University Hospital Lewisham to manage fluctuations in demand and share the resourcing of specialist services.
- There was evidence of well-defined pathways which took account of local needs. Women were offered flexibility of choice in how their care was delivered, such as a midwife-led home birth for uncomplicated pregnancies or an obstetric-led delivery in the maternity unit, while providing for those that needed specialist support.
- There were specialist clinics such as diabetes, HIV, smoking cessation or the Pregnancy Plus clinics for

women with a high BMI. There was a clinic for those women who previously had a caesarean section but who wished for a vaginal delivery (VBAC) which was run by an experienced midwife.

- There were rapid access clinics for gynaecology patients requiring oncology referrals and specialist clinics for colposcopy and hysteroscopy.
- The service had specialist midwives to meet the needs of local women such as midwives for mental health, fetal medicine and infant feeding. The Best Beginnings team worked in partnership with other agencies to safeguard and improve outcomes for vulnerable women.
- Community midwifery teams reflected specialist support offered by the service with specialist leads linked to those at the hospital and community initiatives such as the 'Active Mothers' programme for those with a raised BMI.
- There were links on the trust maternity website to the Maternity Services Liaison Committee (MLSC) which worked with parents and local healthcare providers to take account of the views and experiences of pregnant women and improve maternity services. There were a series of DVDs called 'Women's Stories' which reflected patient experiences which were used to enhance mandatory training for staff.
- There was a 'Call the Midwife' mobile number which women could use to register their pregnancy without having to see a GP to encourage early booking of antenatal care and there was an on-line self-referral form on the maternity website. There was also a maternity helpline available during weekdays for queries. We saw a report on the maternity helpline for 2016 which analysed the volume and type of calls received with recommendations for improvements and developments to this service.
- Due to a change in commissioning intentions, sexual health and HIV services provided in the Trafalgar Clinic had been restructured. This meant there were fewer genitourinary medicine appointments in the clinic, which now focused on complex HIV care. Where patients were unaware of this and attended a walk-in clinic for sexual health screening, staff redirected them to the

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nearest appropriate service. This also meant that patients who were symptomatic of a sexually transmitted infection who walked in to the service were redirected to the community service.

- Staff in the Trafalgar Clinic provided an innovative specialist outreach service to patients in a nearby prison. This included HIV testing, treatment and results counselling. This service had resulted in demonstrably improved care for prisoners at risk by detecting previously undiagnosed HIV and ensuring each individual was prescribed appropriate antiretroviral therapy and education sessions.
- The clinical nurse specialist and health advisor roles in the Trafalgar Clinic had been combined to ensure all patients were seen by staff with clinical and health promotion knowledge in relation to their individual needs. In addition, this team had established a wider programme of sexual health and HIV education through partnerships with local schools. For example, the clinic's outreach team identified schools with a need for sexual health education support and offered special clinics for young people to visit the clinic and speak with staff.
- Clinical nurse specialists and healthcare assistants in the Trafalgar Clinic split their time between HIV services and genitourinary medicine services.
- Staff in the Trafalgar Clinic provided 'fast track' services for certain patients. This meant patients who presented with a high risk for specific conditions would be seen by the next available clinician rather than being sequenced into a queue. This included patients who had a risk of Hepatitis C infection and those under 18 years of age.

Meeting people's individual needs

- Choices were available to women deciding where to have their baby. If assessed as low risk, women could choose to have a home birth or attend the midwife-led birth centre. Women assessed as likely to have a higher risk birth, with medical or obstetric complications, would be advised to have a consultant-led hospital birth. There were also guidelines for women whose preferences fell outside trust guidelines, for example requesting a home birth with either a current or previous high risk pregnancy.
- The early pregnancy unit provided specialist scanning and support for women experiencing problems in early

pregnancy. Some patients we spoke with reported long waiting times here, particularly if waiting for transfer to another department. There was no information on display to provide information on waiting times.

- Antenatal clinics for booking were held in local health centres, GP practices or children's centres so women did not have to travel to the hospital for appointments.
- Vulnerable women were referred to the specialist midwives in the Best Beginnings team who could provide greater expertise and had more time to spend with individual women.
- The service also provided specialist midwife clinics for women requiring specialist care, such as VBAC clinics, those having multiple births, clinics for teenage mothers and those with problems of substance or alcohol misuse.
- Women whose pregnancies had been assessed as low risk and were having their labour induced could choose to initiate this process at home to reduce the amount of time spent in hospital.
- Women had access to information and support throughout their pregnancy. There was a maternity helpline available on weekdays to provide advice and support and an electronic midwife 'Edie' and on-line email service for queries. There were weekly 'Listening Clinics' run by a Supervisor of Midwives to see women who have issues or concerns during pregnancy or in the postnatal period with the option of home visits if required. There were regular 'Pregnancy Evening' and events for prospective parents.
- There was a range of information available on the maternity website including a comprehensive pregnancy booklet and information about events and workshops such as expectant parents' evenings, and a helpline number or email address for queries. There was information on specialist support services available such as the River Clinic for alcohol and substance misuse, support for teenage pregnancy and domestic violence and interpretation services for migrants and asylum seekers.
- Partners were made to feel welcome and involved in the pregnancy, labour and birth. There were leaflets available for fathers and partners covering a wide array of topics relating to pregnancy, birth and becoming a

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parent with useful contacts and links to further information. The service had recently held a series of workshops, 'Whose Shoes', to capture feedback on women's experiences of the service and one of these was dedicated to fathers. There was information for dads and partners on the trust website with information on day courses for new and expectant fathers (The Expectant Fathers' Programme).

- Facilities were available for relatives and partners to stay at the maternity unit. There were reclining chairs available for use in the postnatal ward although women told us that these were limited in number.
- We observed that water jugs in all areas were refreshed regularly and this was confirmed by women we spoke with.
- The maternity day assessment unit was spacious and had seven beds available across two rooms. We were told that the midwife who supported this unit was authorised to prescribe certain medication, such as antibiotics, without referral to the medical team. This freed up space and improved continuity in a busy area.
- The early pregnancy unit provided specialist scanning and support for women experiencing problems in early pregnancy.
- Gynaecology clinics were held next to the early pregnancy unit and antenatal clinics. Decoration in these areas was worn but we were told that refurbishment was planned in the near future as part of a rolling program. There was no dedicated ward for gynaecological inpatients and these women were cared for on general surgical wards. This included women who had late miscarriages or medical termination of pregnancy due to fetal abnormality. They may have been cared for in rooms in the maternity unit at times of high capacity.
- Gynaecology nursing staff told us that patients did not always receive continuity of care in clinics and frequently saw different consultants or doctors.
- We visited one of the wards that cared for gynaecology patients which was crowded with little space between beds. Gynaecology patients were placed next to other surgical patients and there was little opportunity for privacy although we were told that there were side rooms that could be utilised if available.
- We were told that equipment was not always readily available for patients on this ward, for example breast pumps.
- The review of the service in January and February 2017 by the Royal College of Obstetricians and Gynaecologists commented on the 'inappropriate environment in gynaecology outpatients...' and the lack of facilities for women to discuss outcomes in privacy.
- There was a dedicated room for bereaved families (Jade's room), supported by charitable donations. This was a light and airy self-contained room with a double bed, seating area, tea and coffee making facilities and an en-suite toilet and shower room. This was separate to the other areas in the maternity unit to maintain a sympathetic and quiet environment. There were also 'cuddle cots' and cold cots used for babies that had died so that parents could spend time with them quietly either in Jade's room or the Dove room (a smaller room in the main unit).
- The service offered memory boxes and a photography service, 'Remember My Baby', who staff reported as flexible and sensitive, to take photos that would provide positive memories for bereaved parents.
- Butterfly stickers were used on the doors of rooms occupied by bereaved parents to alert staff and ensure sensitivity. The butterfly symbol was also used on patient records for future reference.
- There was access to interpreters when required (although the unit asked that this was booked in advance) but a translation language line was also available if needed for those who had not pre-booked. We saw several women who required the use of translation services.
- The maternity service worked with an independent company to offer women the chance to harvest and store stem cells for a fee.
- Staff in the Trafalgar Clinic were able to provide care and screening services for patients with learning disabilities, with support from senior nurses and consultants. For example, staff had developed a communication strategy with a patient who could not communicate verbally using written communication tools.
- A member of the Trafalgar Clinic team was qualified in British Sign Language and could interpret for patients

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on-demand and in pre-booked appointments. Where a patient attended a walk-in appointment and spoke limited English, staff took as much of a sexual history as they could and used a telephone interpreting service if needed. In each case the patient was re-booked and a translator booked to attend with them. This ensured interpretation services matched the level of risk and need of each patient.

- The Trafalgar Clinic included a general waiting area and gender-specific waiting areas that we noted reception staff offer to each patient. Male and female waiting areas contained health promotion material specific to each gender. This meant patients could access information relating to sexual health, HIV and related areas in an environment that catered to them more specifically than a general waiting area.
- Staff in the Trafalgar Clinic demonstrated how they actively worked to reduce stigma around HIV to help improve the experience of their patients and provide a holistic service that met social needs as well as clinical needs.
- Patients could access information relating to sexual health, HIV and related areas in an environment that catered to them more specifically than a general waiting area.

Access and flow

- The trust had higher than average bed occupancy levels compared to England overall with rates between 75% and 90% over the past two years compared to the England average of 61%.
- Women were able to access the service in a timely way when booking for their first appointment. From February 2016 to January 2017, the service achieved between 83% and 89% of bookings appointments before 12 weeks and six days gestation which was below the target of 90%. The rates for booking appointments by 10 weeks gestation were between 43% and 56% for the same period with the target of 50% being achieved or exceeded for 7 months out of 12.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as necessary. The midwives were available on call, 24

hours a day for home births as needed. Community midwives were on call for delivery suite cover if it was busy and there were cross site arrangements to provide extra resource if needed.

- The service used a 'live' capacity document which was updated every eight hours to reflect the workload and staffing levels in each area of the department along with patient status and risks. The capacity document showed a colour coded overall status for the department (green on the day of our visit) and a contingency plan showing changes or redeployment of staff where needed. This meant that there was flexibility to provide the right level of care to women in a timely way with appropriate allocation of staff.
- Women had access to the day assessment unit and maternity triage service seven days a week for assessment or emergencies during pregnancy. The early pregnancy unit was not open at weekends (although this will be increased to a six day service).
- We spoke to women in the early pregnancy unit who told us that they had experienced long waits to be seen, even when in pain. One woman told us that she had waited for six hours when she presented for her first appointment.
- The area used for antenatal clinics during the week were used by community midwives for some postnatal follow up appointments at weekend or pregnancy booking appointments to provide additional access.
- The Divisional Director told us that gynaecology oncology targets were not always met due to lack of consultant cover and that an action plan had been developed to address this with additional staffing levels agreed.
- We observed that the lack of dedicated antenatal beds meant that the unit needed to use beds on the postnatal ward for these patients, although there were side rooms which could be used. On the days of our visit we observed that the unit was busy but still had enough capacity. The midwife-led birth centre was close to the delivery suite which made for easy escalation and the doctors on the delivery suite were able to attend a woman on the midwife-led unit if the need arose.
- The service was achieving an average two day length of stay for normal, non-elective deliveries. Women were

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discharged home directly from the midwife-led unit if possible. The service was now offering outpatient induction of labour and examination of the new-born was available to women after they had been discharged from hospital. This helped to maintain access and flow.

- Each patient booked for an appointment in the Trafalgar Clinic received a text message reminder in advance that also offered them the opportunity to reschedule if this was no longer convenient. The system was linked to the electronic patient records system and was implemented to reduce the number of wasted appointments due to patients not attending and not cancelling in advance.

Learning from complaints and concerns

- We saw the complaints policy and details about how to make a complaint were displayed on notice boards. Leaflets were available in clinics and on the wards. We also saw details of the how to contact the Patient Advice and Liaison Services (PALS).
- The number of complaints received were recorded monthly on the maternity scorecard. There were 40 complaints received by the department between February 2016 and January 2017 which equated to just over three complaints a month. On average just under half had been responded to within 18 days.
- Department heads told us that there were implementation plans for a quarterly review of complaints which would be consultant-led and involve feedback from the MSLC to look at themes and how to ensure a better response.
- Complaints were discussed at risk and governance meetings and escalated to board level where necessary. We saw documentation for five recent complaints to the maternity service and saw that these had been responded to in a comprehensive, timely and appropriate manner. In each case there was a detailed review of the circumstances surrounding the complaint, evidence of investigation with a clear summary of outcomes and the duty of candour appropriately applied.
- Outcomes and learning from complaints were shared with staff through newsletters and at the daily Just Take 5 meetings. We saw recent gynaecology directorate clinical governance newsletters which reviewed recent

complaints, outlining key issues and lessons learned. We also saw documentation on recent gynaecology complaints summarising outcomes, actions and learning from individual complaints.

- Staff at interviews and focus groups confirmed that the service was good at feeding back learning from complaints.
- There was evidence services worked together to resolve complaints. For example, staff in outpatients, the Trafalgar Clinic and the respiratory ward worked together when a patient inadvertently received an incorrect HIV test result sent by their GP. Investigating staff found this occurred due to a lack of communication protocol between the laboratories, the clinical team who ordered the test and the patient's GP. As a result all services involved declared a joint serious incident and worked with the laboratory to establish testing and communication protocols to ensure only final, accurate results were sent out. The investigating team involved the patient's GP in this to ensure knowledge was more widely shared.

Are maternity and gynaecology services well-led?

Good



We rated well led as good. This was because:

- There was evidence of some outstanding practice in maternity services. There was a strong, cohesive senior leadership team who understood the challenges of providing high quality care and managing increasing demand. This was particularly apparent in the planned increase in cross site collaboration, community initiatives and the development of specialist care for those at risk.
- Governance arrangements were embedded at all levels of the service and enabled the effective identification and monitoring of risks and the review of progress on improvement action plans. Regular robust detailed reporting at departmental and board level enabled senior managers to be aware of performance.
- A positive culture of openness and candour with a collective responsibility for quality, safety and service

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improvement was evident. Public and staff engagement was seen as an integral part of service development and the views patients and staff were actively sought using innovative and inclusive approaches.

- Staff of all levels and experience were encouraged to submit ideas and were empowered to develop and implement solutions to provide a high-quality service.
- Staff were overwhelmingly positive about working in the trust and were proud of the services they were able to deliver to women and their families.
- Staff felt valued as part of a team and they understood and shared the trust's vision to provide high quality service in the face of increasing demand.
- Staff in the Trafalgar Clinic spoke highly of their local leadership.
- The speech and language therapy and Trafalgar Clinic teams had developed a significant research portfolio. This led to opportunities for professional development for staff as well as improved outcomes for patients, including through better nutrition and better one-to-one support for patients recently diagnosed with HIV.

However:

- Gynaecology services were less cohesive with less evidence of collaborative working or innovative strategies.

There was a lack of integrated guidelines across QEH and UHL and cross site working among consultant staff.

Leadership of service

- We observed a strong, cohesive and committed leadership team within the maternity service who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in discussions with department heads, managers and matrons who demonstrated an enthusiastic and proactive approach to developing the service, improving outcomes and managing and motivating staff. We observed that consultants and junior doctors communicated well with midwifery staff informally and at handover meetings.
- The Head of Midwifery (HOM), the deputy and senior staff were visible and had a good awareness of activity

within the service during the inspection. Staff we spoke with said the HOM, matrons and other senior staff were always visible and accessible and worked clinically if needed. All staff, including those working in the community, were clear about who their manager was and who members of the senior team were.

- Midwifery staff we spoke with demonstrated a high level of motivation and commitment to the job with a strong sense of collaborative teamwork. They informed us that they felt valued and well supported as part of the team and said that there was an inclusive approach to management with input encouraged at all levels, regardless of grade.
- Midwifery staff reported that there were reliable systems of support and communication with effective feedback on incidents, complaints, service developments and shared learning. One midwife commented "They (midwifery managers) are fantastic, very knowledgeable and support you in your clinical decisions", while another reported
- Midwives across the service told us that suggestions and new ideas were invited with opportunities to develop initiatives, audit and feedback. One midwife told us that they had recently been encouraged to undertake a risk audit which they were to present at management level.

There was a new system of support for newly qualified staff and students with a dedicated Preceptor Support Midwife in post from 2016. We were told that this had been introduced to address staff turnover issues and had been very successful in encouraging staff retention after qualification and attracting new midwives from the local area.

- The consultants at QEH tended to work across the other sites whereas consultants at University Hospital Lewisham (UHL) worked solely on that site.
- The review by the Royal College of Obstetricians and Gynaecologists, January and February 2017, found that efforts had been made to improve cross site working and that there were good working relationships between consultants at each hospital. However, more work was required to integrate working practices/ guidelines and improve cross site working.

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- A head of nursing for women's and sexual health was supported by an HIV and genitourinary medicine matron to deliver services in the Trafalgar Clinic along with a consultant clinical lead.

Vision and strategy for this service

- The trust had a clear vision for maternity and gynaecology neonatal services. The strategy recognised the increase in demand on the maternity service and incorporated plans for increased staffing, multidisciplinary and cross site working, as well as a range of initiatives to improve operational efficiency, clinical outcomes and patient experience.
- Senior staff we spoke with informed us the views of service users and frontline staff were sought to develop the strategy.
- Divisional managers described the two year transformation action plan which was in line with the Better Births programme. This aim of this was to improve outcomes by delivering continuity of care with more community integration and quality management of women who had higher risk pregnancies or specialist needs.
- The vision and values were displayed throughout the trust. There were banners and posters around the service, created by staff, which highlighting key values embraced by the service including team work, communication, sharing learning and celebrating success.
- We spoke with a range of staff at all levels who were aware in broad terms of the trust's vision and strategy. They were able to state clear examples of initiatives and programmes that were being developed to help deliver these.
- In the focus group midwives talked about new initiatives and improved models of care which were designed to offer flexibility and quality patient care.
- A member of staff in the Trafalgar Clinic said, "I think we are side-lined here [by the trust], I don't feel that they think we're important. They're planning to knock down our building but we don't even know if we'll be part of the main hospital when they re-open us'.

- Sexual health, HIV and genito-urinary medicine services staff had established their own set of values, which were prominently displayed in a public area. This demonstrated the service standards patients could expect and the values staff worked to.

Governance, risk management and quality Measurement

- There was a well-defined governance and risk management structure. There were clear processes for reporting, monitoring and responding to risk. There were monthly risk and governance meetings with directorate and clinical leads for maternity and gynaecology to discuss risk management as well as weekly maternity concerns meetings.
- We saw the minutes of recent governance board meetings which were attended by senior staff, including consultants. Minutes were well documented, and items covered included a review of clinical and national audit programmes, the gynaecological cancer action plan and a review of the risk register. There was a governance board action log with details of required actions, expected outcomes and named responsibilities. This demonstrated an open risk management approach to matters related to quality, safety and performance. Wider service trends and alerts were also tracked at board level.
- There were specialist midwives leading on patient risk with high risk pregnancies overseen by the consultant midwife and a specialist midwife to manage safeguarding concerns.
- The quality and safety committee met monthly to monitor safety and risk throughout the service. We reviewed meeting minutes and found focused and detailed discussions with clear outcomes and actions.
- We saw the maternity and gynaecology services had a comprehensive register of risks. There were eight risks recorded on the maternity risk register and four on the gynaecology register. Risks were graded and action or treatment plans put in place to mitigate where possible. The risks were dated and reviewed regularly with a named risk 'owner' and details of progress on closed risks which had been addressed. Current risks included

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lack of clinical space and staffing in the early pregnancy unit, failure to meet the gynaecology cancer standards and the risk of loss of historic clinical data due to lack of compatibility between old and new IT systems.

- There were weekly multidisciplinary risk and governance meetings where risks were discussed and escalated if needed. We saw the minutes of recent Maternity Multidisciplinary Risk Group meetings which were well documented and covered issues such as incidents and complaints, issues flagged as red on the maternity scorecard requiring escalation and issues on the risk register. We also saw that there was a log of risk issues and action logs. Insufficient theatre capacity had been recently logged as a risk for gynaecology patients. Action logs were reviewed at risk group meetings to address any outstanding actions.
- Performance and outcome data was reported monthly through the maternity scorecard. This was a dashboard system to monitor patient outcomes and risks, using a red, amber and green rating system. This system prompted a performance escalation report if outcomes fell below target and indicators turned red. We saw the latest escalation report with commentary and action points for red indicators, for example the caesarean action plan had been updated to include data on rates within certain ethnic groups.
- We found there were effective systems for learning from incidents, sharing the learning and implementing change across the service. Complaints were used as an opportunity for learning and service improvement.
- The Head of Midwifery (HOM), the deputy and senior staff were visible and had a good awareness of activity within the service during the inspection. Staff we spoke with said the HOM, matrons and other senior staff were always visible and accessible and worked clinically if needed. All staff, including those working in the community, were clear about who their manager was and who members of the senior team were.
- Staff we spoke with demonstrated a high level of motivation and commitment to the job with a strong sense of collaborative teamwork. They informed us that they felt valued and well supported as part of the team and said that there was an inclusive approach to management with input encouraged at all levels, regardless of grade.
- Midwifery staff reported that there were reliable systems of support and communication with effective feedback on incidents, complaints, service developments and shared learning. One midwife commented “They (midwifery managers) are fantastic, very knowledgeable and support you in your clinical decisions”, while another reported
- Midwives across the service told us that suggestions and new ideas were invited with opportunities to develop initiatives, audit and feedback. One midwife told us that they had recently been encouraged to undertake a risk audit which they were to present at management level.
- There was a new system of support for newly qualified staff and students with a dedicated Preceptor Support Midwife in post from 2016. We were told that this had been introduced to address staff turnover issues and had been very successful in encouraging staff retention after qualification and attracting new midwives from the local area.
- The highest risk for the Trafalgar Clinic related to pathology results and the incompatibility with patient records and laboratory results systems. A new electronic patient records system had been introduced in February 2017 that enabled clinical staff to link with the laboratory and view results instantly. This system also ensured timely communication with patients, with a standard turnaround time of four days for the results of an HIV test. This significantly reduced the risk of delayed or misplaced pathology results.
- In sexual health clinical governance and risk management strategies were in place for research studies and clinical trials. This included research meetings in the Trafalgar Clinic led by three coordinators and with consultant input to ensure staff were prepared and familiar with each trial before taking part. This was in addition to monthly meetings in this unit that involved the whole team.
- Staff in the Trafalgar Clinic had identified areas for improvement in how information was shared. For example, they had recently implemented new guidance for the screening of tuberculosis and molecular testing for syphilis. Although this had been discussed in a governance meeting, the senior team felt it could be more broadly disseminated and planned to introduce

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wider a communication strategy to achieve this. Senior teams used monthly directorate meetings to disseminate new information and national guidance to colleagues

- Staff in the Trafalgar Clinic staff told us team meetings were monthly and were held at a time everyone could attend. This meant departmental and ward-based teams met to discuss risks on a regular basis. For example, the Trafalgar Clinic team had identified IT as the greatest risk to the service.
- HIV specialist services staff met quarterly across all trust sites to discuss anti-viral strategies and work.

Culture within the service

- An open, transparent culture was evident during our inspection. Staff we interviewed said they could raise concerns and queries with senior staff who were accessible and sympathetic and they felt involved well informed about changes and developments in the service. Staff were aware of plans for more cross-site collaboration and integration with community services and other health care professionals.
- Staff in maternity and gynaecology were proud of the quality of care they delivered and were striving to offer a good experience for patients, despite the increase in demand on the service. We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles.
- We spoke with newly qualified and student midwives who felt fully supported through the induction programme and senior staff were eager to support them through the process.
- All staff we spoke to spoke of good team work and had a positive 'can do' approach within a friendly and supportive environment.
- Staff in sexual health services were empowered to self-manage how they engaged with governance and leadership. For example, each individual was able to choose which training sessions and meetings they attended in line with their professional and clinical needs. The senior team communicated which training sessions and meetings were mandatory so that the whole team had a baseline level of engagement and knowledge.

- It was not always evident the trust was able to ensure staff health, safety and welfare in all areas. For example, the laboratory in the Trafalgar Clinic had a glass roof that meant it was difficult to control the temperature. Staff we spoke with said in the summer they experienced dry skin, migraines and headaches as a result of the excessive heat.
- We spoke with a healthcare assistant who had worked in six different areas of the hospital. They said, "I have really been supported to gain all of this experience and think every team has been welcoming." The member of staff was based in the Trafalgar Clinic at the time of our inspection and described the working culture as, "welcoming and supportive."
- Senior staff in the Trafalgar Clinic we spoke with did not always feel that the trust provided an equitable or fair system for service development and sustainability. The senior consultant and leadership team had submitted business cases on five occasions for a new electronic patient records system that would improve patient documentation. A member of staff said the trust had declined each application without clear reasoning or feedback and said they were unaware of a process of escalation or appeal. They said, "There were repeated missed opportunities to support innovation and strategies to support patient care." The service ultimately implemented a new electronic system by using funding from private research.

Public engagement

- The service actively sought the views of women and their families. There had been three 'Whose Shoes' workshops, including one for fathers, which aimed to capture user experiences of the service and improve delivery of care. Participants in the workshops used case scenarios to express opinions on care and develop themes. There was an illustrative board on display in one of the corridors in the unit to represent feedback on the workshops and the deputy HOM told us that the service had responded by adjusting some of the clinical terminology used during pregnancy and childbirth so that it was less threatening and more positive and empowering for women.
- There was a good working relationship with the local MSLC and there were links to this on the trust website so that women and their partners could provide input on

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their experiences and make suggestions. We saw minutes of regular MSLC meetings which were attended by representatives from local health services, patient groups and departmental staff.

- There was also engagement with the public via the dedicated maternity website, social media and patient surveys including the Friends and Family Test, feedback links on the website and the national maternity survey.
- The service runs a maternity star campaign where women and their families who have used the service are asked to nominate members of the maternity staff who have provided excellent care. Each month a nominated member of staff receives the Maternity Star award recognising their achievements and celebrating the care they have provided.
- The maternity service has recently been the recipient of an array of public awards from professional bodies including the Royal College of Midwives (RCM) Midwifery Service of the Year award in 2016, RCM Public Health Award, Midwife Supervisor the Year and Student Midwife of the Year.

Staff engagement

- We saw the results for the latest staff survey for gynaecology and maternity staff and saw that over 90% were satisfied with the support they received from colleagues, felt able to ask for help when needed, understood their responsibilities and felt sufficiently trained. Over 80% said they had pride in their work and felt able to make suggestions. However half of maternity staff and 58% of gynaecology staff reported that they didn't have sufficient time to perform their allotted tasks.
- Staff in focus groups and in individual interviews said they felt engaged in decision making. Midwives told us that a new suggestion box for staff feedback had been introduced on the ward with green and red slips to indicate positive or negative experiences, which would be evaluated on a weekly basis.
- The service had recently held three staff wellbeing days organised with the MSLC offering massage, reflexology, cakes and smoothies provided by previous patients and volunteers as a 'thank' you' to staff.

- The trust had signed up to the RCN 'Caring for You' campaign which was developed to improve the workplace for staff. It also aimed to eradicate any negative culture such as bullying or harassment (no staff voiced any concern in this respect).
- Staff told us they felt engaged in improvement projects and departmental initiative such as 'Sign up to Safety' and new guidelines for fetal monitoring and vaginal birth after caesarean.
- We saw evidence of documentation from a range of staff meetings such as senior staff, community midwives, managers and regular labour ward forums to discuss the working of the department.
- We saw examples of newsletters, emails and bulletins to inform staff of service developments and changes and a monthly risk newsletter so that staff were up-to-date and engaged.
- Sexual health services had experienced significant change in structure and staffing. We spoke with staff about this who told us they had been offered human resources (HR) support during this time but felt this had not met their needs. For example, one member of the team said, "I felt HR kept things to themselves and weren't open and honest with us. We're a close team here and they should've recognised the impact [the changes] were having on us."
- Staff in the Trafalgar Clinic told us they had not been fully consulted on trust plans to relocate the service. One member of the team said, "We've been told we're moving but we don't know when or where. We're worried we'll be moved far away or lose our jobs and it's causing a lot of anxiety that [the trust] don't seem to have recognised." One member of staff said the head of nursing had provided some reassurance but this was not reflected by all staff in the clinic and it was clear there were significant differences in understanding and feelings of involvement within the team. We spoke with a senior clinical member of staff about this who said the trust had recognised the lack of consultation and had begun encouraging staff to be more involved. In addition staff had been offered mindfulness and transitions training to help them with the changes. After our inspection we asked the trust about this. They told us the Chairperson had visited the Trafalgar Clinic to present the start of redevelopment plans that were to

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be implemented to increase capacity and create a more welcoming environment for patients and a more professional environment for staff. This would include dedicated space for research. We were not able to find out the reasons for the differences in understanding and involvement in the planned developments.

- Some non-clinical staff in the Trafalgar Clinic did not feel valued or recognised by the trust because of disparities in their benefits and conditions compared with other sites in the trust. For example, one member of staff said, “We work just as hard as our colleagues at the trust’s Lewisham site; I don’t understand why we get paid less. It does not make us feel like we’re valued here. The trust know how we feel but haven’t done anything.” After our inspection we asked the trust about this. They told us the agenda for change team was aware of the issues and worked with staff to find a solution where possible.







Innovation, improvement and sustainability

- Continual improvement was a constant theme in the service and we saw a number of recent innovations. The Sign up to Safety project was designed to enhance effectiveness in fetal monitoring. The service had developed and launched new guidelines and had provided training and reference guides for staff. The maternity unit had installed central monitoring screens on the labour ward to provide more continuous scrutiny.
- There was evidence of a move towards more cross-site working such as a new consultant midwife post designed to span both hospital sites. There were a number of community initiatives to encourage more integration and multidisciplinary working, such as obstetric-led community clinics, MDT study days with ambulance services and other health professionals and joint community and hospital midwife training in alternative birth methods such as hypnobirthing.
- The maternity service reported a number of successful bids for charitable funds which had raised money for a number of service improvements such as TV screens, wallets for hand-held notes, improved teaching aids for community teams and funding for dad’s and partner’s workshops and brochures.
- There were new research projects planned for 2017 including the Phoenix Study to investigate the

management of pre-eclampsia, C Stich to consider choice of material used for cervical suture and Babbles to study how women use social media. There was also planned research by the Poppies team to study whether continuity of carer improves outcomes for those women at risk of pre-term birth.

- As a result of an annual ‘grand round’, consultants in the Trafalgar Clinic identified the need for more consistent and proactive HIV testing in medical care services. Discussions were taking place between consultants in each area to embed point of care testing in admissions processes. In addition, consultants in the emergency department were working with HIV consultants to scope point of care testing for all medical admissions seen there in line with NICE national guidance 60, in relation to national best practice in improving uptake of HIV testing to reduce the prevalence of undiagnosed HIV.
- Staff in the Trafalgar Clinic had implemented new equipment with the laboratory to implement a 24-hour turnaround time for syphilis testing that was more accurate than existing equipment. This meant patients received more accurate testing and faster results.
- In the two years to our inspection, sexual health and HIV services recruited up to 50% of the participants for the trust’s whole clinical trial and research portfolio. This resulted from a policy of proactive and early-adoption participation that was part of a two-year strategy to improve participation in research in other hospital departments and services. At the time of our inspection this service was involved in nine clinical trials. The clinical director ensured nurses and foundation level doctors were included in research and clinical trials as far as possible to build clinical competence and skills. Trials included National Institute for Health and Care Excellence observational studies, a pelvic inflammatory disease clinical trial and research in patients beginning HIV therapy. The clinical lead planned research participation to represent a balanced portfolio that reflected the needs of the clinic’s patient group to ensure results had the potential to benefit their care and treatment. This included participation in a south London physician research network to benchmark research practices and maintains capacity and clinical expertise.

Services for children and young people

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

Information about the service

Lewisham and Greenwich NHS Trust provide services for children and young people at two acute hospitals; Queen Elizabeth Hospital, Greenwich within this report and University Hospital Lewisham, which has a separate report.

Some of the data that we have is data that includes both hospitals and, where this is the case we have referred to it as Trust data.

Lewisham and Greenwich NHS Trust provide services for a population of over 150,000 children and young people aged 0-17 living in Lewisham, Greenwich and North Bexley. The catchment population comes from two of the most deprived boroughs in England, many of whom are vulnerable with significant health needs.

The services for children and young people include diagnostic, treatment and care facilities for children and young people from birth to 16 years of age. The needs of young people aged 16 to 18 years of age are considered on an individual basis with most being admitted to adult facilities within the hospital. Where a young person has particular needs, such as a learning disability or a life limiting condition may be admitted to the children's unit if more appropriate.

Between April 2015 and March 2016, there were 17,841 admissions to the children and young people services at the trust.

The hospital is a specialist centre for children with cancer on a shared pathway.

Children's and young people's services at Queen Elizabeth Hospital consist of two inpatient wards, Safari; a general paediatric ward and Tiger; a specialist paediatric oncology shared care unit. There is a level two neonatal intensive care unit, a dedicated children's outpatient centre (Dolphin Ward) and Hippo ward, which is a paediatric assessment unit open daily providing a range of different services.

The children's emergency department at Queen Elizabeth Hospital is managed as part of the emergency services division and was inspected and reported on as part of the emergency and urgent care core service.

The service was last inspected in 2014. We rated 'safe as inadequate and 'well led' as requires improvement however we rated 'caring' and 'responsive', as good on our previous inspection. 'Effective' was not rated. This gave the service an overall rating of Requires Improvement. We rated safe as inadequate because not all staff grades could report incidents, there was a lack of joint working across the two hospital sites, there were significant staff shortages impacting on the quality of care and there was a shortage of some equipment. We rated well led as requires improvement as capacity management was unclear and there was limited involvement in care plans.

During our inspection, we visited all clinical areas including ward areas, the neonatal unit, and the Dolphin outpatients department. We spoke with 10 parents, four young people, and over 30 members of staff, including a clinical director, doctors, nursing staff, a non-clinical support worker, and administrators.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits provided

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by the trust and observed handovers between the paediatric nursing and medical staff. We inspected ten sets of medical records, nine prescription charts and the environment and equipment.

Summary of findings

At our previous inspection in 2014, we rated the services for children and young people overall as requires improvement. On this inspection, we have maintained the overall rating as requires improvement, as the overall standard and quality of care has not changed. However there were improvements in the safe domain from inadequate to requires improvement and the responsive domain from requires improvement to good.

We rated this service as requires improvement because:

- The neonatal unit (NNU) did not meet national guidelines for staffing. An additional 12 nurses were required in order to meet the demand on the unit.
- The increase in births at the hospital had not led to an increase in neonatal cot provision. This meant that there were occasions when the unit exceeded its funded capacity.
- The lack of specialist neonatal consultants meant that there was little continuity of support for patients and staff on the unit.
- The hospital did not meet national guidelines for paediatric consultant cover. There was only one consultant on call out of hours; this meant they were frequently disturbed which caused fatigue for the next day.
- Some children experienced a delay in having clinical observations taken, due to the pathway that existed between the emergency department and Hippo Paediatric Assessment Unit (PAU).
- Nursing staff on Hippo PAU often worked over their hours, leading to a risk of fatigue despite the senior management team having acknowledged that this was an issue six months prior to our inspection.
- Mandatory training levels for medical staff were low.
- There were very few clinical nurse specialists employed to support specific services. For example, there was no epilepsy clinical nurse specialist employed at the hospital despite a large case load of patients.
- There had been a significant reduction in the number of play specialists and this reduced the availability of this service for patient support.

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- The operating arrangements for the Hippo PAU meant that some patients would have to return to the emergency department when it closed. This could result in a prolonged stay prior to admission and a poor patient experience.
- The risk register and issues log did not reflect concerns that we identified during the inspection.
- A disconnection between senior managers and doctors meant that little progress had been made in adaptation of working structures in three years since the need had been identified.
- There were low levels of attendance at quality and safety boards which reduced opportunities for sharing of information to the appropriate people.
- There were extremely low responses to the Dolphin outpatients department (OPD) friends and family test.

However;

- There was clear evidence of learning from incidents and concerns, for example changes made to the breast milk storage process following an incident.
 - All areas were clean and the hospital demonstrated a high regard for infection and control procedures, such as the implementation of specialist hand sanitiser dispensers on the doorways to the neonatal unit and oncology ward.
 - The unit encouraged breastfeeding mothers to express milk next to their babies' cot. This was introduced following research published which showed clear benefits for mothers and babies.
 - A comprehensive audit schedule supported the use of national guidance within local policies and guidelines.
 - There were good links with the oncology shared care network and specialist staff were provided with support and training to maintain their skills.
 - The hospital participated in national audits and reviews for assessing patient outcomes.
 - Patients and parents spoke extremely positively about the care that they received and we observed kind and compassionate care during the inspection.
 - Staff worked hard to facilitate additional fun activities for children so that their stay in hospital would be improved.
- Tiger ward had provided opportunity for parents and patients to meet informally at a coffee morning. This provided additional support to families and also gave a more positive view of the ward for children.
 - In the neonatal unit parents were encouraged to be present when the ward round took place.
 - Parents and patients were informed about the plan for their care in a compassionate and appropriate manner and patients were encouraged to maintain their independence where possible
 - As Tiger Ward was a Level one shared care oncology unit. This meant that children with cancer were able to receive treatment in a hospital closer to home.
 - Changes had been made to pathways which resulted in a decrease of patients attending the PAU, following recommendations of a review.
 - Two 'check-in' machines had been introduced within Dolphin OPD that provided a confidential way of checking patient details and also identified when families might require additional support.
 - There were a low number of formal complaints made about the service and response rates to complaints received were within the agreed timescales.
 - Since the last inspection there had been clear progress in developing cross-site governance structures, risk management and learning.
 - Staff spoke positively about the nurse leadership and reported that they felt able to raise concerns and suggest improvements.
 - Patient feedback was welcomed and the hospital had innovative ways of engaging with patients, such as the involvement of patients in practical exams for staff, held on site and consultation meetings about the future plan for services.
 - Staff had responded promptly to a small fire on Safari ward and evacuated children quickly and safely. This demonstrated that the business continuity plans and training for emergency planning were effective.
 - Staff reported good support for each other across the service. This was demonstrated in the recent fire when staff that were not on duty or had finished their shift came to support their colleagues in providing care.

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Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement because:

- The neonatal unit (NNU) did not meet national guidelines for staffing. An additional 12 nurses were required in order to meet the demand on the unit.
- The lack of specialist neonatal consultants meant that there was little continuity of support for patients and staff on the unit.
- The hospital did not meet national guidelines for paediatric consultant cover and, as there was only one consultant on call out of hours. This meant that the consultant was frequently disturbed out of hours, leading to fatigue for the next working day.
- Some children experienced a delay in having clinical observations taken, due to the pathway that existed between the emergency department and Hippo Paediatric Assessment Unit (PAU)
- Nursing staff on Hippo PAU often worked over their hours, leading to a risk of fatigue despite the senior management team having acknowledged that this was an issue six months prior to our inspection.
- Mandatory training levels for medical staff were low.

However:

- Staff had responded promptly to a small fire on Safari ward and evacuated children quickly and safely. This demonstrated that the business continuity plans and training for emergency planning had been robust.
- There was clear evidence of learning from incidents, such as the changes to the breast milk storage process following an incident.
- All areas were clean and the hospital demonstrated a high regard for good infection and control procedures. Such as the implementation of specialist hand sanitiser dispensers on the doorways to the neonatal unit and oncology ward.

There was regular safeguarding supervision carried out for staff.

Incidents

- There were no never events reported from December 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in children's services which met the reporting criteria set by NHS England between December 2015 and November 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- Queen Elizabeth hospital children's services reported 407 incidents in the year December 2015 to November 2016. Of these, 81 were reported as low harm and 305 as no harm. There were no incidents causing death, serious or moderate harm. In addition there were 21 incidents recorded as a near miss.
- The most common theme of incidents reported in children's services, including the paediatric emergency department, related to infrastructure including staffing and facilities amounted to 21% of incidents reported compared to a trust average of 7%. This was followed by incidents relating to communication (13%) In data of incidents reviewed between August 2016 and January 2017 and most of this category of incidents were related to staffing levels, primarily within the neonatal unit and Hippo paediatric assessment unit (PAU).
- At the last inspection, not all grades of staff had been able to report incidents. However the incident reporting system had been changed and was accessed with an open system on the computers so that all staff, including those on bank and agency were able to report incidents. We spoke with a range of medical and allied health professionals and nursing staff and they were able to describe the incident reporting system. Most staff explained recent incidents and provided examples of how lessons learned were shared, although one member of staff stated that there was no feedback given for incidents.

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- The head of nursing and matron monitored the electronic reporting system closely. They discussed incidents with staff members and shared information on duty and at ward meetings. Ward meetings were held monthly and staff told us that significant events, errors and near misses were discussed. In addition a notice board in the staff room focussed on learning from incidents.
- We saw in the minutes from the clinical governance meetings that incidents were discussed as a standard agenda item.
- The neonatal unit had made changes to the way that breast milk was stored in the fridges and freezers following an incident reported in August 2016 where a baby was given the wrong breast milk. Each mother now had a unique number to identify their milk rather than just a name. No further incidents had occurred since the new system had been implemented.
- Perinatal morbidity and mortality meetings were held in this service on a weekly basis. The meetings were well attended by staff. In addition a trust mortality and morbidity meeting was held monthly that discussed case reviews of all transfers and included outcomes of cases where children had died at other hospitals, following transfer. We saw presentations from three meetings and saw that these included information on outcomes and also clear learning points following the case review
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. We saw records of five incidents occurring within the Trust children's services where duty of candour actions had been undertaken and patients and their families had been told when they were affected by an event where something unexpected or unintentional had happened.
- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data

from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections between December 2015 and November 2016.

Cleanliness, infection control and hygiene

- All areas of the wards and departments we visited appeared to be visibly clean and we saw cleaning being undertaken during our inspection.
- Between February 2016 and February 2017, there had been no Methicillin Resistant Staphylococcus aureus (MRSA) blood stream infections, within children and young people's services at the trust. MRSA is a type of bacterial infection, is resistant to many antibiotics, and has the capability of causing harm to patients.
- Between February 2016 and February 2017, there were no cases of Clostridium difficile (C.diff) within children and young person's services at the trust. C.diff is a type of bacteria, which can infect the bowel and cause diarrhoea.
- We were told babies on the neonatal unit (NNU) were screened on admission for MRSA and then on a weekly basis if they remained in hospital.
- There were sufficient hand washing sinks and alcohol hand sanitising gel within the wards and departments we visited. The Neonatal Unit had a separate hand washing room at the entrance to the ward with a large sink for hand washing.
- Uniquely designed door handles had been installed on the doors to the neonatal unit and tiger ward that automatically delivered the required dose of sanitising hand rub, when somebody pulled open the door. These handles have been shown to significantly increase hand hygiene in patients, staff and visitors. In addition these hand gel delivery systems have been found to be significantly cleaner than a standard door handle.
- We observed that staff cleaned their hands in accordance with the World Health Organisation's (WHO) 'five moments for hand hygiene', and posters on hand washing technique were displayed above sinks. We observed all staff in the wards and departments we visited were 'bare below the elbow'.
- Hand hygiene audits were completed on a monthly basis as one of the 'Saving Lives' audit measures. Results between February 2016 and February 2017 were all above the Trust target of 95%. We saw audit scores

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displayed prominently on the entrance wards and departments. For example, we saw on the entrance to Safari Ward that their most recent hand hygiene compliance was 100%.

- Infection prevention and control (IPC) training was mandatory for all staff groups, and was undertaken yearly. Data provided showed that 85% of paediatric medical staff, 99% of paediatric nursing staff and 85% of additional clinical services had completed their mandatory infection control training. All staff groups had met the trust target of 85% which meant that the trust could be confident most members of the children and young people service were aware of their roles and responsibilities to keep patients safe.
- If children or young people were found to have an infectious condition or had a poor immune system, single side rooms were used to reduce the risk of cross infection. One side room had a toilet and shower en-suite and a further three had their own toilet. We saw signs available to be placed on the doors informing staff and visitors to see the nurse in charge before entering the room. Two side rooms designated for Safari ward were situated within Tiger ward; however staff assured us that no children with infections were accommodated there.
- Staff used personal protective equipment (PPE), such as gloves and aprons when caring for patients. We observed a doctors ward round in the neonatal unit. The doctors involved used PPE appropriately by changing gloves and aprons as well as washing hands in between seeing patients.
- Equipment was identified as being clean by using 'I am clean' labels, which included the date of cleaning. All equipment we checked was found all to be clean and labelled. A checklist we saw in Safari ward clearly showed what equipment was cleaned daily and what was cleaned weekly by staff.
- Weekly cleaning of toys took place and was included on the Safari ward cleaning checklist. In addition staff were reminded to clean toys before returning them to the playroom. A red tub was provided in the dirty utility room which stored toys waiting for cleaning. The play specialist confirmed they regularly check the toys, to ensure they are intact and safe to use.
- All waste bins we saw were foot-operated and clean, waste was separated in different colour bags to signify

different categories of waste. This was in accordance with the HTM 07-01, control of substances hazardous to health (COSHH) and health and safety at work regulations.

- There were multiple information leaflets provided for parents, patients and visitors throughout the departments we visited advising on the importance of good hand hygiene and hand washing technique. A leaflet designed specifically for children was available in the Safari Ward.
- In the CQC children's survey 2014, the trust scored 8.24 out of ten for cleanliness for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Environment and equipment

- The Safari ward, Hippo PAU and the neonatal unit had controlled access on both external doors and to treatment or utility areas. Tiger ward was only accessible through Safari ward. There were signs in place to warn parents and staff when entering the secure area of tailgating, and to make sure they do not let people onto the ward. This ensured the safety of children and young people and their visitors. The CQC team were asked to provide identification on arrival at the ward.
- Safari Ward had a regular capacity of 20 beds; this included one bay of five beds and 15 side rooms. Two side rooms were situated beyond the doors to Tiger Ward and therefore could be used by Tiger Ward if extra capacity was required. One of the cubicles could be adjusted to make a High Dependency Unit (HDU) for patients requiring additional monitoring and care however there was no CPAP machine available. (A CPAP machine is a continuous positive airway pressure machine that supports patients with breathing difficulties). Tiger Ward was next to Safari Ward and had four side rooms. Patient bedrooms and bays were well equipped with either beds or cots, seating and bedside lockers for personal belongings.
- Children admitted to Safari Ward with mental health concerns were usually allocated one of the side rooms just inside Tiger Ward. These rooms were separated by doors from Safari Ward and were therefore out of the line of sight from the nurses' station. There were no

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adaptations made to these rooms such as removal of potential ligature points. (Ligature points are places to which patients intent on self-harm might tie something to strangle themselves). This was not on the risk register, however mitigation made by the ward was that only those patients who had been allocated a Registered Mental Health Nurse (RMN) would be placed into these rooms and therefore they would be supervised for their safety.

- The neonatal unit provided 16 cots. This included one intensive care cot, four high dependency cots and 11 special care cots. Spare equipment was used to care for additional babies, and the space could be expanded to care for 19 babies or 21 if side rooms were shared by twins or triplets.
- Dolphin outpatients department (OPD) had seven consulting rooms; one room where weight and height of children could be measured and a treatment room.
- Hippo PAU had a large waiting area with toys and books available. It had capacity for six children on trollies as well as one assessment room and one treatment room.
- Paediatric surgery was conducted within adult theatres. Children and young people were recovered within the main anaesthetic room and then moved to an area where a designated area in the recovery room that was partitioned from the main adult recovery area. A separate door allowed parents to access the area without going through the main recovery room.
- A separate playroom on Safari ward with a range of toys and activities was open from 8.30am to either 6pm or 7pm daily. An allocated adolescent area within it had computer games and facilities appropriate for teenagers. Portable toys, including electronic books were available to be taken to children and young people's rooms if they were not well enough to go to the room.
- A sensory room with specialist equipment was available for children with special needs. Due to a recent fire that had taken place on the Safari ward the month before our inspection a portion of the ward, including the staff room were being refurbished. Staff had to use the sensory room temporarily to store personal items and therefore we were not able to see the room being used as it was intended.
- There was an outdoor play area for children on Safari Ward. Supervision of this area was by parents or carers and it closed each day at 6pm.

- Tiger ward had a separate play area with a range of toys and activities available, including 'soft-play' shapes for younger children and table football and music facilities for older children and teenagers. There was also a separate room quiet room for adolescents however due to the recent ward fire, it was temporarily being used as a staff room and therefore we were not able to see the room being used as it was intended.
- Both Hippo PAU and Dolphin OPD had a range of toys within the waiting area that could be used by children waiting to be seen. Dolphin OPD also had an outside play area. The play specialist checked the toys were still serviceable each week.
- In the last inspection we found there was not enough access to key equipment such as blood pressure monitors and thermometers. This time staff we spoke with in all areas felt there was always enough equipment when required.
- The trust's electronics and medical engineering (EME) department serviced equipment. Maintenance was generally undertaken using two methods: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, yearly) to meet statutory requirements, legislation, manufacturer's guidance, and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure.
- During our inspection, we randomly selected five pieces of equipment to check in the Safari and neonatal ward. All were safety checked and in service date.
- In the CQC children's survey 2014, the trust scored 8.59 out of ten for the question 'Did the ward where your child stayed have appropriate equipment or adaptations for your child?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Medicines

- The paediatric pharmacy support was available Monday to Friday during the day and some weekends between 9am and 1pm. Outside of these hours an on-call service could be contacted and an emergency drug room in the hospital was accessible so medications were always available if required.
- The trust set a target of 85% for completion of medicines management training for nursing staff. The current compliance levels for these in January 2017 for

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the children's service staff were 58%, which was well below the target. This meant that the trust could not be assured that enough staff had received recent necessary updates.

- Medications on Safari Ward were stored in a separate room. This was accessed with a code and medication cupboard within the room which we saw were kept locked.
- We checked the temperature logs for medicine fridges and freezers within all children's wards. We found that the maximum and minimum temperatures were mostly recorded daily and that they had remained within the correct range. Dolphin OPD had a small number of days when checks had not been carried out.
- On the NNU we saw that medications were left out of the fridge or cupboard after they had been allocated to each patient. The total time that they were left out was an hour. We asked if they were normally left out and action was immediately taken to put them away.
- We checked the controlled drug (CD) cabinet, located in Tiger Ward and found that it was locked and secured appropriately. There was a CD register and we saw daily checks were carried out. We checked two random medications and found that the numbers in the cupboard tallied with the numbers stated in the book.
- We reviewed five sets of prescription charts within Safari Ward. In two out of the five records checked front sheets had not been completed. Allergies were completed in all but one and although the age of the child was not completed, the date of birth was. Although all prescriptions were signed and dated there was no name stamp of the person administering the medication which meant that if the signature was not recognised, it would not be possible to know who had administered it.
- We reviewed four sets of prescription charts within the NNU. All prescriptions and dosage records were legible and had been signed for. Allergy boxes had been completed and the identity of the nurse administering the does was clear on each one.
- We saw that staff had access to up to date copies of the British National Formulary (BNF) in all departments that we visited. The BNF is a pharmaceutical reference book that provides information and advice to healthcare professionals.

- Medicines management audits were completed monthly for the quality scorecard. These included allergy status documentation, missed does and no harm incident reporting, controlled drugs compliance, daily fridge monitoring and safe and secure storage. Results had improved over the last 12 months and most recently in February 2017 all but one was above the trust target levels with many at 100% compliance. A notable improvement had been made with the compliance with CD checks where in June 2015 it had been at 50%. In the last 6 months it had been at 100% for all months.
- Key messages and learning from reported incidents were published trust wide in the Monthly Medication Safety Newsletters. The 'Just 5' messages for nursing staff, highlighted areas for improving practice and patient care and were informed by the review of medication incidents.

Records

- Staff managed patients' records in accordance with the Data Protection Act 1998. Records within children's services were predominantly paper based and kept confidentially on the wards in lockable trolleys next to the nurses' station. We did not see any unattended notes during our inspection.
- Patients were identified on white boards by the nurse's station on the Safari Ward, showing first name only. This meant patient confidentiality was maintained.
- There were specific templates available for care plans for different conditions. For example, we saw a care plan for patients admitted with diabetes
- We reviewed five sets of medical records on the neonatal unit. All of these had the relevant information recorded such as patient details and management plan. Records were legible were dated and signed and included bleep contact details where relevant by those completing them.
- We reviewed five sets of medical records on Safari Ward. All of these had relevant information recorded such as diagnosis and management plan. Records were legible and were dated and signed by those completing them. However, there were limited additions made to the care plans following the information entered on admission.
- Data indicated that only 38% of paediatric medical staff and 69% of additional clinical services had completed their information governance training. These rates were

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well below the trust target of 85%. However 84% of paediatric nursing staff and 85% of administrative and clerical staff had completed the training which meant there was a good proportion of staff within the department that were up to date with their knowledge and could advise others.

- The Safari and Tiger wards completed a documentation audit monthly. However we did not see results of these audits and they did not feature on the division quality scorecard. In addition we were told about local 'spot check' audits that had taken place on Safari ward, for example review of care plan completion. Results of these would be followed up with individuals and general learning was shared on the handover sheet for cascade, through emails or at the ward meeting.
- Work had taken place over the last year to change the records systems and documentation so it was consistent across the two sites. This had been completed, with only fluid charts outstanding. When a fire in Safari Ward meant that patients were transferred to the UHL to be cared for, the consistency in paperwork had been helpful as it meant that it was easier for staff from both locations to work together.
- Administrative support was provided for Safari and Tiger wards by only one member of staff who did not work full time. This meant that there was no administrative support over weekends.

Safeguarding

- The trust had a safeguarding children policy and we saw dedicated noticeboards in all departments we visited with information about safeguarding children which could be viewed by both staff and members of the public. These boards contained contact details for the teams, where to find them and about the service they provided.
- Staff we spoke with knew who the nursing safeguarding leads for the trust were, and could explain the actions they would take if they had any concerns. They told us that they felt confident and well supported with raising concerns.
- The safeguarding team would come directly to the ward if they were contacted to provide support and if urgent there was support available from a social worker 24 hours a day, seven days per week. We were told a safeguarding team member would also join medical handovers.
- A weekly multidisciplinary team meeting was held within the emergency department and attended by a representative from Safari Ward. Children attending the hospital where there had been a concern or an alert raised would be discussed and any further actions identified and taken.
- The number of referrals made to children's social care by the trust was between 45 and 144 per month between February 2016 and February 2017. In addition the trust had been involved in ten serious case reviews in that time.
- An electronic flagging system was used within Dolphin OPD to identify children with safeguarding concerns.
- The trust audited its attendance at case conference for children with a child protection plan. Data provided to us showed that the trust target was met in the majority of months between February 2016 and February 2017 for both initial and review case conferences. For all months where it was not met, attendance was over 90%.
- The trust set a target of 85% for completion of safeguarding training for all groups of staff.
- Medical & dental staff were required to complete safeguarding adult's level two and Safeguarding Children and Young People Level 3 specialist. The current compliance levels for these in January 2017 were 78% and 68% respectively which were below the trust target. One medical and dental staff member had also completed safeguarding children and young people level 4. These low levels meant that the trust could not be confident all of these staff members were aware of their roles and responsibilities to keep vulnerable people safe.
- All nursing staff were required to complete safeguarding adult's level two and Safeguarding Children and Young People Level 3 specialist. The current compliance levels for nurses in January 2017 were 97% and 83% respectively. These were higher rates of compliance and therefore the trust could be assured that most of this group were aware of their roles and responsibilities for keeping patient safe.
- All other staff groups including administrative staff completed a range of safeguarding training for both adults and children depending on their requirement for their job. All but one of the modules for these groups

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had compliance over the trust target of 85%. The one that fell below was for additional clinical service staff where Safeguarding children and young people level 3 was below at 75%.

- Staff we spoke with had a good understanding of female genital mutilation (FGM). All staff we spoke with knew how to raise FGM as a safeguarding concern. One told us that it had been part of the recent mandatory training update. In March 2016 the trust became an early adopter site for the FGM Risk Indicator System (RIS). The introduction of the RIS ensured that children identified as being at risk of FGM had an alert put on all of their 19 records throughout the patient pathway. A steering group had been established to implement and monitor the RIS and was chaired by the Named Midwife.
- The safeguarding lead nurse conducted safeguarding supervision of senior nursing staff and ward leads. For example the neonatal discharge coordinator had regular one to one supervision to discuss specific cases. Staff were able to access reflective learning forums held by the safeguarding children team and records provided to us showed that four sessions had taken place at the hospital between May 2016 and March 2017. Subjects included reflective practice and learning from serious case reviews and topics such as recognising concerns.
- An audit had been carried out in January 2016 to assess whether case files had up to date details of named professionals working with children identified as at risk under the London borough of Greenwich. This followed concerns reported in a local serious case review. Strengths identified included the discussions held of all children at the hospital safeguarding meeting and the fact that several key services had been identified in the case records of the children sampled. There were areas of improvement required; such as including community records.
- In the CQC children's survey 2014, the trust scored 9.51 out of ten for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Mandatory training

- The trust set a target of 85% for completion of mandatory training. The training was a mixture of face-to-face and on line learning. Mandatory training

modules included equality and diversity, information governance, fire training, infection control and manual handling. Other training was role specific for example, new-born or paediatric life support.

- Medical and dental staff had 14 modules of mandatory training to complete. Data provided by the trust showed as of January 2017, the target was only reached in two modules which were conflict resolution and infection control and prevention. The remaining modules did not meet the trust target; with the lowest scoring module being a workshop to raise awareness of the PREVENT policy which was at 8%. The PREVENT policy is a government initiative for professionals to recognise signs of terrorist radicalisation.
- Nursing & midwifery staff had 17 modules of mandatory training to complete. Nine modules exceeded the completion target and three were just short of the target at 83% or 84%. Out of the remaining modules that did not meet the completion target; the lowest scoring module was fire safety clinical with 63%.
- The trust audited overall compliance with mandatory training as part of its quality scorecard. The most recent numbers recorded were 83% compliance against the target of 85%.
- We were told that there had been issues in accessing training for advanced paediatric life support (APLS) so only four nurses were in date for this training. This meant that they could not ensure that at least one member of the team was qualified on each shift. However, the remaining band six nurses were planned to attend this training within the next six months. In addition we were told that support could be provided by the emergency department nurses who were trained in APLS if required as well as from department doctors. Compliance for the doctors completing their APLS refresher was 65%, also below the trust target.
- Staff were alerted individually when their training was due for renewal by an automatic email sent to them to remind them to book a session.

Assessing and responding to patient risk

- The hospital did not have paediatric intensive care unit. Children who deteriorated were transported by South Thames Retrieval Service (STRS), who specialise in the inter-hospital transfer of critically ill children in South London. If a child on the wards became unwell suddenly the site outreach team were contacted and this included an anaesthetic response. The team would care

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for children requiring intensive care management within the operating theatres prior to retrieval. The NNU was able to provide care for babies requiring an enhanced level of neonatal intensive care prior to transfer.

- Paediatric life support training was mandatory for all staff groups, and was undertaken yearly. Data indicated that all groups of staff were below the trust target of 85% for completion of the relevant level. Nursing staff were only just below the target with 83% compliance for completion of training however only 65% of medical staff had completed the APLS refresher. For neonatal life support (NLS) only 70% of nursing staff had completed this. This meant the trust could not be confident enough staff members within the children and young people service had the necessary up-to-date training to keep patients safe.
- Patients attending Hippo PAU were referred from the Emergency Department (ED) or from the co-located urgent care centre (UCC). Those sent from the UCC would not have had observations taken there and no observations were usually done within the Hippo PAU until assessment. That meant that there may have been a delay for patients accessing the emergency pathway at the hospital to have basic checks completed. However the nurses' station was within the main waiting area so nurses were able to regularly have sight of the patients waiting.
- Resuscitation trolleys in all areas we visited had daily and monthly checklists. Checklists we saw were completed, dated, and signed in all areas with the exception of the NNU where multiple dates since January had not been documented as checked. All equipment against the checklists was in date and available on the trollies. We saw child-sized equipment was available on the trollies.
- The Paediatric Early Warning Score (PEWS) system was recorded on observation charts and discussed on the ward round. Details of the escalation required, for elevated scores, were on each PEWS chart. Four different PEWS charts were used for children of different age ranges. Each chart recorded the necessary observations such as pulse, temperature, and respirations. We saw five records that included PEWS on Safari Ward, and all were completed fully. PEWS were also audited as part of the documentation audit. Early warning scores have been developed to enable early

recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.

- Neonatal unit nurses used New-born Early Warning Trigger Scores (NEWTS) on the unit to assist in identifying deterioration of patients.
- There was a trust abduction policy which we saw that had been reviewed in September 2016. Staff completed training on potential abduction from the ward as part of the induction program on their arrival within the hospital and staff on Safari Ward were able to confidently describe the actions that they would follow in the event of a potential abduction. They told us that security always responded quickly if called.

Nursing staffing

- Paediatric nursing staffing was based on a 1:4 ratio on the Safari Ward with an allocated nurse-in-charge, reflecting the Royal College of Nurses safe staffing levels for children's nursing. This framework adjusted requirements dependent on the age and acuity of children admitted. It was reported to us that children under two years old required nursing cover on a 1:3 ratio and that when there were large numbers of young children on the ward, this was more difficult to meet.
- On Safari ward five nursing staff and one healthcare assistant (HCA) were usually planned for each shift. Between August and November 2016 43% of days had shifts that fell below the planned staffing level. In order to reduce the effect that this had on patients the team were supported by the matron, sister or nurses from the adjoining Tiger ward to maintain a nurse to patient ratio of 1:4. Out of hours the bed numbers were reduced if a bank or agency nurse could not be found. Planned staffing against actual staffing levels provided to us showed that for the Safari Ward registered nurse levels were at 95% which meant that the majority of the time, staffing was as planned. Staff we spoke with told us that that they felt staffing was sufficient and patients and their families all reported that buzzers were answered promptly which indicated there were enough staff.
- A safe staffing and escalation policy ensured staff were able to escalate to senior managers any cases where staffing or skill mix deficiencies were unacceptable against the standards. Bank and agency staff were used

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to cover sickness and holiday absences. Rates of agency and bank staff had remained high in the hospital children's services (between 17% and 27%) over the eight months between April and November 2016.

- Senior nursing staff provision on Safari Ward was two band six nurses on each shift. In addition, on Monday to Friday day shifts a ward sister and matron could provide additional senior nursing advice. Out of hours and at weekends, the nurses were able to contact a senior children's nurse in the emergency department or the clinical site manager if they required senior nursing advice. A nursing staff handover was conducted at the beginning of each shift.
- If a registered mental health nurse (RMN) was required for a patient then this was arranged through an agency. We were told that there had never been any difficulty arranging this and that usually the same two regular RMNs were used.
- Paediatric Oncology Shared Care Unit (POSCU) recommendations were used for planning nurse staffing on Tiger Ward. The ratio used was 1:2 for high dependency children and a minimum standard of 1:3 for all other children. A team of six nurses worked on the ward. They were flexible with their planning as it depended on the number of inpatients and their acuity however staff told us that the use of agency staff on the ward was minimal.
- Two nurses were planned each day on Hippo PAU. They worked a long day to cover the whole shift, although their break was covered by a nurse from Safari Ward. During the winter an additional nurse worked 4pm until midnight. Nurses reported to us that due to the nature of work in the PAU they would often have to stay later than their hours, sometimes up to two hours extra which made them tired. We looked at incidents reported in the six months between August 2016 and January 2017 and found that there were 20 incidents reported relating to staff staying late which confirmed what we were told. We raised this concern with senior managers and were told that nurses were compensated for their time. However this still meant that nurses were fatigued, a well-recognised risk factor for errors. This issue had been acknowledged by divisional managers as part of a quality review following an investigation in August 2016 by Health Education England. However, this remained an unresolved issue during our inspection and although the insufficient nursing establishment was included in the issues list, fatigue of nurses was not.
- Nursing staff levels within Dolphin OPD was two nurses and two healthcare assistants (HCAs) on Monday and Tuesdays and two nurses and one HCA for Wednesday to Friday. None of the staff worked full time and we were told that ensuring appropriate staffing cover was sometimes challenging.
- The Neonatal Unit (NNU) had no vacancies for nurse staffing. They had already recruited to fill the posts of two staff that were leaving. The usual roster planned for five nurses on each shift, however they had increased this to six recently as the demand had increased. Two parents told us that they felt the unit was short of staff, particularly at night which concerned them. Safe staffing records of January showed that registered nurses shifts were filled 96% in the day and 93% at night. February records showed shifts were filled 88% during the day and 95% overnight.
- Between August 2016 and January 2017 between seven and 25 days per month had seen the unit caring for babies over their funded capacity. Eight incidents had also been reported in this time when extra babies were cared for. If additional babies were being cared for there was a risk that staffing numbers would be further stretched and care could be compromised. Although numbers of qualified neonatal nurses was listed as an issue on the children's services risk register, the capacity of the NNU was not. This meant it may not be reviewed or mitigated against appropriately.
- Only two of three of the nurses on shift were Qualified in Speciality (QIS) which was 65% of nursing staff. Although this was an improvement from last year when we were told only 53% were QIS, this meant the unit did not meet the British Association of Perinatal Medicine (BAPM) staffing standards for units providing neonatal intensive care.
- The BAPM standards were for 1:1 QIS nursing ratios in Neonatal Intensive Care (NICU) areas, 1:2 QIS nursing ratios in High Dependency Areas (HDU) and 1:4 nursing ratios for Special Care. However the unit did not meet these standards. On the inspection we saw that NICU and HDU areas were included together and ratios for nursing care in these were one nurse to three babies. For special care the ratio was met for one nurse to four babies. We were told that the unit needed an increase in

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the planned establishment of 12 more full time nurses to comply with staffing standards but there was a delay to submitting a business cases as there was a review of the working model across both hospital sites.

Medical staffing

- Across the trust children's services medical staffing included 32% consultants, 52% registrars, 5% middle career and 7% juniors. Information provided by the trust before our inspection showed that as of February 2017, the vacancy rate for medical staff across children and young people services was 10%, which equated to five whole time equivalent doctors. Sickness levels for doctors were low at 0.6%. Locum use had reduced over eight months from 8% in April 2016 to zero in November 2016. However some doctors reported that they often stayed late, due to workload and estimated this to be around 20% of the time.
- There were 12 consultants in post for the hospital and there were no vacancies. The establishment had recently been increased to 12, following a review of the oncology service. The 12 paediatric consultants all had a speciality, for example there were paediatric consultant specialists for oncology, neurology and diabetes. However, as of January 2017 the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same as the England average. This means there may sometime insufficient numbers of doctors with the qualifications, skills and experience to meet the needs of children and their families who used the service.
- The neonatal unit was not covered by specialist neonatal consultants. The clinical lead for neonates worked with the other consultants as part of the general paediatric consultant rota and they each only covered the unit for four weeks which were spread throughout the year. Therefore, there was little continuity for staff and also parents and patients being treated in the unit. Senior clinical leads told us that they recognised that the system needed to change, particularly as the neonatal department was so busy and that this had been discussed in detail for the last three years. However an agreed option for change was not yet agreed and it had not been added to the risk register.
- We observed one medical handover on the NNU. As well as the consultant and doctors, the nurse in charge also attended. The handover was both verbal and written. Each patient, including their discharge planning was discussed. Potential cases for admission were also discussed. This was a well-structured medical handover, which made sure important information was passed onto each other. A weekly neonatal 'grand round' was held. Junior doctors were supported to present cases. Consultants were encouraged to attend if possible as well as the nurse in charge.
- The Royal College of Paediatrics and Child Health (RCPCH) standard three (2015) states that every child that is admitted to a paediatric ward should be seen by a paediatric consultant within 14 hours of admission. Data provided to us from an audit undertaken in September 2016 showed that the trust compliance for paediatric medicine speciality against this standard was 70%. Although the trust was not yet meeting this standard the levels were in line with national levels of compliance.
- Consultants supported using a 'consultant of the week' system for both the wards and NNU during weekdays. Consultants were available within the hospital between 8am and 5pm Monday to Friday. Evening and weekend cover was provided by one non-resident on call consultant for all children's services. A consultant was present Monday to Thursday until 9pm in Hippo Ward however the RCPCH standard one states that a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week. Consultants and other staff reported to us that they were often disturbed and frequently called in during on call nights however were expected to cover clinics, ward rounds and meetings the next day when they were fatigued. No incidents had been reported relating to this during the six months from August 2016 to January 2017. We raised this with the senior managers who reported this was not their expectation and if a consultant highlighted this to them then they would ensure they were not working when they were tired.
- The consultant of the week undertook two daily rounds on the ward, including weekends which met the RCPCH standard four.

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- The Middle grade doctors worked a split rota for the neonatal unit and general paediatrics and the junior doctors were on a full shift system. These included resident on-call for nights and included two doctors working in the Hippo PAU each day.
- Emergency surgery was provided by adult surgeons. The age accepted was dependent upon what surgeon was on call. Children under seven and those who required complex surgery were transferred to a specialist children's hospital.
- In August 2016, Health Education England (HEE) carried out an urgent review of paediatrics at the hospital following concerns that had been raised by an anonymous member of staff. The concerns were excessive workload, unfilled rota gaps, under reporting of near misses of incidents, lack of consultant supervision and concerns around inadequate referral pathways. The report recognised that the General Medical Council (GMC) 2016 National Training Survey (NTS) found only one negative outlier for paediatric doctors overall, which was for workload, and for the more junior doctors, for feedback. The hospital had responded to the concerns found by the HEE by making changes in response to the HEE mandatory requirements. These included incident reporting, rota filling, a buddy system for junior doctors and a review of emergency pathways. Most doctors we spoke with during the inspection said that there had been improvement since the review; that rotas were well covered and there had been no instances where consultants had been required to cover for junior doctors. However, some doctors within the NNU reported that there was variability between the support offered from consultants and that although there was always support at the end of the phone, they would prefer a more visible presence.

Major incident awareness and training

- There were separate comprehensive paediatric business continuity plan for each department, which included clear instructions on what to do in the event of key identified risks such as loss of staff, information technology failure, loss of utilities or severe weather. As the plans were specific to the relevant area they

contained pertinent information to that each department, They included action cards that staff could grab and use to remind themselves of the appropriate actions The plans were reviewed on an annual basis.

- There had been a small fire the month before our inspection in Safari ward and, as a result of this, children receiving treatment had been evacuated and transferred to UHL. We were told by many different levels of staff during the inspection that the evacuation from the ward had been extremely prompt and patients had remained safe and cared for throughout the disruption. A debrief with staff had occurred on the day to identify any key areas of learning or support required. Staff had moved to work at the Lewisham site for five days until the patients could be returned to the ward and had worked hard to adjust quickly to the changes of the environment and worked together with staff there in order to continue to provide good care for the patients. One doctor told us 'during the fire I was very impressed with all staff who got patients out very smoothly and the whole response was a success.'
- Scenario based training was held jointly with across sites for each type of service which ensured staff responded appropriately to emergencies. For example the inpatient wards from both hospitals had undertaken a joint table top session in August 2016 to exercise the scenario in the event of a sudden loss of power. Trust-wide events had also been attended by representatives from the children's service with regard to testing responses in the event of examples such as heatwave and pandemic flu.
- The trust set a target of 85% for completion of emergency planning for all groups of staff. All groups of staff had compliance of this target above the 85% except for medical and dental staff where compliance was extremely low at 25%.

Are services for children and young people effective?

Good



We rated effective as good because:

Services for children and young people

- The unit encouraged breastfeeding mothers to express milk next to their babies' cot. This was introduced following research published which showed clear benefits for mothers and babies.
- A comprehensive audit schedule supported the use of national guidance within policies and guidelines.
- There were good links with the oncology shared care network and specialist staff were provided with support and training to maintain their skills.
- The hospital participated in national audits and reviews for assessing patient outcomes.
- Peer reviews were used to identify improvements to services.
- Multi-disciplinary working was well-embedded in all departments that we visited.
- Number of babies who received mother's milk exclusively or as part of their feeding at the time of their discharge from the NNU was much higher than the national average.

However:

- There were very few clinical nurse specialists employed to support specific services.
- There had been a significant reduction in the number of play specialists and this reduced the availability of this service for patient support.

No two year follow up of babies admitted to the NNU had been completed as part of a national audit. This limited the ability to assess longer term outcomes of babies treated.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. Most of these policies were shared across both sites to enable consistent practice. Examples of this included the guidelines for neonatal jaundice and early onset infection.
- The hospital was level three UNICEF Baby Friendly accredited. The Baby Friendly initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by

working with public services to improve standards of care. Level three is the highest level that can be achieved and includes the experiences of parents as part of the assessment.

- The hospital had been reviewed over the previous 12 months to identify improvements to services. This included one on inpatient services in July 2016, and another on oncology in July 2016. We saw as a result of the oncology review an additional consultant had been recruited and a secure method of sharing results had been arranged. This addressed immediate risks identified. Other concerns highlighted by the review were being followed up through an action plan.
- The physiotherapy staff used the Alberta Infant Motor Scale to assess gross motor functions of children less than 18 months of age. This is a developmental criteria-referenced assessment tool that measures items related to posture, movement, and weight bearing in different positions.
- A comprehensive audit programme was run by the hospital children's services. The audit plan was devised based on audits required nationally as well as to assess compliance with NICE about paediatrics and neonatology, governance and risk audits as well as local priority audits identified through complaints and incidents. One recent example we were told had recently been presented was on sepsis screening and NICE guidance.
- A review had been undertaken in June 2016 that was based on the recommendations of the National Paediatric Diabetes Audit of 2014/15. It found that the hospital had met all of the recommendations except for one which was partially met.
- The trust used the Paediatric Early Warning Score (PEWS) system as recommended by NICE. The trust had completed an audit across both sites in October 2016 which found that compliance to the standards had improved in all but one area since a baseline audit in July 2015. In six out of 10 standards the results were greater than 90% compliance which was the target. The remaining four standards were between 70% and 83% compliance. Actions identified to address these shortfalls included use of electronic recording, training for healthcare support workers and regular local audits by practice development nurses.

Pain relief

Services for children and young people

- Children received adequate pain relief and there were appropriate systems for assessing pain in children used.
- A variety of assessment tools were used to assess pain depending on the age of the child. Staff assessed pain using recognised methods based on observation (the FLACC scale is based on observation of a child's face, legs, activity, crying, and consolability) or children's own reporting of pain, for example, the Wong Baker FACES pain rating scale. Staff used the visual analogue pain score, where zero meant no pain and 10 meant severe pain for older children. Levels of pain were documented within PEWS charts and were audited as part of the clinical indicator weekly audits.
- Children and their parents received clear explanations regarding medication and pain relief and parents and children we spoke to were happy with the levels of analgesia that they had received.
- Pain relief and topical anaesthetics were available to children who required them in the ward and Dolphin OPD.

Nutrition and hydration

- There were two paediatric dieticians for the children's services. Both had specialisms, one for oncology and the other for diabetes.
- The dieticians formed part of the multidisciplinary team for clinics which included oncology as well as holding their own specialist clinics twice a week.
- Safari Ward nurses used STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) to assess children for malnutrition. This is a simple five step validated nutrition screening tool for use in hospitalised children aged 2-16 years. Dieticians audited completion of the tool weekly and provided feedback to nurses.
- Vitamin D deficiency screening had been introduced by the dietetics team for oncology patients. A vitamin D deficiency has been found to decrease rates of survival of cancer and has an adverse impact on bone health so screening assisted staff to identify and treat it.
- We saw breast pumps within the NNU, which allowed easy accessibility and could encourage mothers who may not have wanted to breastfeed. The unit had implemented a system in which mothers expressed next to their babies cot. This was introduced following research published which showed that this was better for both the mother and baby and increased the volume of milk produced.
- Data provided to us showed that 71% of babies received mother's milk exclusively, or as part of their feeding at the time of their discharge from the NNU. This was above the national average of 58%.

Patient outcomes

- National audits participated in by the children's service for 206/17 included the National Paediatric Diabetes Audit (NPDA) and the NPDA patient reported experience measures, Inflammatory bowel disease registry, neonatal intensive and special care (NNAP) and the Paediatric pneumonia audit.
- The hospital also contributed to the National Confidential Enquires into Patient Outcome and Death (NCEPOD) review for chronic neuro-disability.
- The "Mothers and babies: reducing risk through audit and confidential enquiries" (MBRACE) showed the trust was up to 10% lower than average for neonatal mortality in the country.
- The neonatal unit staff participated in the National Neonatal Audit Programme (NNAP), which was implemented to assess whether babies admitted to neonatal units in England, receive consistent care in relation to key criteria such as the proportion of babies receiving breast milk at discharge. The hospital was above the national average for babies having their temperature checked within an hour of birth and screening for retinopathy of prematurity (a disease that can cause blindness in premature babies). However the number of babies within the target temperature ranges was only 45%, below the national average of 62%.
- The NNAP audited data on two year follow up of babies admitted to the NNU. The hospital had 34 babies eligible for this follow up however had no data entered for 32 (96%) of the babies and the remaining two (6%) had not been assessed. This meant that the hospital was unable to assess longer term outcomes of babies that had been treated in the unit.
- The number of under one year olds readmitted following an elective admission of children between September 2015 and August 2016 was too low to be compared to the England average.
- Readmissions following an elective admission, for children aged one to 17, for the same period was similar to the England average.

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- For readmissions following an elective admission of children aged one and under, between September 2015 and August 2016 no one treatment speciality reported six or more readmissions.
- There were 22 readmissions within two days of discharge following an elective admission of children aged one to 17, between September 2015 and August 2016. The readmission rate for paediatric medical oncology of 2.7% was slightly worse than the England national average readmission rate of 2.4%, for this age group however the general paediatric readmission rate of 0.9% was better than the England average of 1% for this age group.
- Between October 2015 and September 2016 there were too few admissions to measure the trust performance for the percentage of patients under the age of one who had multiple admissions for asthma, diabetes, and epilepsy.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with asthma was 14.7% between October 2015 and September 2016, which was better than the England average rate of 15.9% for this age group.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with epilepsy was 33.3% between October 2015 and September 2016, which was worse than the England average rate of 27.5% for this age group.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with diabetes was 13.1% between October 2015 and September 2016, which was the same as the England average for this age group.
- The National Paediatric Diabetes Audit 2014/15 found the trust performed similarly to the England average of 22% for the measurement related to HbA1c monitoring. This meant the trust was in line with national levels for patient's having an HbA1c value of less than 58 mmol/mol. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time.

Competent staff

- All nurses employed were children trained and additional courses were offered by the trust for care of children with high dependency needs.
- There was only one full time play specialist who worked on both Safari Ward and in Dolphin OPD. They worked

flexible hours over Monday to Friday. There had been a team of four providing play services, however two had left over two years ago and a third retired in the last year. These specialists had not been replaced and this meant there was no play specialist at weekends leave periods. We were told that there were also groups of volunteers that supported play. Play specialists are an important part of the ward and department teams, as they work with children to make sure the hospital environment is welcoming and fun. Staff used the play specialist in providing distraction techniques when a child required a procedure that may be painful or upsetting.

- It was recognised by the senior managers at the hospital that there were gaps in the provision of play specialists, including lack of play specialist provision at the weekends. They told us that they were considering other potential options for providing support for this such as further use of volunteers and medical students as a development option.
- Safari Ward's practice development nurse (PDN) was on long term leave. However planning for the absence had been made in advance. All nurses had had their life support courses booked in advance and six months of cover had been arranged. This meant the vacancy did not disrupt ongoing education and development of staff.
- The trust target for completion of staff appraisals was 90%. Between April 2015 and March 2016, the trust reported a staff appraisal completion rate for children and young people's services of 67%, although this figure excluded estates and ancillary staff where data showed that the completion rate was 0%. Data provided by the trust for the progress between April 2016 and August 2016 showed the appraisal rate had been at 62%. This included an improvement to 100% for estates and ancillary staff. On our inspection we saw more up to date data for the nursing staff and saw that there were only five outstanding appraisals for nurses out of 58 staff.
- One clinical nurse specialist worked across both sites and specialised in caring for children with sickle cell disease. There was another clinical nurse specialist in oncology. Support was provided for diabetes care by clinical nurse specialists from the local community trust. However, staff were supported to develop and learn by completing additional training modules, for example in

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care of the acutely unwell child or in oncology where five out of the six nurses had completed specialist modules. In addition there were link nurses for diabetes, asthma and end of life care.

- Protected teaching time for nurses on Safari ward was timetabled with two sessions per month of 30 mins each. These were led by clinical nurses specialists, sometimes from UHL. Recent sessions had included safeguarding, pharmacy updates, diabetes and PEG tube feeding in children (PEG tubes are passed into the stomach through the wall of the abdomen to provide an alternative means of feeding). In addition there had been two study days held on diabetes for inpatient nurses by the community diabetic nurse and there were plans to increase these to one per quarter.
- Within the last 12 months there had been joint training set up to include paediatric staff for both hospital sites. One session had been focussed on care of a child with complex medical needs and had included tracheostomy (where there is surgical opening made in the neck to assist with breathing) training. A second session had been on sickle cell. Staff told us that these were useful opportunities to meet with and share knowledge with colleagues across sites.
- Three formal sessions of teaching for paediatric junior and middle grade doctors were held weekly. The Health Education England (HEE) review in August 2016 had highlighted that doctors were finding it difficult to attend these due to workload and attendance registers had been started and showed good attendance. Staff we spoke with during the inspection reported that there were areas for improvement within teaching however were not specific about what these were.
- Bereavement care training was provided for administrators as well as nurses who undertook High Dependency Unit (HDU) modules. Additional in-house study days were provided that discussed communication and bereavement support.
- Three of the six nurses who worked on Tiger Ward had undertaken the HDU course. In addition five of the nurses had completed specialist courses relating to childhood cancer which included detailed information on palliative care. The nurses on Tiger Ward also attended an annual update as part of the Oncology Shared Care network.

- Three members of staff working at the hospital had an advanced communication qualification that allowed them to specialise in the support and counselling of children and families.
- The induction program for new nursing staff was tailored to meet the individual need. For example if a nurse had undertaken student placements at the hospital then their induction would be different to a new nurse that had never worked there. All new staff completed a trust induction of three days as well as a trust-led induction for new band five nurses. For staff that had previously undertaken placements at the hospital then a one day meet and greet of key contacts would be arranged instead, prior to a period where the nurse would be shadow other staff members.
- For nurses brand new to the hospital an orientation period of a week was arranged. During this week the nurse would visit different departments, including at UHL prior to a period of shadowing. The length of time that the shadowing would last for would be dependent on the previous experience and confidence of the nurse joining the department.
- The hospital provided student nurse placements within children's services. We spoke with student nurses who told us that they had felt they found senior nurses accommodating and were positive about the rapport they saw being established between doctors and patients.
- Staff who looked after children in theatres and recovery had received paediatric intermediate life support training. They did not undertake any additional competencies to assist in caring for children.
- The trust revalidation team commenced a rolling programme in December 2015 and all nurses within the hospital submitted revalidation on time. Workshops were run by senior facilitators to ensure that have education was provide to nurses about the process.
- Five volunteers worked within Dolphin OPD where they had been supported in a program to gain competencies. Following completion of the program four had been successful in application for full time jobs.

Multidisciplinary working

- Our review of records and interviews with staff, patients and parents confirmed there were effective

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multidisciplinary working practices, which involved nurses, doctors, allied health professionals, and pharmacy. Staff told us they felt supported and that their contribution to overall patient care was valued.

- We observed that staff worked well together during our visits to the various wards and departments. They also worked well with multidisciplinary teams (MDT) within the hospital and with other outside services in order to provide the best care possible for children and young people.
- Dieticians joined the ward round on Safari and Tiger ward so that they were able to share information with doctors and nurses appropriately.
- Dedicated physiotherapy had been provided from September 2016 to both inpatient wards and neonatal unit. Two physiotherapists worked at any one time as part of a paediatric rotation Monday to Friday. On call physiotherapy support was available on weekends. The physiotherapists supported discharge planning for complex care needs and provided care on an individual basis as required. They attended a weekly MDT meeting and a monthly MDT specifically for oncology. Physiotherapy outpatient appointments were provided for children over the age of 12 with musculoskeletal injuries.
- The paediatric emergency department (ED) was not in the same division at the hospital. The children's services team worked closely with the nurses and they would join in training together. In addition the ED matron had been invited to the band six away day. Staff reported that there was a good working relationship between the departments.
- There was no neonatal speech and language therapy services for babies on the neonatal unit. This meant that babies that needed additional help with feeding would have to attend an appointment at another hospital. A neonatal dietician and physiotherapist could be accessed on a referral basis and the dietician attended the unit once a week.
- Child and adolescent mental health service (CAMHS) support was provided by two local teams dependent on which borough the patient was from. We were told by staff that this support was good during the day Monday to Friday but there were challenges for assistance out of hours and at weekends. Out of hours provision was

through the adult psychiatry team, with CAMHS advice provided by an adult psychiatry consultant who would contact the CAMHS consultant if required. No CAMHS doctor attended after-hours or at weekends.

- If children or young people with mental health conditions were required to be admitted as patients on the ward due to a lack of specialist mental health bed then an RMN was requested through an agency for one to one care. Staff told us that this support had always been available when requested and that there were two regular agency RMNs used.
- There were a number of MDT clinics offered within Dolphin OPD. For example the sickle cell clinic included the clinical nurse specialist and the diabetes clinic included a clinical psychologist, which was in line with NICE guidance for Diabetes in children and young people: diagnosis and management.
- Staff we spoke with said that they had a good working relationship with other providers, such as the local community trust and closest specialist children's hospital. An example of how Safari Ward worked together with the community was to facilitate earlier discharges where nurses in the community were able to administer intravenous antibiotics which meant they could be discharged home more quickly.
- We attended part of the NNU ward round. As well as the consultant and doctors, the round included the nurses caring for each baby and pharmacist input.
- The neonatal unit reported good working with social services; the pre-birth team and also a small local community charity that provided support pre and post birth for young mothers.
- We were told that the hospital staff had a good working relationship with the palliative care outreach teams at the primary treatment centres. This meant that care could be supported by specialist teams for a child or young person requiring palliative care on Tiger Ward.
- In the CQC children's survey 2014 the trust scored 8.62 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Seven-day services

- Safari and Tiger wards and the neonatal unit provided seven-days services for children and young people at the trust.

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- Hippo PAU was open between 9.30am to 10pm seven days per week, with the last patient accepted at 8pm.
- Outpatient appointments were scheduled Monday to Friday between 9am and 5pm, with no clinics run at the evenings or weekends. This meant that children and young people and their parents or carers could not always access appointments at times that suited them. This resulted in children having time out from school and parents or carers taking time off from work in order to attend appointments. When asked about whether weekend clinics had been considered, staff told us there were not enough consultants to cover extra clinics.
- Emergency paediatric surgery could be provided at the hospital. However, the age of patients accepted varied depending on which surgeon was on call. At all times, children under seven and those who required complex surgery were transferred to a specialist children's hospital.
- There was a facility to provide high dependency care for children and young people at the hospital. If any children required intensive care management and ventilation, they would be stabilised within one of the Safari Ward side rooms, which had the capability to be converted to a high dependency bay. Alternatively unwell children could be transferred to the anaesthetic department of the operating theatres prior to retrieval by either the South Thames Retrieval Service (STRS).
- Paediatric pharmacist provided specialist cover to the service Monday to Friday. Out of hours an on call pharmacist was available so there was always access to medication if required urgently.

Access to information

- Staff told us they could access most information they needed to deliver effective care and treatment in a timely and accessible way. For example, there were no delays to access blood tests or imaging requirements and results and other investigations such as x-ray and scan results were available as soon as they were ready and on the system.
- Policies, protocols, and procedures were kept on the trust's intranet and staff were familiar with how to access them. There were enough computers available to allow staff to have quick access to trust policies and guidance. In addition some staff had access to guidelines on their phone.
- Patients and families were provided with a copy of the discharge summary prior to leaving the Safari Ward and

the NNU. This would also be sent electronically to the GP. In the case of parents who required further support from services after their discharge then they were able to telephone the ward for verbal advice.

- Dolphin OPD used the 'personal child health record' (PCHR), referred to as the "red book", to record the height and weight of children attending an outpatient appointment and encouraged parents to bring these to hospital if their child attended an appointment or received treatment. This meant that information about the child's growth was recorded and would be available for other health professionals to review outside of the hospital if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff obtained consent from patients and parents appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate. When appropriate teenagers were able to discuss their care and treatment without their parents present.
- Staff described the process of giving consent. Consent forms and care plans shown to us incorporated areas for both parent and children, where appropriate to sign their written consent. However we noted that in all of the five records we checked there was no consent documented although evidence of discussion of the family was recorded.
- Staff used the principles of the Gillick guidelines, when making decisions about the ability of a young person to consent to procedures. 'Gillick Competence' refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision.

Are services for children and young people caring?

Good



We rated caring as good because:

Services for children and young people

- Patients and parents spoke extremely positively about the care that they received and we observed kind and compassionate care during the inspection.
- Staff worked hard to facilitate additional fun activities for children so that their stay in hospital would be improved.
- Tiger ward had provided opportunity for parents and patients to meet informally at a coffee morning which provided additional support to families and also gave a more positive view of the ward for children.
- There were good support available for parents within the neonatal unit and parents were encouraged to be involved in ward rounds.
- Parents and patients were informed about the plan for their care in a compassionate and appropriate manner and patients were encouraged to maintain their independence where possible

However:

There were extremely low responses to the Dolphin OPD friends and family test.

Compassionate care

- We saw and heard staff delivering kind and compassionate care to the children and young people in their care. Staff treated patients with kindness, dignity, and respect. A number of young patients resided on the ward without parents and we saw that staff took time to care for them and console them when their parents or carers were not able to be present.
 - We spoke with five children and young people and 10 parents or carers. They were all positive about the care provided and that they felt well supported by staff. We saw young people being treated with dignity and respect, and observed staff providing child centred, compassionate care. Parents, children, and young people told us that they were kept up to date with plans about their care verbally.
 - Staff protected the privacy and dignity of patients by using children specific bays and we saw curtains were used to screen children from other patients when needed.
 - Staff were confident in describing the process of chaperone provision.
- Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited. Most staff introduced themselves with “my name is”. Additionally, all staff wore a yellow badge that clearly stated their first name.
 - We spoke with ten parents and five children and young people on the wards and departments we visited. All parents and patients we spoke with were very positive about their care. One parent said ‘feel like they are looking after my baby as if it was their own.’ And ‘Hippo staff were wonderful, very reassuring.’
 - Dolphin OPD response for the January 2017 friends and family test (FFT) had an extremely poor response rate of only four people. Although 50% of these responses had been positive, a low response rate meant that it was difficult for the department to gather representative feedback about their services. Managers reported that they hoped to introduce methods used in UHL soon but ideally their aim was for electronic feedback as they felt this would improve the response.
 - The children’s inpatient response for the FFT was a low rate of between 10% and 21% against the trust target of 30%. However of those responses over 95% of patients recommended the service.
 - Safari Ward completed patient satisfaction interviews as part of the quality review audit. The score for the last two weeks of December 2016 had been 86%, below the target of 90%. Areas highlighted as being an issue were cleanliness of the bathroom floors, unaware of safety knowledge and disturbance at night.
 - In the 2014 CQC children’s survey for all 14 questions relating to care were about the same as other trusts. This was the most recent data available at the time of inspection.

Understanding and involvement of patients and those close to them

- We found staff interacted with children and their parents in a polite and friendly manner. Children, young people and their families were given the opportunity to speak with staff, to ask questions and were kept informed of what was happening. One parent told us ‘clear explanation and quick diagnosis.’ and another said ‘Staff are informative; they tell you exactly what is going

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on. I have been given written information as well.' A patient told us '[I was] annoyed as frequent checks meant disturbed sleep but good explanation and he [the nurse] was able to tell me why'.

- We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding. Patients told us that they felt involved in their care plan and had agreed it.
- Older children we spoke with were updated about their care by staff and were involved in their own care when appropriate. We saw that a patient was provided with a sharps bin and encouraged to administer their own injections. Self-management of medications is recognised in NICE guidance as a way to support people to be empowered and involved in managing their condition. Another patient told us 'staff explain everything and have trained [me] and mum so that I can treat myself independently.'
- On each ward and department, it was clear which nurse was looking after each child or young person. The children and young people we spoke with all knew who was looking after them. One patient told us "The consistency of a named nurse means I don't have to keep explaining – they have got to know me".
- A parent who had been in with their child last year told us the 'service improved greatly since last year. ... Much more explanation of what is happening from staff and patient involvement.'
- Parents on the NNU were encouraged to join the ward round when their child was being discussed and this was seen as a positive engagement opportunity by staff.
- We saw thank you cards from parents in appreciation of the support given on every ward we visited.
- In the CQC children's survey 2014 the trust scored 8.92 out of ten for the question 'Did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Emotional support

- Parents told us they felt supported. One parent said 'doctors and nurses treat us as individuals and they take my concerns very seriously.' And another said '[her] door is always open. When I had an issue I was listened to and changes were made accordingly'.

- Tiger Ward had arranged coffee mornings for parents and patients as an opportunity for families to meet and support each other and for children to come and play in the ward without receiving treatment. This helped children have a positive view of the ward. In addition they had links with a charity that made arrangements for patients under Tiger Ward to go on outings on a monthly basis so that they could meet. Examples included a meal out in a restaurant that had been closed to other members of the public. The nurses also provided education for schools and support when children in the school were first diagnosed with cancer.
- Bereavement services offered to families were usually through community teams or a childhood cancer charity. Psychology support for families whose child had passed away on Tiger ward was arranged by the ward staff through the primary treatment centres. If required a pack was also provided to parents containing information and signposting to organisations that could provide support.
- A chaplaincy service was available to all families for emotional support provided by the hospital through this service.

Are services for children and young people responsive?

Good



We rated responsive as good because:

- As Tiger Ward was a Level one shared care oncology unit it meant that children with cancer were able to receive treatment in a hospital closer to home.
- Changes had been made to pathways which resulted in a decrease of patients attending the PAU, following recommendations of a review.
- Two 'check-in' machines had been introduced within Dolphin OPD that provided a confidential way of checking patient details and also identified when families might require additional support.
- Additional training had been arranged for staff following recognition that there had been an increase in the admission rates of children with mental health concerns due to the unavailability of beds elsewhere.

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- There were a low number of formal complaints made about the service and response rates to complaints received were within the agreed timescales.

However:

- The operating arrangements for the Hippo PAU meant that some patients would have to return to the emergency department when it closed. This could result in a prolonged stay prior to admission and a poor patient experience. However, a business case had been submitted to extend the opening hours which would reduce these occurrences.

Service planning and delivery to meet the needs of local people

- Outpatient appointments took place in dedicated paediatric facilities. The environment was child friendly with toys available and access to a play specialist if required. Visiting consultants from other hospitals, for example specialists in plastics, held clinics within the Dolphin OPD which reduced travel time for local people requiring that service.
- The trust had a large case-load of children and young people being treated for sickle-cell disease. At Queen Elizabeth Hospital they had over 400 children and young people on the case load. As a result a clinical nurse specialist for sickle cell had been appointed at the trust and worked across both sites to support provision of care to this group of patients.
- Tiger ward was a level one paediatric shared care oncology unit which meant that children diagnosed with cancer received treatment in a hospital closer to home than the primary treating hospital.
- The hospital had a large case-load of between 400 to 500 patients requiring the epilepsy service with four epilepsy and neurology clinics held each week. However, there was currently no epilepsy nurse specialist. Epilepsy nurse specialists are recommended in NICE guidance quality standard 27 for the care of epilepsy in children and young people. Some epilepsy nursing services were provided by the local community trust, but this was not part of the hospital service.
- There was no trust or hospital formal policy for transition to adult service however; pathways were in place for some children moving to adult services who had conditions such as Diabetes Mellitus. The processes were dependent on speciality and involved a staggered handover of care from children's to adult services. One

parent told us that they were concerned about the transition arrangements for their child as they had complex needs however, they had raised this with their consultant and planning was in progress. Other pathways such as epilepsy transition were under review and transition was included in the operational plan.

- There was no facility within the hospital for patients to be sedated for a magnetic resonance imaging (MRI) scan. Patients requiring this needed to be transferred to another hospital. This had been highlighted within a peer review conducted in July 2016 of the service however, there had not yet been any actions taken to consider changing this.
- There were facilities for parents to be able to stay overnight with their children. Parents had access to shower facilities on the ward.
- The Safari and Tiger wards shared a dedicated school room adjoining the ward which had a full time teacher five days per week and teaching assistant three days per week during weekday term times. If children were not able to mobilise to the room then work could be provided to be completed at the patient's bed. The teachers' liaised with the child or young person's school to minimise the disruption to their learning. The school room was managed under a local education provider which had received a short Ofsted inspection in May 2016 and rated as 'Good'. A patient told us 'my work is being sent by school and supported by ward teacher... It's good.' A parent also praised the school support on the ward.
- In the CQC children's survey 2014, the trust scored 6.9 out of ten for the question 'for parents and carers who stayed overnight saying facilities were good?' This was about the same as other trusts. This was the most recent data available at the time of inspection.
- In the CQC children's survey 2014, the trust scored 8.3 out of ten for the question 'for parents and carers being able to access hot drinks when in hospital?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Meeting people's individual needs

- We judged children and young people services at the hospital had a warm, family-friendly atmosphere despite the clinical setting.

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- Staff on Safari Ward stated that they could be flexible in the accommodation as they had an odd number of single rooms. The bay of five beds was often allocated to teenagers as it meant that they had a separate area.
- On Safari ward, there were facilities available for parents to make drinks and reheat meals in a microwave. All parents we spoke with were happy with the facilities provided. Tiger Ward had its own purpose built kitchen funded by a charity they were linked with. This specific kitchen could be used by parents and carers to make food for their children at any time of day which was reported as a big improvement to the experience of staying in hospital. The NNU had a parent's room and sitting room on the ward, although one parent told us that they thought the room was a bit basic and not as clean as it could be.
- The hospital gave children and young people a choice of meals on Safari Ward. Hot food was available at lunchtime and in the evening. A snack round was also offered to inpatients. However, we were told that the current arrangements meant that pre-prepared baby food was not provided for babies who were being weaned and there were sometimes stock issues with specific formula milk types. The dietetics team were undertaking regular review of stocks and ordering new stock earlier to reduce the risk of running out.
- Breastfeeding mothers on Safari ward were provided with meals. A mother told us 'I'm feeding my baby and they are feeding me.'
- Safari Ward had the option for meals to be collected and eaten in the playroom. This gave patients the options for communal dining away from their beds.
- A sensory room was available on the Safari Ward. This was used for calming anxious children, and was accessible through the nursing staff. It was currently out of use at the time of our inspection, due to the recent fire.
- On Safari Ward we were told by a parent how staff had responded to the request of reducing the volume of equipment alarms as the noise had caused their child distress.
- The hospital offered face-to-face, telephone and written translation services, as well as sign language using an outsourced company. The doctors and nurses we spoke with were able to fully describe how to organise translation services for families. We did not observe any interpreters being used during our inspection. Dolphin OPD staff told us that a flag could be put on the system if an interpreter was required so that one could be booked in advance. The NNU booked interpreters when parents who did not speak English attended ward rounds.
- On the neonatal unit staff told us that specific cultural requests, for example, specific objects placed close to the baby, were accommodated as long as it did not interfere with the babies care. In addition for parents that were unable to read, information leaflets were provided with more pictures, or for specific tasks parents were directed to a phone application with pictures or nurses demonstrated the task to parents.
- We observed a range of information leaflets across the service to help inform families about care, clinics and support services available to them. Examples of these were information leaflets on conditions such as febrile seizures (fitting due to temperature), bronchiolitis (breathing problems more common in young babies.) Additionally signposting leaflets for medical identification jewellery and forced marriage were available.
- We saw all areas visited had noticeboards displaying current and relevant information. This included information on safeguarding information and a 'Meet the Team' board which had a photo of every member of staff and what their role was. We also found a suitable range of information leaflets were readily available for families and children; these were easily accessible.
- It had been identified that the number of children and young people being admitted with mental health concerns had increased over the last two years due to a delay in finding an appropriate placement elsewhere. Data provided by the Trust showed there had been 106 admissions at the hospital due to unavailability of mental health beds over the 12 months before our inspection. The management team had identified that there was a deficit in skills of staff for caring safely for these patients. As a result of this funding had been requested and agreed for staff to undergo training through the Simulation Workshop at the Mental-Physical Interface: Children and Young People (SWAMPI-CYP) provider. There was also ongoing work to review the skills that were required for best care of these children to identify the best professional for this or develop the skills of internal staff for this role rather than relying on agency registered mental health nurses.
- Staff told us that there had also been an increase in mothers with mental health challenges. This raised

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issues if they were an inpatient and their baby was on the neonatal unit as they were not able to visit without a mental health worker present, which could be challenging to accommodate. The unit had also identified an increase in babies admitted who were withdrawing from psychiatric medication, which their mothers had taken during pregnancy.

- Dolphin OPD adapted appointments based on patient need where possible. For example, patients with additional needs were flagged on the computer system and if necessary longer appointment times would be provided. If clinics were running later, staff would let parents and patients know and support them to go for a walk if they were uncomfortable waiting in the department. A phlebotomy (the taking of blood samples) clinic for patients under the age of 10 years old also offered extra support for patients with additional needs.
- Tiger Ward made efforts to individualise care for their patients. An example was given of a patient over 18 years old who had been cared for on the ward for a number of years. As they were due to complete their treatment they had been kept on the ward caseload rather than being transitioned to adult care.
- The hospital had clear specific guidance for principles of care for dying patients. This was not children and young people specific, however we were told that support could be provided from the primary treatment centre and a local hospice for patients on Tiger Ward. A consultation in November 2016 had highlighted this and changes were being planned to the end of life care strategy to incorporate children's needs. Staff were able to explain how they would support parents in the event of a child death at the hospital.
- Staff within children's services worked hard to provide extra fun activities for children to take part in that would make the hospital a fun place to be. Safari and Tiger wards arranged regular visits from entertainers to provide fun activities for the children receiving treatment at the ward. Staff told us that music and story-telling entertainers came each week and a magician came once a month. A local art team had been engaged to provide local artwork and local charities would also provide visits. In addition occasional parties

were planned by staff, for example a 'Willy Wonka' themed garden party had taken place in the summer, special event had been organised at Christmas and a chamber orchestra had played on the ward.

Access and flow

- There had been 17,841 children and young people admissions to the trust between April 2015 and March 2016. For children aged one and under the most common diagnosis was jaundice (22%). This was above the England national average of 7.4%. The most common diagnosis for children aged one to 17 was viral infection, (15%), which was below the England average of 12%.
- The majority of children and young people were admitted to Safari Ward through the children's emergency department or from Hippo PAU. Approximately 60 oncology patients were managed under Tiger Ward and these patients could be admitted directly. Neonates were admitted via maternity as a planned or emergency admission or as a transfer from other hospitals.
- There were regular telephone discussions across sites on a daily basis about bed numbers to improve patient flow.
- There had been an increase in births at the hospital. Births had increased by 500 in the past 18 months. However there had been no increase in the amount of cots within the NNU to support the rise in demand and consequently there had been between seven and 25 days in the months between August 2016 and January 2017 when the unit had exceeded its funded capacity, including 25 days when an additional four to six babies had been cared for.
- The Hippo PAU admitted an average of 700 children and young people each month. This unit provided paediatric assessment and short stay between 9am and 10pm seven days each week. Patients were admitted from the emergency department (ED) and for day care treatment such as blood transfusions for patients with sickle cell disease. Until two weeks before our inspection there had been a rapid access clinic for local General Practitioners (GPs) requesting a same day specialist opinion, however this had now moved to Dolphin OPD with slots allocated as part of the paediatric general clinic.
- We found during the inspection that some patients who were admitted to Hippo PAU from the ED had to return

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to the ED when the unit closed at 10pm. We saw records of five patients from the week prior to the inspection where this had occurred. The time spent in ED before arriving at Hippo PAU had been under an hour on all occasions, however the time spent in Hippo had been longer, between two and five and a half hours. The patients had remained in the ED between two and a half hours and six hours 10 minutes meaning that their length of time in the hospital for assessment and treatment was between eight and nine hours, and in one case, over 12 hours. We asked senior managers how these patients were documented with regard to the ED target times and were told that they would be re-booked onto the computer system. This meant that the total time would not be included in the ED four hour standard. The managers recognised that this was a poor patient experience and told us that a business case had been made to extend Hippo PAU opening hours to midnight in order to reduce times when this happened. We spoke with four sets of parents within the Hippo PAU on the day of our visit. They had all been in the hospital between eight and 12 hours but they had been informed of the proposed plan for their child and were happy with the support they had received from staff.

- The Health Education England (HEE) review in August 2016 found that significant numbers of patients were referred to the Hippo PAU that could have been treated in the ED which increased the workload for staff within the PAU. To reduce the workload the rapid access clinic had moved from Hippo PAU to Dolphin OPD within the last few weeks. In addition the pathway for jaundiced babies had been changed within the last two months which had resulted in 100 fewer babies attending.
- The average length of stay for the hospital's children and young people service was between 2.0 and 2.5 days through March 2016 to February 2017. The average occupancy rates had been above the trust maximum target level of 85% for all of the last year with an overall average of 95%.
- We were told by the trust about reductions in length of admission paediatric haemoglobinopathy (a genetic defect that results in abnormal structures of haemoglobin molecules) patients who required regular blood transfusions. Following changes to the pathway, such as changing the admittance day and assigning a dedicated doctor the length of stay decreased from eight to just over five hours.

- There were arrangements in place for the transfer of critically ill children and young people to specialist centres if required.
- When a death of a patient was expected, access was offered to families, and arranged if accepted, to a local children's hospice.
- Staff we spoke with said that they aimed to keep referral waiting times for the outpatient clinic appointments low. The waiting times for neurology appointments were the longest at 14 weeks, however paediatric surgery and neonatology were only 11 and 10 weeks respectively. Due to the capacity of the department there was limited scope for expansion and additional clinics.
- Patients referred to the urgent oncology pathway were reviewed initially by the consultant of the week and had oncology review within 72 hours. If needed they were seen in the paediatric rapid assessment clinic. Referral of children to the primary treatment centre would then be arranged if required. The patients were tracked by medical secretaries and it was reported that 100% of patients referred were seen within the two week rule.
- A discharge co-ordinator worked within the neonatal unit to support discharge planning and all parents were provided with a copy of the discharge summary.
- In the last year April 2015 to March 2016 only 11.3% of discharges were before 1pm. This was substantially below the Trust target of 40%.
- The trust's target was 95% of electronic discharge summaries completed within 24 hours of discharge. In the last 12 months this target had not been met by the hospital and average rates for compliance were at 85% across the period. We were not told of any specific actions taken to improve this compliance rate; however it was listed as an issue on the risk register...
- We were told that if clinics in Dolphin OPD were delayed then information was put on the whiteboard. However one parent we spoke with had been waiting over 50 minutes past the appointment time but had not been informed of the delay. Waiting times for appointments were not audited so we were not able to identify if this wait was an exception or if delays were common.
- Dolphin OPD had recently installed two 'check-in' machines for parents and patients to use when they arrived. These were introduced to reduce the time taken waiting for a receptionist and prevent patient details being discussed in reception. The machines could be

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used in the nine most common languages to the area and confirmed patients' contact details each time they were used. The introduction of the machines had identified that some parents were unable to read, even in their native language, and this meant that alternative communication methods could be used for these groups.

- Do not attend (DNA) rates for Dolphin OPD between March 2016 to February 2017 were 28%. This was higher than the trust target which was between 12% and 16%. Staff told us that they were aware of the high rate of DNAs and said patient details, such as parents' phone numbers changed which caused an issue for follow up. Volunteers in the department made telephone calls to remind people about appointments and sent a letter if they were unsuccessful in contacting parents by phone. There was no facility currently for texting reminders to patients and parents as they had to wait for the merger of a computer system. Staff we spoke with hoped text reminders would improve DNA rates. One parent we spoke with told us that after he had attended a previous appointment six months ago and told that it had been cancelled, he was contacted after the time to ask why his child had not attended. Although this was the only example of this we were told about, there may have been further instances of incorrect documenting of cancellations as DNAs.

Learning from complaints and concerns

- Between January and November 2016, there were only six complaints about children and young people services at the hospital. Between February 2016 and February 2017, in all but one month the service was above the trust target of 70% of responses within 18 days and it had been at 100% for the last six months. Between June 2016 and February 2017 100% of complaints had been resolved within the agreed timescales.
- We saw information was displayed in wards and departments explaining how parents, children, and young people could raise their concerns or complaints.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.
- The children's services governance lead attended the trust wide patient experience meeting. They would

share a patient story and provide feedback about complaints or concerns raised within the children's services as well as learning from feedback from other departments.

Are services for children and young people well-led?

Requires improvement



We rated well-led as requires improvement because:

- The risk register and issues log did not include a number of concerns that we identified during the inspection.
- A disconnection between senior managers and doctors meant that little progress had been made in adaptation of working structures in three years since the need had been identified.
- There were low levels of attendance at quality and safety boards which reduced opportunities for sharing of information to the appropriate people.
- A review in August 2016 had identified concerns about the Hippo PAU however there had been limited actions in the interim period taken to monitor and mitigate against these issues.

However:

- Since the last inspection there had been progress in developing cross-site governance structures, risk management and learning.
- Staff spoke positively about the nurse leadership and reported that they felt able to raise concerns and suggest improvements.
- Patient feedback was welcomed and the hospital had innovative ways of engaging with patients, such as the involvement of patients in practical exams held on site and consultation meetings about the future plan for services.
- Staff reported good support for each other across the service. This was demonstrated in the recent fire when staff that were not on duty or had finished their shift came to support their colleagues in providing care.

Leadership of service

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- The divisional leads, including director, general manager and a head nurse led both sites and this included spending time at each of the hospitals.
- There was a clear framework for nursing leadership within the hospital. The lead nurse for children's services worked at both sites and held a monthly senior nurses meeting that was attended by the matrons from each hospital as well as the community. In addition both hospitals children's service matron met regularly to discuss and share good practice.
- There had been an away day for children's services staff of all levels held in the last year and been viewed extremely positively with around 90 people attending. There were plans for another away day to be held in April.
- Staff reported that they regularly saw the senior staff and divisional leads visiting children's service areas and staff at all levels stated that they could approach the senior nursing staff. The matron worked clinically in areas on a regular basis to maintain knowledge about the realities of the work for the nursing staff.
- Some senior doctors told us that they felt that there were differences in the management of senior doctors across the hospital and the trust, although they were doing similar jobs. Because of this, there was some unhappiness within the department and they did not feel supported by senior managers. They felt that there was limited engagement between divisional managers and doctors.
- Medical cover had been identified as an issue by senior managers, particularly specialist consultant cover for the NNU and discussions to improve this had been in progress for three years. However, there had not yet been an agreement for change and this showed that senior staff and consultants found it difficult to work together to agree change and improve provision for patients.
- Some staff at all levels reported that there was limited visibility and engagement of the executive management at the hospital, possibly as they were based at UHL. However we were told by managers that executive leads had visited paediatric staff following the fire.
- The trust had been a pilot site for a peer review of children's services that had been conducted in July

2016. The review had observed that the paediatric clinical and leadership teams functioned very well and observed support and commitment to the review by the Board and the Executive team.

- Health Education England (HEE) had undertaken a review in August 2016 following concerns raised by trainee doctors. In this it had been raised that there were emergency pathway problems at the hospital including the Hippo PAU. A business case had been submitted for extended opening times a project plan and associated meetings only started in March 2017. A final date for the extended hours to begin was not confirmed and unlikely to be before June 2017. Although senior leaders had made some changes to reduce demand on the Hippo PAU, there were still significant issues raised from that review that were not being mitigated against in the meantime.

Vision and strategy for this service

- The divisional strategy was to provide consistently safe, high quality services and improved outcomes for their children; which included create a sustainable, well governed division, which is clinically-led; strengthening and extending relationships with their partners; promoting a caring, high performing workforce through good quality leadership; and ensuring the division was in a strong financial position. We saw staff embraced the vision and strategy in the provision of neonatal intensive care, acute care and outpatients.
- The operating plan through to November 2018 included the intention to expand the NNU by four cots to reflect the rise in birth rates.
- Staff spoke about how they continued to work towards the same goals when caring for children and young people.
- The last away day had included the creation by staff and management of 10 divisional aspirations that were compiled by all the staff in attendance.

Governance, risk management and quality measurement

- Analysis of the children's risk and issue register provided by the trust prior to this inspection showed risks that we identified on the inspection. We saw that the risks and issues were being reviewed and updated regularly. Risks and issues for the hospital included numbers of

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qualified staff for the neonatal unit and Hippo PAU and emergency pathway flow. A new issue that had been added recently for both sites was the increasing number of children admitted with mental health conditions and competencies of staff to care for them effectively. Additional training had been arranged so staff were able to safely look after children and young people in crisis. Staff were updated on the division's top five risks through the governance newsletter.

- However, we identified issues during the inspection that were not included on the register. For example the NNU caring for additional babies and nurses regularly working excessive hours on the Hippo PAU (although insufficient nursing establishment was included). As these were not listed on the risk or issues log it meant they may not be appropriately managed by the service.
- At the last inspection we found that there was a lack of joint working between the two hospital sites and this included sharing of learning from incidents. We saw on this inspection that improved arrangements were in place for cross-site governance, risk management, and quality measurement associated with the care of children and infants across the trust. We found the arrangements enabled them to measure their performance and service quality.
- Monthly governance meetings, such as the quality and safety meeting would alternate between each site to encourage attendance and tele-conferencing facilities would also be used where possible.
- Divisional board meetings were held monthly and included senior managers, clinical directors and nurses from both sites and also the community services. Representatives from human resources and communications also attended. Exception reports from each directorate were presented for discussion at this meeting as well as topics such as incidents, complaints and workforce. In all the minutes that we reviewed it showed these meetings were well-attended providing a useful forum for learning and sharing information.
- Divisional Quality and Safety boards were held on a monthly basis and had attendance from both sites. Exception reports from each children's ward were presented for discussion at this meeting as well as topics such as incidents, risks, patient experience, audits and policies and highlighted where cascade of

information was required for staff. All three of the meeting minutes that we reviewed had significant (over 50% of total invitees) apologies which may have meant that there were reduced opportunities for sharing information. We were told that the new video conference system was planned to improve attendance as it meant a reduction in travel if the meeting was on the site where attendees worked. However, staff reported it was difficult to book both video conference rooms at the same time and therefore it was under-utilised currently.

- Neonatal governance meetings were held monthly and alternated between each hospital. Topics such as incidents, infection control, staffing, risks, audits, referrals, policies, complaints, guidelines and research were considered. Actions within these showed where learning needed to be cascaded to staff. These meetings were intended to provide multi-disciplinary team feedback, however two sets out of three meeting minutes that we reviewed showed poor attendance and this therefore limited the MDT input. Although we were told that learning from the meetings was shared within the doctors training each week, one junior doctor we spoke with on the neonatal unit was not aware of the meeting and told us that they had never seen the minutes.
- Minutes of meetings were circulated to ward sisters, although we were told that they were also welcome to attend. We were told that information from these minutes was shared at ward meetings so that staff were aware of relevant items. Minutes of meetings were also put into staff rooms for more accessible access.
- Information from governance meetings was cascaded to staff on Safari and Tiger Wards by monthly team meetings led by the ward manager. In addition a governance newsletter was circulated to staff that included points of interest. For example the one for January 2017 had information and learning on incidents.

Culture within the service

- The recent fire that had occurred within Safari Ward demonstrated the positive team work that existed within the hospital children's services. We were told that

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three nurses came in from home to assist, and nurses who had just completed the night's shift stayed on longer. Senior managers told us that the nursing team was exceptional.

- Within areas of the children's services that we visited there was a large poster detailing the charter of the ward and how they would work with other colleagues. For example there was a charter between the neonatal unit and the maternity department. This charter had been developed by staff from each of the departments meeting in early 2016 to discuss some of the issues that they had and from this a charter was developed about how they could support each other. This had helped each team understand the problems that others faced and improved working relationships.
- Staff talked positively about the service they provided: they enjoyed working at the hospital. Some members of staff had worked there for many years. Most staff felt staff worked well together and supported each other, one reported that there was an 'open culture'. Morale appeared good. One junior nurse gave an example of when they had suggested a change in practice potentially beneficial to patient safety which had been listened to and considered by their manager.
- The 2016 peer review identified that paediatric staff had a mutual respect of each other.
- Sickness rates for all staff within children's services on the quality scorecard showed that between February 2016 and February 2017, the sickness rate within nursing staff working in children's services had reduced to 2.8% which was better than the trust target of 3.5% to 5.6%. We were told that there had been some changes to sickness management including assessing whether reasonable adjustments could be made to support staff to return to work sooner.

Public engagement

- We saw a number of examples of changes that had been made following patient feedback. 'You said, we did' posters were displayed in each department we visited. For example, a wider choice of computer games had been provided for children on Safari Ward following feedback from a patient.
- A consultation evening had been held in March 2017 to discuss proposals to changes for transfusions for

patients with sickle cell. This was well attended by parents of patients receiving services from the hospital and meant that their views were being considered for future planning. We saw that issues raised by the parents were noted in minutes and that following a pilot of the changes a further consultation with parents was planned.

- An event had been held by the trust in November 2016 to engage with the public about end of life care. Following feedback at the event changes were made to the strategy including greater emphasis on end of life care for children.
- Dolphin OPD hosted practical doctor's exams twice a year. As part of this, 16 to 20 children with complex needs were invited to act as patients. This event provided the opportunity for patients and parents to feedback about the care that they received and what improvements would help them when attending the hospital.
- In addition Dolphin OPD supported two secondary school students to assist as volunteers in the department on work placements. This provided a valuable method of local engagement with young people as well as encouraging a career within the health service.
- Safari and Tiger ward had received a large number of donations from the public and parents whose children had been inpatients on the ward. This supported them to purchase new toys and games, as well as crockery for the parents' room and sensory equipment to support children's needs.
- A quality ward review had been introduced throughout the hospital five months before the inspection and was carried out on a fortnightly basis by the matron. This centred on patient experience and the environment and included the views of three parents or older children and young people.

Staff engagement

- Nursing staff were encouraged and supported to develop areas of interest and act as a source of advice and training for the team, such as becoming a link nurse for a specialist subject, for example in diabetes.
- Safari Ward had regular staff meetings and also had a suggestion box so that staff could put forward proposals

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anonymously. Team champions had been selected for each band and there were plans for them to meet regularly with the matron and senior ward staff to share ideas and feedback.

- The 2016 staff survey results found that out of 38 responses at the hospital the vast majority (73%) stated they were always or often enthusiastic about their job which was equal to the national rates of 72%.
- In three questions on the 2016 staff survey which asked whether respondents were involved in deciding, suggestions or making improvements to the service or department the majority of respondents agreed or strongly agreed. These scored an average of 53% across the three questions which was lower than the national average of 63% across the same three questions.







Innovation, improvement and sustainability

- The trust held an annual 'Healthcare Heroes Awards' to celebrate staff achievements and dedication. Safari Ward staff had received two nominations for the 2016 awards and had received the top honour overall. One

nomination had been from the matron and the other from a parent whose son had been cared for on the ward. Some staff we spoke with told us that this was a good way of recognising staff that went the extra mile to improve patients' experience.

- The quality ward round which had been introduced throughout the hospital five months before the inspection was identified as a key way of senior staff engaging with patients, parents and staff on a 'back to the floor' level and driving improvement.
- The trust had introduced a 'Hot topics' poster that included a 'QR' code that staff could scan on their phone for more details. A 'QR' code is a quick response code, consisting of a matrix barcode that stores information capable of being read by the camera of a smartphone. An example of a hot topics poster produced for children's services was about extravasation (when drugs or fluid leak into surrounding tissue) and the QR code linked to information about the Visual Infusion Phlebitis score tool used for monitoring sites.

End of life care

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

Information about the service

End of life care in the hospital is provided by trust staff throughout the hospital.

Specialist Palliative Care services at the Queen Elizabeth Hospital are provided by a small team of a palliative care consultant, staff grade doctor, nurse consultant, 1.6WTE Clinical Nurse Specialists (CNS), a discharge coordinator and an administrator. At the time of inspection, the team had an additional full time CNS vacancy. The team is managed by Greenwich & Bexley Community Hospice (GBCH) who are also responsible for all other adult specialist palliative care in the boroughs of Greenwich and Bexley, the service is directly commissioned by Greenwich and Bexley CCGs. The service operates a visiting service Monday to Friday between 9am and 5pm and provides telephone advice and support to hospital staff 24-hours, seven days a week.

This inspection report refers to the GBCH service but, only the end of life care planning and provision under the direct control of the trust contributes to the rating as GBCH holds a separate registration with us. The medical consultant and staff grade doctor are employed by the trust but are managed by GBCH.

Specialist palliative care services were provided within the division of long term conditions and cancer.

There is a mortuary on site with fridge capacity for 59 adult bodies and six compartments for babies. This includes four bariatric fridges and ability to flex fridges for those who had

died with an infectious disease. The services does not have freezers for adults and has one small freezer for babies only. A bereavement office and multi-faith chaplaincy service is also available.

The trust did not keep data on the number of specialist palliative care referrals made from the hospital to GBCH or the number of patients cared for on an end of life care pathway. We are therefore unable to determine a number of key quality or performance metrics for this service.

During our inspection we observed limited interactions between end of life care patients, relatives and staff. This totalled seven patients on an end of life care pathway.

We previously inspected end of life care services in May 2014, which resulted in a rating of requires improvement. This reflected a lack of consistency and coherence in how ward staff applied end of life care. The hospital did not have data about the number of patients referred to the specialist palliative care team or on the numbers of patients seen with specific long term conditions. There were gaps and inconsistencies in the completion of records, specifically in relation to do not resuscitate orders and use of the early warning scores system for deteriorating patients. Multidisciplinary meetings did not involve the bereavement office, which meant they were unable to discuss issues or share learning.

End of life care

Summary of findings

We rated this service as inadequate because:

- We found persistent confusion with regards to the nature of end of life care services and specialist palliative care services across the hospital. This was due to unclear contractual agreements and a lack of communication between the trust and ward-level staff with regards to the service.
- We observed inconsistent levels of care from ward staff in relation to patients on an end of life care pathway. This included care that did not always ensure dignity and privacy.
- The service could not demonstrate a sustained improvement in patient records, including in risk assessments. We found staff did not always keep these up to date and there were inconsistencies in the recording of observations when patients were transferred to an end of life care pathway.
- Systems to address patient risk were in place but used variably. For example, staff used the national early warning scores system consistently but there was limited knowledge and implementation of the end of life care reassessment protocol.
- There were gaps in understanding of how to initiate the end of life care pathway amongst some medical staff. Referrals were sometimes specific and it wasn't clear if, where appropriate, referrals were made to the SPC team.
- SPC services did not have an established audit programme. The last audit had taken place in October 2015 and there was very limited evidence of progress following this. The trust had not released data specific to this hospital following a national end of life care audit in 2016 and local staff were unsure of actions or outcomes. After our inspection the trust told us as only two individuals provided the substantive service, audits were not possible due to clinical pressures. This meant the service was not able to benchmark care against national or best practice standards.
- There were limited facilities for the relatives of deceased patients and no dedicated quiet bereavement areas.
- Although complaints were tracked and responded to, there was no evidence of an overarching drive to

identify and implement improvements. There were also no action plans or evidence of a strategy to improve the most common theme, which related to poor communication.

- Clinical governance and leadership structures did not demonstrably contribute the operation and development of the service. This included governance meetings that were poorly attended and a lack of action or planning as a result of identified problems. The hospital was slow to respond to findings from audits, including a projected gap of over two years in establishing a feedback process for relatives and patients.
- Staff did not believe the service was sustainable and raised concerns with us about what they felt were significant safety risks.

However:

- There was evidence of learning and improvements in service and practice as a result of incident investigations. Staff were proactive in identifying risks and submitting incident reports.
- There had been improvements in medicine management since our last inspection in February 2014. This included better training for medical and nursing staff and guidance on prescribing for anticipatory medicine.
- A carer's charter was in place in the hospital and staff had adopted the principles of the national John's Campaign to provide a more welcoming and flexible approach to carers visiting patients.
- The palliative care team had established a daily care plan review strategy to ensure individual needs were met, including social needs and the needs of relatives. We did not see consistent evidence that this was completed.
- Despite the lack of demonstrable improvement relating to complaints, the trust had invested in efforts to improve this such as training in breaking bad news.

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Are end of life care services safe?

Requires improvement



We rated safe as requires improvement because:

- The hospital specialist palliative care service is provided by Greenwich & Bexley Community Hospice, this service is directly commissioned by NHS Greenwich and NHS Bexley. Although this service was available for telephone advice 24-hours, because the visiting service is only 5 days a week, there were significant and consistent gaps in the ability of the service to respond to increasing need. This included short staffing due to an unsuccessful attempt to recruit consultant full time CNS.
- Out of hours cover arrangements for consultants were unclear and ward staff had varying levels of understanding of the end of life care provision overnight and at weekends.
- Risk assessments, medical and nursing notes were not always kept up to date. We found that patients cared for on an end of life care pathway had inconsistent access to medical staff and structured care.
- There were gaps in patient records in relation to end of life care. For example, we found some patients were documented as being cared for on an end of life care pathway but there was no record of a referral or appropriate review. It wasn't clear if, where appropriate, referrals should have been made to the SPC team.
- The SPC team established a reassessment protocol as part of the trust's principles of care for dying patients pathway. Although this was an improvement in how the staff responded to patient risk, we did not find consistent, thorough understanding of this amongst medical teams and there was limited evidence of implementation in patient records.

However:

- SPC staff and mortuary staff demonstrated a proactive approach to submitting incident reports, which we saw were investigated and used to improve practice and policy. This included the introduction of improved guidance for staff to correctly identify deceased patients before they were transferred to the mortuary.

- Safety processes in the mortuary were well established and the mortuary manager maintained an accurate log of records such as fridge temperatures and the details of bodies received there.
- Infection control measures in the mortuary had been updated with the implementation of the principles of care of the dying patient framework. This included regular external audits to identify areas for improvement and comprehensive policies for porters and nurses in the transfer of deceased patients.
- Medicines management processes had been improved since our last inspection in May 2014. This was because medical staff had better access to anticipatory medicine prescribing guidance and dedicated pharmacy support was in place, particularly in relation to cancer care.
- Standards of mandatory training, including safeguarding training met the trust's minimum target amongst the SPC care, mortuary and bereavement office teams.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between December 2015 and November 2016, SPC services did not report any Never Events.
- In accordance with the Serious Incident Framework 2015, SPC services reported no serious incidents between December 2015 and November 2016.
- In the same period, SPC services reported seven incidents, six of which resulted in no harm and one resulted in low harm. Three incidents related to infrastructure or staffing, two related to grade two pressure ulcers, one was a medication incident and another related to access and flow. The service tracked the location of incidents to identify any areas or wards in which additional support was needed. However, in this period the seven incidents occurred in six different areas and there was no identifiable pattern to this.
- In the same period the mortuary reported 33 incidents, all of which resulted in no harm. Five incidents related to critical care and three incidents related each to the

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AMU, ward 16 and ward 19. The remaining incidents took place across five different wards. We spoke with the mortuary manager about the incidents who told us most related to missing identity bands on patients who were brought to the mortuary. They said most patients did not have a wrist band and one patient had two wrist bands. As a result a new checklist was implemented to remind ward nurses to ensure the patient had an identity band before being moved.

- The chaplaincy did not report any incidents in the 12 months prior to our inspection..
- The end of life care steering group, which maintained oversight of end of life care in the trust , reviewed incidents at six weekly meetings and provided individual feedback to reporting members of staff.
- A clinical effectiveness coordinator worked across the hospital to review patient deaths as part of a monthly mortality review meeting.

Cleanliness, infection control and hygiene

- An up to date infection prevention and control policy was in place and applied to nursing staff, mortuary staff and portering staff involved in the preparation, transport and storage of deceased patients. This included guidance on the use of personal protective equipment (PPE), managing hygiene and ensuring cadavers were safely prepared for viewing by family members. From our observations in the mortuary we saw staff adhered to this policy.
- Staff used body bags for patients who had died with an infectious disease or where there was a leakage. In such cases ward staff notified the mortuary separately to ensure infection control procedures were followed.
- We saw appropriate use of PPE in the mortuary and amongst staff moving patient bodies, including disposable gloves and aprons.
- An external infection control specialist conducted a cleaning audit of the mortuary every three months. This included all areas of the environment such as low and high surfaces, floors, showers and sinks. The latest available audit results were from September 2016 (97%) and December 2016 (92%). In December 2016 five areas achieved 100% and other areas ranged from 75% for a

store room to 93% for an office. The most common area of non-compliance in December 2016 was the cleaning of high-level services. In September 2016 the most common area was low-level surfaces.

- The digital thermometer used to check fridges were maintained appropriately could not be used due to a broken printer, which had not been fixed since being reported in December 2016. The mortuary manager recorded temperatures daily in a log book instead and we saw the temperature range had been maintained consistently between three degrees Celsius and six degrees Celsius.

Medicines

- The medicines management committee had implemented a non-medical prescribing policy for nurses, pharmacists and allied health professionals. This enabled appropriately trained staff to administer medicines against patient group directions. This meant patients had access to medicine without the need to wait for a doctor.
- A principle pharmacist for cancer was in post and provided specialist medicine reviews and advice.
- Junior doctors were trained to prescribe end of life care medicine and those individuals we spoke with could explain this process and how they could obtain support.
- The Greenwich and Bexley Community Hospice (GBCH) team ensured anticipatory medicine was available for patients, including discharge medicine before the district nursing team took over their care. Staff prescribed this in accordance with the hospital's symptom control guidance, which was up to date and readily available to staff.
- Pharmacy staff conducted daily spot checks of the storage of controlled drugs (CDs) and ward nurses ensured these were always administered and signed for by two nurses. Medicines were stored and audited on individual wards and not by the end of life care team. The GBCH team prescribed medicine, following hospital policy, which was then dispensed from the hospital's pharmacy department.

Records.

- The specialist palliative care team used a mixture of paper notes and electronic records. Their intervention

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was documented in the ward notes and these were copied and inserted into their own record which could also be viewed by the wider hospice team. It was not always possible to differentiate between nursing and SPC notes in patient records.

- Although ward doctors and nurses demonstrated awareness and knowledge of the end of life care pathway and contacting the SPC team, it was not always evident that referrals were documented. For example, on one day of our inspection on ward 19, a patient had been seen by the palliative care team but there was no evidence of a formal referral from a clinician. In addition, a healthcare assistant told us trust volunteers regularly visited the patient but there was no evidence of this documented and during our inspection no volunteers were available.
- The trust planned to implement a centralised end of life care patient records and tracking system by March 2018 to ensure staff had rapid, seamless access to care plans and medicine reviews.
- The chaplaincy team recorded notes of discussions and meetings with patients and relatives in patient records and marked these with a brightly coloured 'Chaplaincy: Spiritual Care' sticker. This team also kept a contact log book to help them track when they had spoken to people and plan to return at an appropriate time.
- We looked at the records of 10 patients who were on an end of life care pathway on wards 20 and 21. In each case there was a clear record of a doctor-led decision to complete a do not attempt resuscitation (DNACPR) authorisation as well as appropriate risk assessments. However, this was not a consistent finding. For example, during our weekend unannounced inspection we looked at the notes of three patients who were being cared for on the end of life care pathway. All patients had an appropriate do not resuscitate authorisation in place and each patient had their consultant clearly noted. However, risk assessments and observational notes were not clearly documented. For example, one patient had no documented fluid balance, daily stool chart or wound assessment in over four weeks. Although daily medical reviews had been documented, there was no regular structured assessment for specific

risks. We spoke with a nurse about this who said if they were given instructions to stop observations they would do so but the reasons for this would not necessarily be documented.

- Porters completed a log in the mortuary on delivery of a body and this information was verified by the mortuary manager and entered into a local log, which we saw in practice.

Safeguarding

- Both members of the mortuary team, the bereavement team and the end of life care team had up to date safeguarding training.
- The SPC team and ward staff referred to the safeguarding lead proactively when they had concerns about a patient's welfare. This included in relation to family members, home care or visitors.

Mandatory training

- As the main employer GBCH provided mandatory training to the hospital's SPC team in addition to the trust's basic training. Both members of the trust's SPC team had up to date mandatory training that met the minimum requirement of 85% completion.
- The mortuary manager and agency mortuary technician were up to date with mandatory training. This was provided by the agency for the technician and the mortuary manager ensured it was kept up to date.

Assessing and responding to patient risk

- The trust established a reassessment protocol as part of their principles of care for dying patients pathway. This included a minimum of four hourly reviews by nursing staff and daily review by the medical team. The reassessment protocol instructed nursing staff to escalate the patient's care to the specialist palliative care team if the patient experienced uncontrolled symptoms or the multidisciplinary team felt the care and treatment plan was not working. Not all ward staff we spoke with were aware of this and there was not always evidence of it taking place from looking at patient notes.
- We saw consistent use of the national early warning scores (NEWS) system in medical inpatient wards. This included escalation of deteriorating patients to the critical care outreach team (CCOT). However, some

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clinical staff raised concerns with us about the effective use of the NEWS tool by nurses out of hours. In addition although the GBCH team were available for specialist palliative care on a 24-hour basis, ward staff were not always clear when they should be contacted. For example, some nurses said they would contact the CCOT team if a patient deteriorated, others said they would declare a peri-arrest to the resuscitation team and others said they would attempt to contact the end of life or GBCH teams. After our inspection the trust told us they did not have an end of life care team or service at this site and so it was not clear who staff were referring to when they repeatedly spoke about the end of life care team.

- An alarm system was fitted to the mortuary fridges and alerted estates staff out of hours if the equipment failed. An emergency protocol was in place to ensure bodies were not compromised as a result of this through arrangements with other local mortuaries.
- Where bodies were received in the mortuary with the same name, the mortuary manager highlighted this on the mortuary board and in the log book.

Nursing staffing

- The SPC service had a nurse consultant, 1.6 WTE CNSs and a discharge coordinator, in addition there was 1 WTE vacancy at the time of the inspection. The Hospice had been unsuccessful in recruiting. This impacted on patient care because the low staffing levels meant the service was not able to provide a seven day face to face service and it was not always able to meet the needs of all the patients. The GBCH service provided specialist telephone advice out of hours.
- The Macmillan Brook ward, ward 21, had provision to provide inpatient end of life care but did not have dedicated palliative care beds. In October 2016 the ward had a nursing staff fill rate of 95% for day shifts and 100% for nightshifts. In the same month 97% of day shifts and 96% for night shifts for healthcare assistants were filled.

Medical staffing

- A palliative care consultant working across the hospital and Hospice and a staff grade doctor provided face to face medical care for patients with specialist palliative

care needs Monday to Friday. Staff we spoke with on the wards were unsure of who the doctors were or of how to contact them, unless they had already been to review a patient.

- We were told consultants from another NHS trust provided on-call support at weekends but during our unannounced inspection ward-based staff we spoke with were unaware of this arrangement. GBCH provides an out of hours telephone support service.
- A mortuary manager led the mortuary service at this site and University Hospital Lewisham as well as leading cellular pathology. An agency mortuary technician was in post as a permanent role had been vacant for two years without successful recruitment.

Major incident awareness and training

- The mortuary had a major incident and business continuity plan in place. This included an arrangement with a local funeral provider to receive up to 165 bodies in the event of mass casualties.
- Hospital and GBCH staff worked across all hospital areas and were subject to the business continuity plans of the wards or clinical areas in which they were based at the time of an incident. GBCH had its own organisational major incident plan to ensure continuity of care for patients.

Are end of life care services effective?

Inadequate



We rated effective as inadequate because:

- At our previous inspection in February 2014 the trust was in the process of establishing a framework for all staff to use on the principles of care of the dying patient. At this inspection we saw the framework was in place and staff had access to this throughout the hospital. However, there was limited understanding of this and the service had not completed any audits or benchmarking exercises to establish the effectiveness of the framework.

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- No local audit activity had taken place specifically for end of life care at this hospital in the previous 12 months. The last audit data related to October 2015 and there were significant gaps in progress and a lack of evidence of planned, structured improvements.
- The trust participated in the national care of the dying audit and the latest available results were published in May 2016. However, outcomes specific to this site were not available and the specialist palliative care team said they were unaware of any action plans or requirements as a result of it.
- We found variable use of end of life care pathways across the hospital. This included missing, inappropriate and incomplete referrals. Junior doctors and nurses demonstrated varying levels of knowledge on the use of such pathways.
- Short staffing on one ward had resulted in no care plan being prepared for a patient who was placed on an end of life care pathway.
- Equipment necessary to reduce patient risk was not always immediately available. This included waits of over 24 hours for air mattresses.
- Patient outcomes were significantly affected by a lack of capacity and the inability of the service to meet needs. For example, 50% of patients were referred to the specialist palliative care team too late and in January 2017 24% of referrals were not seen. There was no evidence senior divisional teams were aware of this and no demonstrable strategy to improve it.
- Organ donation was carried out in line with National Institute of Health and Care Excellence clinical guidance 135 Organ Donation for Transplantation and audited against the referral guidance of the NHS Blood and Transplant special health authority.
- Pain relief was readily available and staff prescribed anticipatory medicine as well as syringe drivers and opioids in accordance with local prescribing guidance.
- Speech and language therapists and dieticians provided individualised nutrition plans for patients.
- As part of the 2016 – 2019 end of life care strategy, training in end of life care and the use of syringe drivers was being rolled out across the hospital. A three hour training session as part of induction for healthcare assistants had already been established. This represented a broad improvement in education in end of life care.

Evidence-based care and treatment

However:

- End of life care was provided by a multidisciplinary team according to the principles of an 'Aspiring to Excellence' programme that included a number of improvements including the new care framework and establishment of end of life care link practitioners. This included link practitioners and a range of clinical specialists and support services.
- The Macmillan cancer lead nurse had established a 'care of the deceased and their family and friends' policy in consultation with the end of life care working group to provide ward staff with more structured support.
- The multidisciplinary team provided care for dying patients in line with a set of principles established from the 2013 independent review of the Liverpool Care Pathway. The principles established the requirements of clinicians to provide high-quality care to patients. In addition, the trust implemented a number of improvements under the 'Aspiring to Excellence' programme. This included the implementation of a Principles of Care for Dying patients policy, the implementation of a treatment escalation plan and provision of new syringe drivers. In addition, end of life care link practitioners were established across the trust by the Macmillan lead cancer nurse.
- Ward-based staff had access to the hospital's principles of care for the dying patient framework. Although this was provided on the care of the elderly wards, not all staff we spoke with were aware of it.
- There was limited evidence of local audit activity specific to end of life care at the Queen Elizabeth Hospital. However the specialist palliative care (SPC) team had implemented a bereavement audit and end of life care documentation audit for specialist palliative care. The first results from both audits were due to be published between June 2017 and August 2017.
- The Macmillan cancer lead nurse had established a 'care of the deceased and their family and friends' policy in

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consultation with the end of life care working group and heads of nursing and matrons. This policy provided ward staff with a checklist and template to use following a ward death and guidance for staff on maintaining safety, privacy and dignity as well as adhering to the patient's cultural or religious wishes.

- The specialist nurse organ donation and clinical lead organ donation implemented an organ and tissue donation policy in line with NICE clinical guidance 135 Organ Donation for Transplantation. This included adherence to the best practice guidance and national policy of organisations such as UK Transplant, the Human Tissue Authority and NHS Blood and Transplant.
- We found variable standards of appropriate use of end of life care pathways. For example, one patient on ward 20 had a status of 'end of life care' but there was no record of an associated care plan. We spoke with the senior nurse on the ward who told us short staffing on the ward meant there was a shortage of paperwork and forms and the end of life care plan was paper-based. They were not able to locate any copies of this and we were not able to find a member of staff who could explain the plan for the patient. There was an end of life care section in the patient's nursing assessment book but this was blank.
- The hospital's principles of care for dying patients pathway indicated that the decision to commence an end of life care plan should be consultant-led in consultation with a senior nurse with knowledge of the patient. Where a consultant was not available, an experienced registrar could make this decision provided they liaised with a senior nurse and after discussion with an available consultant. We saw this happened in practice from looking at patient records.
- Rates of organ donation were very small and between April 2016 and March 2017 represented 0.2% of the total organ donation patients nationally. However, the trust audited performance against the referral and quality guidance of the NHS Blood and Transplant (NHSBT) special health authority and demonstrated performance better than national averages. For example, the hospital achieved a 98% referral rate using the NHSBT referral criteria for donation after brain death or circulatory

death. This was better than the national average of 91%. In addition, the hospital achieved a 100% testing rate for neurological death, which was better than the national average of 86%.

Pain relief

- From looking at patient notes we saw staff consistently documented pain relief plans and administration. We also observed doctors arrange for a syringe driver to be provided quickly for a patient who deteriorated whilst admitted to the AMU. In addition, pain analgesia was provided and nurses were able to administer as-needed pain medicine following instructions from a doctor.
- The palliative care team provided end of life symptom control and pain relief in line with a trust policy that had been updated in November 2016. From looking at patient records we saw staff used the treatment algorithm for pain to assess the need for a syringe driver and opioids.
- Ward staff were able to assess pain and prescribe medicine in accordance with the hospital's symptom control guidance and with the support of the SPC team or end of life care link nurses. For complex pain management, staff referred to the SPC team.
- The most recent audit of pain relief was from October 2015 and found 76% of patients had anticipatory pain medicine prescribed. There was no evidence this had been re-audited or that there was an action plan in place to improve it.

Equipment

- Ward staff were able to order specialist equipment for patients on a palliative care pathway. This included airflow mattresses. However, the ordering process did not guarantee a fast response. For example, on one day of our inspection a patient on ward 19 had waited over 24 hours for a special mattress to be delivered despite having significant needs and risks.

Nutrition and hydration

- A designated dietician was available on referral and we saw evidence of their involvement from reviewing patient notes. This included use of the malnutrition universal scoring tool and regular assessments for

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dehydration. We observed this system used consistently on the oncology ward and all inpatient wards used the 'red tray' system to identify when a patient needed one-to-one support with feeding.

- Speech and language therapists (SaLTs) provided nutrition and hydration support to patients on end of life care pathways in line with feeding protocols.
- An end of life care audit in October 2015 identified a need for improved documentation of the justification for 'nil by mouth' (NBM) orders. The audit concluded an NBM decision should only be made by a doctor, nurse or SaLT. The audit did not include an action plan, outcome or update for this finding.

Patient outcomes

- There was no formal audit programme for end of life care or SPC at this site although the SPC team had carried out some local audits to improve care. This meant the service could not demonstrate how it benchmarked practice, quality and clinical outcomes against similar services nationally. This also meant there were limited means to identify how well the service was meeting patient needs at a local level.
- The SPC team monitored current patients who were referred or being cared for on a palliative pathway using a daily tracker. This included each patient's location, main diagnosis, psychosocial and spiritual needs and their medication. However, there was no live or electronic system to track activity or the effectiveness of the service.
- The trust participated in the National Care of the Dying Audit and the latest available results were published in May 2016. Data was published at a trust-wide level and the trust was not able to provide site-level data for the Queen Elizabeth Hospital although the audit included 39 patients who had died there. The trust performed variably against national averages in the audit. The SPC team at the hospital were aware of the audit but said no actions had been identified or implemented as a result.
- The hospital did not participate in the national Gold Standards Framework.
- The lead resuscitation officer maintained up to date guidance on the use of the do not attempt

cardiopulmonary resuscitation policy for clinical staff. This documentation was readily available on each ward, on the staff intranet and attached to each resuscitation trolley.

- Between April 2015 and March 2016, 67% of patients referred to the palliative care team were seen within 24 hours. However, patients were often referred too late for the palliative care team to respond effectively or be able to offer substantive care. For example, in the year prior to our inspection 50% of the patients referred to the SPC team were already dying. In addition, 24% of patients referred to the end of life care team in January 2017 were not seen due to a lack of capacity or because they were a 5 day service and referrals were not actioned over the weekend. It was not evident that senior division teams were aware of referral delays. For example, the leads for acute and emergency medicine told us there was, "never a palliative care delay" and said that senior nurses could make referrals without the need to consult a doctor.
- Trust staff and the GBCH SPC team provided care for the dying adult in line with a series of algorithms established as part of the clinical guidelines for symptom control in the dying adult policy. This enabled staff to ensure symptom control for breathlessness, nausea and vomiting, restlessness and agitation and respiratory tract secretions. In the records we looked at we saw evidence staff assessed individual need against each of these areas.
- The end of life care team had worked with the care of the elderly clinical team to develop and implement a 'proactive elderly advance care' (PEACE) framework for patients admitted to hospital who normally lived in a care home. This aimed to enable clinicians to more effectively identify patients who would benefit from end of life care and to structure an appropriate care and discharge plan with input from care home staff who knew the patient. This was a new initiative from March 2017 and the end of life care steering group was in the process of disseminating it.

Competent staff

- Ward staff nurses had basic end of life care training and care of the elderly ward nurses had completed an end of life care training course as part of a recent away day.

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- Healthcare assistants undertook a three hour end of life care training programme as part of their induction and nurses undertook this training as part of preceptorship and nursing development programmes. In addition, medical staff undertook an annual grand round on end of life care and all foundation level doctors received specialist palliative care training as part of their induction.
- The specialist palliative care team had delivered training to healthcare assistants and nurses across the hospital as part of the 2016 – 2019 end of life care strategy. From our observations not all staff were knowledgeable or trained on the use of syringe drivers, but training was being gradually completed between 2017 and 2018.
- Between 2015 and 2016, 1617 band five and six staff completed end of life care training, including 12 endoscopy nurse practitioners, junior sisters, ward managers, tissue viability nurses and bank nurses. This included nurses from all acute medical areas, the discharge lounge, endoscopy unit, emergency department and laboratories as well as non-clinical staff of a similar grade.
- All clinical staff undertook end of life care training as part of their initial induction.
- The SPC team provided training to ward teams on the use of the palliative care pathway and how to use the guidelines.
- Healthcare assistants on care of the elderly wards had been trained to provide care to patients living with dementia as well as companionship to patients being care for on an end of life care pathway.
- End of life care link nurses were in post across medical wards and received training in the use of syringe drivers and anticipatory medicine. Syringe driver training was repeated annually and nurses on the oncology ward provided ad-hoc support and updates.
- End of life care link nurses we spoke with demonstrated knowledge of the five priorities of care for dying patients. This group of staff met with the end of life care team three times each year to discuss cases and update training. Recent training had included communication training to be able to hold difficult conversations with patients and relatives.
- Ward teams were supportive of student nurses and assigned them a mentor to support their learning and development. This had a demonstrably positive effect. For example, we spoke with a third year student nurse of ward 21 who had returned to the ward electively following an earlier placement there. The ward's end of life care link nurse was their mentor and had provided clinical guidance in active curative and non-curative prescribing as well as palliative and end of life care pathways and care.
- We spoke with a ward sister and core medical trainee on ward 14 who had both received educational sessions on palliative care. Both members of staff demonstrated a good level of knowledge of their responsibilities after a patient died, including in relation to caring for relatives and transferring the body to the mortuary.

Multidisciplinary working

- A weekly multidisciplinary team meeting took place between the SPC team, and specialist nurses, consultants and allied health professionals (AHPs) from across the site. The children's ward team also joined this meeting.
- The speech and language therapy team were involved in care planning for each patient on an end of life care pathway.
- A range of multidisciplinary staff contributed to end of life and specialist palliative care pathways. This included a Macmillan lead cancer nurse, the lead resuscitation officer, a lay representative communication officer, elderly medicine nurses and allied health professionals, paediatricians, nurse development manager, the head of PALs, chaplaincy and pharmacists.
- Two community HIV nurses and the clinical director of the Trafalgar Clinic supported the trust in providing care and treatment for HIV positive patients.
- The SPC team or end of life care link nurses liaised with district nurses to enable patients discharged home had seamless access to medicine and syringe drivers. The team coordinating each discharge ensured that the to take away medicine prescription was sufficient to meet the patient's needs until the first planned visit from a district nurse.

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- There was evidence that clinical staff used end of life care referrals and pathways inconsistently. For example, a SaLT had intervened in a situation where a junior doctor was telling a patient they were being cared for on a palliative care pathway, but they had not been formally referred. This meant the patient would not have received the appropriate specialist care or medicines. We spoke with seven AHPs who said they often identified gaps in knowledge of palliative care amongst clinicians and they needed to provide one-to-one support in the absence of a seven day permanent specialist palliative care team presence every day. Similarly, we found one patient was on the register of end of life care patients, but there was no record of a discussion with the patient about this, despite them being able to communicate.
- The mortuary team and bereavement team worked closely together to support families, but there was limited multidisciplinary working with the end of life care team.

Seven-day services

- An end of life care audit in October 2015 identified the need for a review of out of hours and seven day palliative care services. This was due to be completed in March 2018 and there was no indication work had taken place between these dates to assess the times of service provision.
- Palliative care services were provided 24-hours, seven days a week provided by the hospice.
- The mortuary service was provided Monday to Friday from 8am to 4pm. Outside of these hours the mortuary was accessible through the site manager.

Access to information

- SPC staff had access to medical and nursing notes on the wards. They also liaised with district nurses to ensure patient discharge notes included a summary of prescriptions and anticipatory medicine.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The SPC team supported clinicians with the completion of do not attempt resuscitation (DNACPR) documentation when appropriate. For example, the team liaised with family members during the

decision-making process and ensured the wishes of the patients were reflected. We saw evidence of this from looking at patient records and also saw that consultants and registrars documented best interests decisions and who had been involved in these. For example, we saw examples of multidisciplinary decision-making between consultants, social workers, the GBCH team and patient's relatives.

- The chaplaincy team saw all patients provided they had their consent or the consent of a person the patient had nominated to make decisions on their behalf.
- We looked at 10 patient records of patients receiving end of life care. None of the patients had mental capacity, but there was no evidence of an assessment in any of the cases. However, a doctor had completed a best interest's decision in each case.
- The developing PEACE framework included a requirement that clinical staff planning an end of life care plan include patients as far as possible in this, including by obtaining consent and adhering to the principles of the Mental Capacity Act (2005) when a patient lacked capacity.

Are end of life care services caring?

Requires improvement 

We rated caring as requires improvement because:

- We did not always find that ward staff had the knowledge, training or resources to provide appropriate levels of dignity and privacy.
- The hospital had not acted on an October 2015 audit that identified a need for improvement in how staff documented the justification for not discussing end of life care needs with patients and relatives.
- There was no system in place to track or assess standards of documentation in relation to organ donation and other elements of the principles of care for dying patients pathway. This meant the service could not be assured of the standard of service it was providing.

However:

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- The chaplaincy provided a multi-faith service that was available 24-hours, seven days a week. The team was able to provide talking therapy as well as spiritual and religious services, including the provision of prayer beads and lavender bags.
- The mortuary team provided compassionate care through the provision of body washing and same-day body release.
- The hospital had subscribed to the John's Campaign carer's charter to ensure staff facilitated a more accessible and flexible environment for carers.
- At this inspection we noted the dedication and compassion of the mortuary team and bereavement office staff.

Compassionate care

- The chaplaincy provided items free of charge to patients to help with them with emotional, spiritual and religious needs. This included holding crosses, prayer beads for different religions and lavender bags.
- The mortuary team met patient's religious wishes through services such as body washing and releasing the body on the same day of death.
- We did not always see that ward staff were able to accommodate patients and relatives with dignity and respect. For example, during our observations of a handover on ward 19 we saw three relatives of a patient cared for on an end of life care pathway were crowded around their bed in a shared bay. This meant the space was so cramped staff could not access it and had to ask the relatives to move to be able to carry out observations. This also meant the patient and their family had no privacy. Staff also carried out an open discussion of how to use the syringe driver in front of the patient's relatives without explaining to them what they were doing.

Understanding and involvement of patients and those close to them

- An end of life care audit in October 2015 identified a lack of engagement with relatives or those responsible for patients who were unconscious or lacked capacity. This was in relation to decision-making around nutrition and hydration plans. There were no documented updates or action plan to this audit result and no evidence staff

more proactively involved relatives in this way. This audit also stated that where staff had not discussed the possibility of dying with the patient or their nominated person, the reason should always be documented. The audit identified that the hospital had 'partially' met this but not to what extent or what still needed to be implemented. From looking at patient records, we did not see that this information was routinely recorded, which meant it was not clear whether relevant people had been involved in discussions.

- In all 10 of the patient records we looked at on wards 20 and 21, there was documented evidence a consultant or other appropriate doctor had discussed care planning with relatives.
- During our weekend unannounced inspection we observed positive interactions between the clinical team and the relatives of a patient who was receiving end of life care. This included involvement in clinical decision making about multiple comorbidities and documented discussions about the ceiling of care.
- Staff were guided on communicating with patients and relatives as part of the principles of care for dying patients pathway. This included a requirement to document conversations and identify and record details such as preferences around the place of care, support needs and wishes around organ and tissue donation. However, staff did not always record this and the hospital did not routinely collect or audit it. This meant the service was unable to demonstrate their track record in this.

Emotional support

- A carer's charter was in place in the hospital and staff had adopted the principles of the national John's Campaign to provide a more welcoming and flexible approach to carers visiting patients. This included ensuring staff provided emotional support where needed and facilitated visiting hours to meet individual needs, including those of patients cared for on an end of life care pathway. This campaign was advertised around the hospital and clinical staff demonstrated knowledge of the principles of this during our discussions.
- Care after death, bereavement and chaplaincy support formed a key element of the principles of care for dying patients pathway. This included a requirement for timely certification of death, informing the

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multidisciplinary team involved in care and providing the family with the trust's bereavement booklet. We saw this took place in practice, but the service did not audit this, which meant we could not be certain this took place consistently.

- The chaplaincy team provided on-demand bereavement support for relatives. At the time of our inspection pressures on the chaplaincy team due to short staffing meant they could not send out a bereavement card to the families of deceased patients. However, this was part of the team's development plan for 2017.
- A psychologist had recently been appointed who would provide dedicated support to end of life care oncology patients and their relatives.

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Patients who transitioned to an end of life care status whilst an inpatient in the hospital received variable levels of specialist input.
- There was evidence of poor and inconsistent communication between teams, including between medical teams and allied health professionals. This resulted in delayed or inappropriate care.
- There were no dedicated facilities for bereaved relatives. This meant people had to find private space depending on the ward their family member died on.
- There were no rapid discharge pathways in place and we saw ward staff had limited resources to facilitate this. However, the trust had recently established a task and finish group to develop and implement a dedicated pathway for end of life care discharge.
- Patients could be discharged to Foxbury ward, which provided community-based end of life care. However, staff at this site raised concerns with us that discharges were poorly planned and unsafe. There was no audit or tracking data to help us investigate this further.
- Complaints indicated variable and sometimes poor levels of communication between staff in different

departments and with relatives. Although trends and themes were highlighted and there was a governance process in place to review complaints, there were no structure action plans to implement improvements.

However:

- The chaplaincy team worked to a patient-led model that included a daily 'walk around' of the whole site to proactively offer support to patients, relatives and visitors.
- Services and resources were available to meet people's needs. For example, a baby remembrance book was available at the chapel and the chaplaincy team were able to assist with hospital funerals. In addition the mortuary was equipped to accommodate bariatric patients.
- The trust had established a daily care plan review strategy to ensure each patient on a specific pathway had their individual needs reviewed, including social and psychological needs. However, we saw limited evidence this consistently took place in practice.

Service planning and delivery to meet the needs of local people

- Patients known to the community palliative care team were seen immediately on admission by the hospital team. Where patients were admitted and transitioned to an end of life care pathway, they typically received variable levels of specialist care. For example, one member of staff said, "If a patient is not known to us then their care is hit and miss. Getting them seen and getting equipment for them is variable."
- Ward 21 was an oncology ward equipped with resources for end of life care. Ward nurses were trained in end of life care, but for specialist palliative care needs they contacted the specialist palliative care team.
- The allied health professional (AHP) team described difficulties in communication between the medical team and the specialist palliative care team that resulted in poor planning for patients. For example, staff said even if a patient had a hospital bed at home and district nursing care in place, doctors did not always have access to this information. This meant

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communication with patients and relatives was often confused and patients were sometimes inappropriately referred to a hospice when their preferred place of death was at home.

- The chaplaincy team conducted a daily 'walkaround' of the hospital's inpatient areas to be a visible presence and to proactively be available if anyone wanted to talk to them. This team provided a variety of services, including time to chat, remembrance and to meet religious or spiritual needs. This was in accordance with a patient-led model that enabled staff to encourage patients to discuss their needs and lead the discussion.
- The chaplaincy team provided support in arranging hospital funerals including for the parents of children to take important items with them, such as clothes, toys or products of conception.
- A memory book for babies was kept in the chapel.
- Annual remembrance services were held at a nearby chapel, one for babies and children and a second for adults.
- The mortuary had two bariatric trollies and a bariatric hoist to ensure they could meet the needs of bodies up to 413kg in weight. Four bariatric fridges were also available.
- A process was in place in the mortuary for unidentified bodies, which included a transfer to a nearby public mortuary.
- A clinical lead and nurse specialist for organ donation were in post and monitored the hospital's compliance with the referral guidance of the NHS Blood and Transplant special health authority. Although overall numbers of organ donation were small, the hospital demonstrated an improvement in referral criteria between 2015 and 2017. This included 100% neurological death testing rate in 2016/17 compared to 80% in 2015/16. In addition, staff achieved a 67% success rate in consent for donation after brain death in 2016/17 compared to 25% in 2015/16. In the same period in donations after circulatory death, staff improved the consent rate from 50% to 75%.

Meeting people's individual needs

- The trust had established a daily care plan review strategy as part of the trust's principles of care for dying

patients pathway. This included the requirement to identify the support needs of the patient's family and ensure they were accommodated on site as far as possible. The strategy also included guidance on identifying spiritual needs and maintaining basic care such as bladder and bowel function and oral care. We did not see documented evidence of this in patient records.

- The chaplain provided needs-based services 24-hours, seven days a week. A team of 11 provided services on-site for major faiths, with the capacity to source other faiths in if needed. This service had a new team of 28 volunteers who would also provide spiritual and religious support services to patients and their families. This team was being trained at the time of our inspection.
- Printed information was available for patients, relatives and staff on the scope of the chaplaincy service and how to contact staff and volunteers out of hours and in an emergency. Information was also provided on scheduled services, such as Sunday worship and Friday prayers.
- We asked palliative care staff about facilities for relatives, in particular a relative's room or bereavement suite. The member of staff said they did not know what facilities were available for relatives.
- The mortuary had one viewing room and two relative's rooms.
- Remembrance boxes were offered for oncology patients, including for children.
- The mortuary had implemented fridge storage for an additional 24 bodies to meet a high level of demand.

Access and flow

- The hospital did not have an established process for identifying patients on an end of life care pathway on admission. Instead clinical staff in each area would conduct their own assessment and refer to the palliative care team as needed.
- The hospital did not have a rapid discharge pathway. Instead staff worked with the GBCH team, ward-based staff and the GBCH discharge coordinator to facilitate rapid discharge of patients expected to die within days or weeks. This included referrals to the community

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palliative care team and coordination of medication. We did not see this was effective in practice. For example, one patient remained on ward 19 throughout our inspection with a 'rapid discharge' status on the end of life care pathway. We asked a senior nurse about this who told us a rapid discharge status did not make any difference to discharge times. The trust had recently established a task and finish group to develop and implement a dedicated pathway for end of life care discharge.

- Patients could be discharged to Foxbury ward, which provided community-based end of life care. However, staff at this site raised concerns with us that discharges were poorly planned and unsafe. For example, one member of staff said that because Foxbury ward had no dedicated pharmacy cover, palliative care patients would not receive the best medicine reviews. In addition they said discharges often took place overnight and with no communication with the SPC team. As the hospital did not audit this, we were not able to verify the information further.
- A non-emergency patient transport service was available on-site and could transport patients home within two hours of the request. However, this depended on the patient's discharge assessment being completed and was not related to rapid discharge.
- An end of life discharge coordinator was involved in securing care packages for end of life care patients, such as to a care home or to their family home.
- The trust monitored frequent attenders to the hospital who were cared for on an end of life care pathway. This formed part of a commissioning for quality and innovation (CQUIN) quality monitoring tool and enabled staff to identify patients whose needs may not have been met because of frequent hospital attendances.

Learning from complaints and concerns

- Between December 2015 and April 2017, the trust received SPC services documented five formal complaints about this service. Each complaint related to communication between staff and patients or relatives in different inpatient areas. In one instance staff had followed correct privacy and confidentiality protocols by following the wishes of a dying patient in not disclosing information to their relatives. However, in three cases the hospital identified gaps in communication or

professional practice from ward staff. Each instance identified a lack of understanding from ward nurses regarding end of life care practice, policy and/or communication. For example, in one instance a patient had suffered serious injuries as a result of a fall from their bed on ward 14A. The investigation could not confirm if this had contributed to their rapid medical decline afterwards and identified gaps in communication afterwards. Another investigation found poor nutrition management and poor communication from staff on ward three. The hospital provided end of life care training for nurses after this incident. SPC staff told us previous complaints related to late referrals and inappropriate treatment plans. Although these themes had been identified, there was no evidence action had been taken to make improvements. There was also additional evidence senior hospital staff were aware of issues around end of life care communication. For example, a clinical team identified poor communication with relatives as an area for urgent improvement in a mortality review meeting in February 2017. However, there was no evidence of a resolution within the following three months.

- In the 12 months prior to our inspection the mortuary service received two formal complaints. Both related to the lack of a post mortem carried out on deceased babies. The mortuary manager investigated both complaints and found the parents had not consented to a post mortem in either case. In response, they developed a modified form for parents that made the requirement for consent clearer.
- The multidisciplinary end of life care steering group reviewed complaints at monthly meetings. From looking at the minutes of meetings we saw staff discussed themes and trends. For example, in January 2017 the group identified staff discomfort with breaking bad news and late decision-making about palliative care as sources of complaints. Although this was highlighted, there were no action points or clear plans for improvement.

Are end of life care services well-led?

Inadequate



We rated well-led as inadequate because:

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- Leadership and clinical governance structures were in place. A multidisciplinary end of life care working group was responsible for clinical governance and consulted with the palliative care team, acute medicine and surgical consultants and pharmacists over end of life care policies. However, this structure had not resulted in demonstrable improvements to end of life care and we found a deterioration of services since our last inspection in February 2014. Although the trust did not provide us any information about improvements, GBCH have provided some information about evaluations they have undertaken which have shown some improvements.
- Teams involved in clinical governance had not had a positive impact on the range of gaps in service we have identified elsewhere in this report, including in the quality of records, inconsistent referral practices and significant gaps in capacity.
- We found persistent confusion with regards to the nature of end of life care services and specialist palliative care services across the hospital. This was due to unclear contractual agreements and a lack of communication between the trust and ward-level staff with regards to the service structure and provision. This included unclear referral pathways and a lack of understanding of who delivered end of life care services.
- Clinical governance meetings were attended variably, including in one case with a 54% attendance rate of those invited. The outcomes of meetings were not always clear and did not consistently result in improvements to processes, practices or care.
- The specialist palliative care (SPC) team was not aware of the sole risk to end of life care services on the corporate risk register. This related to a need for better communication with relatives and was reflected by findings from an audit in October 2015. Training for ward staff had been implemented to address this. There were no identified risks to the SPC service and no process in place to enable the team to identify related risks raised in individual wards or services.
- Staff involved with delivering palliative care spoke with us about significant concerns in relation to the operation and delivery of the service. This included concerns the service was unsafe and they had no means of escalation.

- An October 2015 audit found there was no system in place to gather feedback from patients or relatives. This was not due to be addressed until March 2018.

However:

- An end of life care strategy was in place for 2016 – 2019 and planned to improve the trust's capacity and expertise in end of life care. All staff who joined the trust after January 2017 received training on the new strategy.
- A public consultation was held in November 2016 to gather public input into the development of the new end of life care strategy. Contributors and attendees were encouraged to stay in touch and provide on-going feedback.

Leadership of service

- The Director of Nursing was the executive lead for end of life care, but the service did not have a non-executive lead.
- Greenwich and Bexley Community Hospice (GBCH) provided the specialist palliative care service at the trust. The nurse consultant and medical consultant reported in to senior staff at GBCH, who maintained responsibility for SPC services.
- GBCH supported the specialist palliative care clinical nurse specialists and the discharge coordinator reported in to the nurse consultant who was managed by the hospice Chief Executive, who maintained responsibility for end of life care services across the pathway. The Nurse Consultant had regular meetings with the Hospital EoLC leads (based on the University Hospital Lewisham) to ensure consistency and communication across the trust as a whole.
- A cellular pathology manager maintained oversight of the mortuary service, which was provided day to day by a mortuary technician.
- The assistant director of quality improvement and patient experience led the chaplaincy team, who met monthly to discuss their work and caseload. This was supplemented by a weekly huddle to ensure they could meet the immediate demands on the service and identify opportunities for multidisciplinary working.

Vision and strategy for this service

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- An end of life care strategy was in place for 2016 – 2019 that established the trust's planned trajectory of development and improvement in end of life care. The end of life care working group had established the strategy against national guidance including National Institute of Health and Care Excellence (NICE) guidelines for the care of dying adults in the last days of life and the 2015 National Palliative Care and End of Life Care Partnership Ambitions for Palliative and End of Life Care.
- All staff who joined the trust from January 2017 received training on the new strategy as part of their induction and the palliative care team had visited each ward to discuss the new strategy with the local senior team.

Governance, risk management and quality measurement

- At our previous inspection in May 2014 the trust was in the process of implementing a cross-site end of life care steering group. This was in place at the time of this inspection.
- The director of nursing and clinical quality was the end of life care trust board representative. The associate director of nursing was leading the improvement work through the corporate nursing team for end of life care.
- GBCH provided the in reach specialist palliative care. Monthly meetings were held between the lead for the GBCH service and the Macmillan lead cancer nurse. Patients identified as needing specialist input were transferred to a GBCH facility.
- The trust did not hold a service level agreement (SLA) with GBCH and instead both teams worked to a draft operational policy that was yet to be ratified by the trust board at the time of our inspection. However, following the inspection GBCH told us that a draft SLA did exist. In addition, after our inspection the trust told us they did not have a named, formal end of life care service at the Queen Elizabeth Hospital. However, the majority of ward staff we spoke with referred to an 'end of life care team' that was aligned with the trust's named end of life care strategy, steering group and other resources such as end of life care link practitioners. GBCH told us, following the inspection that a draft SLA did exist, and they had honorary contracts for the whole team and that was a directly commissioned service. This

demonstrated overall confusion and a lack of clarity about the service provision for patients at the end of life, which was evidenced by the significant gaps in service detailed in this report.

- A multidisciplinary end of life care steering group, including staff from the GBCH team, was responsible for clinical governance and consulted with the acute medicine and surgical consultants and pharmacists over end of life care policies. The group worked closely with the acute medicine governance group, the surgical governance group and the medicines management committee. The group met monthly and included representation from a wide range of specialties across the trust, including elderly care physiotherapy, a consultant paediatrician, speech and language therapy and the nurse development manager, the head of the patient advice and liaison service, chaplain and the nurse lead from the in-reach hospice service.
- We reviewed the end of life care steering group meeting minutes from November 2016 to January 2017 and found the meetings were attended variably. For example, the December 2016 meeting had a 54% attendance rate of those invited. Meetings sometimes resulted in clear action points, such as reinforcing the referral criteria for the discharge lounge, integrating end of life care policies with elderly care services and providing support to ward staff in breaking bad news. However, in other instances it was not clear what the outcome of concerns or issues were. For example, the dementia lead nurse specialist had identified a communication issue with a family whose relative was admitted near the end of life and with end stage dementia. The group identified missed opportunities in this case but these were not explicitly highlighted and there were no documented learning outcomes.
- The trust used a risk register to identify risks to the service, assign them to a responsible person and track how they were mitigated. At the time of our inspection there were no documented risks specific to the SPC service at the Queen Elizabeth Hospital and there was one risk attributed to the trust-wide service. This identified a lack of evidence that discussion with relatives about do not resuscitate certificates may cause patient best interests to be compromised. In response to this, an education programme was underway for foundation level doctors and nurses, which was due to

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be completed by the end of March 2017. Members of the palliative care team we spoke with said they were not aware of any specific risks to the service on the risk register. Risks in relation to end of life care provision were reflected by individual services in divisional risk registers as there was no centralised hospital end of life service provision.

- A link practitioner group met quarterly to track the implementation of end of life care training and identify areas for improvement in the end of life care pathway and strategy. We looked at the minutes of the meetings between September 2016 and February 2017. Staff from a surgical ward, a medical ward, the acute medical unit and the intensive care unit acted as link practitioners for the Queen Elizabeth Hospital and we also saw staff from GBCH provided support. However, there was limited evidence this approach had improved services. For example, staff attending the meetings had noted their improved confidence and ability in challenging and mentoring doctors in the provision of end of life care. However, this was not reflected in the standards of care we observed in some areas during our inspection, including in evidence from complaints, incident reports, observations and in discussions with staff.
- Mortuary services were provided by the pathology division and bereavement services were provided by the governance division.
- A monthly multidisciplinary mortality review meeting took place that included end of life care services. We looked at the minutes of review meetings between February 2017 and April 2017 and saw there was no specific representation for end of life care services, including from the trust's own SPC team. Although we saw evidence the clinical effectiveness facilitator and the associate director of nursing worked to implement improvements to end of life care services, it was not evident that this governance structure was effective in achieving timely changes. For example, a meeting in February 2017 highlighted the need for more consistent coding of end of life care and a consultant noted that not all doctors were equipped to coordinate end of life care effectively. Although an action was noted to provide more in-depth training for the medical team, there was no evidence of progress three months after the team identified a need for improvement.

- Staff on the oncology ward had access to the GBCH team who provided support and training on end of life care and advice and support on patient management.
- End of life care staff were aware of their responsibilities under the duty of candour.
- We did not find a well-coordinated or coherent end of life care team and there was little contact information posted on wards about how staff could contact either the trust team or GBCH for help. None of the ward staff we spoke with could differentiate between the teams and said they were unsure of how it was decided who would attend a referral.

Public engagement

- An end of life care audit in October 2015 identified there was no formal process to collect and analyse feedback from the relatives of patients. An action from the audit included the implementation of a 'bereavement card' that would be sent to relatives after a patient death and used to encourage them to submit feedback. However, this was not due to be implemented until March 2018.
- In November 2016 the associate director of nursing, Macmillan lead cancer nurse and trust chaplain led a public engagement consultation about the new end of life care strategy. This included details of the evidence base for the strategy and the intended benefits for patient care and relatives. Staff encouraged attendees to stay in touch by signing up to an e-mail list that would include them in developments of the strategy implementation.

Staff engagement


- Staff involved with delivering palliative care spoke with us about significant concerns in relation to the operation and delivery of the service. For example, staff told us they believed patient readmissions occurred because of "truly inadequate care" as a result of "chronic short staffing", which meant they were discharged too early. These staff said there was no process of escalation for them to obtain support from senior hospital staff.
- A hospital counselling service was available for staff who were affected by patient deaths.

Innovation, improvement and sustainability

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- We found limited evidence this service was sustainable. For example, there had been no progress in filling the 1 whole time equivalent posts for Hospice employed palliative care nurse and the existing team was concerned that funding for the discharge coordinator had been removed by the CCG. GBCH have provided information demonstrating they had been discussing concerns about staffing/workload and had been open with the hospital management team regarding' their current difficulties'.
- End of life care staff had implemented a trial project alongside the proactive elderly advance care (PEACE) framework to find out if a symptom observation chart could help clinicians to make better decisions in relation to end of life care. At the time of our inspection this trial had begun on ward 14 and was being extended to other medical inpatient wards.

Outpatients and diagnostic imaging

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

Information about the service

Queen Elizabeth Hospital (QEH), offers a range of services and clinics for outpatients in the outpatient area of the hospital on the ground floor.

The outpatients department is open from 8.30am to 6pm Monday to Friday. However, extra clinics are also scheduled in the evening and at the weekend if required.

The department provided 347,466 outpatient appointments between October 2015 and September 2016.

The diagnostic imaging department provides x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), mammography, nuclear medicine and interventional radiography.

During our inspection we visited a number of clinics and diagnostic imaging areas. We spoke with ten patients and relatives, nine staff and looked at five patient records.

The previous inspection in 2014 rated the outpatients department and diagnostic imaging as requires improvement.

Summary of findings

We rated this service as good because:

- An electronic incident reporting system was in place. Staff were encouraged to report incidents and a learning culture was reported by staff.
- The environment was suitable, clean and tidy
- In all the areas we visited, staff adhered to the 'bare below the elbow' policy.
- Staff had access to systems, policies and best practice guidance suitable for their role.
- Availability of records had improved since the last inspection.
- Staff provided compassionate care and patient privacy and dignity were respected.
- Senior staff were able to describe the risks to their service and these were reflected on the risk registers.
- Staff were proud of working at QEH and were positive about the future.
- Staff spoke highly of the leadership.

However:

- Compliance with mandatory training and appraisal rates did not always reach the trust's target.
- There were staff shortages in both outpatients and diagnostic imaging.

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- The current strategy for outpatients did not seem well communicated to staff.
- The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments

There was a lack of cross-site working across the outpatient departments.

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- Staff had a good understanding of the incident reporting process.
- Patients were cared for in a visibly clean environment.
- Equipment was readily available to staff and they were trained to use it.

However:

- Medical staffing vacancies were having an impact on the team.
- Two different patient archiving computer systems (PACS) were in use across both QEH and UHL sites for the storage of diagnostic imaging tests. The systems were not always compatible with the radiology information system (RIS) or across site with UHL. This meant results not always being available on the PACS system for clinicians to view in a timely manner.

Incidents

- There were no never events recorded on the QEH site for outpatients and diagnostic imaging in the reporting period from January 2016 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The outpatients department had recorded 209 incidents of which the majority were categorised as causing no harm.
- Incidents were recorded on an electronic software system (SAFEGUARD). Staff were familiar with the electronic reporting system and told us they were more confident to use it. We found incidents were reported in line with trust policy. Staff in diagnostic imaging told us they were supported to use the system by the new quality lead.
- Feedback and lessons learnt were shared in staff meetings, morning huddles and via email. Nursing staff in outpatients told us of a change to practice following

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an incident with pathology specimens. Two nurses now check the contents of the specimen pots and sign to confirm. Reception staff in pathology also sign to confirm the contents of the specimen pot.

- We spoke with the newly appointed quality lead for diagnostic imaging who told us they had raised awareness of the incident reporting procedure with all staff and ensured reports were available for all governance meetings. The staff we spoke with confirmed this. We saw the number of open incidents for diagnostic imaging had reduced from 204 in November 2016 to 83 at the time of the inspection. The open incidents were all classified as low or no harm.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2000. Diagnostic imaging services had procedures to report incident to the correct organisations, including the CQC. The trust had reported incidents to CQC. All incidents relating to radiation exposure were recorded as 'red' (serious incidents) on the incident logging system. At the time of the inspection there were eight red incidents open. These were being appropriately investigated.
- Radiation incidents were discussed at the departmental governance meetings and also at the quarterly radiation safety committee.
- All staff we spoke with were aware of how to access the documentation relating to IRMER.
- We found not all staff in outpatients had a complete understanding of the duty of candour requirements but they knew it related to being open with patients. The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- The main outpatients and diagnostic imaging areas we inspected were visibly clean. Staff effectively managed, prevented and reduced the risk of infection by following good hand washing procedures and keeping the rooms clean and tidy.
- Staff adhered to "bare below the elbow" guidelines.

- Regular hand hygiene audits demonstrated high compliance rates although, had not reached the trust target of 100% in the last reporting period. Compliance was consistently 98%.
- Patients and visitors were reminded to use the alcohol gels at various locations across the departments. We observed staff using them on a regular basis.
- Disposable curtains were in use across outpatients and diagnostic imaging. These had all been changed within the last twelve months in line with the infection control policy.
- We saw posters displaying the process to follow in the event of a sharps injury. We also sharps bins were available in treatment and consulting rooms. This demonstrated compliance with the health and safety regulation 2013 (The Sharps Regulations) 5,(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the area of work.
- All soft furnishings were wipe able and were overall in good condition. The vinyl floor in the departments was in good condition and there were no carpeted areas.
- Mandatory training records showed that 98% of nursing staff in outpatients, 70% of medical staff and 92% of diagnostic imaging staff had attended infection control training against a target of 85%.
- Nasoendoscopes used in the Ear, Nose and Throat (ENT) clinics were cleaned appropriately and in line with guidance.

Environment and equipment

- All items of equipment were labelled with the last service and review date.
- The diagnostic imaging department's risk register included replacing ageing imaging equipment. The CT machine was in need of replacement and the business case had been recently approved.
- The nuclear medicine machine was now operating out of warranty, although a company was still willing to service the machine. A contingency plan was in place for equipment breakdown, using the machine on the UHL site.
- There was resuscitation equipment available in both outpatients and diagnostics imaging. We found the

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checklists to be checked and signed on a daily basis.

The staff in outpatients told us they only needed to check on a weekly basis but had been undertaking the tests daily as best practice.

- A variety of disposable items of clinical equipment was available in the treatment rooms. All the items we checked were in date.
- The waiting areas across both outpatients and diagnostic imaging were spacious and well equipped.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- Risk assessments were done in diagnostic imaging for all clinical areas. Adjacent areas were also risk assessed to ensure the radiation dose was not above permissible levels.
- There were radiation warning signs outside any areas that were used for diagnostic imaging which we observed were in working order. This ensured visitors or staff could not accidentally enter a controlled area. The MRI suite was restricted to authorised personnel only via key pad entry.

Medicines

- Medicines in the outpatients department were stored in locked cupboards or a fridge.
- Fridge temperatures were recorded daily when the department was open. We saw that the minimum and maximum temperatures were checked and recorded daily to ensure the temperature remained within the required range. Fridge temperature recordings were within the required range.
- Staff were aware of trust policies and procedures in relation to the administration, management, storage and disposal of medicines.
- The outpatient and diagnostic imaging department did not store any controlled drugs.

Records

- Staff told us the number of missing notes from clinics had greatly reduced since the last inspection in 2014. Recent audits from December 2016 showed that notes were available for 98.43% of the clinic appointments.
- Following the merger between UHL and QEH, a new electronic health records system was rolled out across

the trust. This caused issues for missing notes from clinics, more so for the QEH site. A business case had been approved for radio-frequency tagging of notes. Staff told us the project was due to start in June 2017. The majority of the clinics we attended had a full set of notes for each patient. One set of notes was missing in the ENT clinic. Staff were able to create a temporary set of notes in this instance.

- We reviewed five sets of patient notes for patients having consultations within outpatients. The records were complete, legible and signed.
- A patient archiving computer system (PACS) was in use for the storage of diagnostic imaging tests. However, staff told us and we saw in the radiology 'deep-dive' report of December 2016 that the systems was not always compatible with the radiology information system (RIS) or across site with UHL. Two different PACS and RIS systems were in operation which resulted in results not always being available on the PACS system for clinicians to view in a timely manner. Staff told us a business case had been submitted to install one system across both sites to improve safety and efficiency.
- We saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol.

Safeguarding

- We saw records to confirm that nursing staff in the division had reached 96% for safeguarding adult's level 2, 89% for children and young people level 2 and 89% for children and young people level 3 specialist training. This exceeded the 85% completion rate target. Medical staff from across the division had reached 82% for safeguarding adult's level 2, 76% for children and young people level 2 and 79% for children and young people level 3 core training.
- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control, information governance and manual handling.
- All the staff we spoke with were aware of the mandatory training they were required to undertake.
- Completion rates varied from 100% to 35%. Overall the hospital had an average completion rate of 78% which did not meet the trust requirements. Eight out of the

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sixteen modules had reached or exceeded the target of 85% for nursing staff across the hospital. The overall training rate for the division representing outpatients and diagnostic imaging was 80%.

- We saw local reports in diagnostic imaging that over 85% of staff had completed the mandatory training relevant to their roles. We also saw evidence of a comprehensive equipment training programme for radiographers. Staff were signed off as competent to use the equipment by a senior supervisor.

Assessing and responding to patient risk

- Staff in the outpatients department were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for the deteriorating patient.
- All nursing staff were required to completed basic life support for adults and paediatrics. The completion rate was 70% for nursing staff across the directorate for this mandatory training course against a target of 85%. The staff we spoke with were all fully compliant with their training.
- There was a radiation protection advisor available for any advice and support. We saw evidence that risk assessments had been carried out with the RPA input.
- We looked at the latest IRMER compliance audit done in June 2016 and saw there was an action plan in place to address the shortfalls with compliance. This included updating policies and procedures which we saw were in progress.
- Following a reported incident of unexpected findings from diagnostic imaging not being followed up, a new system was in place on RIS to flag the patient details and send an email to the referring clinician.
- The diagnostic imaging department gave a questionnaire to patients having an MRI or CT scan and took a blood test for patients having a contrast agent. This meant the service was able to reduce the risk to patients who may have allergies, heart complications, renal failure and metallic foreign bodies.
- In diagnostic imaging, any patients attending from the ward were first assessed to establish how poorly they were. Any patient with a high early warning score were accompanied by ward staff. We observed patients being escorted by a healthcare assistant whilst waiting for a CT scan.

- The World Health Organisation (WHO) Surgical Safety Checklist was used before all diagnostic imaging interventional procedures.

Nursing and diagnostic imaging staffing

- In the main outpatients department there should have been an establishment of 24 whole time equivalent (wte) staff. At the time of the inspection, there were 18.5 wte staff in post.
- Senior staff told us the breast, colorectal and dermatology clinics were run wholly by bank staff. We spoke with one of the bank staff and they confirmed they had been given a thorough induction and were given good support to carry out their roles.
- Information provided by the hospital showed that in December 2016, there was a 13% vacancy rate in the adult outpatients department.
- As from December 2016, the outpatients department recorded a turnover rate of 14% against a trust average of 7.6%. The turnover rate in diagnostic imaging was high at 32%, however, staff confirmed the establishment was more stable and vacancies were being filled.

Medical staffing

- Medical staff were provided for clinics by relevant divisions within the trust.
- There was a shortage of radiologists. In breast services, they were training mammographers in advanced practice to relieve the pressure on the service.
- The interventional radiology service had staffing challenges. Although there were enough radiographic staff to cover the service, there was no contingency plan to cover sickness and holidays. The staffing issues were not reflected on the local risk register. However, a paper had been considered by the trust board in December 2016, outlining the workforce concerns.
- There was no consultant cover on site after 6pm. This service was outsourced to a private company. Monthly 'discrepancy' meetings including education sessions were in place and attended by radiologists to share the learning from incidents and share best practice.

Major incident awareness and training

- The trust had a major incident plan which was available to staff on the intranet.
- Staff understood their roles and responsibilities within a major incident.

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Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective.

- The trust provided a service that was based on national good practice guidance.
- Staff had access to relevant trust policies and best practice guidelines.
- Staff were competent and supported to provide a good quality service.

However:

- The overall appraisal rate figure for staff within outpatients was 56%.

There was little cross site cover across the site for both diagnostic imaging and outpatient staff.

Evidence-based care and treatment

- Staff had access to trust policies and procedures. They told us they were able to access national and local guidelines via the internet and internal system
- We saw the diagnostic imaging department had a full range of standard operating procedures. We were told that protocols were being standardised across both the hospital sites.
- Imaging staff had good working knowledge of IRMER 2000 regulations and how they impacted on their working practice.
- We observed a receptionist in diagnostic imaging reviewing a patient referral letter that had not been signed by the referring GP. They explained the situation to the patient and contacted the GP practice. A signed referral form was faxed over within ten minutes.
- Radiographers told us how they followed the departmental policy on consent. We observed the practice and saw the department was in line with professional guidance.
- A new radiology discrepancy meeting had been established in 2016 and radiology staff told us it was

working effectively. Feedback from the meetings was given to the outsourced company and detailed notes of the meeting were stored on the departmental shared drive.

- We saw nurses in the outpatient department ensured that protocols used in the pre-admission clinic followed guidelines from the National Institute for Care and Health Excellence (NICE).
- Early work was in progress for imaging to gain accreditation with the Imaging Services Accreditation Scheme (ISAS).
- National and local audits were monitored via the divisional governance and risk meeting.
- We looked at the results from an outpatient audit on 'did not attend' (DNA) rates for endoscopy procedures. Data was collected and analysed and an action plan produced to improve attendance at appointments. This included the improvement of patient information leaflets and an educational video.

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic settings.

Patient outcomes

- There was no formal record or audit of patient waiting times for clinics. We observed many of the clinics running considerably later than planned.
- Between October 2015 and September 2016, the follow up to new rate for QEH was lower than the England average. Rates below the England average are seen as more efficient as it means more new patients are being seen rather than the same patients returning for follow up appointments.
- Diagnostic imaging staff had completed an audit on the appropriateness of actions taken following a 2 week wait ultrasound scan. Audits and results were discussed at the end of the monthly discrepancy meetings.

Competent staff

- The trust target for completion of appraisals was 90%. We saw reports of the completion rates for all staff groups across the hospital. From April 16 – August 2016, the nursing and midwifery staff reached 49% completion and allied health professionals reached 91%

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completion. The overall figure for staff within outpatients was 56%. The figure was worse than the trust target. However, the staff we spoke with told us they had an appraisal within the last twelve months.

- Staff were trained in core subjects such as infection control, safeguarding and health and safety. We saw specific competency workbooks for radiographers, healthcare assistants and nursing staff specific to their own areas.
- Nurses who worked in main outpatients told us they worked across all outpatient clinic specialties, which meant they had a broader range of experience.
- There were a number of trust non-medical referrers that were able to request imaging. We were shown the training records and staff told us they were delivering refresher IRMER sessions to staff across the hospital.
- All new staff completed a corporate and local induction.
- On-line training had been developed by diagnostic imaging for the insertion and checking of naso-gastric tubes.
- There was a good range of skill mix across both diagnostic imaging and outpatient teams. Specialist nurses worked in the outpatient clinics. Diagnostic imaging employed a consultant mammographer and were in the process of recruiting to another similar post.
- Nurses were aware of the need to revalidate their professional registration and processes were in place to ensure nurses did not work unless their registration was current.
- Radiographers told us that new departmental leadership was supportive of radiographer role progression.
- We saw that all employed radiography staff were registered with the Health Care Professions Council (HCPC).
- Patients told us they felt the staff were competent and able to do their jobs effectively and safely.

Multidisciplinary working

- We saw examples of multidisciplinary team (MDT) working across clinics. Staff we spoke with gave examples of MDT working in breast one-stop clinics. Doctors, nurses, allied health professionals and support staff worked well together.
- The outpatient department ran some one-stop clinics where patients could attend and have diagnostic tests and consultations in one appointment slot.
- There was little cross site cover across the site for both diagnostic imaging and outpatient staff. This meant the departments did not work closely together. A staffing review in diagnostic imaging had resulted in cross site modality leads which had started to improve the cross site working relationships and encourage efficiencies across the service.

Seven-day services

- The diagnostic imaging service provided a seven day on-call service. This was in line with NHS Services priority clinical standard 5, 2016.
- MRI services were available seven days a week from 8am-8pm. Emergency slots were allocated at the weekend for treating people with spinal cord compression.
- The full range of CT scans were available over twenty four hours, seven days a week.
- The radiologist service was outsourced from 6pm to 8am each weekday and at the weekends. Radiologists covered from 8am-6pm on a Saturday and Sunday and were available on site to do CT/MRI and ultrasound cases as required.
- Radiographers worked a shift system to cover the seven day service.
- The outpatient clinics were held Monday to Friday with additional clinics held in the evening and at weekends if required. Staff told us these happened on a monthly basis.

Access to information

- Patient details including past medical history were present within the paper records we reviewed.
- Patient investigation results, including blood tests and diagnostic imaging were available electronically for consultants to view in clinic.

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- Staff accessed radiology images through the PACS system. For images acquired off site, the image exchange portal was utilised.
- The trust had implemented a new clinical record system at the end of 2014. Outpatient records had been migrated from the previous administration system to the new system. Staff told us there was historical records missing mostly from patients at QEH. This meant some records were not available on the system.
- GP referrals were sent electronically to diagnostic imaging and staff processed these on a daily basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with told us they had received training in the Mental Capacity Act and were able to articulate how it might apply to their role.
- We saw an in date policy on consent which included the Mental Capacity Act and the Deprivation of Liberty Safeguards (DOLS) policy.
- We observed verbal and written consent procedures and staff were confident about the process.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- We spoke with patients in outpatient clinics and diagnostic imaging who told us the staff were approachable, kind and always willing to help.
- We saw many positive interactions between staff and patients.

However:

- Conversations could be overheard at the phlebotomy reception.
- We saw two patients who were waiting in gowns in wheelchairs with no blankets to cover themselves.

Compassionate care

- We observed receptionists in both the diagnostic imaging and outpatients department speaking to patients in a polite and helpful manner.
- People we spoke with told us the staff were 'kind.'
- We spoke with a relative in the diagnostic imaging department who told us they always received good care whenever they attended and were 'very pleased' with the service.
- We saw many staff who spoke with patients respectfully, politely and in a caring manner.
- However, we observed that privacy and dignity was not always maintained for some patients in diagnostic imaging. We saw two patients who were waiting in gowns in wheelchairs with no blankets to cover themselves.
- The phlebotomy department was very busy on the day of the inspection. A sign was visible to encourage patients and visitors to stand back whilst the receptionist was talking to people but the queue stretched back into the main corridor and conversations could be overheard.

Understanding and involvement of patients and those close to them

- Patients received relevant information both verbal and written to make informed decisions about their care and treatment. We observed one patient given time to discuss their concerns during a consultation. However, one patient told us they needed a blood test as part of their consultation which they did not know about and this had added an extra hour to their time.
- Patients were encouraged to provide feedback about their care and their experience in both outpatients and diagnostic imaging.
- Patients and relatives that we spoke with felt they had a good understanding of the care that was given to them and that they were involved with their care. One patient told us 'everything was full explained.'

Emotional support

- We saw that clinics had access to clinical nurse specialists (CNS) who formed part of the multi-disciplinary team to provide support to patients

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with a cancer diagnosis, as well as their families and carers. We spoke with two patients who had consultations with the CNS's and they felt they gave excellent support.

- Chaplains could provide spiritual support and pastoral support to people of all faiths, those who were unsure and those who had no faith.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Referral to treatment times on the 18 week non-admitted pathways were not met across all specialties.
- Between October 2015 and September 2016, the trusts did not attend (DNA) rate was higher than the England average. The DNA rate was slightly higher at QEH.
- There was a mixed performance for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment of cancer.
- QEH was not meeting the operational standard of 93% for people being seen within two weeks of an urgent GP referral for suspected cancer.
- Only 75% of complaints within the LTCC division were dealt with within the agreed timescale against a target of 95%.
- The patient journey from reception to clinic in outpatients was not clear.
- There was no reminder service for clinic appointments.
- We observed many of the clinics running considerably later than planned but there was no formal recording or audit of clinic waiting times.

However:

- Services were generally planned around the needs and demands of patients. Outpatient clinics were arranged in line with the demand for each specialty. Ad-hoc clinics were arranged as required.
- The percentage of patients seen within six weeks for their diagnostic tests was consistently higher than the target of 99%. Data from October 2016 shows 100% of patients were seen within 6 weeks.

Reporting turnaround times performed consistently well.

Service planning and delivery to meet the needs of local people

- Routinely, there were no extended days for offering outpatient appointments with the last booked appointment being 6pm. This meant working patients had limited options to attend appointments that were convenient for them. Occasional weekend and extended clinics were arranged to meeting the waiting list demands.
- The diagnostic imaging department provided a walk in GP service Monday to Friday from 8am-7.30pm and on Saturday mornings.
- The CT and MRI service offered extended days and weekend sessions.
- Most clinics in outpatients were running a little over time, on average twenty minutes.
- The clinics were well designed and patient seating areas were comfortable.
- Between October 2015 and September 2016, the DNA rate was higher than the England average at an average of 14%.
- Senior staff told us there was an improvement plan in place to review many of the issues identified within outpatients. Early work was in progress to conduct a demand and capacity analysis to assess and effectively manage the demands on the outpatients department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.
- Diagnostic imaging reports were outsourced after 6pm each day to ensure a timely turnaround.
- Patients and relatives told us that an issue for them was limited parking facilities.

Meeting people's individual needs

- Outpatient staff had access to a vulnerable adults and dementia link nurse.
- Staff in both outpatients and diagnostic imaging told us they had training in caring for patients living with

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dementia. They told us most patients with dementia would be accompanied by a relative or carers and provisions were made to ensure that patients were seated in a quiet area and seen quickly.

- Staff confirmed they had access to an interpreter service and it was available and accessible as required.
- In diagnostic imaging, patients with complex needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. The MRI department told us they had a good understanding of patients with phobias and were able to reassure patients when attending for an MRI scan.
- Both outpatients and diagnostic imaging departments were able to accommodate patients in wheelchairs or who needed specialist equipment.
- There were good patient information leaflets available across the hospital.
- We felt the signage was not always clear. to the outpatient areas could be improved. It was a long walk from reception to some of the clinics and therefore patients needed to retain information about where to go. The clinics signs were numbered but did not list any specifics such as cardiology or orthopaedics. However, a motorised buggy was available to transport patients if required due to the walking distance involved.

Access and flow

- Hospital Episode Statistics for October 2015 – September 2016 showed that 347,466 outpatient appointments were made at QEH.
- In November 2016, the trust's referral to treatment time for non-admitted patient pathways for outpatient services was worse than the England overall performance. This data showed 86% of patients were treated within the 18 weeks versus an England average of 90%. There is no national operational performance standard for the data however, CQC monitor this data as part of their assessment of timely access to care and treatment for patients.
- In November 2016, the trust's referral to treatment time for incomplete pathways for outpatient services was better than the England overall performance and similar to the operational standard of 92%. This data showed

92% of patients were treated within the 18 weeks versus an England average of 90%. The incomplete operational standard is the measure of a patients' constitutional right to start treatment within 18 weeks. No one should wait longer than 52 weeks for treatment.

- The percentage of people seen by a specialist within two weeks for all cancers was similar to the operational standard of 93% from quarter three 2015/16 to quarter two 2016/17.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was above the England average and the operational standard of 96% from quarter three of 2015/16 to the present reporting date.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was below the England average in quarter three of 2015/16 and quarter two 2016/17. Improvements had been made in quarter one of 2016/17.
- We saw that weekly patient tracking list (PTL) meetings were held to monitor the position of each outpatient specialty in regards to the 18 week target. Areas of concern were highlighted at this meeting and cascaded down to the relevant teams.
- The waiting times for clinics at QEH as recorded in December 2016 ranged from 5 weeks to 22 weeks.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients waiting more than six weeks for a diagnostic test ranged from 0% in December 2015 to 0.2% in November 2016. This was overall lower than the England average.
- A survey undertaken across the trust in September 2016 showed that access to immediate diagnostic tests for emergency admissions varied from 100% for microbiology, 94% for CT and 49% for MRI.
- The trust was engaged with a capacity and demand exercise to review the current situation and make recommendations going forward.
- Turnaround times for radiology reports were monitored and were in line with Keogh national standards. Records showed that in October 2016 96.26% of GP plain films were reported in less than 2 days
- 97.44% of GP CT tests were reported in less than 2 days

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- 97.39% of inpatient ultrasound tests were reported in less than 1 day
- The majority of all reports were completed within 1 week.
- The average clinic overrun time during our inspection was approximately 30 minutes. The trust did not measure the percentage of patients waiting over 30 minutes to see a clinician. This meant the trust could not assess performance in the time patients wait to see a clinician.
- Patient feedback indicated that the clinic waits were acceptable and an update of the waiting times were given by staff. However, patients were concerned about clinic waits impacting on their car parking arrangements.
- The cancellation policy states that a minimum of six weeks' notice should be given for cancellation of clinics. We looked at clinic cancellation data from December 2015 to November 2016. We noted that 4.5% were cancelled within six weeks of the appointment date and 5% were over the six weeks. The main reasons for clinic cancellations were reported as annual leave, sickness and the recent doctor's strikes.

Learning from complaints and concerns

- We saw minutes of departmental and clinical governance meetings detailing discussions about complaints received and learning from investigations
- Records from October 2015 to August 2016 showed the division had a total of 172 complaints in that timeframe. It was not clear how many of these were directly attributable to outpatients or diagnostic imaging.
- We saw complaints had not been managed within the recommended time frames with complaints taking an average of 55 days to investigate against a trust policy of 25 days. Staff, however, were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose.
- The common themes for complaints were in relation to medical and surgical treatment, communication, staff attitude and administration.

- We saw complaints were discussed at the Radiology governance meetings with an anonymised complaint and response presented at the meeting to share the learning or best practice.
- Staff had attended 'Sage and Thyme' training sessions and actions taken by the diagnostic imaging service included improving communication with patients, patient notice boards, updating of patient information leaflets and addressing the attitude of staff through appraisals.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- The diagnostic imaging department had a five year plan in place to ensure the diagnostic imaging department was fit for the future. Cross site working with key senior posts was in place.
- There were governance processes in place to ensure any risks and incidents were able to demonstrate lessons learnt.
- Diagnostic imaging services had implemented quality indicators. These were now measured on a dashboard and were reviewed on a regular basis by the directorate senior management team.
- Staff were mostly positive about the local leadership and they felt supported in their roles.
- Daily staff huddles had improved staff engagement and information sharing.
- Staff enjoyed working at the hospital and were positive that the trust was moving in the right direction.

However:

- There was limited cross site working for outpatients.
- There were key vacancies within diagnostic imaging.
- Not all the risks identified during the inspection were logged on the risk register.

Leadership of the service

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- Staff were positive about local leadership and we were told most managers were visible and approachable.
- There were clear management structures in place and staff felt supported by their direct line managers.
- The new leadership team had made significant progress in improving cross site working. Modality leads were in place and working in this cross site model.
- The diagnostic imaging department had recently, in 2016, employed a radiographer responsible for quality governance. Staff told us this was making a difference to the team in supporting key areas of service development such as increased focus on learning from incidents and reflection on practice.
- The diagnostic imaging senior team told us they were more confident for the future of the service. They felt a focus on diagnostic imaging with the improvement plan and the steps currently being taken towards becoming ISAS accredited were positive. ISAS stands for the Imaging Services Accreditation Scheme. Work had commenced on recruitment and reviewing cross site protocols and procedures to allow more consistency across the service.

Vision and strategy for this service

- We found staff were able to describe the values of the trust and were positive about the changes to date and the planned changes for the future.
- Both outpatients and diagnostic imaging had a documented strategy in place for improving services over the next five years.
- The outpatient improvement plan identified key areas of work from patient referral through to discharge. This included a need to review the utilisation of clinic space, waiting times, signage and staffing levels. Outpatient's staff were less clear of the strategic plan in place to make improvements but all staff told us they felt improvements had been made in recent months.
- The newly appointed lead in diagnostic imaging was keen to tell us about the strategic plans in place and how they were working on the plan to ensure the department was able to cope with future demands on the service. Due to the difficulty in recruiting radiologists, radiology management told us they had looked at alternative arrangements with the use of locums and developing advanced practice for some radiographers.

Governance, risk management and quality measurement

- The outpatients and diagnostic imaging departments were part of the long term conditions and cancer division (LTCC), with the divisional lead feeding back to the board.
- Governance, risk and quality meetings were in place at directorate and departmental level. We looked at minutes from the outpatient's weekly operational group meeting, the monthly LTCC governance meeting and the diagnostic imaging governance meetings. Appropriate risks, policy and process reviews and other key safety information were discussed in detail at each meeting.
- The directorate used a performance scorecard providing information on RTT performance, complaints and incidents. This information was disseminated to the department leads.
- Senior staff told us the governance structure for escalating risks was through a number of regular meetings and we saw evidence of meeting minutes at all levels of the organisation to support this.
- Medical record provision had been highlighted as a concern during the previous inspection in 2014. Staff told us and records showed that improvements had been made. This issue was no longer highlighted as a risk and was not shown as an area for improvement on the outpatient plan.
- Risk assessments and risk registers were in place for both outpatients and diagnostic imaging. Staff were able to articulate the risks to their service on the register and we saw this information was reflected on the register. Staff in diagnostic imaging told us the risk to ageing equipment had been on the register for a long time and was not yet resolved. We noted that although the risk to ageing equipment was logged on the register, there was no reference to the CT scanner which was urgently due for replacement. The risk of the gamma camera in nuclear medicine being over 15 years old, beyond lifespan with increasing breakdown and therefore inadequate for service demand was documented on the issues register. The concern about the lack of a contingency plan for radiology cover for sickness and annual leave was not on the register.
- Following a review of the trust wide Serious Incident report presented to the Trust Board in June 2016, the Board requested a more comprehensive report summarising the detail of the quality and safety issues

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which had arisen within the service of radiology. The report was completed in December 2016 and outlined the key safety and quality issues as Workforce, Information Technology, Communication e.g. there is a lack of a unified Picture Archiving and Communications (PACs) and Radiology Information System (RIS) across both sites which necessitates differences in standard operating procedures across the sites and Infrastructure.

- We found in speaking to senior staff that some actions had been progressed such as increased cross site working with the modality leads, a recruitment and retention programme and discrepancy meetings in line with Royal College of Radiologists guidelines.

Culture within the service

- All the staff we spoke with at QEH told us they felt respected and valued. Overall, staff said they enjoyed their roles despite going through some challenging times.
- In diagnostic imaging, there was a robust culture of safety. Staff were encouraged to report incidents and complaints and felt they would be investigated fairly.
- Staff supported each other and they felt part of a team.

Public engagement

- Members of the public were invited to leave their comments about the service they had received by means of questionnaires.

- Service performance boards were lacking in both departments.

Staff engagement

- Staff told us about daily huddle meetings and how they found them helpful.
- Nursing staff explained that they saw senior staff every day and felt kept up to date.
- We saw minutes from both outpatients and diagnostic imaging staff meetings.
- Staff were recognised and received awards for their achievements.
- Several staff told us they enjoyed reading information sent on-line from the chief executive as it kept them informed of any new developments.

Innovation, improvement and sustainability

- Diagnostic Imaging had been successful in winning a bid for developing CT colongraphy reporting radiographers.
- A recent Macmillan project had been piloted in outpatients to improve accessibility to Systemic Anti-Cancer Therapy (SACT). The project had been reviewed and 100% of patients were satisfied with the care provided and felt it had improved their overall experience of the service.
- In November 2016, the lead pharmacist won a staff award.

Outstanding practice and areas for improvement

Outstanding practice

- The uniquely designed door handles that had been installed on the doors to the neonatal and oncology units demonstrated the culture was focused on reducing infection risk.
- Tiger ward had provided additional support to families and patients by introducing an informal coffee morning open to all patients on their case load and not just receiving treatment.
- The speech and language therapy manager had implemented a risk feeding protocol following a successful research pilot project. This resulted in demonstrable outcomes for patients, including a 10% reduction in the admission of patients with dysphagia through more effective feeding regimes. As part of the project new guidance was issued for patients and staff and a risk feeding register was implemented to help the multidisciplinary team track patients cared for under the new protocol.
- Staff in the Trafalgar Clinic provided care and treatment for patients in a nearby prison. Each patient's records were maintained on the service's electronic patient record system. This meant when a patient left the prison service, there was no disruption in care or treatment because clinical staff always had access to this. In addition, if the patient moved out of the area, the electronic records could easily be shared with pharmacists and health workers in the offender resettlement programme. This meant patients received continual care and were at reduced risk of developing health problems associated with an interruption to antiretroviral therapy.
- In the two years to our inspection, sexual health and HIV services recruited up to 50% of the participants for the trust's whole clinical trial and research portfolio. This resulted from a policy of proactive and early-adoption participation that was part of a two-year strategy to improve participation in research in other hospital departments and services.
- In critical care there was a dynamic programme of research and development enabled by the full time appointment of a research nurse working with doctors including consultants.. Examples of research studies completed in the past year included a study exploring the relationship between family satisfaction and patient length of stay, and a pilot study looking at the improved physiotherapy outcome measure by the use of cycle ergometry in critical care patients. The trust recognised only a small sample size was used for each study. There was also participation in national audits and research programmes

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Review and improve the systems for monitoring and improving the quality and safety of care including attendance at key meetings in ED, surgery, critical care, services for children and young people and end of life care.
- It must ensure all risks are included on the risk register and are regularly reviewed and updated and carry out audits to monitor the effectiveness of treatment and care, ED, surgery, critical care, services for children and young people and end of life care.
- Ensure all risk assessments are carried out on patients in critical care.
- Ensure medical and nursing staffing levels are in line with national standards in services for children and young people, ED and end of life care, to provide safe continuity of care for patients.
- In surgery ensure that patients are cared for in areas that are appropriate to their needs and have sufficient space to accommodate all equipment and does not compromise their safety and staff have the relevant skills and knowledge to care for them.

Outstanding practice and areas for improvement

- Ensure patients requiring end of life care receive appropriate and timely care.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Work to share and embed learning from incidents in all services and across sites.
- Ensure staff comply with infection prevention and control policies and procedures.
- Ensure the ED has a separate room for the storage of medicines and medicines are stored safely in all areas.
- Ensure staff working on medical wards and in end of life care have the values and attitude necessary to treat patients, their relatives and visitors with dignity and respect. This includes staff treating them in a caring and compassionate way at all times.
- Ensure medical patients are appropriately reviewed when they are cared for on other wards and that all staff know who is responsible for them and they are contactable.
- Ensure that in surgery patient records are stored and held securely in one document.
- Ensure all patient records are complete and accurate including risk assessments.
- Ensure all patients have their pain assessed and receive analgesia in a timely manner
- Improve compliance with mandatory training completion rates for modules that are below the trust target in all staff groups.
- In critical care consider ways to introduce multidisciplinary meetings and ward rounds to review care and treatment of patients.
- Ensure there are ongoing arrangements for measuring and reporting patient satisfaction in critical care.
- Review the arrangements for bereavement services.
- In critical care, ensure formal arrangements for emotional and psychological support of patients and families including access to clinical psychologists are in place.
- Review and update the operational policy for the critical care outreach team and ensure sufficient staff are deployed every day to provide an effective service.
- Review the environment and waiting times for women using the gynaecology service.
- Develop outcomes for gynaecology.
- Ensure staff working in HIV, GUM and sexual health services are informed and involved in any future plans for the service.
- Review the provision of care on Hippo Ward to ensure it is adequately staffed and is open long enough to support patient flow.
- Review the level of cover currently provided by play specialists to make sure that children are supported appropriately.
- In services for children and young people, encourage attendance at quality and safety board meetings so that information can be shared and discussed effectively.
- Complete two year follow ups of babies admitted to the neonatal unit as part of the national audit.
- Ensure patients who are at the end of their life, and their relatives, are ensured privacy.
- Improve cross site working in all services.
- Work to reduce the number of cancelled operations and improve referral to treatment times and reduce the 'did not attend' (DNA) rate for outpatient appointments.
- Continue to recruit to medical and nursing vacancies in outpatients and diagnostic imaging
- Respond to complaints within agreed timescales.
- Improve communication and working relationships between different staff groups.
- Provide sufficient staff to care for patients who need one to one care.
- Identify ways to empower and support staff to make improvements and take the lead in decisions and improvements in their services.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1), 17 (2) (a) 17 (2) (b) 17 (2) (f)</p> <ul style="list-style-type: none">• The hospital did not have effective systems to assess and monitor the quality and safety of the care and treatment in all services across the hospital including ED, surgery, critical care, services for children and young people, end of life care.• In the ED mitigating plans in place were insufficient to manage the issues of capacity and flow within the ED. Data provided by the trust shows that the ED had failed to achieve the objectives set out in the ED delivery plan and there had been no improvement in this area since the last inspection.• In Surgery the risk register did not include all the risks we identified during the inspection.• In Critical care recorded risks in relation to the number of medical staff had not been acted on.• Regular mortality and morbidity meetings were not taking place to review all relevant cases.• In Services for children and young people an increased demand on the neonatal unit was not recorded on the risk register and no action had been taken to manage the increased demand.• The neonatal unit was not covered by specialist neonatal consultants and the medical cover arrangements meant there was a lack of continuity of care. Discussions had been taking place for three years about how to improve the system but no action had been taken.

Requirement notices

- In End of life care (EoLC) the hospital did not have a service level agreement with specialist palliative care provider and the draft operational policy had not been ratified by the trust board.
- There was no named EoLC non-executive director on the board and the end of life care corporate target was not referred to in the trust's annual report 2015-2016.
- The risk register did not include any risks to the service at QEH and attendance at key meetings was not consistent and it was not always clear what the outcome of concerns or issues were.
- No local audit activity had taken place in EoLC in the 12 months prior to this inspection. Staff were not aware of the findings of the National Care of the Dying Audit 2015 or any action plans arising from it.

The hospital must take action:

- To address all of these issues and ensure it is compliant with Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)

- The ED, critical care, services for children and young people, end of life care did not have sufficient numbers of suitably qualified medical and/or nursing staff to care for patients.

The hospital must take action to:

- Ensure there are sufficient numbers of suitably qualified medical and/or nursing staff to provide safe effective care at all times.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1), 12 (2) (a), 12 (2) (b)

- In surgery additional patients were admitted to rooms five and six on Ward 12, which were designed to accommodate two patients. This meant there was insufficient space to care for them safely and accommodate all the equipment that may be required. Risk assessments had not been completed.
- In critical care staff were not collecting or reporting data about venous thromboembolism as part of the safety thermometer scheme.
- In end of life care there were delayed referrals of up to 50% of patients to the end of life care team.

The hospital must take action to:

- To address all of these issues and ensure it is compliant with Regulation 12 HSCA (Regulated Activities) Regulations 2014 Good governance.