Care Quality Commission

Royal Surrey County Hospital NHS Foundation Trust

Royal Surrey County Hospital

Quality Report

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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	**Good**
Accident and emergency	Good
Medical care	Good
Surgery	Good
Intensive/critical care	Good
Maternity and family planning	Good
Services for children & young people	Good
End of life care	Good
Outpatients	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

The ratings in this report were awarded as part of a pilot scheme to test CQC's new approach to rating NHS hospitals and services.

The Royal Surrey County Hospitals NHS Foundation Trust is based at the Royal Surrey County Hospital. It is a leading general hospital and specialist tertiary centre for cancer, oral and maxillofacial surgery and pathology. The trust also has a very strong reputation for minimally invasive and laparoscopic surgery, which are used widely across the surgical specialties. It runs outpatient clinics at Cranleigh, Haslemere and Woking hospitals.

The trust has over 520 beds, 14 operating theatres, two MRI scanners, four CT scanners, interventional radiology equipment and a gamma camera.

It serves a population of 320,000 for emergency and general hospital services and employs 3,100 staff, making it the second largest employer in Guildford. Every year, the trust sees 240,000 outpatients, 58,000 inpatients, and 72,000 patients in Accident and Emergency. It delivers more than 3,200 babies every year.

Overall, the trust was providing services that were safe, effective, responsive, caring and well-led. However, there were some areas for improvement.

The culture throughout the trust was very open, and staff were very enthusiastic, positive and knowledgeable about the trust's overall vision and strategy.

The Board structure and portfolio structure is relatively new and there is still some embedding required. The CEO is well respected and popular with the staff and he and board members were visible throughout the trust. There was evidence of good leadership at the majority of department levels and a lot of innovation by staff to continually improve the patient's experience. There are a number of processes for communication flow from and to the Board and departments. However, priorities at the departmental level had not been captured at trust level, and there is some lack of connection to the Board. This led to the executive team being unclear on its understanding ofsome of the issues in departments, and there was a general perception throughout the trust that the executive team and local teams are progressing at different paces and priorities were not always aligned

The quality strategy focused on national targets and future developments without defining some key quality and safety priorities of the organisation. Thus members of the Board were not able to articulate all of the quality strategy for some basic quality issues specific to the trust.

Operational management was not fully connected from Board to departmental level and not all middle management had a clear understanding of the range of risks across the trust. There is a risk register that looks at risks highlighted by the specialist business units, but it was not evident that the Board reflect a trust wide perspective.

The trust was working to full capacity in most departments with cancellations of elective surgery on one of the days of the visit, and this was providing a challenge for them. The trust recognised this problem, and it had a number of plans to improve the capacity of the hospital in the long term. The full alignment of capacity issues and the impact of patient experience could not be fully articulated by the trust. Although capacity was being created within theatres and critical care to support cancer services, the impact of this in pressure on ward beds could not be evidenced within the business planning. The trust had paid less attention to how it would manage the current capacity issues, and the impact they were having on the experience of patients, until it implemented the long-term plans. These capacity issues included:

- Staffing levels for support/administration staff.
- Staffing on some wards, particularly care of the elderly.
- Managing capacity issues in outpatients, particularly in ophthalmology.
- Managing issues such as discharge letters and GP correspondence.

The trust had plans for the development of its cancer services to meet the needs of patients. This will inevitably put further challenges on capacity and staffing requirements. The trust will need to address these before it puts its plans to expand cancer services into action.

Patients were generally very positive about the care they received at the hospital. They were very supportive of the trust and keen to be involved in the improvement at the

Summary of findings

hospital. The vast majority of patients that contacted us and those we spoke with commended the care they received at the trust. However some patients we spoke to at the listening event and who had contacted us directly had not had good experiences and some reported delays in their complaints being dealt with a timely fashion. They had little opportunity to engage with the trust other than through the complaints system. The trust was developing more ways to engage with patients and the community, but it had not fully implemented its ideas. However, there was some innovative work taking place at departmental level.

Cancer services were safe, effective, responsive and well-led. They were at full capacity, and staffing in some areas left little allowance for contingency planning and unplanned absences. On occasions this did impact on the effectiveness of services and their ability to be caring. The staff themselves were caring, but not all patients had their expectations met, and the cancer patients experience survey identified a number of areas where the trust needs to make improvements.

Staff were positive and engaged, and nursing staff levels were being managed well at departmental level, despite staff shortages in some areas.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Overall services were safe, but some improvements were needed in medical services.
- Patients' needs were assessed and staff provided care to meet those needs.
- Systems were in place to minimise risks to patients. Including the safety thermometer (to measure patient safety).
- Although services were safe, in some wards, in Merrow, Wisley, Eashing and Albury wards and outpatient departments we found that the level and mix of staffing might create a risk to the safety of patient care, particularly in areas of care for frail elderly patients and administration support services.
- Analysis of falls in the Wisley ward had indicated that they had all occurred at night, and three had occurred when a staff member had been removed to provide cover elsewhere. This meant the ward was unable to operate the night time protocol safely due to staff shortages.
- Not all the equipment in accident and emergency had proof of having been tested, so the trust could not be sure that all equipment was safe.
- Trust priorities were not clearly articulated within a robust quality strategy.
- Root cause analysis of pressure ulcers were undertaken locally at grade 2 and corporately at grade 3, but there was no evidence of a connection between them.

Are services effective?

Good

- Overall the trust is effective, but the trust needs to make some improvements to ensure that all services are effective at all times particularly in outpatients and A&E
- Some clinical pathways needed improvement,for example the management of neutropenic sepsis in A&E was not always being followed.
- The management of people's pain in A&E needed improvement as patients presenting with pain were not always given or offered pain relief in a timely manner.
- In some areas, the trust had not been consistent in making changes identified in its action plans in response to complaints and incidents.
- Staffing levels were impacting on the effectiveness of some services. Current management of staffing levels, processes and patient numbers made effectiveness inconsistent.

Summary of findings

Are services caring?

Good

- Overall, services were caring, but there were some areas for improvement.
- Overall staff treated people with compassion, respect and dignity. The time given to care depended on patients' specific needs. Patients felt cared for and listened to by staff, though some patients we spoke to at the listening event and who had contacted us directly had not had good experiences.
- Staff generally maintained people's privacy and dignity.
- The vast majority of patients commended the trust on the care provided by the nurses and doctors.
- Patients told us that, despite delays for appointments and long waits in outpatients, when they were seen the staff were very caring. However, there were a number of people who had not had this experience and reported a poor attitude in the way they were spoken to by some nursing staff, doctors and consultants.
- The majority of patients and their relatives said that staff kept them informed about treatment.
- Patient records reflected where staff had sought consent to deliver care and treatment, and discussions regarding treatment decisions had been recorded.
- Staff involved patients and their families in the planning of care, and there was effective communication.
- A 'dementia passport' was used to identify patients with dementia and ensure they got the support they needed when in hospital.
- A 'communication passport' was used for adults with learning disabilities.
- The cancer patients' survey had identified some areas that required improvement.

Are services responsive to people's needs?

Good

- Overall, services were responsive, although there were some areas for improvement particularly in outpatients
- Maternity services were particularly good at responding to patients' needs.
- The children's ward responded well to patients' needs, though the department could make further improvements to the children's environment in A&E.
- Surgery services had responded well to patients' needs, although patients did tell us that there were some delays at times due to staff shortages.

Summary of findings

- Records showed that A&E was now reaching the national target of seeing, discharging or admitting 95% of patients within four hours. Evidence showed that on arrival patients were seen by the triage nurse within 30 minutes.
- Some medical wards (particularly the frail and elderly and outpatients) were not always able to respond to patients' needs in a timely manner when there were staff shortages or overcapacity.
- The trust now faces the challenge of how to meet people's needs effectively until it can put more staff in place.
- Overcapacity issues had led to delayed appointments and long waits in some outpatient departments, particularly ophthalmology.

Are services well-led?

Good

- Overall there were some areas for improvement.
- The trust was well-led at departmental level, with the exception of outpatients and there was a transparent, open, supportive culture. Everyone was clear on trust priorities, but priorities at departmental level had not been captured at trust level.
- Current operational structures had a lack of connection to Board level, which led to the executive team being unclear on its understanding of issues at a department level.
- The trust's quality strategy focused on national targets and future developments. The Board was not able to articulate the quality strategy for some basic quality issues specific to the trust.
- Not all middle management had a clear understanding of the spread of risk across the trust.
- The risk register highlighted risks by the specialist business units, but it was not evident that there was a trust-wide perspective.
- Consultants told us that they needed more leadership training, and that there was no provision for their leadership roles within their current job plans.
- We were told that there was currently no leadership development plan.
- There were clear lines of accountability within the maternity department.
- Staff were confident about their roles and responsibilities.
- Staff within the maternity unit trained together and operated as an efficient and cohesive team.

Summary of findings

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

Accident and emergency

Good

The A&E department was safe, caring,responsive and well-led. However, we found that the department's effectiveness could be improved. Some clinical pathways were not being followed, (for example management of Neutropenic sepsis) and the management of people's pain needed improvement as patients presenting with pain were not always given or offered pain relief in a timely manner.

Medical care (including older people's care)

Good

Overall, medical care was caring, effective, responsive, well led but improvements were required in safety. We had concerns about Merrow, Wisely, Eashing and Albury wards that we visited, where staffing levels were low and there was a risk that patients may not receive safe care. The trust had acknowledged that Eashing and Wisley did not have a sufficient number of staff to provide the care needed by acute patients, and it was taking action to address the problem but had not identified shortages on Merrow and Albury. We saw that staff were busy and that patients' basic care needs were attended to. However, sometimes staff were not always able to update bedside documentation to reflect patients' present care needs, or attend to patients in a timely manner.

Surgery

Good

Over all we found Surgery to be safe, caring, effective, responsive and well led. We found that staff assessed patients' needs and planned care to meet those needs. Staffing levels were acceptable on all wards except Ewhurst, where there had been no senior sister for eight weeks. Since the recent appointment of a senior sister on this ward, we were told that things had improved.

Practices and procedures within theatres were safe. The trust had recently revised the World Health Organisation Surgical Safety Checklist. Most patients we spoke with told us that their treatment had been effective at each stage, from admission as an emergency or referral by the GP to successful surgery and recovery. The surgical wards had an 'early warning score' that detected deterioration of patients' conditions and called for urgent medical help. We saw that all wards had safety performance heat maps.

Patients were satisfied with their care. Some patients said that they had quick personal care when they needed it, but a few said that staff did not answer call bells as quickly as possible. Overall, we found that staff kept patients informed about their treatment. However, there were a few instances when patients had not been kept adequately informed. This resulted in patients feeling isolated. Patients told us that the overall service was good and the wards

Summary of findings

were well run. They told us that members of staff worked well with each other. We found that staff had completed training in a number of areas including dementia awareness, infection control, and health and safety.

Intensive/critical care

Good

Over all we found intensive/critical care to be safe, caring, effective, responsive and well-led. Staff assessed patients' needs and planned care to meet those needs. There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Intensive Care National Audit & Research Centre (ICNARC) data shows that the trust were performing well within expectations nationally, though there were significant delays in discharging their medically well to the wards. The department recognised that the number of beds in the unit was not adequate. It had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional nursing,other staff and beds in other wards to accommodate the increased amount of patients requiring discharge from ICU, or how it will manage discharge of medically well patients.

Staff respected patients' privacy and dignity. Family members told us that the care in the ICU was "first class". The department had carried out a survey of the views of patients' families. Responding to the feedback, it was going to put in place accommodation for relatives. We found there was a multi-professional team working across the unit and with other hospital providers in the area. This meant the service was well-led.

Maternity and family planning

Good

Over all we found maternity services to be safe, caring, effective, responsive and well led. The maternity service had good and effective leadership, and an open and supportive culture. Positive leadership had led to high levels of staff morale and a service that met the needs and expectations of the people who used the maternity services.

Patients were mostly very complimentary about the care and dedication of the staff looking after them. They said that communication was good, staff referred to individual birth plans and women felt supported, listened to and had confidence in the quality and safety of their care.

We found clear lines of accountability in the department, and staff were confident about their roles and responsibilities. We were told that there was consistent and immediate access to specialist consultant paediatricians, obstetricians and anaesthetists. We saw how the trust had learned lessons from incidents, found solutions to problems and promoted risk reduction.

Summary of findings

Services for children & young people

Good

Over all we found Childrens services to be safe, caring, effective, responsive and well-led. The children's unit was modern and well equipped and reflects the ideas and contributions of children and young adults who use the service. The unit was a testament to how the organisation has used staff and patient suggestions to develop a state-of-the-art environment that provided high levels of care in a calm and relaxed atmosphere. Parents told us that the facilities were outstanding and that staff paid great care and attention to the needs of the children and their families.

The paediatric service had good and effective leadership within an open and supportive culture. The staff reported that there was a close and integrated team spirit in the unit that worked closely with maternity services.

There was a dedicated children's outpatient department that provided a service within the children's unit and offered a range of general paediatric and specialist clinics. A&E facilities were functional and provided a high level of care and support. However, the environment for children and young people attending the A&E department did not reflect the care and attention to detail of the design of the main paediatric area.

End of life care

Good

Over all we found end of life care to be safe, caring, effective, responsive and well-led. Patients and relatives were positive about the quality of end of life care. None of the people we spoke to had any concerns about the way staff maintained patients' privacy and dignity. We found that staff were caring and services responded to patient's needs. Services were well-led.

Outpatients

Requires improvement

Over all we found outpatients to be safe and caring. Improvements are needed in effective, responsive and well-led domains. We found out-patient departments that did not always have the capacity to meet demand.

The eye outpatient service was especially overcrowded. Patients said they had been waiting for up to four hours, and data that we received before and during the inspection confirmed that this was a regular occurrence. The trust was aware of this and had plans to expand the service to address its capacity issue. However, it had not taken sufficient action to minimise the impact of this issue on patients while the service was expanded.

Problems in accessing medical records also made delays worse and put extra demands on the nursing staff to cope with the capacity

Summary of findings

levels. We had concerns that eye testing was being performed in a busy corridor and that there were significant delays in communicating with patients' GPs, which had the potential to disrupt patients' treatment.

The hospital made arrangements for people to attend appointments at a time that was convenient for them. However, the long waiting meant that appointments did not take place at the time planned, and patients expressed concern about that a lack of available parking spaces made it difficult to be on time for appointments.

We observed that staff were kind, caring and courteous in their dealings with patients. Staff were familiar with and understood the hospital's vision and strategy.

Summary of findings

What people who use the trust's services say

Over the four months April – July 2013, the Trust has scored below the national average for inpatient scores, and above the national average for three months in the A&E Friends and Family Test. The Trust's response rate for A&E has been consistently below the national average since April 2013, so the results should be treated with caution.

Areas for improvement

Action the trust COULD take to improve

- Although services were safe, in some wards and outpatient departments we found that the level and mix of staffing might create a risk to the safety of patient care, particularly in Merrow, Wisley, Eashing, Albury medical wards, Ewhurst surgical ward, outpatients and administration support services.
- The action plan for the eye outpatient department did not reflect the reality and requires review.
- Plans for the refurbishment and expansion of the eye outpatient area need to be speeded up to enable care to be delivered on-time and in an appropriate environment.
- Analysis of falls in Wisley ward had indicated that they had all occurred at night and three had occurred when a staff member had been removed to provide cover elsewhere. This meant the wards were unable to operate the night time protocol safely due to staff shortages.
- Not all the equipment in accident and emergency had proof of having being tested, so the trust could not be sure that all equipment was safe.
- Some clinical pathways needed improvement,for example management of neutropenic sepsis in A&E was not always being followed.
- In some areas the trust had been inconsistent in monitoring how it made changes based on learning from complaints and incidents. Changes identified in action plans in reponse to complaints and incidents need to be implemented and monitored consistently.
- Staffing levels were impacting on the effectiveness of some services. Current management of staffing level processes and patient numbers made effectiveness inconsistent.
- Local priorities at the departmental level need to be captured at trust level.
- Operational structures need a stronger connection to Board level to enable them to be clear on their understanding of issues at ward level.
- The trust quality strategy needs to include basic quality issues specific to the trust as well as national targets and future developments and the trust priorities need to be clearly articulated within a robust quality strategy.
- The trust risk register highlighted risks by the specialist business units but need to have a trust-wide perspective.
- There is a need for a leadership development plan and provision for Consultants leadership role within their current job plans
- Business planning needs to be more rigorously tested to ensure innovation control,impact on support services, resource implications and workforce are accounted for.
- Root cause analysis for grade 2 and 3 pressure ulcers needs to be connected.
- Management of patient's pain in A&E needs to ensure that pain relief is administered in a timley manner. We found that patients presenting with pain were not always given or offerred pain relief in a timely manner.
- The incidence of poor attitude of consultants and staff needs to be managed to prevent recurrence.
- The areas of dissatisfaction for cancer patients identified in the cancer patients survey need to be addressed.
- There were significant delays in discharging medically well patients from ICU to the wards. The trust had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional

nursing, other staff and beds in other wards to accommodate the increased amount of patients requiring discharge from ICU or how it will manage discharge of medically well patients.

Good practice

Our inspection team highlighted the following areas of good practice:

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- Paediatric ward in the responsive domain
- Maternity services in caring and well-led domains
- Nurse-led cancer clinics
- Breast cancer service
- Hepatobilliary cancer service

Royal Surrey County Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

Chair: Gill Harris, Regional Director of Nursing for the North

Team Leader: Elaine Biddle, Care Quality Commission

The inspection team comprised doctors, nurses, senior managers, CQC inspectors, lay people and experts by experience. Experts by experience have personal experience of using or caring for someone who uses this type of service.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new 'Intelligent Monitoring' tool. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations.

Under this model Royal Surrey County Hospitals NHS Foundation Trust was considered to be a medium risk service.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection.

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Detailed findings

As the trust is a tertiary specialist centre for cancer services, we also looked at the pathway that patients follow through outpatients, surgery and oncology.

The lines of enquiry for this inspection were informed by surveillance data and information we received from contacting a number of key stakeholders including, Healthwatch, The General Medical Council (GMC), the Medical Royal Colleges, the NHS Litigation Authority, Monitor, clinical commissioning groups and Health Education England.

Information from people who use the hospital services was very important to our inspection. We used a range of methods to find out what people thought about care and treatment at the trust. These included:

Focus groups with patients, their families and carers, and staff.

A listening event for the general public on 17 October.

Using the media to encourage people to contact us by telephone, email or through our website.

We carried out an announced inspection visit on 17, 18 and 23 October 2013. As part of the inspection, we looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients. We talked with people who use the services. We talked with carers and family members. We held six focus groups with staff and a focus group with the Board of Governors. We spoke with and interviewed a range of staff including the Chairman, Chief Executive, Medical Director and Director of Nursing, non-executive directors, clinical and non-clinical leads.

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

We held drop-in sessions for staff and patients on the 23 October in the hospital for anyone who wished to talk privately with an inspector.

We used the Short Observational Framework for Inspection (SOFI) in one area of the hospital. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Are services safe?

Summary of findings

- Overall services were safe, but some improvements were needed.
- Patients' needs were assessed and staff provided care to meet those needs.
- Systems were in place to minimise risks to patients. Including the safety thermometer (to measure patient safety).
- Although services were safe, in Merrow, Wisley, Eashing and Albury medical wards we visited staffing levels were low and there was a risk that patients may not receive safe care. Staffing levels on five of the surgical wards were acceptable, the exception being the Ewhurst ward. The roster on Ewhurst ward showed that it had been without a senior sister for eight weeks. Two band 6 sisters on Ewhurst provided cover to maintain the stability of the ward, supported by the orthopaedic matron. Previous to these eight weeks the ward had been without a band 7 sister for 12 months. The cover arrangements were for a senior sister from another ward to 'keep an eye on the ward'. There was no interim replacement of senior sister (either by secondment or other measure) for this 12-month period. This meant that there were times when this ward may have been providing services that were not safe. However, we were told that since the appointment of a senior sister on this ward (in September 2013) things had improved.
- ICNARC data shows that the trust were performing well within expectations nationally, though there were significant delays in discharging their medically well to the wards. The department recognised that the number of beds in the unit was not adequate. It had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional nursing, other staff and beds in other wards to accommodate the increased amount of patients requiring discharge from ICU, or how it will manage discharge of medically well patients
- In outpatient departments we found that the level and mix of staffing might create a risk to the safety of patient care, particularly in the eye clinic and administration support services.
- Analysis of falls in Wilsey ward had indicated that they had all occurred at night and three had occurred when a staff member had been removed to provide cover elsewhere. This meant the ward was unable to operate the night time protocol safely due to staff shortages.
- Not all the equipment in accident and emergency had proof of having been tested, so the trust could not be sure that all equipment was safe.
- Trust priorities not clearly articulated within a robust quality strategy.
- Root cause analysis of pressure ulcers were undertaken locally at grade 2 and corporately at grade 3, but there was no evidence of a connection between them.

Our findings

Prior to our inspection visit, we reviewed a number of factors relating to patient safety at the hospital. These included infection rates, reporting of incidents, the occurrence of 'never events' (mistakes in care that should never happen), reported deaths, harm with falls and staffing. We found that maternity services accounted for 30% of serious incidents, the number of reported incidents was low and the trust had been under reporting between April 2012 and March 2013. Never events were not an outlier but there had been some never events. The staff survey showed the percentage of staff who had witnessed potential harmful errors or incidents had increased to 31% in 2012 from 28% in 2011, and the number of full time nurses per bed day was lower than the national average. There had been a higher than average percentage of urinary tract infections (UTI) for patients with catheters, a fluctuation in veno-thromboembolism (VTE) rates and a spike in harm with falls.

Safety governance

Services were safe in Accident and Emergency (A&E), Surgery, Intensive/Critical Care, Maternity, Paediatrics/ Children's Care, Outpatients and Cancer Services. Improvements were needed in Medical Care

Board assurance was through multiple routes: performance against targets, complaints, walkabouts and reports from external reviews. The risk register contained risks identified by more than 30 specialist business units. Non-executive

Good

Are services safe?

Governance/Quality Directors told us that the trust's governance arrangements worked well. The Clinical Governance Committee met monthly and had good membership, including the Director of Nursing. The current quality strategy was 96% met, and the trust monitored effectiveness, safety and patient experience on a monthly basis. The new strategic priorities were: mortality rates, Clostridium difficile (C. difficile) infections and harm free falls. Ward heat maps went to this committee for review and they regularly viewed current high issues such as catheter urinary tract infections, venous thromboembolism, falls and pressure ulcers. Most of these went automatically to the Board and others only when there was a concern. The committee had a good practice of looking at learning from other trusts.

The trust held mortality meetings quarterly to discuss all surgical deaths. The medicine unit reviewed deaths monthly. The Medical Director also reviewed deaths by consultant.

Systems were in place to assess patient needs and plan their care, and the majority of patients said that they felt that their care had been safe though some patients we spoke to at the listening event and who had contacted us directly had not had good experiences.

The trust has two streams to its strategic direction:

Developing its district general hospital work.

Developing its tertiary cancer services.

The Non-executive Directors were well informed on the strategic direction and understood well the quality agenda, although the pace to manage these was slow. The trust had not clearly articulated the risks associated with developing cancer services concurrently with district general hospital services.

There was no evidence of how frontline staff got training in how to handle complaints, and the trust acknowledged that the percentage of medical staff trained in this area was non-compliant. There was also a lack of quality and safety involvement in the complaints process.

Infection control

MRSA infection rates were satisfactory when compared with rates for other trusts. The trust had exceeded its target for Clostridium difficile (C. difficile). Minutes from a range of meetings revealed that earlier analysis of C. difficile incidents had highlighted shortfalls in practice. The Director of Infection Control and the infection control team had developed an action plan to reduce cross-infection. These had been incorporated into a trust-wide action plan. The trust had also commissioned an independent review. Early indications were that C. difficile rates were now decreasing.

The Non-executive Director of Quality and Safety had noted an increase in catheter urinary tract infections, but not a trend. The trust had refined its policies and catheter care plans, and it was carrying out audits. However, it was not clear if a reason for the increase had been identified at a departmental level.

Pressure ulcers

At the time of the inspection, tissue viability was not a focus of the governance committee, despite the level of pressure ulcers in the trust. There is a trust strategy but no trust-wide action plan. There was no clearly understood reason by the staff we spoke with for any increase in pressure ulcers. Root cause analysis were undertaken at local level for grade two pressure ulcers and at a corporate level for grade three, but there was no evidence of a connection between them and thus opportunities for learning were lost. Local action plans had been put in place. However, it was not clear that all staff were fully implementing the actions, particularly when there were capacity or staffing issues. The audits that were being carried out did not provide evidence on whether actions were being fully implemented consistently across the trust.

Falls

There were appropriate risk assessments in place to reduce the occurrence of falls. The trust had developed a falls protocol and had appointed a full-time falls prevention nurse to provide advice, support and education to ward staff. Nursing staff felt this had been effective in reducing falls. All wards had access to new equipment to help reduce the risk of falls. This included chair alarms and low beds.

We saw that the trust was carrying out an analysis of falls, and that where trends were identified staff were providing appropriate support to people at times of high risk. Risk documentation had been updated and it informed staff of what steps they needed to take following a patient fall. There was a process for referring to senior management investigations of falls that had resulted in harm. Staff were told about learning from events at ward meetings. However, we were informed that analysis of the falls on Wisley ward had indicated that they had all occurred at

night and three had occurred when a staff member had been removed to provide cover elsewhere. This meant the ward was unable to operate its night time protocol safely due to staff shortages.

Staffing levels

The trust is working at full capacity in most departments and this is providing a challenge for them. This included staffing levels for support/administration staff and staffing on some wards, particularly medical wards and care of the elderly, Merrow, Wisley, Eashing and Albury. We looked at whether the hospital had safe staffing levels. Although patient satisfaction with care was generally good, staff said that staffing levels were a concern across the hospital. They were particularly concerned about numbers of nursing and healthcare support workers. We were told that if staffing levels were felt to be unsafe wards would be closed, but there was no clear criteria as to what would inform this decision. A number of falls on Wisley ward correlated with lower staffing levels than normal, particularly at night.

The Human Resources Director told us that there was a workforce plan that looks at the staffing resources needed to expand services, although a more predictive model was required. We found that the impact assessment for the planned growth in the Intensive Care Unit (ICU) did have a business plan that included a summary of risks. This was not very detailed, and the HR Director had not seen the modelling for where patients would go from ICU and the impact of that. This was particularly pertinent as there was evidence of patients experiencing delays transferring from critical care to wards because of bed shortages, as well as cancellations of routine surgery due to lack of capacity experienced while the team were on site.

ICNARC data shows that the trust were performing well within expectations nationally, though there were significant delays in discharging their medically well to the wards. The department recognised that the number of beds in the unit was not adequate. It had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional nursing and other staff to provide care for patients on wards resulting from these extra beds, or how it will manage discharge of medically well patients to the wards.

The Chief Executive informed us that the impact of any development had been reviewed. However, our discussion with directors and departmental leads revealed a disconnect between Board aspirations and knowledge of how they are being shared and managed, the impact they will have and how risks are going to be managed at a local level.

The HR Director told us that at the current rate of recruitment it will take until autumn 2014 to reach 95% of the target to meet current establishment requirements.

The trust had had difficulty recruiting nursing staff. At the time of our investigation, it had started recruiting from Spain, which had started to provide results: 15 nurses had been offered posts. There were some opportunities for developing other recruitment strategies.

Out of hours support

We visited the hospital out of hours and looked at how many doctors were available at night and what support they had. There was a clear handover system at night and doctor cover was good. There was consultant support that was responsive, and junior doctors said that they were well supported and that senior staff and executive level staff did listen to them.

The Medical Director told us that the system of cover and support for out of hours was that there was consultant cover at night and weekends. We had seen that this was the case at night. Consultants carried out weekend ward rounds in the morning and again in the evening, and consultants were on call to attend the hospital between these times and at night.

Discharge letters

Before our visit, we were told that GPs were experiencing delays of up to six weeks in receiving a copy of their patients' discharge letters. This had impacted on safety as patients were unable to get repeat prescriptions and GPs were not informed of a patient's condition or treatment in a timely manner. A shortage of support staff was impacting on the time it was taking to type letters, and GP letters were sent out by the pharmacy. The trust had established a project group to look at how this could be improved. A pharmacist confirmed that the trust had started a pilot programme that sent out discharge letters to GPs electronically. Information as to how well this was working to cut delays was not yet available.

Cancer services

The cancer network carries out peer reviews that look at cancer services in detail and provide recommendations, where necessary, to improve services. The last cancer peer

Good

Are services safe?

review was generally positive and found cancer services to be safe. However, the cancer patient experience survey did show the patient experience to be below average. One important area was access to cancer specialist nurses. This means there is a possible risk to patient safety. There has been a successful business case for specialist nurses and doctors. The cancer service is adequately staffed at most times, but in some specialist areas there is difficulty in contingency planning for unplanned absences.

A medical device alert had recommended that all spinal (intrathecal) bolus doses be performed using safer connectors that will not connect with intravenous Luer connectors and that the same was put in place for epidurals. The trust had carried out a risk assessment, and as appropriate connections to replace Luer locks are not yet available for epidurals it had concluded that to run two separate systems within the trust would pose a greater risk. This was based on the fact that only 2.6 whole time equivalent consultants and 1 registrar carry out intrathecal bolus injections, so risks were low. The trust decided that until epidural connections change, it would be safer to remain with the current system. A policy is in place to administer bolus intrathecal drugs.

A PICC line is a form of intravenous access that can be used for a prolonged period of time for treatment such as chemotherapy. The PICC replacement team is based at the St Luke's centre, where there is an invasive device policy and staff were fully trained.

The trust planned to have e-prescribing across the trust by 2014. There was an action plan in place for each tumour site service to have e-prescribing and this was in place for 50% of the service at the time of the inspection. This means that consultants could access records from off-site and prescribe directly, which reduced any delay and minimised risk.

Access to notes posed a risk in many outpatient departments, but The Director of Haematology told us they always ensured they had their notes by planning and checking before the clinic starts. We were also told that referrals were promptly followed up.

The Cancer Service Business Unit had a weekly governance meeting and fed into the trust-wide governance meetings. There were problems with support for clinical work, but communication was good and everyone was working together to address this. The main concern at the service business level was that the oncology service was at full capacity. Other risks included infrastructure, IT and data availability.

Acute oncology services were safe, but the trust acknowledged that they needed further improvement. For example, more work was needed to identify what happened if a patient with cancer went to another hospital for emergency treatment. The services also needed more staff. There were currently two acute oncology posts, but four are needed and recruitment is difficult.

Patients had access to a chemotherapy nurse via a 24/7 hotline through the trust's switchboard, and there was an on-call register for out of hours assistance.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

- Services are effective, but the trust needs to make some improvements to ensure that all services are effective at all times:
- Some clinical pathways needed improvement, for example the management of neutropenic sepsis in A&E was not always being followed.
- The management of people's pain in the A&E needed improvement. We found that patients presenting with pain were not always given or offered pain relief in a timely manner.
- In some areas, the trust had not been consistent in making changes identified in its action plans in response to complaints and incidents.
- Staffing levels were impacting on the effectiveness of some services. Current management of staffing levels, processes and patient numbers made effectiveness inconsistent.

Our findings

Prior to our inspection visit, we reviewed data relating to the effectiveness of the care provided at Royal Surrey County Hospital. Parameters were within expectations with some elevation in death from diagnosis of CCS group musculoskeletal. All but one of these had other more significant conditions which led to their deaths.

Care pathways

Most patients said that their treatment had been effective at each stage, from admission as an emergency or referral by the GP to successful surgery and recovery. Initiatives had been put in place to improve effectiveness of services for patients. Examples of these included the 'Dementia Passport' for improving services for people with dementia and the introduction of 'intentional care' rounds (planned, regular checks that patients were getting the care they need). Surgical wards had an 'early warning score' that detected deterioration of a patient's condition and called for urgent medical help. In Accident and Emergency (A&E), staff followed clinical pathways of care to best treat patients. These included neutropenic sepsis, (a life threatening condition), old persons and adult liaison (OPAL) and stroke. The stroke and OPAL pathways were working well, and we saw the stroke pathway in progress.

However, the neutropenic sepsis pathway was not effective. Staff were able to explain the pathway in detail, including the 'door to needle time' (the time from a patient's arrival to getting antibiotics) of one hour. Audits undertaken between April 2013 and September 2013 showed that the average door to needle time was two hours, with some patients waiting over three hours for antibiotics. This meant that although some pathways were working well others required improvement.

Patients were seen by the triage nurse within 30 minutes in A&E. However we found that patients presenting with pain in A&E were not always given or offered pain relief in a timely manner. For example, we reviewed 43 medical notes of patients presenting or mentioning pain when first assessed. We found that 19 of the 43 patients received no pain relief including one patient whose pain score indicated severe pain; 20 of the 43 notes did not record a pain score. Of the remaining patients who received pain relief and whose pain score indicated severe pain, two waited over two hours and one waited over an hour for pain relief. This meant that patient's needs were not always met.

Clinical Negligence Scheme

Maternity services had recently been successful in attaining Level Three for the Clinical Negligence Scheme for trusts for the third consecutive time. This scheme was set up by the government to try to improve safety and quality of care for service users. It also provides hospital trusts with assistance if a patient makes a claim against them for negligence. In order to achieve Level Three the trust needed to demonstrate that it had robust processes in place to enable staff to provide the highest level of care.

Maternity

The community midwives team matron explained that women who chose to have their babies at home were supported through their labour and birth by a team of experienced midwives. There were robust protocols in place clearly defining the steps that staff should take if complications occur.

The Midwifery-Led Unit offered similar services to the home-birth option and was suitable for women over 37 weeks pregnant who were anticipating a normal birth. It was staffed by midwives. But in the event of complications, or if women decided they needed an epidural, they were transferred to the consultant-led delivery suite.

Good

Are services effective?

(for example, treatment is effective)

The Consultant-led Unit provided care for any complicated or high-risk pregnancy and birth. It had 24-hour access to all members of the obstetric team including obstetricians, anaesthetists and paediatricians. Maternity and paediatric teams worked in tandem and provided access to specialist consultants and advice at all times. Doctors felt that they were always supported.

Care pathways designed to ensure that women with specific needs were cared for were in line with recognised clinical guidelines and standards of care. These included protocols for care for women with diabetes, those with a high body mass index (BMI), women found to be non-immune to Rubella and those who have chosen to have a vaginal birth after a previous caesarean section.

One woman told us that staff had closely monitored her throughout her pregnancy, because of a previous miscarriage, and that she had received superb care. She told us, "I was given the option of an early scan, so I chose to have it, and they have told me everything I need to know." We were told by another woman who had returned for a postnatal check following a caesarean delivery that her care had been great and staff had given her appropriate pain relief. She told us, "I'm a diabetic and have suffered from pre-clampsia, so I'm so grateful for the wonderful care here." We were able to see that the specialist midwife had supported her during her pregnancy and delivery.

Complaints and serious incidents

There were systems in place for learning from complaints and serious incidents. This was working particularly well in the maternity service, where we found that a strong clinical audit programme had been put into action. It aimed to ensure that quality and safety standards were maintained and was linked into the trust-wide audit strategy.

The trust had systems in place to undertake audits where concerns or trends were highlighted, and to respond to their findings. It was clear that as a result of previous incidents there had been changes to practice and staff had tried to implement them. However, it was unclear if learning from serious incidents or safeguarding had been incorporated into strategies to ensure changes were applied consistently and their effectiveness could be measured. For example, mattress settings had been identified as a possible factor in the development of pressure ulcers. This was not included as a check, either in the pressure ulcer risk assessment information or the nursing documentation audit. The trust was carrying out informal checks on documentation, but it was unclear how some changes would be monitored across the trust to ensure that they were being made consistently. In addition, although actions plans were in place, staff did not always follow them. For example, the trust undertook a month-long audit of the intensity of care required by patients on wards where staff and patient feedback had indicated staffing was not adequate. Those audits showed an under establishment on four wards and approval was given to recruit to the new posts. Though some gaps were filled with agency and bank staff (staff who agree to fill in gaps in the rota), this had not provided the required number of staff, and patient beds had not been reduced until the posts had been filled.

End of life care

The Royal Surrey is a pilot site for the implementation of Route to Success, which is the Department of Health's End-of-Life Care Strategy for acute hospitals. It had a dedicated palliative care team led by one specialist consultant. In response to the government's proposals for phasing out the Liverpool Care Pathway, the trust had made a number of changes, either immediately or for the longer term. It had put systems in place to monitor how these changes were carried out, to ensure the end of life care pathways were effective.

Outpatients

In the outpatients department, problems in accessing medical records had made delays worse and put extra demands on the nursing staff to cope with the capacity levels. Eye testing was being performed in a busy corridor. There were also significant delays in communicating with patients' GPs, and this could disrupt treatment.

Infection control

While systems to control infection were generally effective across the trust, staff did not always follow World Health Organization guidance when washing their hands.

Cancer services

E-prescribing has been partially introduced in some cancers specialist areas and should be fully implemented in accordance with national trends.

The trust reviews all deaths that occur within 30 days of chemotherapy, and there are nurse led clinics for assessment of toxicity.

Good

Are services effective?

(for example, treatment is effective)

Surgery

The surgery wards had implemented an enhanced recovery programme that enable patients to return home as soon as possible following surgery. This was being used well in laproscopic surgery for cancer patients.

All surgical patients with dementia were cared for in one bay. The staff support on that bay was more intense than other bays because of the conditions of the patients. This meant patients with dementia were provided with additional support to help them in their recovery.

Good

Are services caring?

Summary of findings

- Overall, services were caring, but there were some areas for improvement.
- Staff treated people with compassion, respect and dignity. The time given to care depended on patients' specific needs. Patients felt cared for and listened to by staff, though some patients we spoke to at the listening event and who had contacted us directly had not had good experiences.
- Staff generally maintained people's privacy and dignity.
- The vast majority of patients commended the trust on the care provided by the nurses and doctors, though some patients we spoke to at the listening event and who had contacted us directly had not had good experiences.
- Patients told us that, despite delays for appointments and long waits in outpatients, when they were seen the staff were very caring. However, there were a number of people who had not had this experience and reported a poor attitude in the way they were spoken to by some nursing staff, doctors and consultants.
- The majority of patients and their relatives said that staff kept them informed about treatment.
- Patient records reflected where staff had sought consent to deliver care and treatment, and discussions regarding treatment decisions had been recorded.
- Staff involved patients and their families in the planning of care, and there was effective communication.
- A 'dementia passport' was used to identify patients with dementia and ensure they got the support they needed when in hospital.
- A 'communication passport' was used for adults with learning disabilities.
- The cancer patients' survey had identified some areas that required improvement.

Our findings

Prior to our inspection visit, we reviewed a number of factors relating to the trust's ability to be caring towards patients at the hospital.

The trust had performed about the same as other trusts in all 10 areas of the adult inpatient survey and had improvement on seven individual questions compared to their 2011 survey. The Friend and Family Tests were introduced to give patients the opportunity to feedback on the quality of care they received. In July 2013 the trust performed above the national average for accident and emergency but below average for inpatients. The trust was in the bottom 20% for nine questions within the cancer patient experience survey 2012/2013. This was particularly in receiving written information, ability to contact a cancer nurse specialist, understandable answers from ward nurses, privacy for discussions, and emotional support. There were also some areas of concern identified form the National Bereavement Survey of 2011.

Patient and family views

The majority of people were very positive about the caring nature of the staff. There were a number of people, however, that had not had this experience and reported a poor attitude in the way they were spoken to by some nursing staff, doctors and consultants.

Overall, patients said they felt cared for and listened to by staff. They said that staff treated them with dignity and respect. We saw that staff generally respected people's privacy and dignity. For example, one patient had mobility problems and needed help to access the facilities. Although the department was busy, the nurse helping the patient did not rush them and spoke to them politely and in a gentle manner. They protected the patient's dignity at all times. We saw that staff curtains were pulled around patients' beds to ensure privacy and facilities were available so doctors and nursing staff could speak with relatives of unwell patients privately.

Involving people in their care

The majority of people said that staff had kept them informed about their treatment. Patients' records showed that staff had sought consent to deliver care and treatment and that they had recorded discussions about treatment decisions.

Staff involved patients and their families in the planning of care, and there was effective communication. We saw a patient who had a hearing impairment and appeared confused with their current situation. The doctors spoke clearly to the patient, explaining who they were and where the patient was. The patient was given time to absorb the information and agree or disagree with the plan.

Good

Are services caring?

Good record keeping

Staff generally kept good records, but there were some instances on medical wards where staff had not updated records to reflect patients' current needs. For example, we saw a person walking and sitting unassisted when their moving and handling assessment said they required assistance. Staff said the person no longer needed this support, but records had no information about the improvement or assessments of whether new risks were present.

Being responsive to needs

A 'dementia passport' was used for patients with dementia to identify them and ensure they got the support they needed when in hospital. Where possible, this was completed with the help of relatives to help inform staff support. There were also 'communication passports' for adults with learning disabilities, and there were supplementary care plans that could be added to end-of-bed notes to inform staff about any specific needs patients might have (for example communication needs or the need to stop patients feeling isolated in a side room).

In one area we used the Short Observational Framework for Inspection (SOFI) to help us understand the experience of people who could not talk to us. There was substantial interaction or engagement with various activities such as providing drinks and talking to patients including regular checking of care. Members of staff were aware of patients' needs and responded appropriately. This meant patients' needs were met.

Cancer services

The cancer patient experience survey had identified some areas that needed improving, and teams spoken had taken this very seriously. They had developed plans to address those areas where they were not meeting the needs of patients. It was too soon to judge the impact of this work.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

- Overall, services were responsive, although there were some areas for improvement.
- Maternity services were particularly good at responding to patients' needs.
- The children's ward responded well to patients' needs, though the department could make further improvements to the children's environment in A&E.
- Surgery services had responded well to patients' needs, although patients did tell us that there were some delays at times due to staff shortages.
- Records showed that A&E was now reaching the national target of seeing, discharging or admitting 95% of patients within four hours. Evidence showed that on arrival patients were seen by the triage nurse within 30 minutes.
- Some medical wards, particularly Merrow,Wisley, Eashing and Albury wards and outpatients were not always able to respond to patients' needs in a timely manner when there were staff shortages or overcapacity.
- The trust now faces the challenge of how to meet people's needs effectively until it can put more staff in place.
- Overcapacity issues had led to delayed appointments and long waits in some outpatient departments, particularly ophthalmology.
- Some people told us their complaints were not responded to in a timely way.

Our findings

Prior to our inspection, we had reviewed a number of factors relating to the responsiveness of services. These included: referral to treatment under 18 weeks, diagnostic waiting times; all cancers; wait for first treatment from urgent GP referral; day wait from diagnosis; number of patients cancelled operations and discharges. We found that these were all within expected parameters. Accident and Emergency (A&E) waiting times were below the national target. Figures for the number of patients leaving A&E before being seen were better than the national average.

Before and during the inspection we received comments from around 500 patients.

Maternity services

In many areas, the trust was responsive to patients' needs. Particularly of note were maternity services.

The maternity unit held informal forums that involved midwives and patients, where information and views were used to improve maternity care at the trust and also to inform the wider maternity services through the Maternity Service Liaison Committee (MSLC). There were policies and procedures in place to ensure that when a pregnant woman attended A&E there were facilities so that she could to be seen immediately by a midwife or obstetrician, and there were arrangements for contacting an on-call obstetrician at all times. There were also policies and procedures to inform staff about the handling, responding and recording any comments and complaints.

Women who attended antenatal maternity clinics told us that although there were often delays staff worked extremely hard to be supportive and kind. One person told us, "Sometimes I get seen very quickly and other times it's a long wait." Another person said, "On one occasion, I was here for three hours, and after a caesarean it can get uncomfortable waiting around on these chairs." Nurses told us that they spent a lot of time on paperwork and general administration tasks due to the lack of appropriate administrative staff.

Paediatric services

Paediatric services had responded to the comments of children and parents. For example the paediatric unit had a dedicated minor treatment room for ear nose and throat (ENT) treatments as a result of feedback of a less satisfactory experience for children attending the main ENT department with adults. They were also working with the ENT team to provide a bespoke service in a more child friendly environment supported by paediatric nurses. The trust also had a shared teenage cancer unit with West Sussex and Hampshire. This is one of four in the south of England to ensure that teenagers are able to receive their care in private. Children were involved in the improvement of their care, and children we spoke with told us that staff asked them about their care and helped them to complete a questionnaire.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Surgery

The surgical service had highlighted improvements needed from the Friends and Family Test and had an action plan that it was working through to respond to people's feedback. This included the planning of discharges. They had identified problems with transport and finding next step places, particularly in the evening, and had now opened a ward for people who were fit for discharge but were waiting for arrangements for transport or their care in the community to be finalised. The maximum stay on this ward was 24–48 hours. In the heart ward people who were fit for discharge had been delayed due to them being able to manage their medication at home. To improve this outreach nurses visited patients prior to discharge to discuss their needs at home and to support them on discharge.

Responding to individual need

Translation services were available and in outpatients we were also told us of access to translation using the British sign language. Outpatients had responded to patients' needs by running some evening and Saturday clinics, which were proving popular.

The critical care team had developed an outreach team led by a consultant nurse that provided a service from 8am till midnight, and out of hours was provided by a critical care consultant to respond to any early warning triggers for patients on wards to enable prompt transfer to critical care when needed.

End of life care

We saw good multidisciplinary discussion around end of life care and reviewed patient records that showed the right level of care during this time. This care included discussion with relatives and placing patients who recovered sufficiently on the Amber care pathway, enabling them to be discharged home with appropriate palliative support.

Staffing issues

Patient comments prior to the inspection had told us that call bells were not always answered promptly. The trust had identified that this occurred regularly on some wards where they were understaffed. The trust is recruiting to posts but staffing is still an issue for some wards.

Staffing impacted also on outpatients, where overcapacity made responding to patients' needs more challenging. It was clear that efforts had been made to address problems and that there were long term plans in place, but the response is slow to address patients' needs, particularly in ophthalmology.

Complaints

The majority of people we spoke with were very compliamnetary about the quality of care they received. Some patients we spoke to at the listening event and who had contacted us directly had not had good experiences and said that their concerns or complaints had not been responded to in a timely way.

Car parking problems

Both before and during the inspection patients had expressed their dissatisfaction with car parking at the hospital. Patients were rushed and stressed about missing appointments due to difficulty finding parking spaces. Some missed delayed appointments because of their ticket expiring and some faced costly parking due to having to wait up to four hours in the outpatients to be seen due to overbooking. There was insufficient disabled parking, so the needs of patients were not being met. Staff were arriving between two to three hours before their shift to get a space and eating breakfast in their cars, which is not conducive to care for staff. The trust informed us that it had applied for planning permission from the local authority to enlarge the car park, which is very much needed. It is unable to sustain adequate parking for current activity levels and as the trust develops its services this may get worse. However, the trust acknowledged that there are actions it could be taking now to improve disabled parking.

Are services well-led?

Good

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

Summary of findings

- Overall the trust was well-led, although there were some areas for improvement.
- The trust was particularly well-led at departmental level, and there was a transparent, open, supportive culture. Everyone was clear on trust priorities, but priorities at departmental level had not been captured at trust level.
- Current operational structures had a lack of connection to Board level, which led to the executive team being unclear on its understanding of issues at a department level.
- The trust's quality strategy focused on national targets and future developments. The Board was not able to articulate the quality strategy for some basic quality issues specific to the trust.
- Not all middle management had a clear understanding of the spread of risk across the trust.
- The risk register highlighted risks by the specialist business units, but it was not evident that there was a trust-wide perspective.
- Consultants told us that they needed more leadership training, and that there was no provision for their leadership roles within their current job plans.
- We were told that there was currently no leadership development plan.
- There were clear lines of accountability within the maternity department.
- Staff were confident about their roles and responsibilities.
- Staff within the maternity unit trained together and operated as an efficient and cohesive team.

Our findings

Prior to our inspection we looked at a number of factors regarding how well-led the trust was. These were generally within normal parameters. The staff survey showed that he trust was in the top 20% for 28 of the staff survey questions. Staff sickness levels were consistently below national average. However, the trust was in the bottom 20% for staff working extra hours, and there were more staff suffering from work related stress than previous years, and 1.25% of primary diagnosis was recorded incorrectly compared to a national average of 7%. The Department of Health monitors cancelled operations, and this can be indicative of management and quality of care within the trust. This trust was rated as similar to as expected in comparison to other trusts.

The culture throughout the trust was very open, and staff were very enthusiastic, positive and knowledgeable about the trust's overall vision and strategy. The Chief Executive is also the operational manager of the hospital and is supported by two Deputy Directors of Operations, each overseeing a proportion of service business units. They deal with day-to-day operational management, with the CEO providing oversight and managing strategic issues and risks.

There was overall good leadership at departmental level and a lot of innovative work at ward level to continually improve the patient's experience. Priorities at the departmental level had not been captured at trust level and there was some lack of connection to the Board. The executive team had a clear understanding of strategic priorities but was less clear on its understanding of local issues. Members said they had taken assurance on some areas that they should not have. There was a general perception throughout the trust that the executive team and local teams were progressing at a different pace.

The quality strategy focussed on national targets and future developments and the members of the Board we spoke with were not able to articulate the quality strategy for some basic quality issues specific to the trust.

Operational management was not fully connected, from the Chief Executive and Board to departmental level, and not all middle management had a clear understanding of the risks across the trust. There was a risk register that looked at risks highlighted by the specialist business units, but it was not evident that there was a trust-wide perspective.

Consultants told us that they needed more leadership training, although there was a lot of informal support. They told us there was no provision for their leadership roles within their current job plans.

We were told that there is an assumption that some clinical directors already have leadership skills, and there was currently no leadership development plan.

Are services well-led?

Good

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

The A&E department was well-led. Staff told us they got good support from the management team. One student nurse told us, "The matron and lead nurse practitioner are very approachable and do welfare checks on us regularly." There was a new sickness policy in the department to reduce sickness levels and improve support for staff. Records showed that sickness levels had fallen since the new policy was introduced. This meant a reduction in workload pressure and better support for staff on return from sick leave. Management carried out regular audits of a number of areas. They analysed the results and created action plans in response. This meant that the management team was using appropriate tools and data to help it achieve best practice.

In medical wards, staff said they had support from the Chief Executive and the Board, who were visible and effective at making things happen. There were Board walks (visits to the wards by Board members), and each ward was allocated a specific Board member. Staff felt supported by their departmental managers. Staff told us that they were getting access to all mandatory training, but levels of compliance were between 75% and 80% on the medical wards we visited.

There were clear lines of accountability in the maternity department. Staff were confident about their roles and responsibilities. We were told that there was immediate access to specialist consultant paediatricians, obstetricians and anaesthetists. We looked in depth at this service's risk management structure. Job descriptions encompassed the risk management role. A risk management policy informed staff of the steps to take when reporting and responding to risk. This included how to immediately escalate any risk issues from the maternity service to Board level.

We were able to see from records that obstetric medical staff of all grades, and midwives, together with other staff within the maternity unit trained together and operated as an efficient and cohesive team.

Staff told us that the positive leadership contributed to a high level of staff morale. In outpatients staff told us that the outpatient matron was frequently in the clinical area, and was visible and supportive.

The department was participating in the Department of Health's Productive Outpatients Department programme. It displayed information about the programme, problems identified and solutions it had introduced. Staff were knowledgeable about the programme and its aims. A monitoring tool gave all the team information about staff sickness in real time and we were told that sickness levels had improved since this monitoring had begun.

There was some disconnect between the reality of service delivery and patient experience and the view the Board had of the situation. The trust was aware that there were issues and challenges facing the eye outpatient service. Staff told us that governors and Board members had been in the department talking to staff and patients as these issues had become more sharply focussed. We looked at the eye outpatients action plan in some detail. However, when we tested some of the progress detailed in the action plan we found that in some areas the situation we saw and that which staff and patients described did not correlate. For example, the plan said that clinic templates to set the numbers of patients seen had been finalised, yet we witnessed double and triple booking of appointments. The action plan also suggested the typing backlog was resolved, but we found this not to be the case. We discussed this with a Board member who told us that the Board received briefings at Board meetings. They said, "We have not got sufficient traction on the action plan," and "We have taken assurance where we should not have done."

Good

Accident and emergency

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The accident and emergency (A&E) department provides a 24 hour, seven days a week service to the local area. The department has an annual attendance rate of 72,000. A&E consists of triage, minors, majors, resuscitation and a clinical decisions unit (CDU).

Summary of findings

We inspected the A&E and CDU. The A&E department was safe, caring, responsive and well-led. However, we found that the department's effectiveness could be improved.

Good

Accident and emergency

Are accident and emergency services safe?

Good

After patients arrived at the department, staff assessed their needs quickly. Nursing staff consulted the relevant doctors to ensure patients received appropriate support. At the end of every shift, nursing staff and doctors had handovers (where staff exchange information about patients' care). We observed the handover for the evening nursing team and saw that discussions were discreet, so patients couldn't hear what was being said about other people's care and treatment. Staff exchanged detailed information about patients' treatment and procedures they were still waiting for. This meant that all staff on the shift were fully aware of all patients in their care and could provide a continuous and safe service.

A&E was clean and tidy, and hand hygiene gels and soaps were available throughout the department. One patient told us, "It's clean in here. Mind you, I've been here before and it's always clean.' One staff member said, "When we need a cubicle cleaned, the cleaning staff come down quickly and do a good job." Waste bins for clinical waste and sharp objects had the correct labels, and staff used them appropriately. This meant that patients received care in a clean and hygienic environment.

Records showed that staffing levels were safe and that there were additional staff at peak times. Doctors told us that they never had a problem contacting consultants, or getting them to come to the hospital, outside of normal working hours. This meant that patients received treatment from an appropriate person with the right skills.

The department had an appropriate system for recording and investigating any serious incidents that occurred. There was also a robust safeguarding pathway, and the department had computers that staff could use to report safeguarding concerns. Staff had regular training in safeguarding, the Mental Capacity Act and the Deprivation of Liberties. Those we spoke to were knowledgeable about these areas and could demonstrate what they had learned in training. This meant that patients were protected against the risk of abuse.

Staff had tested medical equipment to ensure it was safe, but we could not find evidence that every piece of equipment had been tested. This meant that the provider could not be sure that all equipment was safe.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Care and treatment were based on guidance from appropriate professional bodies, and staff followed established clinical pathways of care. This included pathways for neutropenic sepsis (a life threatening condition), old persons and adult liaison (OPAL) and stroke. We saw the stroke and OPAL pathways in action, and observed that they worked well.

However, records showed that the neutropenic sepsis pathway was not effective. For example, staff were able to explain the pathway in detail, including the target to give patients antibiotics within an hour of their arrival at the department (the 'door to needle time'). Audits undertaken between April and September 2013 showed that the average door to needle time was two hours, with some patients waiting over three hours for antibiotics. This meant that although some pathways were working well others required improvement.

We found that patients presenting with pain were not always given or offered pain relief in a timely manner. For example, we reviewed 43 medical notes of patients presenting or mentioning pain when first assessed. We found that 19 of the 43 patients received no pain relief including one patient whose pain score indicated severe pain; 20 of the 43 notes did not record a pain score. Of the remaining patients who received pain relief but whose pain score indicated severe pain, two waited over two hours and one waited over an hour for pain relief. This meant that patient's needs were not always met.

Records showed that the department reached the national target of seeing, discharging or admitting 95% of patients within four hours. Evidence showed that on arrival patients were seen by the triage nurse within 30 minutes One patient told us, "After I got here, I was seen within 20 minutes." Another patient told us, "It was about ten

Good

Accident and emergency

minutes waiting to be seen by triage." We found that there was an equally effect discharge pathway. For example, vulnerable or older patients with complex needs were referred to the OPAL team. This was a multi-disciplinary team that ensured the correct care packages were in place so patients were discharged safely.

Are accident and emergency services caring?

Good

Patients we spoke to told us they felt cared for and listened to by staff. One patient told us, "When I was seen by the first nurse who assessed me the nurse listened to what I had to say. She then brought me straight around to here." Another patient told us, "Reception are very friendly, I can't fault them. The nurse was very good as I was a bit concerned if it was the right thing to do, to come here. She reassured me I had done the right thing."

We observed staff caring for patients and saw that they were treated with dignity and respect. For example, one patient required support with mobility to access the facilities. Although the department was busy, the patient was not rushed. The nurse spoke to the patient politely with a gentle manner and ensured the patient's dignity was protected at all times. We saw that curtains were pulled around patients' beds to ensure privacy and a relative's rest room was available so doctors and nursing staff could speak with relatives of unwell patients privately. This meant that patient's dignity, privacy and respect were maintained.

We found that patients and their families were involved in the planning of care and there was effective communication. For example, we observed the arrival of a patient into the resuscitation area who had sustained a serious injury. The patient had a hearing impairment and appeared confused with the current situation. We saw that the doctors spoke clearly to the patient explaining who they were and where the patient was. We noted that the patient became less anxious. The doctors continued to speak directly to the patient explaining what they would like to do and their plan of action. The patient was given time to absorb the information and agree or disagree with the plan. This meant that patients and their families were able to be involved in their care.

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

(for example, to feedback?)

Good

There were systems in place to learn from incidents and complaints and make appropriate changes.

Records showed that concerns had been raised by patients who had been admitted to the CDU around the care of patient's nutritional needs. The Matron in charge of A&E told us, "In the past hot drinks had to be carried through from majors and hot food came from the main kitchens which meant the food was often cold". Records showed that a risk assessment had been undertaken and an action plan was in place to address the issues. We saw that a new area had been created in CDU for beverage making and storage of cups and jugs. Hot food now arrived via the food trolley of the adjacent department and systems had been put in place to identify and support patients who required assistance at mealtimes. This meant that patients were listened to and their concerns acted on.

Staff told us that regular meetings were held around learning from and understanding patient concerns and clinical incidents. One staff member told us, "We have monthly meetings on clinical matters we are then emailed with a newsletter which informs us of the change in practice."

Information collected by the department showed that the needs of the local population had changed. The result was an increase in demand around the minors area of A&E from early evening until 23:00 hours. The department responded to this demand by increasing nursing and practitioner levels at peak times. This meant services were planned around the needs of the population.

Although we found that most of the time patient's needs were met at each stage of their care we found that some improvement was required.

Staff were able to explain in detail and with knowledge how they responded to patients' individual needs. For example, a sister told us, "When we see patients who have learning disabilities or challenging behaviour we adjust care to their needs. If the patient is agitated we ask them where they

would feel safest and we take advice from the patient's carers. I have assessed patients in the back of ambulances as they have been too scared to come in." The safeguarding lead told us, "For patients with challenging behaviour we speed up their review process to reduce the impact on them and remove the stressful environment." This meant that reasonable adjustments were made as appropriate.

Are accident and emergency services well-led?

Good

We found the A&E department to be well-led and motivated. Staff were open and honest, and we observed a friendly atmosphere. Staff told us they were supported by the management team. One student nurse told us, "The matron and lead nurse practitioner are very approachable and do welfare checks on us regularly." Another nurse told us, "Matron is always around the department and will support us when needed."

Matron informed us that a new sickness policy had been put in place. Its main purpose was to reduce sickness levels and support staff better. One staff member told us, "The procedure for reporting sick has changed so now you have to speak to a sister when reporting and then the following day you have to speak with matron or the lead practitioner." Records showed that sickness levels had fallen since the new policy was introduced, with managers better placed to monitor patterns or trends of sickness. This meant that workload pressures were reduced and staff were supported when returning from sick leave.

Management had taken an active approach to reducing the use of agency staff within the department. For example, records showed that a recruitment campaign had taken place resulting in nine new nursing staff, leaving three vacancies to fill. Bank staff were generally used to fill the gaps, one staff member told us, "We use bank staff that know the department which is safer." We reviewed the staffing rota for the last four weeks, which showed there was appropriate cover and skill, mix. This meant that management understood areas of concern with the department and took action to address these.

Audits were undertaken on a regular basis by management on a number of areas, these included: hand hygiene, infection control and documentation. The results were analysed and action plans put in place when required. Staff told us they found these helpful and the management team told us they could focus on leading areas of improvement. Matron told us, "The audits are especially helpful as most are the basic principles of nursing." This meant that the management team were using appropriate tools and data to help achieve best practice".

Good

Medical care (including older people's care)

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

Information about the service

The trust has 22 specialist wards at Royal Surrey County Hospital. During our inspection we visited seven of the medical wards. We included those wards specifically highlighted through patient feedback to the trust and to CQC, where patients thought improvements were needed. These were Wisley, Eashing and Merrow. We also visited Albury Ward, Tilford ward, Hindhead ward and the recently established escalation ward, which is located off of Hindhead ward. The trust has had consistently lower bed occupancy than the national average, Over the period April to Oct 2013, all medical wards averaged an occupancy level of less than 83%. However, individually some wards exceeded 85% in some months, with one ward averaging an occupancy of 98.7% and another 93.9% in May 2013 It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Summary of findings

Overall, medical care was responsive effective and well-led. However, we had concerns about Merrow, Wisely, Eashing and Albury wards we visited, where staffing levels were low and there was a risk that patients may not receive safe care. The trust had acknowledged that these wards do not have a sufficient number of staff to provide the care needed by acute patients, and it was taking action to address the problem. We saw that staff were busy and that patients' basic care needs were attended to. However, sometimes staff were not always able to update bedside documentation to reflect patients' present care needs, or attend to patients in a timely manner.

Good

Medical care (including older people's care)

Are medical care services safe?

Good

Staff assessed and reviewed patients' needs and planned care to meet those needs, including care after discharge from hospital. They demonstrated an awareness of their roles and responsibilities in respect of protecting people from harm. They understood how to report serious incidents that occurred on the ward. They administered medicines safely, and there were systems in place to monitor this.

Discharge letters

Before our inspection, we were told that GPs were waiting up to six weeks for a copy of their patients' discharge letters. The trust told us that the hospital pharmacy was responsible for sending out these letters and that it had set up a project group to look at how this could be improved. A pharmacist confirmed that a pilot programme was now in place and discharge letters were being sent to GPs electronically. Information was not yet available as to how well this was working and whether delays in letters arriving with GPs had been reduced.

Staffing issues

Before our investigation, patients had expressed concerns about how staffing levels on some wards were impacting on the quality of care. The trust told us that it had added these staffing issues to its risk register. Our conversations with staff revealed that they had a very positive attitude and were tolerant of the present shortfalls because they knew that the trust was trying to do something to alleviate the problem. The majority of staff said that they felt patients were safe, but they also said that they were continually busy and unable to spend time with patients. One staff member felt that this impacted on their ability to provide care essentials, including help with feeding. Staff told us that wards were able to request agency cover for unplanned sickness and leave. In response, the trust had simplified procedures for approving use of agency staff to speed up the process.

At the time of our visit, The trust had acknowledged that Eashing and Wisley did not have a sufficient number of staff to provide the care needed by acute patients, and it was taking action to address the problem but had not identified shortages on Merrow and Albury. However, interim arrangements to operate understaffed wards at the new staffing levels had not been put in to place. On Wisley ward for frail elderly patients, identified as understaffed by the trust we found that nursing staff were still being moved on some shifts to support staff shortages elsewhere in the hospital. We saw from a record of shift staffing maintained on the ward by the sister that in the previous two weeks staff had been taken on at least two shifts per week, and this was usually a night time shift.

We asked a senior member of the management team whether the trust considered risks before removing staff from an already understaffed ward. They told us that the trust was developing a risk assessment policy that gave a red, amber, or green rating to a ward that would help inform such decisions, once it was in place.

Patient falls

The trust told us that as a result of measures they had implemented the number of patient falls had been declining. On Wisley ward we were told that there had already been seven falls in October. Analysis of falls had found that all of the falls had occurred at night and that three out of seven had occurred on shifts where a staff member had been removed to provide cover elsewhere.

There were appropriate risk assessments for reducing the occurrence of falls. The trust had developed a falls protocol and had appointed a full-time falls prevention nurse who provided advice, support and education to ward staff. Nursing staff felt this had been effective in reducing falls. All wards had access to new equipment to help reduce risk of falls. This included chair alarms and low beds. The trust was analysing data on falls and using findings to improve support for patients at times of high risk. Risk documentation had been updated and prompted staff to what steps they needed to take if a patient fell. There was an escalation process (a process for raising an issue with higher management) for reviewing falls that had resulted in harm. We saw that ward managers discussed learning from serious falls events with staff at ward meetings.

Pressure ulcers

There had been an increase in the number of hospital acquired grade 2 pressure ulcers. There was no clearly understood reason by the staff we spoke with for this increase. Root cause analysis of pressure ulcers were undertaken locally at grade 2 and corporately at grade 3, but there was no evidence of a connection between them. The trust had developed a pressure ulcer strategy to

address the problem. This included revised risk documentation and education of ward staff. We asked a member of staff to take us through the pathway of someone admitted to the ward. We saw that appropriate arrangements were in place to risk assess people on admission to and discharge from wards. Medical photography was used to record ulcers people arrived with or developed during the course of their stay. There was appropriate monitoring and equipment for those people seen to be at risk. Many of the staff were confident about managing the care and treatment of pressure ulcers up to grade 2, and they told us that they could refer patients directly to the tissue viability nurse specialist, who visited wards weekly. However some of the staff we spoke to were less informed than others about how to access pressure relieving equipment out of hours.

Infection control

Staff followed the trust's policies and procedures for infection control. Wards were clean with no unpleasant odours. The trust had experienced a sudden increase in the number of hospital acquired urinary tract infections. It had implemented a number of measures to try to reduce this, including a review of the use of catheters. Clinical audits were routinely undertaken to improve overall infection control practice.

The trust had exceeded its annual target for cases of Clostridium difficile (C. difficile). We saw minutes from a range of meetings, and these indicated that analysis of C. difficile incidents had highlighted shortfalls in practice. In response the trust had developed a trust-wide action plan. Early indications were that C. difficile rates were now declining.

Managing medicines

The trust had appropriate systems in place for the management of medicines. Staff who were administering medicines wore tabards so that other staff and patients knew not to disturb them while administering. Trolleys were secured when not in use or when the administering staff member was away from the trolley. There were systems for the management of spoiled medicines and the reporting of drug errors. We were informed about the storage and systems in place for the administration of controlled drugs, and these were appropriate. Hospital pharmacists were undertaking audits of medicines on the wards, and we saw feedback from these in ward minutes.

Staff told us that most agency staff had not been cleared to administer medicines in the hospital, and this could sometimes be a problem when there was a shortage of substantive staff on a shift. The trust took patient safety seriously. They told us that only agency staff assessed as competent with medicines administration were approved to administer. Trust management told us that they were looking into how they could improve the current arrangements thereby reducing the pressure on substantive staff on shifts where there was a high usage of agency staff.

Are medical care services effective?
(for example, treatment is effective)

Good

There were systems in place for learning from complaints and serious incidents. Staff told us that important information was fed back at ward meetings or highlighted through safety information that was circulated to all wards. We saw in ward minutes examples of feedback on incidents.

When we spoke with staff about pressure ulcer care, falls or discharge it was clear that as a result of previous incidents there had been changes to practice and that staff were implementing them. However, it was unclear if learning from serious incidents or safeguarding had been incorporated into strategies to ensure that changes were applied consistently and their effectiveness could be measured. For example, mattress settings had been identified as a possible factor in the development of pressure ulcers. But this was not included as a check either in the pressure ulcer risk assessment or the nursing documentation audit. There was evidence from ward meeting minutes that there were informal checks on documentation, but it was unclear how some changes would be monitored across the trust to ensure they were consistently applied.

The trust had systems in place to undertake audits where concerns or trends were highlighted, and to respond to their findings. For example, it carried out a month-long audit of the severity of patients' conditions on wards where staff and patient feedback had said that staffing was not adequate. Those audits revealed understaffing on four wards and approval was given to recruit new staff.

Good

Medical care (including older people's care)

Are medical care services caring?

Good

Staff generally respected patients' privacy and dignity during treatment and care.

Patients and their families told us that they felt informed about their treatment, and patient records showed that staff had asked for consent to deliver care and treatment. Staff had also recorded discussions regarding treatment decisions.

Patient records showed good evidence of referral to other specialists and involvement of therapy staff. There were some omissions on end-of-bed notes, which were not always up to date to reflect patients' progress. For example, on one patient record food and fluid chart intake was recorded inconsistently after the first two days. We saw the same person walking and sitting unassisted, even though their moving and handling assessment said they required assistance. Staff said the person no longer needed this support, but records did not mention the improvement or reassess whether new risks were present. There were documentation audits every six months, and there was some evidence of informal spot checks by sisters and feedback from these to staff at ward meetings.

Patients with dementia had a 'dementia passport' to alert staff to their condition and ensure they got the support they needed when in hospital. Where possible, this was completed with the help of relatives. Staff were also aware of 'communication passports' for adults with learning disabilities, and they said they found these useful.

There were supplementary care plans that could be added into end-of-bed notes to inform staff about any specific needs people may have (for example communication needs or support to stop patients feeling isolated in side rooms).

Staff were positive in their attitude and proactive in trying to solve problems. For example, a relative told us that a patient's GP had been unhelpful in referring a hearing impaired patient back to audiology. When we discussed this with the nurse arranging the patients discharge they told us they would see if a referral could be made from the ward.

Staff said that when a patient needed one-to-one support, there was no problem in providing the support or getting extra staffing. On one ward, we saw a patient who was quite challenging. They were getting one-to-one support from an additional staff member. This reduced the impact of the patient's behaviour on other people sharing the bay, and reduced the risk to all patients.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Staff were responsive to people's individual needs. For example, on one ward a staff nurse told us that a patient we met had been declared fit to be discharged, and she had the discharge letter and medication ready. Records showed that staff had consulted the patient and their relatives appropriately, and this was confirmed in conversation with the patient. The nurse advised us that transport had not been able to collect the patient that day until 4pm. Staff were concerned that the patient would arrive home too late for carers to visit. They had therefore taken a decision to discharge the person the following morning. Staff told us that as soon as the patient was collected a nurse would ring the care provider to inform them the patient was on his way. This was so that a staff member was available to meet him at home and settle him in.

A patient told us that they were still unsettled by the onset of their condition and following a ward round had become very upset. They told us that a staff member had come and sat with them offering comfort while another had telephoned their relative to ask them to come to the hospital. The patient thought that this was very kind of staff and spoke positively about their experience of care to date, commenting "I cannot fault it".

On the cardiology ward we were told that sometimes people who were fit for discharge were delayed. This was because their medication on discharge was too difficult for them to manage on their own. To avoid unnecessary delays to their discharge, referrals were made to outreach nurses called 'HOST' nurses. Staff told us HOST nurses initially

visited patients on the ward to discuss their medication needs after discharge. They then supported patients on discharge. Nursing staff on the cardiology ward felt this had been very effective in getting people home without delay.

One ward had been highlighted for improvement through the Friends and Family Test (which asks patients if they would recommend services they have used to people they know). The trust had developed an action plan with the ward, and we were told that nursing and medical staff had taken ownership of the plan and had subsequently added to it.

Arrangements were in place for multidisciplinary working and planning of patients' discharge from hospital. There was a discharge lounge, but this closed at 7pm at night. Staff told us that difficulties with transport sometimes delayed people's return home, as did the funding of care placements through the local authority. An escalation ward had recently been opened for people who were fit for discharge but were awaiting arrangements for their care in the community. The maximum stay on this ward was between 24 and 48 hours. People who were moved to the escalation ward were given a letter that explained the reasons for the move to them. A protocol was in place for opening and closing the ward dependent on the bed status.

Some patient feedback suggested that staff did not always respond to call bells in a timely manner. A patient told us that if the bell was pressed they had to wait for it to be responded to before it could be reset, other patients told us that they were happy with responses to call bells from staff. We saw from ward meeting minutes that staff were regularly reminded of the importance of responding to call bells. When we visited wards, we observed them to be busy but calm, staff were seen to respond appropriately to call bells.

Are medical care services well-led?

Good

Staff at all levels spoke positively about working at the trust. They expressed a good level of support for the chief executive and the Board, who they thought were visible, approachable and effective at making things happen. There were Board walks, and each ward was allocated a specific Board member. Staff held their own managers in high regard and felt supported by them.

Staff had an awareness of the vision and values of the trust and its new strategy. They were enthusiastic and engaged in the change process. Staff did not appear 'change weary' and felt valued and part of the wider community.

Discussions with senior managers showed that there was a culture of encouraging staff at all levels to become involved in taking forward ideas and implementing projects. Staff told us that communication was good and they felt informed through internal meetings, the trust newsletter, safety flyers, and the intranet.Staff told us that they were getting access to all required mandatory training, but we had some concerns that levels of compliance were between 75% and 80% on the wards we visited.

Good

Surgery

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

Information about the service

The Royal Surrey County Hospital NHS Foundation Trust provides emergency surgical care and treatment to its local population. The hospital provides a range of surgery including orthopaedics, general surgery, urology and gynaecology.

There are 155 surgical beds across six wards: Bramshott, Clandon, Compton, Elstead, Ewhurst and Frensham. During our inspection we visited all of these wards and the theatre suite. These included an orthopaedic trauma ward and the day surgery unit. We spoke with 28 patients, five visitors and ten members of staff.

Summary of findings

We found that staff assessed patients' needs and planned care to meet those needs. We inspected all six surgical wards and the theatre at the hospital. Staffing levels were acceptable on all wards except Ewhurst, where there had been no senior sister for eight weeks. Since the recent appointment of a senior sister on this ward, we were told that things had improved.

Practices and procedures within theatres were safe. The trust had recently revised the World Health Organisation Surgical Safety Checklist. Most patients we spoke with told us that their treatment had been effective at each stage, from admission as an emergency or referral by the GP to successful surgery and recovery. The surgical wards had an 'early warning score' that detected deterioration of patients' conditions and called for urgent medical help. We saw that all wards had safety performance heat maps.

Patients were satisfied with their care. Some patients said that they had quick personal care when they needed it, but a few said that staff did not answer call bells as quickly as possible by members of staff. Overall, we found that staff kept patients informed about their treatment. However, there were a few instances when patients had not been kept adequately informed. This resulted in patients feeling isolated. Patients told us that the overall service was good and the wards were well run. They told us that members of staff worked well with each other. We found that staff had completed training in a number of areas including dementia awareness, infection control, and health and safety.

Good

Surgery

Are surgery services safe?

Good

Staff assessed patients' needs and planned care to meet those needs. Patients' clinical records contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. The trust has introduced a Patient Risk Assessment Booklet, which gave comprehensive information on the different risks a patient may experience. This included pressure ulcer risk assessment, falls prevention and malnutrition assessment. We saw 15 records and all of them had an up-to-date and appropriately filled in Patient Risk Assessment Booklet. We spoke with three matrons who told us they do random checks on their wards to ensure the documentation of the records were up to date. However, patients we spoke with told us they had not been involved in the planning of their care.

Staff told us that the numbers of nurses on the wards had been increased. However, some staff were not happy that the focus was on just increasing the number of qualified staff without increasing the number of other support staff on the wards.

Staffing levels on five of the wards were acceptable, the exception being Ewhurst ward. The roster on Ewhurst ward showed that it had been without a senior sister for eight weeks. Two band 6 sisters on Ewhurst provided cover to maintained the stability of the ward, supported by the orthopaedic matron.

Previous to these eight weeks the ward had been without a band 7 sister for 12 months. The cover arrangements were for a senior sister from another ward to 'keep an eye on the ward'. There was no interim replacement of a senior sister (either by secondment or other measure) for this 12-month period. This meant that there were times when this ward may have been providing services that were not safe. However, we were told that since the appointment of a senior sister on this ward (in September 2013) things had improved.

All the wards we visited were clean. Hand sanitizers were available outside wards, bays and side rooms. Information on infection control was displayed at strategic points. Personal and protective equipment such as gloves and aprons was available in sufficient quantities. We checked ten commodes across the wards and found they were visibly clean and labelled as ready for use. We saw members of staff use hand gels every time they visited a patient and as they entered or left the ward.

Patients told us that the ward areas were regularly cleaned. One person told us that after the cleaner had completed the cleaning, someone would come around and check that the cleaning had been undertaken. Another person told us, "They are hot on cleaning."

There were appropriate arrangements for managing medicines, and we witnessed staff administering medicines safely. Patients told us that nurses always asked them their name and date of birth before giving them any medicines.

There were processes in place for monitoring patient safety. We saw data on incidences of pressure ulcers, patient falls, number of patients contracting MRSA and other recorded information. Where incidences had occurred, the department had carried out investigations and shared the learning across the wards. The department applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolisms such as deep vein thrombosis.

Practices and procedures within theatres were safe. The trust had recently revised the World Health Organisation Surgical Safety Checklist, which was designed to reduce any potential complications from surgery. Our check of patient records revealed that the new revised checklist was in operation and that staff were recording information appropriately. Mortality rates were within normal ranges. This showed care was safe and appropriate checks were in place.

We saw that all wards had safety performance heat maps.

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

Good

Most patients we spoke with told us that their treatment had been effective at each stage, from admission as an emergency or referral by the GP to successful surgery and recovery. One person told us how they had been diagnosed for cancer and were seen in the outpatient department and

subsequently referred for surgery in a very short space of time. Another person told us how they had come through Accident and Emergency on a weekend and had seen a specialist and had appropriate tests for diagnosis. However, one patient told us their care had not been effective. They had been told that they were going to be sent to another hospital for continuing care. However, plans were changed and the patient was not told. We highlighted this to the matron, who then explained to the patient the next steps in their care and the plans for discharge. We subsequently went to speak to the patient and found them more assured about the care they were receiving.

We saw that the trust had introduced initiatives to improve the effectiveness of services for patients. Examples of these included the 'Dementia Passport' for improving services for people with dementia and the introduction of 'intentional care' rounds (planned, regular checks that patients are getting the care they need). These initiatives were working well on wards.

The surgical wards had an 'early warning score' that detected deterioration of patient's conditions and called for urgent medical help. We were shown the processes and the protocol that were in place. This system ensured patients were provided with the right care at the right time. The department had weekly multi-disciplinary discharge meetings. Ward rounds were also multi-disciplinary. Patients we spoke with told us that they were able to speak with the doctor during these rounds and ask questions of them. This confirmed effective processes were in place to meet patients' needs.

All dementia patients were cared for in one bay. The staff support on that bay was more intense than other bays because of the conditions of the patients. This meant patients with dementia were provided with additional support to help them in their recovery.

Are surgery services caring?

Good

Patients were satisfied with their care. Some said that they got personal care quickly, but a few patients said that staff did not answer call bells as quickly as possible. For example, one patient told us that they had to wait 30 minutes before help came. A random check of ten call bells revealed that all were working. However, we did find that some bedside lamps were not working. One patient told us that he had reported this to the nursing staff a few days previously. We checked the repair log register on that ward, and the member of staff had not recorded this incident. We subsequently asked a matron to check all the bedside lamps on all the surgical wards and found that 14 out of 155 bedside lamps were not working. The department subsequently rectified this. We spoke with an electrician who told us that they had been asked to check bedside lamps throughout the trust.

The hospital used red trays and red jugs to indicate patients who needed assistance or supervision with their meals and drinks. This ensured patients received appropriate care at mealtimes. All wards had protected meal time when staff ensured people could eat without interruptions from visitors or other staff. People were given help to eat their food where necessary. We saw one patient change their mind about dessert, and a staff member brought them an alternative. However, although some people were satisfied with the food provided, a number of people told us that they found the food unappetising and unappealing.

Patients we spoke with told us that the nursing staff were busy. One person said they were "rushed of their feet". However, staff were still polite and respectful to them. A few patients told us that it was other members of staff such as the domestic staff and health care assistants who took time out to speak with them. One patient told us how they felt cared for and how they had been given support in a very difficult situation. We concluded that patients were treated with care and respect.

Patients told us they were treated with dignity and respect. For example, there were single-sex bays and single side rooms to ensure privacy and dignity for patients. When personal care was provided, we observed curtains were pulled around the bed. Patients told us that staff had closed the curtains around their bed area for procedures and personal care. On one ward we observed a doctor trying to learn how to say "hello" in Polish to one of their patients who only spoke Polish. The doctor insisted that their team say hello to him in Polish so he would feel at ease and comfortable.

Good

Surgery

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

Good

Overall we found that staff kept patients informed about their treatment. However, there were a few instances when this had not happened, and patients had been left feeling isolated.

Staff responded to the needs of patients promptly and appropriately. Patients told us that when they raised any concerns, these were addressed promptly. For example, one patient asked for additional pillows and they were given them promptly. One visitor told us how they had highlighted some concerns about their relatives' care, and the staff had responded immediately. Patients on the wards we visited told us that the matron usually visited the ward regularly to ask them about their care. This showed senior clinical presence on the ward.

There was a complaints procedure in place, and the department had responded to all complaints in a timely manner. The department had also learned from complaints and had shared lessons learned at staff meetings. Patients said that they were aware of the complaints procedure.

Members of staff responded appropriately to individual needs and request. One person asked to be moved to a single room, and staff made arrangements to accommodate the request. Another person asked to be moved away from the window as they were feeling quite cold during the night, and they were promptly moved.

There were processes for supporting people with learning disabilities. For example patients had an appropriate person to provide personalised support, and this person usually came from the home the patient came from.

However, if an appropriate person was not provided, the trust would ensure that an appropriate person was constantly available to care for the patient. This meant people with learning disability were well supported during their care.

Are surgery services well-led?

Good

Patients told us that the overall service was good and the wards were well run. They told us that members of staff worked well with each other.

Records showed that staff had completed training in a number of areas, including dementia awareness, infection control, and health and safety. The management team is making sure that staff are appropriately skilled. This means the unit is well-led.

In October 2013, matrons introduced matron clinics between 2pm and 3pm to support relatives with any queries. Some relatives were aware of this service; others were not. There was no information on the wards to advertise this initiative.

We saw that there was a management structure in place for the surgical unit. Each ward was led by a matron, who was supported by a senior sister. The matron was there to provide overall leadership for the ward. We spoke with three matrons and found they were aware of their roles and responsibilities. For example, they told us that if the wards needed additional members of staff, their decision to provide this would not be challenged by the management team. One senior clinical member of staff told us, "Patient safety and patient care comes first at this hospital. There is no compromise and management know matrons will not allow for quality to drop."

Good

Intensive/critical care

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

Information about the service

The Critical Care Unit has a total of 16 beds, divided into three units:

The Intensive Care Unit (ICU) has three beds.

The High Dependency Unit (HDU) has three beds.

The High Care Unit (HCU) has ten beds.

The HDU and the ICU were co-located in one area. The High Care unit was located separately.

Summary of findings

HDU, ICU and HCU were all inspected. Staff assessed patients' needs and planned care to meet those needs. There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. ICNARC data shows that the trust were performing well within expected nationally, though there were significant delays in discharging their medically well to the wards. The department recognised that the number of beds in the unit was not adequate. It had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional nursing and other staff to provide care for the extra beds or how it will manage discharge of medically well patients to the wards.

Staff respected patients' privacy and dignity. Family members told us that the care in ICU was "first class". The department had carried out a survey of the views of patients' families. Responding to the feedback, it was going to put in place accommodation for relatives. We found there was multi-professional team working across the unit and with other hospital providers in the area. This meant the service was well-led.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

The department is fully compliant with NICE 50 (the clinical guidelines on how to identify and care for patients whose health worsens). We found the unit was meeting national benchmarks for critical care in terms of staffing numbers.

Staff assessed patients' needs and planned care to meet those needs. For example, they filled in daily observation sheets. We saw staff caring for patients in a timely manner. This showed that patient care was delivered as planned to meet patient's needs.

The unit had two side rooms which were used to manage patients if they developed infectious illnesses. The ICU, HDU and HCU were clean, organised and clutter free. Hand sanitizers were available near the beds and throughout the wards. Information on infection control was on display at strategic points. Personal and protective equipment such as gloves and aprons was available in sufficient quantities. We saw members of staff using hand gels every time they visited a patient and when they entered or left an area. Staff were aware of how to decontaminate equipment after use, and we saw them decontaminating equipment appropriately.

There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff. There was always a senior nurse identified as the lead for the unit, 24 hours per day. There were appropriate nurse to patient ratios for nursing and medical staff and there was a staffing recruitment plan in place to recruit more staff, in line with the expansion plans.

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The trust had recently revised the World Health Organisation Surgical Safety Checklist. This checklist has been designed to reduce any potential complications from surgery. Our check of patient records revealed that the new revised checklist was in operation and that staff were recording information appropriately.

There was a robust audit programme and review process of benchmark standards in the intensive care unit and submitted data from its intensive care unit to the Intensive Care National Audit and Research Centre. The audit provided the trust with comparative data on the quality of care in its intensive care unit and made a comparison with other intensive care units at other hospitals.

The department recognised that the number of beds it had was not adequate. It had added this issue to its own risk register and the trust-wide risk register. It also recognised that the recruitment of skilled staff for the unit was a challenge. As such, it has devised an in-house critical care foundation course to help staff acquire the necessary skills. To ensure the nurses on the wards were equipped to treat critically ill patients, members of nursing staff from other parts of the ensured that services provided on the wards are safe.

Critical care had an 'early warning score' that detected deterioration of patient's conditions and called for urgent medical help. This system ensured patients were provided with the right care at the right time.

The department had 'learning panels' in place for all serious incidents in critical care, including deaths. The panel reviewed these incidents and shared the learning with members of staff in critical care. This ensured a safe environment for patients.

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

Good

The unit had plans for expansion for an additional 12 beds. . However, we are concerned that the trust has not clearly thought through the requirement for additional nursing, other staff and beds in other wards to accommodate the increased amount of patients requiring discharge from ICU or how it will manage discharge of medically well patients.

Good

Intensive/critical care

We were informed that nurses will be recruited from overseas.

There were good networks across specialities that used critical care services. This enabled effective care to be provided to patients across the hospital. We found there was information available for patients and relatives. Relatives we spoke with were told the care that was being provided. One relative told us how the care provided was "the best and very good".

Are intensive/critical services caring?

Good

Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs.

Family members referred to care in ICU as "first class." They were regularly kept updated on the condition of their relatives. They told us that "staff could not do enough for them". We observed how a member of staff came out to update the family members in the family room next to ICU and requested that other people in the room not related to relative leave so that personal information was not shared with others. This showed that patient confidentiality was maintained.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

The hospital had an ICU outreach team which was led by a consultant nurse. The team provided a service from 8am to midnight, seven days a week. Out of these hours, the consultant from critical care and the hospital at night team were in place to deal with any emergencies. Its remit included bed management and dealing with people who develop early warning scores triggers (people whose condition is getting worse). It also responded by reviewing patients who staff were concerned about. Staff told us that the outreach team worked well and was responsive to needs of patients on the wards. They shared with us examples of how patients were transferred to ICU following the early warning system and explained the response from the ICU outreach team. On one occasion, a transfer took place out of hours. This showed that the service was responsive to patients' needs.

The department had carried out a survey of the views of relatives. Responding to the feedback, it was going to put in place accommodation for relatives. We were shown the accommodation plans. The department had a plan to follow up patients who leave ICU. Staff had already undertaken training to enable this. The follow-up of patients was linked to the rehabilitation pathway.

Are intensive/critical services well-led?

Good

There was an overall matron in charge of the intensive care unit. She was aware of her role and responsibilities and was accountable jointly to the director of operations and the director of nursing for professional matters. The department had flagged the capacity issue for intensive care beds and a business case had been submitted to expand the number of beds. For the present capacity, the numbers of nurses to patient staffing ratios were acceptable. This meant that there were currently enough suitably qualified skilled nurses to provide patient care.

We found there was multi-professional team working across the unit and with other hospital providers in the area. There were regular meeting and sharing of knowledge through audits and this meant the services were well-led.

Good

Maternity and family planning

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

Information about the service

Approximately 3,200 women and their families are cared for every year by the team of midwives, obstetricians and maternity team at the Royal County Surrey Hospital. The hospital offers a full range of maternity services. Women receive care according to their patient level of need and this is managed via consultant- and midwifery-led care pathways. The antenatal service includes the provision of obstetric and ultrasound screening. Women are able to choose to get care in the obstetric led delivery suite, the midwifery-led birthing unit or in the community with a specialist home birth team. The hospital offers postnatal care on an individual basis, and there are specialist midwives who manage complex needs through a postnatal listening service.

In addition to the main delivery suite, the maternity unit also provides a small midwife-led unit of two rooms, designed for women who are at a low risk of developing complications and therefore, unlikely to need interventions. Following additional funding of £300,000 from the Department of Health, the unit has made significant improvements to the maternity department, including two birthing pools and four new en-suite rooms within the labour ward.

For babies who are born prematurely or who require a higher level of care post-birth, the Special Care Baby Unit (SCBU) is located adjacent to the delivery suite. There is also a transitional care unit based in the postnatal ward for babies who may need a little extra care for a short time but not enough to warrant admission to SCBU. The significant benefit of this unit is that mums can stay with their babies. The Royal Surrey County Hospital also has a dedicated home birth team.

Summary of findings

During the inspection we visited the antenatal clinic, the maternity ward, labour suite and theatres.

The maternity service had good and effective leadership, and an open and supportive culture. Positive leadership had led to high levels of staff morale and a service that met the needs and expectations of the people who used the maternity services.

Patients were mostly very complimentary about the care and dedication of the staff looking after them. They said that communication was good, staff referred to individual birth plans and women felt supported, listened to and had confidence in the quality and safety of their care.

We found clear lines of accountability in the department, and staff were confident about their roles and responsibilities. We were told that there was consistent and immediate access to specialist consultant paediatricians, obstetricians and anaesthetists. We saw how the trust had learned lessons from incidents, found solutions to problems and promoted risk reduction.

Good

Maternity and family planning

Are maternity and family planning services safe?

Good

Maternity services account for six (30%) of the serious incidents. Overall, there were 121 incidents reported between June 2012 and May 2013. The Inspection Team reviewed Royal College of Obstetricians and Gynaecologists audit data for the period 2011/12 and identified no significant concerns.

Managing risk

The department identified, assessed and managed risks effectively, and it monitored the quality of the service that people received. It had a robust risk management process that was linked to the organisation's overarching governance and risk management processes. Minutes from various meetings, including Management Risk and Divisional Safety meetings, revealed that there were systems to identify, assess and manage risks to the health, safety and welfare of patients.The risk management policy included appropriate procedures to inform staff of the steps to take when reporting and responding to risk. This included how to immediately escalate any risk issues from the maternity service to Board level. There were members of staff in the department who acted as leads in the management of risk processes. Risk management was also included in staff's at job descriptions, and we saw documentation that confirmed that key staff had attended appropriate risk management.

A 'no blame' culture

Staff at all levels were confident and competent at describing how to report serious incidents using the organisation's incident reporting system (Datix). They told us that the organisation promoted a 'no blame' culture that encouraged and supported everyone to take a proactive approach to identifying poor practice and promoting improvement. One student nurse told us, "It feels really healthy that incidents are used to help everyone improve." This meant that the trust promoted an open honest culture that investigated and encouraged learning from incidents helping to understand what went wrong.

Learning from serious incidents

We saw evidence that the trust had recorded serious incidents, investigated the root causes and used the results of the investigation to improve services. The Advanced Neonatal Nurse Practitioner demonstrated how the unit had made changes and shared lessons learned with maternity staff. Meeting minutes revealed changes in policy and practice, training scenarios that had enabled staff to confirm practice and examples of how documentation had been developed in line with recommendations.

Staff were able to give examples of how they had been involved in finding solutions to identified risks through team meetings, departmental newsletters and training events. For example, an incident revealed that staff were not always recording observations appropriately when women were admitted to the department. In response, a student nurse had created a 'prompt card' for midwives and support workers to carry in their pocket. The card was widely used by staff in the unit. This demonstrated how staff responded positively to improving the level of care.

Systems to ensure patient safety

There were clear referral pathways for women who needed consultant-led care, including surgery. Women who needed surgery were properly prepared, and there were appropriate safeguards for preventing harm. Staff made correct use of the World Health Organization (WHO) Surgical Safety Checklist for maternity and the trust's Obstetric Early Warning System (OEWS), which shows clearly where a woman's observations have fallen outside the usual parameters and tells staff what action to take. We saw staff using this system correctly.

There were effective systems and training to help staff recognise and respond to emergencies promptly. In addition to formal training, staff had multidisciplinary 'skills drills' (practice emergency scenarios), which incorporated guidance from national regulatory bodies and learning from local clinical incidents. These were held on a weekly basis, and documentation showed that staff from all disciplines in the maternity team attended them. There were also a series of live, unannounced exercises within the hospital for staff to participate in. This demonstrated that there were processes in place to enable all members of the maternity and obstetric teams to learn from incidents.

Women's health needs were appropriately and continuously assessed throughout their pregnancy and delivery. This included ensuring that individual circumstances such as mental health issues, alcohol and drug use, weight and any previous obstetric history had been considered as part of their birthing care plan. When

specific risks were identified appropriate actions were taken. For example when a woman was assessed as being at low risk of a venous thrombolytic event (VTE – a blood clot forming inside a vein) but needed an emergency caesarean section, then appropriate steps were taken to prevent blood clots forming. This meant that women received care to meet their health and welfare needs.

Staffing

The vast majority of patients we spoke with said that they felt their care had been safe though some patients at the listening event or had contacted us directly had not had a good experience when a patient at the hospital.

An audit of the midwife to mother ratio for 2012 revealed that although the department had an official ratio of 1:35 (midwife to mother), due to a number of factors its performance could range from 1:34 to 1:41, with a mean average of 1:36. This was below recommended staffing levels. The Board had acknowledged this and had recently approved plans to adopt a ratio of 1:30, to ensure the required number of staff to provide appropriate, safe care. During times of high activity, the bank was used to increase the numbers of midwives to support a ratio of 1:30. The trust will implement this increase in the number of midwife posts from April 2014. This ratio will meet the service regional demographic level set by the Royal College of Obstetricians and Gynaecologists in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.

Staff job descriptions set out their responsibilities clearly. Staff in the maternity forum said that the maternity team was cohesive and supportive and that there were appropriate numbers of supervisors available for midwives. Supervisors were experienced midwives who supported other midwives to access effective clinical supervision and provide excellence in care.

Midwives told us that they felt the staffing levels and skill mix across all consultant, nursing and support staff within the maternity department were appropriate and essentially ensured a safe environment for women to deliver their babies. However, we were told that currently there was no provision for 24-hour cleaning arrangements within the ward and delivery areas. This specifically affected the work of labour ward midwives and staff, particularly during busy periods and times of increased sickness or absence.

Midwives said that during the day a dedicated scrub nurse was available to support procedures in the operating theatre. But with unplanned and out-of-hours theatre procedures an appropriately trained midwife was required to assist. Although staff said that this did not usually cause a problem, they felt that it may possibly compromise patient safety during busy periods or if staff were absent – particularly if there was also no cleaning provisions. Matrons shared this concern, but they showed us contingency plans to address short-term staffing shortfalls. Staff were able to describe how they had used these plans to maintain high levels of care and support to women on the ward, and they said that in the exceptional cases when they used agency staff they only used very experienced people.

Environment

The maternity unit was clean, cleaning protocols were available and we saw evidence that audits had been carried out. The results of cleaning audits were displayed and the department identified areas for improvement. Staff compliance with infection control procedures such as hand washing was monitored and the results were displayed in the staff rooms and ward corridors. We saw staff wearing personal protective equipment and saw that there were effective arrangements in place for the classification, segregation, storage, handling and disposal of clinical waste.

We inspected emergency trolleys in the labour ward, general maternity area and in the special care baby unit. We found that these had been checked and records completed in line with the department's policy and procedure. A team of staff was equipped with emergency bleeps that would alert them in the case of an emergency. This meant that there were arrangements in place to deal with emergencies and equipment was complete and available when needed.

The antenatal clinic environment was challenging, and staff described some facilities as inadequate. They were concerned that there were no separate toilets with appropriate sluice facilities, because this meant that people were not always protected from the risk and spread of infection. Our observations revealed that a lack of these facilities could also prevent women having privacy in the event of an emergency. Documentation was provided to show that the trust had put plans in place to address these issues.

Good

Maternity and family planning

Safeguarding

Staff had an understanding and awareness of safeguarding procedures. They were able to identify the safeguarding lead in their department and had knowledge of Deprivation of Liberty Safeguards legislation and procedures, including mental capacity assessments. They confirmed that they had attended training for this and that they knew how to identify, report and record any concerns. Staff told us that information, procedures and forms are easily accessible for them on the intranet.

We saw that there were clear procedures for staff to follow raising a concern or allegation. Senior management monitored these procedures to ensure that staff issues were acted on and followed up correctly. The trust audited incidents and disseminated lessons learnt from these incidents to staff across the trust to reduce the risks of further incidents occurring in the future. In the case of midwives, this included assurance that midwives were aware of the issues surrounding domestic abuse and how to implement universal screening. Midwives were also required to be fully conversant with the mental capacity act and how it affected their practice. There was also an expectation that midwives were aware of their responsibility in undertaking and participating in safeguarding audits. The ward manager told us that staff were made aware of both the hospitals safeguarding policy and the whistle blowing policy. This was done as part of the induction programme, and staff were regularly reminded of these through team meetings and trust-wide initiatives to promote these policies.

A midwife had the role of safeguarding lead and monitored training, specifically within maternity services. A major part of this role involved reassuring the organisation that that neonatal nurses knew about the safeguarding team and understood their role within the organisation. They described the refresher training that neonatal staff had to ensure that they were aware of the issues which make an adult vulnerable and how to make a safeguarding referral. We observed how this training was recorded, monitored and reported both within the department and to a wider governance audience within the trust. This included any concerns regarding non-attendance of staff required to attend. This demonstrated that people who used the service were protected from the risk of abuse because the service had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Overall, we found the department's services to be effective.

The NICE clinical guideline Routine Postnatal Care of Women and Babies (NICE 2006) and the UK National Screening Committee both advocate a complete physical examination of the newborn after birth. We looked at the baby records of several newborn babies. We were able to see from the records that they had been examined appropriately at birth and seen and examined appropriately by the Paediatrician prior to discharge. Midwives assessed each baby on a daily basis and had recorded any changes or concerns around feeding, skin colour or observations. Where concerns had been noted, a specialist had been requested to review the baby.

Staff said that that multidisciplinary handovers between shifts worked well. They reported that communication was good and doctors, midwives and care assistants reinforced how flexible all levels of staff were. We heard how the Head of Midwifery had been particularly instrumental in developing a culture of inclusiveness and how this contributed to staff feeling enabled and supported. One person told us, "Everyone respects our Head of Midwifery – she never forgets to say thank you." Another person said, "I am so impressed that all levels staff muck in to help out during really busy times. It's great."

Staff at the antenatal clinic were friendly, patient and welcoming, even if the environment was cramped and extremely busy, with several clinics taking place at the same time. Staff knew how to use interpreting services, if needed, so women had the right support during consultations and especially when receiving information regarding their diagnostic tests and scans.

The obstetric-led unit provided care for any complicated or high-risk pregnancy and birth with full access to all members of the obstetric team including obstetricians, anaesthetists and paediatricians on a 24-hour basis. Staff described how the maternity and paediatric teams worked in tandem and provided access to specialist consultants and advice at all times. When we spoke with doctors they

told us they felt supported at all times. This meant that people had 24 hour access to maternity and obstetric services Can we draw a conclusion here – are we saying that services are effective because there was 24-hour access?>

Staff told us that the trust had introduced a triage system to try to reduce the number of women arriving at the delivery suite unnecessarily. They said that this had initially been difficult to for staff but had proved to be successful in alleviating the need for women to attend the unit unnecessarily. We saw one midwife speaking on the phone, offering reassurance and discussing options with a woman who had concerns. One woman told us "This helped me to focus, and with a first baby I was very anxious. Staff supported me and they were brilliant. It saved me so many anxious moments." This meant that women were able to access help and information prior to admission to the unit.

Women with specific needs were cared for in line with recognised clinical guidelines and standards of care. These included care pathways with protocols for care for women with diabetes, those with a high body mass index (BMI) women found to be non-immune to Rubella and those who have chosen to have a vaginal birth after a previous caesarean section (VBAC). One woman told us that she had been closely monitored throughout her pregnancy, due to being diabetic and told us "I'm so grateful for the wonderful care here."

The Special Care Baby Unit provided specialist high dependency facilities for babies who needed additional support. There was a low dependency nursery to assist babies who needed to grow prior to discharge and dedicated isolation facilities available for babies returning to the unit from other hospitals.

There was a strong clinical audit programme embedded into practice, working to ensure that maternity services maintained quality and safety standards. The department held multidisciplinary audit meetings monthly. During 2012/2013, audits had been undertaken and presented by midwives, obstetricians, anaesthetists, neonatologists and medical students. The robust and comprehensive audit plan designed for maternity services linked into the trust-wide audit strategy. This demonstrated that the organisation had processes in place to monitor the quality and effectiveness of maternity services.

Are maternity and family planning services caring?

Outstanding ☆

Overall, we found services to be caring.

Patient views

Patients were mostly very complementary about the care and dedication of the staff looking after them. They said that communication was good, and that staff referred to individual birth plans when planning and providing care. Women felt supported and listened to, and they had confidence in the quality and safety of their care.

People said that the doctors, midwives and other staff were dedicated, and one woman said, "The care here is absolutely amazing and I wouldn't dream of going anywhere else." Another told us, "One of the midwives who helped care for me through my labour came to tell me she was going off shift and to give me her congratulations. This meant a lot to me and showed that she really cared about me as a person."

We saw staff treating women in a calm, friendly, supportive and professional manner. They closed curtains while providing personal care and they knocked on doors before they entered side rooms. We heard medical staff introducing themselves to people as they entered rooms and cubicles. Staff confirmed that they had received training on privacy and dignity and said this subject was constantly discussed at team and staff meetings. Staff gave us examples of how they personally ensured that they promoted privacy and dignity for women in their care. Service users told us that all levels of staff went to great lengths to explain what was happening and to give patients options throughout their labour and directly after birth. They said they had felt fully involved and that staff had respected their privacy and dignity, especially during a time like childbirth, when sometimes it could be challenging. One new father told us, "I was involved at every stage, terrified but fully involved."

There were various mechanisms in place for capturing the views of women. One of these was the opportunity for women to participate in birth stories. This was a service provided by two senior midwives for women who felt they

Good

Maternity and family planning

had a traumatic experience related to the pregnancy or birth. This demonstrated that the service wanted to understand people's experiences and improve its ability to be caring towards patients and their families.

A midwifery supervisor said that all women who needed a caesarean section were offered a 'debrief', a chance to reflect during their postnatal stay. Staff explained that many women undergoing emergency caesarean sections were not always able to recall what had happened prior to the surgery. This debrief offered them an explanation of why the surgery had been necessary. This shows that the department had a caring approach to women and their partners when birth had not gone according to their plan or expectations.

The labour ward was very calm, peaceful and quiet. Staff were answering phones and giving advice to women about whether to come into the unit. Staff were reassuring to relatives and partners, and they told us that pain relief on the ward was well managed. An anaesthetist was always on call, in case a woman wanted an epidural or needed an anaesthetic. women told us that staff had discussed post-delivery pain relief with them and that they had offered them appropriate analgesics.

The department had a special suite called the 'Forget me Not' suite for women and their partners when a baby died during pregnancy or birth. The room was close to the emergency facilities but outside of the labour ward itself. Here, mothers were able to have the level of privacy and support they wanted as they said goodbye to their babies. Chaplaincy services were available, including memory books for the parents to keep. Staff described to us how important it was to be able to provide people with practical items like personalised boxes, handmade shawls, cribs, as well as supporting people emotionally.

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

Good

Overall, we found services to be responsive.

Most women at the clinics told us that although there were often delays staff worked extremely hard to be supportive and kind. One person told us, "Sometimes I get seen very quickly and other times it's a long wait." Another person said "On one occasion I was here for three hours, and after a caesarean it can get uncomfortable waiting around on these chairs". Nurses told us that they spent a lot of time on paperwork and general administration tasks due to the lack of appropriate administrative staff. When we spoke with the matron we were advised that recruitment was underway to support the antenatal team.

Women had several options about where they would like their baby to be born. There was a wide selection of information available to help women make the most appropriate choice for their individual circumstances. Women told us that staff had clearly explained the options to them and helped them develop their own birth plan. One woman told us, "Obviously things change on a day-to-day basis, but there are so many opportunities to talk to midwives about what I want and need." The community team matron explained how women who chose to have their babies at home were supported through their labour and birth by a team of experienced midwives. These midwives told us that there were robust protocols in place clearly defining the steps to be taken should complications occur.

The maternity unit held informal forums for new parents who had received maternity care at the hospital. These forums were held regularly and were designed for people to share their experience of pregnancy and birth. Staff told us that these forums were essential in ensuring that care was responsive to the needs of families. One person told us, "It is really important that mums and dads let us know how we are doing. We often hear what has gone really well and sometimes not so well but that helps us make improvements to make sure people get the best care we can give." We saw evidence that feedback from the forums was used to shape and improve the care at the hospital and inform the wider maternity services through the Maternity Service Liaison Committee.

The department had procedures to ensure that pregnant woman who went to accident and emergency with problems other than obvious minor injuries could see a midwife or obstetrician immediately. For example, an on-call obstetrician was available at all times.

We looked at how induction of labour was managed within the maternity unit and found that there were procedures and guidelines describing how induction of labour was

implemented and monitored. We spoke with one woman who had been admitted for a planned induction and we were told "Everything has been explained to me and I know what my plan is – hopefully it will happen like that." We saw that the management of induction of labour was managed in line with NICE guidelines. Records were available and demonstrated that when induction had been instigated an individual management plan had been developed and discussed with the woman. We observed staff undertaking maternal and foetal observations and saw that these had been undertaken appropriately during induction and prior to the establishment of labour.

Women attending postnatal appointments said that staff had given them sufficient information to take away when they left hospital after giving birth. They said they had felt fully supported and had been given information about breastfeeding and sleeping arrangements. They had also been given contact numbers for further support or advice. One woman told us, "I cannot fault the maternity care here. They seem to think of everything and I feel so lucky to have been cared for here."

There was sufficient information on display about how to make a complaint to the trust. The complaints policy was supported by procedures to inform staff about handling, considering, responding and recording comments and complaints. We viewed two complaints and found the trust had responded appropriately in each case. We saw that in response to a complaint about the privacy of mothers expressing milk, the trust had set up a room that offered new mothers a more relaxed and private area to express milk. One person told us, "It's much more comfortable for new mums and offers them much more privacy when expressing milk."

Women had access to midwives with specialist knowledge to support them through pregnancy, labour and the postnatal period. These specifically trained midwives provided services and information on smoking cessation, substance misuse, teenage pregnancies, diabetes, HIV and infectious diseases, access to services for travellers and bereavement counselling. Midwives told us how they were trained as speciality leads to support women using the service and colleagues within the maternity team. Additional learning and training was provided for speciality leads and during a focus group with a group of midwives we heard how important they considered this was in developing, supporting and monitoring women with specialist needs. For example we heard how the bereavement midwife had been involved in the development of the 'Forget me Not' bereavement suite and would be involved in the care of the woman and family throughout their care. We saw how these leads had been instrumental in providing training and support to colleagues through skill drills and training days.

These specialist midwives and nurses were able to influence the design of the service and offer support and advice to colleagues. We saw examples of how information had been designed to support women with advice such as breastfeeding and managing sleep. When we spoke with the manual handling specialist we were able to see how the generic manual handling training had been adapted to make it more appropriate to staff working in the maternity department. Practical sessions had been included within the training to specifically address techniques for lifting babies from cots. Staff told us how beneficial this had been and one person told us, "It made the training so much more meaningful."

Are maternity and family planning services well-led?

Outstanding ☆

Overall, we found that services were well-led. Staff told us that the maternity service had good and effective leadership, within an open and supportive culture. They told us that the positive leadership contributed to a high level of staff morale and provided a service that fulfilled and met the needs and expectations of women and their families using their service.

There were clear lines of accountability in the maternity department. Staff were confident about their roles and responsibilities. We were told that there was consistent and immediate access to specialist consultant paediatricians, obstetricians and anaesthetists.

The service had a clear structure for risk management, with a detailed leadership structure and identified leads in the management of risk processes. There was a clear process for escalating risk issues from the maternity service to Board level.

Staff were very positive about the senior management of the organisation and the department. They reported an

open and inclusive culture within the hospital. We were told that the employee of the year award had been awarded to the head of Maternity Services in recognition of successfully completing an MSc in Management and Clinical Leadership while simultaneously leading the maternity team through a level three Clinical Negligence Scheme for trusts (CNST) assessment. CNST Level three is the highest level of risk management standards that can be awarded to a service, and this is the third consecutive time that the hospital has achieved this. This means that women are cared for and give birth in a safe environment with rigorous risk management procedures and evidence of robust research-based policies and protocols.

The Advanced Neonatal Nurse Practitioner described work with the Clinical Performance Development Midwife to ensure that training within the maternity and paediatric departments was focussed and tailored to meet the current and ongoing needs of staff. We saw that mandatory and developmental training for all staff within the maternity unit was monitored with appropriate records recording attendance and certificates to demonstrate competence. We saw examples of recent competency training that had been undertaken by all members of staff in the labour ward to refresh clinical skills. We saw that senior staff had also participated and a matron told us, “It’s important that everyone rolls up their sleeves and gets involved to support each other.”

A new midwife told us that their induction had been very thorough, with good support and supervision. We spoke with a student midwife who was undertaking a two-week placement, who told us, “The training has been well structured, well organised and I have been made to feel valued in the department.”

Staff told us that there were regular departmental meetings for management to share lessons learned and quality improvements. There were also other meetings, forums and committees that provided information for team meetings, case reviews and study days. These included: the Maternity Risk Management meeting and Women and Children’s Strategic Business Unit meeting, divisional quality and safety meetings, women's services, perinatal mortality meetings and audit meetings.

Good

Services for children & young people

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

Information about the service

The centre of acute general paediatric care at the hospital is located on Hascombe ward, which opened in 2005. This is a dedicated inpatient service that has recently been refurbished and provides a family-centred care facility with a dedicated multi-disciplinary team facilitating a 24-hour service for children and young people aged between 0 and 15, and to their families and carers. It now has 36 beds, a minor treatment room and a well-equipped playroom. The service provides not just a full range of care facilities for its patients but also support for patients' families at what can often be very difficult times.

The Royal Surrey County Hospital is a Royal Marsden Hospital (RMH) shared care cancer site for children and teenagers with cancer. This unit is led by a dedicated nurse specialist and is working towards becoming the regional cancer network / RMH shared care site for teenagers with cancer.

The hospital has an additional Special Care Baby Care Unit with 12 special care cots providing intensive medical care for babies and newborn children. It is part of the Neonatal Network for Surrey and Sussex with St Peter's Hospital, East Surrey Hospital and Frimley Park Hospital.

Summary of findings

During the inspection we visited Hascombe ward, the childrens outpatient department and the Special Care Baby Unit.

The children's unit is modern and well equipped and reflects the ideas and contributions of children and young adults who use the service. The unit is a testament to how the organisation has used staff and patient suggestions to develop a state-of-the-art environment that provided high levels of care in a calm and relaxed atmosphere. Parents told us that the facilities were outstanding and that staff paid great care and attention to the needs of the children and their families.

The paediatric service has good and effective leadership within an open and supportive culture. The staff reported that there was a close and integrated team spirit in the unit that worked closely with maternity services.

There was a dedicated children's outpatient department that provided a service within the children's unit and offered a range of general paediatric and specialist clinics. A&E facilities were functional and provided a high level of care and support. However, the environment for children and young people attending the A&E department did not reflect the care and attention to detail of the design of the main paediatric area.

Good

Services for children & young people

Are services for children & young people safe?

Good

Children, parents and carers were mostly very complimentary about the care and dedication of the staff looking after them. They said that the facilities were superb, levels of communication were extremely good, staff understood how to care for children and that they worked hard to ensure that parents were supported and kept fully informed.

Managing risk

The department had a system to continuously identify, analyse and review risks, adverse events, incidents errors and near misses. We saw evidence that the department used findings to develop solutions and promote risk reduction. This meant that the service effectively monitored the quality of the service that children received and responded to identified risks.

The department had a robust risk management process that linked into the trust's overarching governance structure. Staff at all levels were confident and competent at describing how to report serious incidents using the organisation's incident reporting system (Datix). They told us that the organisation promoted a 'no blame' culture that encouraged and helped everyone to take a proactive approach to identifying poor practice and promoting improvement. One paediatric nurse told us, "Incidents happen, but we use them positively to improve our practice."

Systems for safety

Staff used paediatric early warning score systems to ensure the safety and wellbeing of children. This system enables staff to monitor a number of indicators to identify If a child's clinical condition is deteriorating and indicates when a higher level of care is required. We saw evidence that staff were confident and competent in their use and that they knew the steps to take if they needed to escalate any concerns.

There were other safety measures in place: all staff on the children's ward had completed paediatric basic and intermediate life support training. There was always a European Paediatric Life Support provider on duty.

Accident and emergency

In A&E, all staff were trained and equipped to provide paediatric life support. There was a clear process for staff to get appropriate advice from paediatric nurses and consultants in the children's unit, and there was a named nurse in the children's unit to provide support on issues such as pain management and consent. Although A&E did not have a general paediatric consultant, we were assured that staff had immediate access to a paediatric consultant at any time. This demonstrated that the service had processes in place to deal with emergencies and safeguard the care of children within the A&E environment.

Children arriving at A&E during the hours of 8am and 11pm were seen in a separate area, away from the main A&E treatment areas. Efforts had been made to decorate this environment in a less clinical and formal manner, with a range of play equipment available for children of all ages. There was a more private room with computer and electronic games facilities for teenage patients. There were no toilets for parents or children to use within this paediatric waiting area. This meant that children, their parents and carers did not have access to appropriate toilet facilities while waiting for treatment or care in the designated paediatric area. One person told us, "I could not have let my child go to the main toilets unattended, and with another sick child it is difficult."

Although children's A&E hours had been extended from 8pm to 11pm in response to feedback from staff and patients, staff were still concerned that children would have to wait in the main A&E waiting area once the children's service was closed. By its very nature, an A&E waiting room is not the most appropriate place for children, particularly later at night. Staff said they had submitted recommendations to have the children's A&E services open and staffed appropriately for 24 hours.

The paediatric resuscitation area was located in the main resuscitation area. There was a designated bay that was well laid out and equipped with appropriate paediatric resuscitation equipment. The equipment was well organised, clearly labelled and easily accessible to the resuscitation team. Emergency guidelines were on display. The environment was clean, functional and clinical but was not decorated in a child-friendly manner.

Security

Security doors are located at the entrance to the ward area, and there are video cameras and closed circuit television

throughout the ward (with the exception of the toilets). All medical, nursing and other staff wore their identity badge. In the main ward area, there was a large wallboard displaying photographs of the regular staff members that a child or relatives may meet during their stay.

Staff felt that staffing levels in the paediatric unit had improved. They reported that the skill mix across all consultant, nursing and support staff within the paediatric department was appropriate and essentially ensured a safe environment for children. However, there were times (particularly during busy periods and times of increased absence or sickness) when people were expected to cover shifts during off-duty times. The department also relied on the good will of staff to cover sickness and absence.

Environment

The paediatric unit was exceptionally clean. Cleaning protocols were available, and we saw evidence that audits had been undertaken in line with the published audit programme. The results of cleaning audits were on display, and the department had highlighted areas for improvement. The department monitored how well staff followed infection control procedures such as hand washing, and it displayed results in the staff rooms and ward corridors. We saw staff wearing personal protective equipment and saw there were effective arrangements in place for the classification, segregation, storage, handling and disposal of clinical waste.

Emergency trolleys were appropriate for paediatric emergencies, and staff checked in line with the department's policy and procedure. A team of staff had emergency bleeps that would alert them of an emergency. This showed there were arrangements in place to deal with emergencies and equipment was complete and available when needed.

There were systems in place to safeguard and promote the welfare of children and young people. We saw evidence that staff had been trained in the safeguarding of children and vulnerable young adults, and staff were able to confidently demonstrate an understanding and awareness of how to identify and report any concerns. Staff told us that there was a dedicated safeguarding lead within the department and information, procedures and forms were easily accessible for them on the intranet. This demonstrated that people who used the service were protected from the risk of abuse because the service had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Are services for children & young people effective?

(for example, treatment is effective)

Good

Staff knew the steps to take if interpreting services were needed to ensure that children, their parents or carers had the right support during consultations and especially when receiving information regarding diagnostic tests and treatment options.

The department had specialist nurses to support children and their parents/carers throughout their care. These specifically trained paediatric nurses provided services and information on a wide range of conditions such as diabetes, epilepsy, HIV and infectious diseases. There were also facilities for bereavement counselling. The paediatric team told us how important the specialist nurse role was in supporting children, their families and colleagues. They told us that additional learning and training was provided to ensure these speciality leads were up to date with current guidelines and techniques. One nurse with a specialism in epilepsy described how important it was for children to have continuity of care and a point of contact throughout their stay. When we looked at training documentation we were able to see how these leads had been instrumental in providing training and support to colleagues through 'skill drills' and training days.

There were some excellent displays on walls throughout the paediatric unit. Members of the paediatric team had produced these to specifically inform and advise children and their families on a range of conditions and treatment options. For example, the display relating to broken bones described in a language appropriate to children the different types of fracture and break and how these were treated. The display was informative, graphic and had supporting leaflets for adults with more in-depth information if required. We asked one young person for their views on the display and we were told, "They are brill."

Good

Services for children & young people

There was a strong clinical audit programme to ensure that staff maintained quality and safety standards. The department had monthly multi-disciplinary audit meetings. During 2012/2013 audits had been undertaken and presented by paediatricians, obstetricians, anaesthetists, neonatologists and medical students. The robust and comprehensive audit plan designed for paediatric services linked to the trust-wide audit strategy. This demonstrated that the organisation had processes in place to monitor the quality and effectiveness of paediatric services.

The Paediatric Consultant carried out daily ward rounds between 10am and noon, and parents told us they were encouraged to be an active part of this review of their child's condition. We saw structured, multi-disciplinary handover of children at each change of shift with appropriate supporting documentation for the continual and seamless care of the patients between consultant and medical team. Parents and carers told us that they were able to access a dedicated member of staff with whom they could discuss treatment options, diagnostic finding, expected recovery timescales, concerns or complications. One parent told us, "We have a named nurse and nothing is too much trouble. When I need to ask something they always come back to me." This demonstrated that parents were given appropriate information and support regarding the care and treatment of their child.

Are services for children & young people caring?

Good

Parents of the children in the department said that the care had been exemplary. We heard that staff kept them fully informed of their child's care needs and treatment and further information was available if they needed it. One parent told us, "Our care has been excellent from when we walked first walked into Accident and Emergency to being taken to the ward." Another said, "Staff are really on the ball, attentive, friendly, and that gives you real confidence about your child's care." This demonstrated that staff gave parents appropriate information and support regarding the care and treatment of their child.

There were displays throughout the ward and corridor areas with information about common ailments and conditions specific to children and adolescents. Information racks contained leaflets explaining how the department operated, treatment and care options, common surgical procedures and anaesthesia.

Staff explained how parents and carers accompanied their children to the anaesthetic room in line with guidance issued by the Royal College of Surgeons. One parent told us, "I stayed with her until she was asleep and then staff gave me a pager to alert me when she started to wake up. It was very reassuring for both of us."

There were pain management policies in place with specific procedures for staff to follow when managing pain in children and young adults. Documentation confirmed that a pre- and post-operative pain assessment had been undertaken for each child and supervised by a paediatric anaesthetist. Staff managed pain using the 'Wong Baker Faces' pain scoring chart (which uses pictures of faces to demonstrate different levels of pain). We saw a nurse administering analgesic medication to a child who had just returned from minor surgery. The nurse established the level of pain with the child, described what the medication was for and asked the child, "Do you want to do this yourself?" They then helped the child to take the oral medication themselves. The patient told us, "I thought it might hurt but the nurse was lovely and made me feel better. When I went down to have it done they gave me magic glue and I fell asleep and then when I woke up my nurse was there with me and told me I was ok." We spoke with the child's parent, who told us that they had attended a pre-operation appointment earlier in the week where a staff member had explained the procedure and given the child opportunities to ask questions. They commented, "This had been done extremely well and a very well handled explanation was given to my child – it was fantastic."

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

(for example, to feedback?)

Outstanding

The paediatric unit had developed a minor treatment room fully equipped for paediatric ear nose and throat treatments. We were told that this was developed in direct

response to the experiences of a member of staff who found taking her young child to the main Ear Nose and Throat (ENT) department a traumatic experience both for her and the child. As a result of working closely with the medical team in ENT, the department developed a streamlined and focussed service in a child friendly area, with paediatric nurses in support. This demonstrated that the organisation had directly responded to the needs of child service users to make improvements that greatly reduced the levels of stress and anxiety of both patient and parent.

The hospital shared a teenage cancer unit with West Sussex and Hampshire. This is one of five such cancer units in the South of England. The hospital treats between two and five cancer patients at any one time, and this new unit ensures that they are able to receive their care in private. There are four rooms which are equipped with a bed, en-suite bathroom, flat screen TV, laptops, Wi-Fi and games consoles. The unit also has a kitchen area for patients and their relatives.

There were a range of mechanisms in place to capture and audit patients' experiences, and this included child friendly surveys carried out by staff, questionnaires and feedback forms.

Throughout the department, there were posters and leaflets informing children, parents and relatives of how to raise concerns or make a complaint. They were in a format that were suitable to children. We saw that the complaints policy was supported by procedures to inform staff about handling, considering, responding and recording comments and complaints. Staff told us that they continually monitored how children were experiencing their care and that complaints were unusual. However, they said that when there were complaints everything was done to respond positively and make any necessary changes to practice. Children in the department said that staff asked them about their care and helped them to complete questionnaires.

We found that paediatric staff working in the A&E department and the main paediatric unit did not work on a rotational basis and therefore opportunities were missed for developing good practice and innovative ideas in both areas. An example of this was the excellent displays in the main paediatric ward, for example on fractures and broken bones, which would be appropriate and informative in a paediatric A&E waiting area.

Are services for children & young people well-led?

Good

Staff told us that the paediatric service had good and effective leadership, within an open and supportive culture. They told us that the positive leadership contributed to a high level of staff morale and provided a service that fulfilled and met the needs and expectations of children and their families using their service.

Staff were very positive about the senior management of the organisation and their department. They reported an open and inclusive culture within the hospital and were very proud that the Hascombe Children's Ward was winner of the 2012 Staff recognition awards.

There were clear lines of accountability within the paediatric department. Staff were confident about their roles and responsibilities and told us that they were supported with the correct levels of training and supervision.

The risk management structure in the hospital identified staff in the paediatric department with lead roles in the management of risk processes. There was also a risk management policy with appropriate procedures to inform staff of the steps to take when reporting and responding to risk. This included how to immediately escalate any risk issues from the paediatric service to Board level.

The Paediatric Practice Development Nurse had additional Clinical Performance Development (CPD) responsibilities to ensure that training within the paediatric department was focussed and tailored to meet the current and ongoing needs of all members of staff. Mandatory and developmental training was monitored, and there were appropriate records recording attendance and certificates to demonstrate competence. Staff told us that there was also a 'buddy' system in place.

Staff told us that there were regular departmental meetings at which all staff were welcomed and minutes were taken and published. There was also a range of other meetings that produced information that was used in team meetings, case reviews and on study days. These meetings

included the Paediatric Risk Management meeting and Women, the Children's Strategic Business Unit meeting divisional quality and safety meetings, children's services and audit meetings.

The organisation promoted collaborative, multi-disciplinary practice sessions or 'drills' for dealing with emergency situations. This encouraged and allowed staff to know and understand their specific roles and responsibilities in an emergency. Records showed that paediatric medical staff of all grades, together with other staff within the maternity and paediatric unit, trained together and operated as an efficient and cohesive team.

Good

End of life care

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

Information about the service

The trust has a dedicated palliative care team led by one specialist consultant. The Royal Surrey is a pilot site for the implementation of the 'Route to Success', which is the Department of Health's End-of-Life Care Strategy for acute hospitals.

Summary of findings

Patients and relatives were positive about the quality of end of life care. None of the people we spoke to had any concerns about the way staff maintained patients' privacy and dignity. We found that staff were caring and services responded to patient's needs. Services were well-led.

Good

End of life care

Are end of life care services safe?

Good

Systems were in place for the referral, assessment and review of end of life patients that ensured they received appropriate care and support. The Liverpool Care Pathway (LCP) was being phased out nationally. The Department of Health had recommended that trusts continue with the LCP until such time as it had completed its consultation on alternative care plans for patients nearing the end of their life.

When we spoke with the palliative care team, staff confirmed that the trust was continuing to use its own amended version of the LCP for end of life care and to seek verbal consent from patients or carers before moving a patient onto the pathway and also ensure that appropriate medications were administered to patients. This showed that the trust had responded to concerns regarding implementation of the LCP and ensuring a safe approach to care.

Following referral, patients on the LCP were reassessed on a regular basis by the specialist palliative care team to ensure the LCP remained appropriate for them.

Patients whose end of life was less imminent were placed on an Amber Care Pathway.

Are end of life care services effective?
(for example, treatment is effective)

Good

In response to the published report about the LCP, the trust had made a number of changes, some immediately and some within a set timescale. It had put in place systems for monitoring how these changes were made. This demonstrated that the trust had systems in place to ensure the end of life care pathways were effective.

In response to media attention about the LCP, the trust had published a 'frequently asked questions' document to try and address some of the concerns raised by patients and their families.

Are end of life care services caring?

Good

In the 2011 bereavement survey, the trust was rated in the bottom 20% of trusts in respect of privacy and dignity and quality of care. However, the relatives we spoke to made positive comments about the care their relative had received and understood that they were following an end of life care pathway.

A student nurse told us about her experience and observations of end of life care support from staff at the trust. For example, they told us that staff took time to make patients comfortable in all aspects of their care, and allowed family to visit outside of visiting hours. This showed that patients experienced caring and compassionate care.

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

Good

On those wards where patients were on the Amber Care Pathway we witnessed good multi-professional discussions around end of life care.

We viewed the records for a patient discharged prior to our visit. We saw that the person had initially been put onto the LCP. Their records of care were well completed with few omissions, and showed that staff had given an appropriate level of care and treatment. We saw that staff had recorded a multi-disciplinary discussion approving the move to the LCP. There was recorded consultation with relatives before this happened. Records showed that the patient had responded to treatment, recovering sufficiently to be transferred onto the Amber Care Pathway. This had enabled the person to be discharged back home with an appropriate package of palliative care support. This showed that the team was responsive to the needs of patients. We viewed three records where decisions not to

Good

End of life care

resuscitate had been made for patients. We saw that in each case appropriate consultation had been undertaken with the patient or their relatives where there were issues of capacity.

Are end of life care services well-led?

Good

We were informed that the palliative care team is made up of a consultant and two palliative care specialists. They provide a holistic plan of care support seven days a week and carried out ward rounds twice weekly to those people referred to them.

The palliative care team undertook the education and training of ward staff in regard to the palliative support needs of patients. They told us that feedback from nursing staff on the wards they visited had been positive regarding the proactive and supportive approach they had taken in delivering this training.

We spoke with the trust relative's officer who explained their role in advising relatives who had suffered bereavement. Bereaved relatives also received an information booklet about what needed to be done following a death. Volunteers provided a bereavement support service. We spoke with a bereaved relative who confirmed that somebody from the bereavement support team had contacted them, but they had declined the offer of an appointment

Staff understood that the trust was continuing to use its amended version of the LCP along with the Amber Care Pathway and understood the difference between them. This demonstrated that they were well-led.

Requires improvement

Outpatients

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

Information about the service

The trust saw about 250,000 patients a year in its outpatient departments. Most were seen at the Royal Surrey County Hospital, but outreach clinics were held in Aldershot, Cranleigh, Farnham, Haselmere and Woking. At the Royal Surrey County Hospital there were a general outpatients dealing with a wide range of specialities including general surgery, cardiology and respiratory medicine. There were also specialist outpatient departments for children, cancer, eyes, ear nose and throat and audiology, rheumatology and obstetrics and gynaecology. We inspected the general outpatient areas and the specialist audiology, gynaecology, children and eye departments.

Summary of findings

Improvements are needed. We inspected all areas of the outpatients department and clinics taking place during our inspection. We found out-patient departments that did not always have the capacity to meet demand.

The eye outpatient service was especially overcrowded. Patients said they had been waiting for up to four hours, and data that we received before and during the inspection confirmed that this was a regular occurrence. The trust was aware of this and had plans to expand the service to address its capacity issue. However, it had not taken sufficient action to minimise the impact of this issue on patients while the service was expanded.

Problems in accessing medical records also made delays worse and put extra demands on the nursing staff to cope with the capacity levels. We had concerns that eye testing was being performed in a busy corridor and that there were significant delays in communicating with patients' GPs, which had the potential to disrupt patients' treatment.

The hospital made arrangements for people to attend appointments at a time that was convenient for them. However, the long waiting meant that appointments did not take place at the time planned, and patients expressed concern about that a lack of available parking spaces made it difficult to be on time for appointments.

We observed that staff were kind, caring and courteous in their dealings with patients.There was strong, visible leadership in the department, and staff were familiar with and understood the hospital's vision and strategy.

Requires improvement

Outpatients

Are outpatients services safe?

Good

Staff were familiar with the hospital's computerised system for reporting serious incidents. They said that there was a training programme in place. Some staff confirmed they had received this training and others told us when they expected to do so. There were arrangements for making sure that those who still needed training got help to use the system for reporting, analysing and investigating incidents so these staff members were able to report concerns and incidents. Staff understood the need to report any safety concerns and incidents and knew the procedure for doing this. One sister told us "We're very good at it. If you don't report it, you can't learn from this".

There was a system for disseminating safety alerts that were received from national bodies such as the National Patient Safety Agency. These were kept in a file and staff knew where to find this information.

Staff were appropriately trained to recognise and report actual and potential abuse. Records showed that staff had received training in safeguarding procedures (protecting people from abuse) for children and vulnerable adults. Staff were able to tell us the actions they would take if they felt a child or vulnerable adult was being abused or was at risk. The children's outpatient department held weekly multi-agency safeguarding meetings.

There were adequate numbers of staff available to meet patients' needs. The department used bank staff (staff who work to fill any gaps in the rota) to cover expected and short-term absence and ensure there were sufficient numbers of staff were on duty, and there were adequate numbers of appropriately qualified and skilled staff available.

There were appropriate measures in place to ensure safe management of medicines. Medicines and prescription pads were locked away and access to them was controlled. This ensured that there was no unauthorised usage or loss.

There were arrangements to deal with medical emergencies. These included an emergency trolley situated in the general outpatients department containing all the equipment and medicines to deal with a medical emergency. Staff carried out appropriate checks to ensure that equipment and medicines were functional and ready for use. When allergy tests were carried out, the emergency trolley was moved to be in close proximity to patients, and a large sign was put on display to show its current location.

Systems were in place to reduce the risk of infection. The outpatients departments were clean and audits of the quality of cleaning were displayed in the general outpatients department. A system of checklists used by care assistants and nursing staff monitored the cleaning of clinical areas. These checklists were consistently completed. At the entrance to outpatient department areas, there were supplies of hand sanitizer for staff and patients to use. In general outpatients there were large signs to remind patients to use the sanitizer after touching the computer screens used for the check-in process. However, we saw that few patients used the hand sanitizer, and the staff who were helping them to check in did not remind them to do so. We also noted that staff did not always use the sanitizer after touching the screens or when the World Health Organization's guidance suggested they should.

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

Not sufficient evidence to rate

Improvements are needed. Clinics often ran late, especially in the eye clinic. There were also long waiting times when people attended to have a blood sample taken due the numbers of patients requiring this service

The hospital had a system of screens linked to the electronic check-in system that advised patients of waiting times and other clinic details, so that patients had adequate information. One patient told us, "The screens are very good. Before, we wouldn't know the waiting time, and now we do."

However, the system was not used in the eye clinic on either of the days we visited. When patients checked in they were not advised of the delay. People who came to have blood samples taken took a number from a

machine and they were called by turn. Patients said they felt that they had been waiting a long time. They had not been told how long they may need to wait. One patient told us that they had not been given any information on an alternative way of having blood taken, such as having the sample taken by their GP. This meant that, despite systems being in place, patients were not always aware of how long they may need to wait for their appointment.

Although the outpatients departments were busy, there were enough chairs to accommodate all those waiting. However, we found that the eye clinic was exceptionally crowed, cramped and noisy. Two patients in wheelchairs and their escorts found it difficult to manoeuvre and find a space they could wait. This posed a risk of injury to the wheelchair user and other patients using the waiting room. We were told that often there were not enough chairs, and we saw evidence of this later in the day when people had to stand in the waiting room and corridors. Patients were having eye tests performed in the corridor; this did not give them any privacy or preserve their dignity. There were constant interruptions to their view of the eye test sheet, which meant that the accuracy of the result might be affected. It was also difficult to hear clearly when patients' names were called. Nursing staff had to repeatedly call names, and sometimes there was no response. This meant that patients could miss their appointment time and have an extended wait.

To meet demand, the eye clinic booked appointments with inadequate time for necessary procedures. On one of the mornings we visited, 120 patients were booked into the clinic. There were not enough clinic rooms to handle this number of patients. Nor was there time for staff to see patients in a timely and effective way. The trust was aware of the capacity issues, and there were plans to rebuild the eye clinic. However, the new unit will not be completed until 2015. The service did not have capacity to meet demand and the eye outpatients department was not fit for purpose in that it did not provide a pleasant or safe environment to deliver the service in a timely way. There have been attempts to make improvements within the current limitations, and patients said that waiting times used to be even longer. Any improvements that have been made have been insufficient to manage the current capacity issues.

Before our inspection, a number of patients had reported that there the hospital was taking too long to get letters to GPs. This meant that GPs were sometimes inadequately informed about a patient's condition or the patient had problems getting repeat prescriptions. A manager told us that GP letters following outpatient attendance were usually sent within seven days. The department had recently introduced initiatives such as digital dictation to streamline and improve processes. There were plans in progress to outsource some typing. However, we were told that there were still delays in sending out letters to GPs following attendance at the eye outpatients. We saw there was a large backlog of notes in the secretaries' office and noted some of these went back to early September 2013. We witnessed a telephone call from a GP who needed to issue a repeat prescription for a patient who had attended the eye clinic in August 2013 but was unable to do so as they had not received the consultant letter informing them of the patient's treatment. This significant delay in advising GPs of the outcome of consultations at the clinic posed could adversely affect patients' treatment.

There were regular multi-disciplinary clinics that aimed to meet all the needs of patients with complex needs. We saw that therapists such as speech and language therapists and audiologists conducted separate clinics to meet patients' needs. This meant that there were arrangements for the most appropriate clinician to treat patients.

Nurses and care assistants working in outpatients had an appropriate induction and competency assessments relevant to their role. Training records showed that staff were up to date with their statutory and mandatory training. In the eye and audiology clinics, staff told us that regular educational updates were held to enable people to maintain and extend their clinical skills and knowledge. This showed that care was delivered by competent staff who were supported in their development.

Are outpatients services caring?

Good

Staff were kind, caring and courteous in their dealings with patients. There were staff available to help people

Requires improvement

Outpatients

with the electronic checking in process. One person told us, "I have a lot of faith in the people here." Another said, "No fault at all, very good overall considering the shortage of money in the NHS."

Staff maintained people's privacy and dignity. In the main outpatients departments staff carried out consultations in private and they marked rooms as 'engaged' when they were in use. We saw that staff knocked before entering consultation rooms. We did not overhear any private conversations regarding patients' personal or medical details. Staff addressed patients by their name and title, and there were notices to explain the hospital's chaperone policy. Staff knew how to put this policy into action.

There were adequate facilities for patients attending the outpatients department. However, we found that signage was sometimes difficult to see and was confusing.

Waiting rooms had water machines and some (for example the eye clinic) had hot drinks machines. Toilet facilities, including those for disabled people, were available in or close to waiting rooms. There was a range of health information and promotion literature for patients to read, which would help them understand their conditions and their management. The children's area had appropriate toys that could be decontaminated by staff. The waiting rooms themselves were well maintained, welcoming, well lit and pleasant, although they were very busy.

We saw a copy of the six-monthly patients' questionnaire. Unfortunately, we did not see any copies of the results or any resultant action plans, but it was clear that the department did ask patients or their feedback about the outpatient service.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Overall, services had systems to respond to people's individual needs.

Staff were able to tell us how they accessed translation services (including British Sign Language) for people who did not have English as their first language. This was through the Patient Advocacy and Liaison Service (PALS), and a receptionist told us that the system was simple and effective.

We saw that when patients were referred by their GP, the 'Choose and Book' scheme gave them a choice in the date and time of their appointment. We saw how this operated in the audiology outpatient service. In the eye clinic, we saw the receptionist giving people a choice of appointment times and dates. Schedules and duty rotas showed that the hospital was running some evening and Saturday clinics. Staff told us these were proving popular with patients. This showed the hospital was offering people access to their outpatient service at a time that suited their needs.

Staff told us that they received feedback from investigations into complaints, which enabled them to learn from them. For example, we were told that an appointment had been sent a patient who had had a miscarriage. Staff were able to tell us the actions they had taken to prevent a recurrence. Another example related to delays in answering the phone in the audiology outpatients department. We were told that a telephone system was now in place which gave people the options to access the extension number or person they needed. This showed that the hospital learnt from complaints and responded appropriately to improve services.

Parking difficulties was a common theme in comments from patients. They said that it was so hard to find a parking space that they got stressed and were late for appointments. We saw an elderly person arriving slightly late. They were flustered and out of breath, as their relative had spent a considerable amount of time locating a parking space. They told us they had sat in the car for so long they needed the toilet but were reluctant to use the facilities as they feared they would lose their space in the appointment queue. The standard outpatient letter sent to patients did not contain any information on travel. There was also no information to tell patients that patients who fulfilled certain criteria could claim travelling expenses. This meant that the trust was not taking effective action to respond to patients' need for ease of access to outpatient services.

Are outpatients services well-led?

Requires improvement

Outpatients

Requires improvement

Overall, services were well-led. trust leaders had clearly engaged staff .We saw posters of the hospital's vision and strategy displayed in all outpatient areas. Staff we spoke with were aware of the vision and strategy and enthusiastic in their support. A sister told us, "It's something we should be aspiring to."

There was strong and visible clinical leadership in the department. Staff confirmed that the outpatient matron was frequently in the clinical area, and was visible and supportive, and we saw evidence of this during our visit.

The department was participating in the Department of Health's Productive Outpatients Department programme, and it displayed information about the programme, programmes identified at the hospital and solutions that it had come up with. Staff were knowledgeable about the programme and its aims. We saw that there was a tool displayed that gave all the team information about staff sickness in real time. A sister told us that sickness levels had improved since this monitoring had begun and that "people are so much more aware of the impact their absence has on the rest of the team". This demonstrated the outpatient department management team was using nationally recognised schemes to lead service improvement programmes.

There was some discrepancy between the reality in the way services were delivered and patient experience and the view the Board had of the situation. The trust was aware that there were issues and challenges facing the eye outpatient service. Managers told us that governors and board members had been visible in the department, talking to staff and patients as these issues had become more sharply focussed. Staff confirmed this to be true. We looked at the eye outpatients action plan in some detail. However, when we tested some of the progress detailed in the action plan we found that in some areas the situation we saw and that which staff and patients described did not correlate. For example, it said that clinic templates that set the numbers of patients seen had been finalised, yet we witnessed double and triple booking of appointments. The action plan also suggested the typing backlog was resolved, but we found this not to be the case. We discussed this with a Board member who told us that the Board received briefings at board meetings. They commented "We have not got sufficient traction on the action plan" and "We have taken assurance where we should not have done".

Good practice and areas for improvement

Areas of good practice

- Paediatric ward in the responsive domain
- Maternity services in caring and well-led domains
- Nurse-led cancer clinics
- Breast cancer service
- Hepatobilliary cancer service

Areas in need of improvement

Action the hospital COULD take to improve

- Although services were safe, in some wards and outpatient departments we found that the level and mix of staffing might create a risk to the safety of patient care, particularly in Merrow, Wisley, Eashing, Albury medical wards, Ewhurst surgical ward, outpatients and administration support services.
- The action plan for the eye outpatient department did not reflect the reality and requires review.
- Plans for the refurbishment and expansion of the eye outpatient area need to be speeded up to enable care to be delivered on-time and in an appropriate environment.
- Analysis of falls in Wisley ward had indicated that they had all occurred at night and three had occurred when a staff member had been removed to provide cover elsewhere. This meant the wards were unable to operate the night time protocol safely due to staff shortages.
- Not all the equipment in accident and emergency had proof of having being tested, so the trust could not be sure that all equipment was safe.
- Some clinical pathways needed improvement,for example management of neutropenic sepsis in A&E was not always being followed.
- In some areas the trust had been inconsistent in monitoring how it made changes based on learning from complaints and incidents. Changes identified in action plans in reponse to complaints and incidents need to be implemented and monitored consistently.
- Staffing levels were impacting on the effectiveness of some services. Current management of staffing level processes and patient numbers made effectiveness inconsistent.
- Local priorities at the departmental level need to be captured at trust level.
- Operational structures need a stronger connection to Board level to enable them to be clear on their understanding of issues at ward level.
- The trust quality strategy needs to include basic quality issues specific to the trust as well as national targets and future developments and the trust priorities need to be clearly articulated within a robust quality strategy.
- The trust risk register highlighted risks by the specialist business units but needs to have a trust-wide perspective.
- There is a need for a leadership development plan and provision for Consultants leadership role within their current job plans
- Business planning needs to be more rigorously tested to ensure innovation control, impact on support services, resource implications and workforce
- Root cause analysis for grade 2 and 3 pressure ulcers needs to be connected.
- Management of patient's pain in A&E needs to ensure that pain relief is administered in a timley manner. We found that patients presenting with pain were not always given or offerred pain relief in a timely manner
- The incidence of poor attitude of consultants and staff needs to be managed to prevent recurrence.
- The areas of dissatisfaction for cancer patients identified in the cancer patients survey need to be addressed.
- There were significant delays in discharging medically well patients from ICU to the wards. The trust had plans for expansion for an additional 12 beds. However, we are concerned that the trust has not clearly thought through the requirement for additional nursing, other staff and beds in other wards to accommodate the increased amount of patients requiring discharge from ICU or how it will manage discharge of medically well patients.