King's College Hospital NHS Foundation Trust

Princess Royal University 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.

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Overall summary

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching hospital trusts, with a strong profile of local services primarily serving the boroughs of Lambeth, Southwark and Lewisham. Its specialist services are available to patients across a wider catchment area, providing nationally and internationally recognised work in liver disease and transplantation, neurosciences, haemato-oncology and foetal medicine. The trust is one of four founder partners of King's Health Partners, one of England's five academic health science centres for research collaboration.

The trust provides general and specialist services to patients in South London, and also coordinates, or is a part of, various regional centres for trauma, breast screening, diabetes, cystic fibrosis, stroke and liver disease.

The Princess Royal University Hospital (PRUH) was acquired by King's College Hospital NHS Foundation Trust on 1 October 2013. Before this it was part of the South London Healthcare Trust, which was placed into administration by the Secretary of State in July 2012.

This report relates to the acute services provided by the Princess Royal University Hospital. The hospital has over 500 beds and serves a population of approximately 300,000 in the borough of Bromley of which 91.6% are White and 8.4% are Black or minority ethnic people."

Prior to being dissolved, the South London Healthcare Trust experienced severe financial challenges, which impacted on many areas of care and systems for monitoring the quality of care provided. The due diligence reports carried out by King's College Hospital NHS Foundation Trust, dated June 2013, identified a number of significant problems, including the processes for managing risk, complaints and clinical effectiveness, which were perceived to be weak and understaffed. They highlighted the urgent need for clinical governance systems to be put into place at all levels of the PRUH. The current trust is aware of the issues and has developed action plans and started to address the problems.

The scale, number and longstanding history of many of the problems the current trust has inherited should not be underestimated. They include long waiting times in the accident and emergency (A&E) department and significant problems with the availability of medical records. Poor management of patient movement ("flow") around the hospital means some patients are having their elective surgery cancelled and some patients cannot be transferred from the critical care unit. Systems for monitoring the quality of care had also been much reduced.

Along with (until recently) a lack of resources and support, staff were working in very difficult circumstances and under enormous pressure to provide safe care. Despite the history of problems morale amongst the majority of staff was good and staff were motivated and keen to improve care and services. They are to be commended for maintaining their commitment while working in difficult circumstances for a long period of time. The current trust has recognised that it needs to invest and support staff and has started to do this by increasing staffing levels, and providing a clear management structure for each of the divisions and a dedicated site management team.

During the inspection we were concerned about the degree of urgency in responding to the long waiting times that patients were experiencing in A&E and the lack of capacity within the hospital. To mitigate some of the risk, more staff were being brought in to care for patients. Although senior managers/executives reassured us that they were taking prompt action, this was not supported by what the inspection team saw during the inspection. Some staff working in clinical areas appeared to have become resigned to the situation and worked around the problems rather than addressing them. This attitude was evident in some interviews with staff and during our observations of clinical areas. The plans of senior managers had not yet had enough visible impact on the delivery of care.

At the time of the inspection, the trust was implementing its escalation plan which is now in place, although there has been no improvement in the A&E waiting times.

There was also a significant lack of data available about the quality and effectiveness of the care and treatment provided to patients.

Summary of findings

We also identified a number of areas where we felt the trust could and should be taking more prompt action – for example, improving the waiting times in the A&E department.

Some action has been taken to improve the availability of medical records in the outpatients department, but this has yet to have an impact on the service. More action is in process but a lack of records meant that at times patients were undergoing complex medical procedures without clinicians having access to complete set of notes. We reported these areas to the trust and, since the inspection, we have received a letter outlining the immediate action the trust intends to take.

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?

Many of the services are safe but some require improvements, including the A&E department, medical wards and the outpatient departments. There are long waiting times in A&E and we found inaccurate recording (on the medical wards) of those patients who are not for resuscitation. Lack of availability of medical records in some outpatient clinics meant some patient were either having their appointment cancelled on the day or undergoing fairly complex procedures without their full medical notes being available. Not all staff in all clinical areas were using the alcohol hand gel, and hand-washing sinks were not available in every area. Although some staff reported incidents and the trust was putting in arrangements to improve investigating incidents and providing feedback to staff, they did not always receive feedback about any action that had been taken.

Are services effective?

Some areas such as the critical care unit were able to demonstrate that they provided effective care through the collection and analysis of data. However, we were unable to obtain this data for many areas. Other areas, such as the A&E department, had clinical pathways for managing patients with specific conditions but these were not always adhered to. Participation in audits was variable across the services and staff groups.

Are services caring?

Patients and relatives we spoke with were positive about the care they received and we observed good interactions between staff and patients. However, this was another area where limited data was available due to the recent acquisition. People who came to the listening event were generally positive about their experience of the hospital. Information from Bromley Healthwatch highlighted some areas of good practice and areas that needed improvement including discharge planning.

Are services responsive to people's needs?

Many of the areas we inspected need to improve how they respond to patients' needs. The movement of patients through the hospital is hampered by delayed discharges, which in turn causes pressure in the A&E department as well as other areas such as the critical care unit and theatres. Services had responded to complaints but there was very little information about learning and changes as a result of complaints.

Summary of findings

Are services well-led?

Many staff were positive about the hospital being acquired by King's College Hospital NHS Foundation Trust and told us about recent improvements as a result. In some areas it was clear that some senior staff had not taken action to try and address some of the longstanding problems and staff told us that, until recently, there had been little support for them. Over the last few years, under the previous trust, the systems to monitor the quality of care provided have been significantly reduced.

Summary of findings

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

Accident and emergency
A&E is very busy and patients experience long delays waiting to be assessed and for a hospital bed to become available. The department often has to take more patients than it has been designed to accommodate and staff were trying to provide care and treatment to patients under very difficult circumstances

Medical care (including older people's care)
Patients on medical wards receive safe care, but some aspects need improvement. Documentation, including fluid balance charts, were not always completed. Discharge arrangements were not always effective. Although the majority of patients we spoke with were happy with their care, some felt they could have been more involved in decision making and received more information about their progress. Staff received little information about the number of complaints and incidents or any changes made as a result of these being received.

Surgery
Surgical services required some improvements in terms of staffing levels and staff following infection control procedures, to ensure they provide safe care. The service was not always able to respond to patients' needs: operations were cancelled due to a lack of beds and patients were delayed being discharged from hospital because arrangements were not in place. Patients were satisfied with the care and treatment they received.

Intensive/critical care
Patients received care and treatment in line with national guidance and the unit was well-led. There were enough staff to care for patients and the unit had a similar standardised mortality rate compared with similar peer units. Relatives told us they received good support from staff who gave clear explanations about what was happening. Although the unit had a lower-than-average bed occupancy, they experienced problems transferring patients in and out of the unit due to a lack of available beds elsewhere in the hospital.

Maternity and family planning
Most of the women we spoke with had had a positive experience in the maternity services and had confidence in the midwives and obstetricians, but we found a number of areas that require improvement. Although staffing levels had been improved, they need further enhancement in terms of skill mix and experience. Consultant cover at the weekend is only part time. Some aspects of

documentation were not fully completed and, at times, there was a shortage of some equipment. Equipment, such as suction equipment, was not always checked in line with trust policy. Arrangements for monitoring the quality of care provided need to be further developed and embedded.

Services for children & young people

Overall, children received good care and the standard of hygiene in both the children's ward and the special care baby unit was good. However, the children's ward was not fully open as there were not enough nurses for the number of beds. Additional staff had been brought in and more were being recruited. The skill mix also needed to be improved as children requiring high dependency care had to be cared for in the A&E department or transferred to other hospitals. The lack of beds also meant that, on occasion, surgery had to be cancelled. Children and patients we spoke with were generally positive about the care they received.

End of life care

Where possible, the palliative care team were responsive to people's needs. Over the last year, under the previous trust, the number of referrals to the team had risen significantly, with no increase in staffing levels, and they need more staff. Staff were only able to provide a face-to-face service from Monday to Friday, which could cause delays with discharges or transfers to hospices over the weekend. The increase in capacity was also having an impact on the completeness of patients' records. Discussions about resuscitation had not always been accurately recorded and we found conflicting information for some patients about whether or not they were for resuscitation.

Outpatients

The outpatients department did not always provide safe and effective care. Patients were often kept waiting for their appointment and medical records were not always available. This meant that, on occasion, appointments were cancelled or patients were seen and having complex procedures carried out without doctors having access to their full medical history. Clinics were often overbooked and some doctors felt that insufficient time was allocated to see each patient. Patients were seen in private rooms and were positive about the staff and felt involved in their care.

Summary of findings

What people who use the trust's services say

In comparison to the rest of England, the hospital has a decreasing response rate for the NHS Friends and Family Test (patients' feedback on the quality of care) and scores are consistently below the England average.

For inpatient areas, in September 2013, 37 people completed the test and 81.1% of those asked were either "likely" or "extremely likely" to recommend the ward they stayed on to friends or family. For the same month, 25 people in the A&E department completed the test. Of those, 76% were either "likely" or "extremely likely" to recommend the A&E department to family or friends.

To address low response rates, the current trust launched its 'How are we doing' inpatient survey on 1 October 2013. The survey incorporates the Friends and Family survey.

Feedback from Bromley Healthwatch included positive comments care on surgical wards and day surgery and A&E. Concerns were raised about discharge planning due to transport delays and patients and relatives not always being able to identify staff as they don't always introduce themselves clearly or they were not wearing name badges and the "poor " complaints process.

Areas for improvement

Action the trust MUST take to improve

- Engagement and support of all senior medical staff.
- Ownership for improvement must be embedded at every level in the hospital.
- The trust must address its discharge planning and patient flow problems and ensure all action is taken to minimise the risk of elective surgery being cancelled and improve capacity
- The trust must take action to urgently address the long waiting times in the A&E department.
- Problems with accessing and availability of medical records must be addressed urgently.
- Nursing documentation, including fluid balance charts, must be accurately completed.
- Decisions related to patients' resuscitation status must be regularly reviewed and accurately recorded and shared with staff.
- Develop and embed systems for monitoring performance, quality and safety of care at all levels in the hospital.
- Ensure staff use the alcohol hand gel.
- Training, appraisals and support for all staff
- Appropriate training and sufficient staff to provide care for children who require high dependency care and improved planning for elective surgery for children
- Recruitment of new staff should continue to ensure the reliance on bank (in-house overtime staff) and agency staff is reduced.

Good practice

Our inspection team highlighted the following areas of good practice within the trust:

- Use of patient diaries in the critical care unit for patients who have been unconscious for a long time. They aid patients' recovery by helping them understand what happened while they were unconscious.

Princess Royal University 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; and Outpatients

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Singleton, Clinical Director of Innovation Cumbria Clinical Commissioning Group

Team Leader: Margaret McGlynn, Care Quality Commission

The team included Care Quality Commission (CQC) inspectors and a range of specialists: consultant anaesthetist, consultant surgeon/medical director, consultant endocrinologist, junior doctor, senior nurses/director of nursing, a senior radiographer, a student nurse and members of the public.

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 the CQC introduced our new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care according to our new surveillance model. 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.

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

Detailed findings

- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Prior to the inspection we reviewed the information we hold about this location and asked other organisations to share with us what they knew about the hospital.

We carried out an announced inspection from 2-4 December 2013. During that visit we held focus groups with a range of staff in the hospital, nurses, doctors, physiotherapists, occupational therapists and pharmacists, porters and administration staff. We talked with patients and staff from all areas of the hospital, including wards, theatre, outpatient departments and A&E. We observed how people were being cared for and talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held a listening event on the evening of 3 December 2013. People were able to talk to us about their experiences and share feedback on how they think the hospital needs to improve.

We carried out an unannounced inspection on 10 December 2013 when we followed up on areas we had inspected the previous week.

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

Are services safe?

Summary of findings

In most of the areas we inspected we found aspects of care that needed improvements to increase safe care consistently. Some staff were not using hand gel and there were insufficient sinks for staff to wash their hands, equipment and medicines were not always being checked or available, and there were problems with the availability of medical records.

Patient documentation was not always fully completed or there was conflicting information about patients' resuscitation status. Staff reported incidents but, in many areas, although improvments were being put in place, they did not receive feedback.

Nursing staff levels had been a significant problem but, since 1 October 2013, the trust has taken prompt action to address this by recruiting more staff and, in the meantime, allowing staff to use bank (overtime) or agency staff. Recruitment for more medical staff in the A&E department was also in progress. Arrangements for other aspects of safety, such as safeguarding children and vulnerable adults were in place.

Our findings

Before 1 October 2013, the hospital had one never event in maternity services in March 2013, following an instrumental delivery. The woman was readmitted several days later with a retained vaginal swab and sepsis.

Staff in many areas told us they reported incidents but were unable to tell us about any feedback they had received in terms of learning/changes or trends. In theatres, staff reported incidents related to delayed or cancelled operations but no action had been taken. Critical care was the one area that was the exception; staff gave us examples of changes as a result of reporting incidents.

Staff in theatres used the World Health Organization (WHO) surgical safety checklist to ensure that patients had the necessary checks completed before, during and after surgery. Patient records reviewed showed that the WHO checklists had been fully completed.

Wards were not using the NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing patient) and data from Dr Foster Safety Indicators showed that the hospital had a higher-than-average number of patients developing deep vein thrombosis (DVT) after surgery.

Information provided prior to the inspection showed that, for the last 12 months, the hospital rate of new pressure ulcers was higher than the national average. In October the hospital recorded that 4.22% of patients had new pressure ulcers compared with the national average of 1.09%.

Following the hospital's acquisition by King's College Hospital NHS Foundation Trust in October 2013, a falls prevention team and tissue viability team were put in place and are beginning to collect data for these areas.

In the A&E department, daily checks of the resuscitation equipment had not been done due to staff being too busy. Similar problems were found in the maternity services; the post-partum haemorrhage and pre-eclampsia kits, along with oxygen and suction equipment, had not been checked on several occasions.

On the medical wards, on two occasions, we found contradictory information about decisions to resuscitate patients had been recorded. For example, information boards or handover records stated that patients were for resuscitation but they also had a 'do not resuscitate' form in place. Some records had not been fully completed, did not always include the patient's or a relative's signature and decisions had not always been reviewed. For one patient, the decision had not been reviewed since January 2011.

Information provided prior to the inspection showed the hospital had low rates of avoidable infections such as methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C.diff). In some of the surgical wards, staff did not use hand alcohol gel and in others there were not enough hand-washing sinks. The physical layout of the hospital did not promote infection prevention as four wards could only be accessed via other wards.

Problems with the availability of medical records, for both inpatients and outpatients, potentially compromised patient care by having their appointment cancelled on the day or patients undergoing fairly complex procedures without the complete set of their notes being available. On one day of the inspection, 25% of the medical records were not available in two outpatients clinics. Staff told us this was a longstanding problem since June 2012 when the

Are services safe?

system was reorganised. Non-availability of medical records is noted in the clinical and operational due diligence report (4 June 2013) and rated "red". There is limited space to store records and many are kept off site and prepared elsewhere for clinics and inpatients. The problem is compounded by clinical and administrative staff not recording the location of the records in the IT system. The trust has developed an action plan with immediate and medium-term actions, but at the time of the inspection although some action had been taken there was little impact on the situation .

Staff had received training on safeguarding vulnerable adults and child protection and were aware of the different types of abuse and how to report any concerns. However, in the A&E department, information from local authorities about children who were on the "at risk" register was not up to date.

During the inspection many nursing staff commented on the improved levels of staffing since 1 October 2013. At the time of the acquisition, the hospital had a 17% vacancy rate across nursing and midwifery. Staff told us the numbers put patients at risk of receiving unsafe care. The midwife-to-birth ratio is 1:38 whereas it should be 1:28. Following the acquisition, the situation improved. There has been a review of the staffing establishments and recruitment is underway. In the meantime, staff are able to book bank and agency staff. On the children's ward some beds have been closed until more staff are recruited. Staff told us they felt that there was a much stronger focus on patient safety.

Are services effective?

(for example, treatment is effective)

Summary of findings

We received very little information about the effectiveness of services. This is due to a number of factors; the recent acquisition of the hospital and the financial position of the SLHT meant that activity related to collecting data to assess performance against a range of benchmarks was significantly reduced.

Some services, such as the critical care unit, were able to demonstrate that they provided effective care, but many were not.

A range of national guidelines were in use but there was little evidence of a system to monitor their implementation. Participation in local and national audits was variable and medical services were unable to provide us with any information about audits.

Our findings

Mortality data specifically for this hospital was not available.

For the standardised maternity indicators, the hospital's outcomes were within expected limits for all the indicators. Although the ratio of midwives to women was low: 1:38 when it should be 1:28.

For surgical services the national hip fracture database showed 1.2% of pre-operative assessments were carried out by a geriatrician compared to the national average of 50.2%. National guidance recommends that patients should have an assessment by a geriatrician before their operation.

Outcomes for patients in the critical care unit were in line with other similar units across the country. The critical care outreach team was responsible for reviewing patients on wards whose condition may be deteriorating. They also saw patients who had been in the critical care unit for more than 24 hours.

Princess Royal is in the second quartile of performance in the latest Stroke Improvement National Audit Programme (SINAP), which means although they are performing below their London counterparts, nationally they are above average. In addition the current trust was introducing the use of telemedicine so consultants could assess patients remotely to ensure decisions were not unduly delayed.

The hospital was not meeting the referral-to-treatment time (GP referral to first treatment) target for lower gastrointestinal, lung and upper gastrointestinal cancer patients. There were also delays for referrals to cardiology and ophthalmology clinics.

Systems were in place to obtain consent and staff were aware of their responsibilities under the Mental Capacity Act (2005). Where necessary, a patient's mental capacity was assessed and, if there was any doubt, the hospital's social work team carried out an assessment.

In accordance with national guidance, the Liverpool Care Pathway for delivering end of life care had been withdrawn. Staff told us "they worked in a vacuum" for a few months as the previous trust had not provided alternative guidance. The current trust had introduced guidance and the palliative care team were using the 'Principles of Care for Dying Patients'.

Some services, such as palliative care and medical services, had good multidisciplinary team working and a good working relationship with the local hospice. Handovers on the emergency assessment unit and elderly care wards included consultants, nurses and therapy staff.

Participation in audits was variable; doctors have protected time to participate in audit work but nursing staff do not. There were variable results in national audit performance with no information about action taken. There was no information about how compliance with National Institute for Health and Care Excellence (NICE) was monitored. The current trust is now putting systems in place to improve information in relation to the implementation of NICE guidance.

In many areas staff told us they did not receive information about the standard of care they provided. Due to low staffing levels, ward meetings were not taking place which meant there was no forum where staff could discuss patient safety and quality issues.

Are services effective?

(for example, treatment is effective)

Junior doctors raised the issue of not always being able to identify which wards patients were on. The IT system does not allow for numerous changes and, given that patients are often transferred to two or three different areas during their stay, junior doctors are wasting time locating patients.

The trust was aware that it needed to introduce robust governance arrangement and has developed an action plan to do so within three months.

Are services caring?

Summary of findings

Response rates for the Friends and Family Test is noticeably low compared with the England average.

Many of the people we spoke with were positive about the care they received. They described the staff as "lovely" and "marvellous". We observed nurses, doctors and other health professionals caring for and treating patients in a kind and friendly way. Staff explained procedures and sought consent as well as providing reassurance. However, due to the recent acquisition there was limited data about patients' experience.

Our findings

In September 2013, 37 people completed the Friends and Family Test and 81.1% of those were "likely" or "extremely likely" to recommend the ward they stayed on to friends or family.

For the same month, in the A&E department, 25 people completed the test and 76% of those were either "likely" or "extremely likely" to recommend A&E to friends and family. The response rate for both tests is low.

Due to the acquisition no NHS inpatient or A&E survey information is available for this hospital.

In the A&E department, patients were generally positive about the care they received, although they often had to wait for a bed. They were provided with some food and drinks but no hot food was available. On other wards, assistance with eating was provided to patients who needed it.

The hospital operated a "red tray" policy to indicate how patients' meals should be prioritised and if they needed assistance. Patients had a choice of food and religious and cultural needs were accommodated. Patients had mixed views about the food. A protected meal time policy was in place, but it was difficult to implement on the surgical wards, as some were used as a thoroughfare to access other areas.

In most areas patients said they were given enough information and involved in decision making, but in medical services some people said they did not always receive regular information from nurses and doctors.

Parents on the children's ward were positive about the care their child had received. One parent described a difficult situation that had been handled well by the staff. Staff were always available and they received regular updates about their child's condition. Women in maternity services said they felt involved in their care and commented positively on the level of support available for breastfeeding.

Patients in the outpatients department described the staff as "friendly" and "professional". Consultations took place in private rooms and chaperones were available.

Where possible, patients on the wards were cared for in single-sex bays. Staff on the emergency assessment unit and some wards, such as the stroke ward, told us they needed to be flexible which sometimes meant that single-sex bays were not available.

During the inspection we noted that staff were wearing trust badges but their names were not visible. Patients should know the name of the person caring for them. We raised this with the trust and they took immediate action.

Overall, patients and relatives were positive about the staff and the care provided.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

There are some arrangements in place to respond to patients' needs but the hospital faces significant challenges in relation to capacity much of which can be attributed to poor management of patient movement in the hospital, delayed discharges and long waiting times in the A&E department. While some of the problems require the engagement of partner organisations, there is much the hospital can do to bring about improvements and reduce pressure on wards and A&E.

Prior to the hospital's acquisition, response time for complaints was poor. Between April and September 2013, performance for responding to complaints within the internal 25-day target was 25% and there was little evidence of learning from complaints. Following the acquisition in October 2013, a Patient Advice and Liaison Service has been established in the hospital and this has helped reduce the number of complaints from 47 in September to 22 in November.

Our findings

Patient flow throughout the hospital was poor and impacted on the delivery of care in a number of services in the hospital.

Data shows that many patients often waited more than four hours in the A&E department and, once the decision to admit had been made, had a significant wait for a bed to become available. This puts patients at risk of not receiving appropriate care and treatment. Although staff in the A&E department were working under pressure and in difficult circumstances, many of them had become resigned to the situation and there was a lack of urgency in taking action when the department was full. Some patients had been in A&E for up to 22 hours.

During the first day of the inspection, the A&E department was under extreme pressure and the situation was declared as an 'incident' – the first time this had happened. To free up space in the department, approximately ten patients were transferred to the recovery area which meant all elective planned surgery for the following day was cancelled. We spoke with several patients previously affected by this who were distressed and upset about having their operation cancelled.

During the unannounced inspection the department was full and beds on wards did not become available until 7pm.

The trust has now introduced daily bed management meetings but these were described as "fire fighting". A weekly meeting was held at the trust headquarters to review the previous week's breaches. The scale of the problems in A&E are such that the trust anticipates it will take 18 to 24 months to turn the situation around, but improvements should be seen before then.

Cancellation of planned operations due to lack of beds is not uncommon. In the last three months, 148 had been cancelled and 48% of these were due to beds not being available. The hospital is not meeting the theatre utilisation target of 80%. For the month of October it was 67%.

Delayed discharges are contributing to the problems with patient flow. In medical services, delays in obtaining medications and waiting for transport meant that patients were not always discharged as planned. In turn, this delayed patient transfers from the A&E department. Discharge planning did not start until the patient began to show signs of improvement. It was more difficult to arrange care packages for patients who lived outside the borough of Bromley.

Lack of available beds means that patients who are well enough to leave the critical care unit (CCU) often experience delays in being transferred to a ward. Between April 2012 and April 2013, 237 CCU bed days were used for patients who were medically fit to be cared for on inpatient wards. This had the knock on effect of rushed discharges when a critical care bed was needed in an emergency.

Waiting times in some of the outpatient clinics ranged from 40 minutes to three hours. There were also delays for referrals to cardiology and ophthalmology clinics.

The range of care provided for children was limited due to a lack of suitably trained staff able to care for children needing high-dependency care. These children were managed in the A&E department or transferred to another hospital.

On average, the hospital received around 500 complaints per year but there was little information about learning and

Are services responsive to people's needs?

(for example, to feedback?)

improvements as a result of complaints. Staff in many areas were unable to tell us about any feedback they had received following a complaint or changes that had been made as a result. Between April and September 2013, performance for responding to complaints within the internal 25-day target was 25% and, since October 2013, this had improved to 35%. For the same period the main cause of complaints was staff attitude.

Until October 2013 there was no effective Patient Advice and Liaison Service in place. Since then, the service has been put in place, with three staff resolving frontline problems and the number of complaints has reduced from 47 in September to 22 in November.

The IT systems do not make it easy for junior doctors and consultants to locate and keep up-to-date with their patients. Many juniors use do-it-your-self spreadsheets that they struggle to keep up to date with patient movements and new admissions.

Are services well-led?

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

Summary of findings

Many staff were positive about leadership at service level and about the hospital becoming part of King's College Hospital NHS Foundation Trust and were already beginning to see improvements as a result.

Major improvements are required in operational processes to manage patient flow through the hospital and in the systems to monitor patient safety and quality of care.

The trust has inherited significant challenges and the scale of change required to bring about improvement should not be underestimated.

Our findings

Over the last two years, staff have continued to provide care under very difficult circumstances. Despite this, we found morale was good in many services and among many staff groups.

The trust is aware of the scale of the problems it needs to address and has put arrangements and staff in place to address the problems. Although it was unable to take any real action until October 1st, when it legally took responsibility for the hospital, we were concerned that in some areas, although some action has been taken, this has not yet had an impact on the service. An example of this is in relation to the availability of medical records which has been an ongoing problem since 2012. The trust has taken some action and has further plans to resolve the problems, including recruiting more staff and the arrangements to prepare notes.

The trust is aware of the importance of investing in staff and that in order to improve patient care, staff need to have the necessary resources and support. It has started to recruit more nursing and medical staff and it has strengthened the nursing and medical leadership. Each clinical division is overseen by a senior doctor, nurse and manager. There are more matrons and heads of nursing and plans are in place to recruit more consultants. Also, consultants from the Denmark Hill site are to spend time at the PRUH. There is a dedicated site team consisting of a deputy director of nursing, assistant medical director and an operational site lead. On many wards the leadership was visible and nurses wore uniforms appropriate to their grade so they could be identified

As part of the integration work, the trust carried out its own staff survey in November 2013. They sought the views of staff through focus groups and individual responses. Key issues identified were making patients the top priority, putting the right staffing levels in place and creating an environment where concerns can be raised. The reaction to integration was generally positive, with the majority of staff feeling that the trust was somewhere they could build a long-term career. Over half of the respondents felt motivated and connected to the trust. Staff felt that, in the past, they had not been recognised for the good work they had done and that managers never acted on feedback.

Staff were positive about their managers at service level and ward leadership was visible in many areas.

They were pleased to be part of King's College Hospital NHS Foundation Trust and were already beginning to experience some of the benefits such as increased staffing levels and availability of support for staff. Comments included that it "felt different to previous mergers" and "It has been a more pleasant process and I have been asked my opinion". The majority of the staff felt the trust was listening to them and they were making decisions based on the quality of care. Many senior clinicians recognised the importance of good communication between managers and clinicians and were keen to engage in developing solutions for some of the patient flow problems. There were still a few who made it clear that they thought it was the responsibility of managers alone to resolve operational issues.

In terms of professional development for staff, this is an area that has suffered and work is starting to ensure that all staff have appraisals and clinical supervision.

Some areas, including the CCU and maternity services, had some arrangements in place to monitor the quality of care, but many others did not. This is an area where work had virtually come to a halt when the previous trust was placed in administration. Work is in progress to re-establish systems to monitor performance and quality of care.

Accident and emergency

Information about the service

The A&E department provides a 24-hour service, seven days a week and consists of a triage area, major injuries areas ("Majors"), a resuscitation area and a dedicated children's department. The hospital is a hyper acute stroke unit for South East London and receives all acute stroke patients across that area. An urgent care centre (UCC), which is operated by another provider, is available to treat people with minor injuries or illness who do not require emergency treatment at A&E.

When people enter A&E, a nurse assesses their medical condition and directs them either to A&E or the UCC. Patients attending in an ambulance have a dedicated entrance. They are assessed and directed through to an appropriate area. The Majors area consists of 21 cubicles, and the resuscitation area has four bays, one of which is designated as a paediatric bay. Once the hospital has made a decision to admit a patient, they should be moved as soon as possible from A&E to the main hospital wards or to the medical assessment unit.

We talked to patients, relatives and staff, including nurses, doctors, consultants, managers, support staff and paramedics. We observed care and treatment and looked at care records.

Summary of findings

People were waiting too long to be either discharged or admitted. Staff said excessive waits in A&E were not unusual. One doctor said that patients waiting 15 to 18 hours was not unusual and 18 to 23 hours was usual. Some patients were returning to A&E for intravenous antibiotic treatment. This placed extra pressure on the department because these patients presented at A&E at some of the busiest times.

Not all staff followed correct care pathways and more guidance is needed on managing the appropriate pathways for dementia, fractured neck of femur and diabetes care.

Most patients said they were happy with the care they had received and overall we found that patients' privacy and dignity was being respected.

We talked to patients, relatives and staff, including nurses, doctors, consultants, managers, support staff and paramedics. We observed care and treatment and looked at care records.

Accident and emergency

Are accident and emergency services safe?

Staffing levels

Nursing staff levels in the A&E department had increased since the hospital was acquired by King's College Hospital NHS Foundation Trust. The head of nursing told us there were 2.6 matrons in A&E, there was a new Deputy Head of Nursing, a Project Manager as well as a Service Manager and there was a Deputy Divisional Manager who worked across the hospital and the Denmark Hill site. Recruitment has started for more A&E consultants. A nurse in the ambulance assessment unit told us that, before the trust took over, there had been a heavy reliance on agency staff. However, the situation had now improved with the recruitment of a second nurse and more staff currently being recruited. The trust was still using agency staff to cover nursing and medical staff vacancies due to patients having to wait a considerable length of time in the A&E department. However agency staff were now given a formal induction.

The number of administration staff had also increased during busy times. There were three receptionists on throughout the day and into the evening and two on at night. This ensured that patients coming to A&E via ambulances could be promptly admitted. We asked administration staff what they would do if a patient became unwell in the waiting room. They said they contacted clinical staff and they always responded quickly.

During our unannounced visit, we found that all areas were covered and the department was waiting for night staff from NHS Professionals recruitment agency. There was a consultant on shift until 10pm and, after that they were on call from home. We saw four other locum doctors on shift, and all had previously worked in the A&E.

Infection control

The A&E department was clean and tidy. Hand-wash dispensers with alcohol gels were all full and in working order. However, on occasions, their positioning didn't allow for easy access for staff, visitors or patients. One example was at the main entrance to the waiting room where the general public first enter the A&E. The dispenser was sited on the reception desk, making it easy to miss and not use. Staff told us they received annual update training on infection control and they had access to personal protective equipment. We saw records which confirmed that staff had completed training on infection control as part of their mandatory training.

Safeguarding

Staff told us they had received training on safeguarding children and adults from abuse. They told us that, if they suspected an adult or child was being abused, they would report their concerns to the Head of Nursing or the Matron. We saw records which confirmed that staff had completed safeguarding training. However, we found that information from local authorities about children on the at-risk register was not up to date.

Serious incidents

Information provided by the trust indicated that, between November 2012 and October 2013, 63 serious incidents occurred at the PRUH, and 38 of these had occurred in A&E. Of these, 35 were for ambulance delays, two were for delayed diagnosis and one was for ward/unit closure. A nurse in the ambulance assessment unit showed us a new system which had recently been introduced for monitoring ambulance arrivals, clinical assessments and patient handovers. They said the system was much better for tracking delays, reducing serious incidents and had significantly improved efficiency. We spoke to two ambulance crews who also said the patient handover process had improved.

We asked six members of staff about any learning that had resulted from incidents. They all struggled to answer this question and the example we were given related to an incident that occurred three years ago.

Equipment

We saw that blood samples were sent to the laboratory on a pneumatic chute. Staff said the chute was often broken and, due to a working agreement, porters were not permitted to go to the laboratory more than once an hour, so results sometimes took a long time to come back which impacted on the waiting times in the department.

On the first day of our inspection we reviewed a daily equipment checklist for the resuscitation room. We found that the checks were not always being completed each day. A nurse told us that, when they were busy, the checks were not done.

Accident and emergency

Are accident and emergency services effective?
(for example, treatment is effective)

The PRUH is recognised as performing poorly against the A&E (emergency care) four-hour target. The last time this was achieved was in June 2013. It was 72% in October 2013 and had risen very slightly to 74% in November.

Patient movement from the A&E to other parts of the hospital

The effectiveness of the service was hampered by the long delays patients experience in waiting for a decision to be made to admit them and then for a bed to be found in the hospital. Delays in moving patients through the department meant there were further delays in patients receiving care and a lack of space to see patients as they arrived. The sister in charge said the department had been consistently busy since our inspection. Staff had placed chairs in the Majors area to accommodate additional patients. The sister in charge told us they walked round the unit to monitor the condition of these patients.

One patient had returned to A&E for intravenous antibiotics and we were advised that about four patients attended A&E each day, seven days a week for this treatment including patients who were receiving treatment at a local mental health care facility. This sometimes caused delays in patients receiving care. Staff said this placed extra pressure on the department because these patients presented at A&E at some of the busiest times. Some patients were also referred from within the hospital to the A&E department. The head of nursing was aware of the problems and we were told discussions were taking place about how to address the problem. On the morning of the second day of our inspection, we were informed that some patients had been moved out of A&E and into the theatre recovery area in order to create space within the A&E department.

Patient pathways and protocols

Some pathways and protocols were available but some staff told us that medical staff did not always follow the pathway for managing patients who had a fractured neck of femur. We were also told the department had no guidance in place for staff about how to support patients with dementia. There was no mechanism in place to monitor compliance with the protocols.

During our unannounced visit, we again found the department was full. We saw that the longest waiting patient in Majors had been there 19 hours and was due to breach the 12-hour waiting time for a bed. Another patient had been there for 12 hours. These patients, along with several others, were waiting for beds but none were available. Many patients had waited longer than four hours for a decision to admit. Most patients waiting to be admitted were male. We were advised there was a shortage of beds on wards allocated to men at that time. Staff told us they wrote incident reports if they were unable to get people into beds.

The Deputy Director of Nursing said they were expecting 20 beds to become available through discharges. The discharges were happening late in the day due to late ward rounds, waiting for blood tests to come back, or for medication for patients to take home. The sister in charge of the acute medical unit had transferred several patients to the ward and created five male beds and two female beds to accept patients from A&E.

The A&E department had a policy that all patients should have hourly observations. A review of three sets of patients' notes in the Majors area during the first morning of our inspection showed that observations had not always been carried out in line with the policy. A further review of three more sets of notes later in the day showed that two had observations recorded two hourly and one had been checked hourly in line with the policy.

Staff training

We spoke with the Practice Development Nurse. They told us that, since the trust took over, they were able to provide more training opportunities for nursing staff. They showed us records indicating that all nursing staff had completed mandatory training. They told us there were five nurses currently on an emergency nursing course and four paediatric nurses had recently completed a course on emergency paediatric life support.

Are accident and emergency services caring?

Patient experience

The hospital's results for the NHS Friends and Family Test were below the England average score and response rate. The response rate in A&E for October was was 2.4% compared to the England response rate of 13.2% and A&E

scored lowered when compared with the rest of England. A member of staff said they had been appointed one week ago to focus on, promote and explain the Friends and Family Test to patients. We saw them talking with and requesting that patients complete the tests on arrival and on departure from the department. They said there were plans to publish results of the test on noticeboards in the waiting area and the results would also be discussed at A&E team meetings.

The majority of patients we talked with said they were happy with the care they had received since arriving at the hospital. One patient said, "I thought I would have got seen quicker but I didn't really have to wait that long". Another person who had been there overnight said the staff were "very caring". Some were concerned about not being given information and felt the care could be better.

We saw that staff treated people with respect and kindness, talking to them in a soft and responsive way. We saw nurses putting vulnerable patients and patients who were waiting for an inpatient bed on to a bed in the A&E department. We also saw them access specialist equipment such as a bariatric chair to assist patients who needed support.

A lead nurse told us about the "Goldfish Exercise" they were introducing to obtain feedback from patients. They invited four patients to share their experiences, both positive and negative, with a multidisciplinary team. They said they plan to carry out these exercises regularly and use patients' feedback to make improvements in A&E.

Discharge information

Patients received information and follow-up advice when they left the department. There were a range of information leaflets available for patients.

Food and drink

We asked staff how the patients with excessive stays within the department were provided with food and drinks. We were advised that the housekeeper organised this. The housekeeper works 9am to 5pm from Monday to Friday. Staff also told us snack boxes could be provided to people who were waiting in A&E, but no hot meals. We saw that some patients had been provided with drinks and sandwiches. We saw a drinks trolley regularly moving around the department ensuring that people were offered hot and cold drinks.

Privacy and dignity

Staff ensured that the environment allowed privacy so that they could meet the personal care, treatment and support needs of the patient. Curtains were drawn around each bed and discussions with patients were sufficiently confidential. We saw a patient being guided to the toilet by a member of staff, and assisted to keep her hospital gown in place. However, we overheard one gentleman talking privately to a streaming nurse (role is to take an initial history and direct patients to the appropriate area). The trust may wish to note that the positioning of the streaming nurses' table at the entrance to A&E did not afford visitors to the department a place where they could discuss their condition confidentially.

The department had only one very small relatives' room. The room did not have a telephone or any facilities for making drinks. There was only one chair in the room. The resuscitation area was usually full or had at least three people in it. We saw relatives of some patients standing in the corridor. There was a viewing room opposite the resuscitation area. However, a senior nurse said the room was being used as a store room. The room used to assess people with mental health problems was also used for other patients which meant it may not always be available.

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

(for example, to feedback?)

The PRUH is recognised as performing poorly against the 95% NHS target for a decision to be made within four hours to admit, discharge or transfer all patients attending the department. In October 2013, they achieved 72% and in November there was a slight increase to 74%. The service is not responsive enough to patients' needs as they are waiting too long for a decision to admit or discharge them.

On the first day of our inspection, an 88-year-old patient was in the department for just over 22 hours before being admitted to the stroke ward. Another 10 patients had waited more than 12 hours in the A&E department for a bed to become available.

During our unannounced visit, the department was full and one patient had been in the Majors department for 19

hours. Another patient had been there for 12 hours. Several other patients were also waiting as there was a shortage of beds on male wards, which only became available later in the evening following patient discharges.

We were told that access to psychiatric liaison staff was limited.

Complaints

The matron produced a list with the number of complaints received each month in 2013. However, they told us that there was no process in place to monitor and review these complaints and they were not audited to identify trends and take appropriate action. We reviewed one complaint, where an elderly person had been sent home in the middle of the night. We saw the complaint had been fully investigated and a response had been sent to the complainant. However, there was no evidence of either departmental or trust-wide learning from the incident.

Are accident and emergency services well-led?

Staff morale was good and all the staff we spoke with were positive about becoming part of King's College Hospital NHS Foundation Trust. The Lead Nurse and the Practice Development Nurse said that the addition of extra managers and nursing staff and training had significantly raised morale within the team.

We saw evidence of close team working. Doctors and nurses told us they valued each other's contributions. They referred to the department's ability to retain medical staff which they felt was due to the comradeship within A&E.

A staff nurse in the ambulance assessment unit told us, "The new managers listen to what we have to say, they know what's going on and know what to do. They are recruiting more staff which will help". An office manager who had worked at the A&E department since 1975 said, "There have been definite improvements since King's came. The new managers are nice people and they are caring. The volume of work has increased but it's been positive and exciting since day one". A volunteer working in A&E said that positive changes were already beginning to happen as a result of the takeover.

We spoke with three junior doctors. They said they it was hard work in the A&E department but they were happy to work there. They all said they had a good induction and received a department handbook.

Managing quality and performance

The Deputy Director of Nursing said they had held a workshop with administration staff, nurses, doctors (consultants) therapists and pharmacists to discuss how they could make improvements in A&E. It was recognised that a lot of work was needed and there was a need to change the culture; all of which would take time.

The nurse in charge told us the department carried out a "mock" inspection on 8 November 2013 and showed us the report. The purpose of the inspection was to assess the standard of care being provided. The report covered areas such as care and treatment, cleanliness, infection control, staff training, staffing levels, equipment, clinical records and audits. The report identified shortfalls in the service being provided and an action plan had been developed in response to the findings.

The Head of Nursing showed us minutes from management team meetings. Items discussed at the last meeting on 26 November included a walk through the medical pathway by the Chief Operating Officer, nursing and medical vacancies, the trust's approach to governance, complaints, friends and family feedback and doctors' inductions. They also saw a newsletter Tackling Risk in the ED which was circulated to staff in the department.

Medical care (including older people's care)

Information about the service

We inspected Medical Care (including frail elderly) at the PRUH over the course of two days. We visited 10 wards, including three care of the elderly and dementia care wards; the hyper acute stoke unit and the stroke unit; the emergency assessment unit; the winter pressures elderly care ward; one respiratory ward; and one cardiology ward. We spoke with some patients in the discharge lounge and also checked the arrangements in place for eight medical outlier patients on surgical wards.

We spoke with a total of 36 patients and three visitors, reviewed 10 patients' nursing and/or medical records and spoke with 35 staff from a wide range of disciplines.

Prior to our inspection we received data and information which we used to determine our key lines of enquiry. This included information such as low patient feedback responses, higher-than-average rates of patients with new pressure ulcers, venous thromboembolism or blood clots, urinary tract infections, falls and infections. Although we found staff were carrying out the appropriate risk assessments and actions to minimise the risk of many of these happening. We also had information which highlighted a potential lack of governance and, until the recent acquisition, an inadequate response to complaints. We noted the location was compliant with the regulations at the time of our inspection, but that previous CQC inspections had raised concerns in a number of areas, including medication.

Summary of findings

The acute medical wards we visited assessed patients'nursing and medical needs adequately and we found care was delivered in accordance with patient's needs. However, some documentation, such as fluid charts, was not completed and we found the systems in place for 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were not sufficiently robust.

Patients were cared for on wards which were adequately staffed, and in most cases, had appropriate consultant cover. We found there was a reliance on bank (overtime) and agency nursing and healthcare assistant staff, but the trust had begun further recruitment. Mandatory staff training was out of date for the majority of nursing staff which increased the risk of unsafe care.

Most patients we spoke with were happy with the care they received, although some patients told us they had not been fully involved in their care, or informed about their progress. Our observations found that patients on medical wards received good care from mostly compassionate and caring staff, but there was limited data to support this. We found staff reported incidents. However, governance arrangements were not yet in place to identify trends to drive improvement. In addition, ward staff were not always aware of their performance in audits, and we found very little evidence of learning from complaints.

Discharge arrangements were not always effective to manage the flow of patients through the hospital which meant that beds were sometimes occupied for longer than was necessary. We found this impacted on the care patients received, as some patients could not be admitted to the ward which specialised in their condition.

Medical care (including older people's care)

Are medical care services safe?

Risk assessment

In most cases patients' care needs were adequately assessed, planned for, and delivered to ensure they were provided with safe care. We looked at a sample of patients' nursing and medical records on the majority of wards we visited and found this to be the case. Although the data showed the hospital had a high incidence of pressure ulcers, appropriate risk assessments had been completed relevant to patients' needs, including their risk of pressure ulcers, falls, blood clots or venous thromboembolism (VTE) and any moving and handling risk. The majority of risk assessments were reviewed on a regular basis to ensure they remained appropriate. Risk assessments included implementing measures to prevent and reduce any risks. For example, patients who were immobile and at risk of developing a pressure ulcer were repositioned on a regular basis. In addition, patients had their call bells within reach to ensure they could call for assistance if it was needed, particularly those at risk of falling. Staff we spoke with were aware of the potential risks to patients and the actions they could take to minimise risks occurring.

Charts

Patient's care records did not always ensure that planned care was delivered. Patients who needed to have their fluids monitored, such as those with a urinary tract infection, had not had their fluid balance charts adequately completed. This meant staff were unable to establish whether the fluids patients received were adequate for their needs. For example, on one of the dementia care wards, staff had failed to record any fluid input for one person on one day, and very small amounts on other days. In addition, daily fluid intake was very rarely totalled. Staff told us that, although now they felt they had time to deliverpatients' care, they sometimes forgot to record it, and they said that this was the case with fluid charts. Patients had drinks within their reach, and none of the nursing or medical records we reviewed indicated that patients were dehydrated, despite their fluid charts not being fully completed.

Identifying deteriorating patients

Appropriate systems were in place to ensure when patients' health deteriorated they received prompt attention. The medical wards we visited used the national early warning score (NEWS) to monitor patients' observations at frequent intervals. Depending on the outcome of regular observations, patients were given a score which determined whether their health was stable or if they needed more frequent monitoring or urgent medical input. We saw examples on some wards where the NEWS tool had been appropriately implemented. For example, soon after being admitted to the emergency assessment unit (EAU), one patient's observations indicated they were in danger of further deterioration. In accordance with the assessment tool, staff urgently sought medical intervention in order to stabilise the person. We found this intervention had been received quickly and prevented any further deterioration in the person's health.

Professional input

Patients received input from relevant professionals, including consultants, junior doctors, nurses, healthcare assistants and therapy staff. Ward staff we spoke with told us that since King's College Hospital NHS Foundation Trust had acquired the PRUH site they had access to specialist input when it was needed. For example, staff were able to consult with or receive support from a tissue viability nurse if patients had pressure sores. We heard examples where this intervention had improved the care patients had received. For example, one patient's pressure ulcer had improved since nursing staff changed the way they dressed one person's wound following advice from the specialist tissue viability nurse.

Safeguarding

Safeguarding procedures were in place and had been appropriately implemented. Nursing staff told us about the different types of abuse and how they would report any concerns. They told us they had completed training in safeguarding vulnerable adults; however, details provided by the trust showed that almost 100% of staff required refresher training. Staff we spoke with had not been informed when this training would take place. We found staff had appropriately reported safeguarding concerns when issues had been raised. For example, staff on medical wards had made a report when patients had been admitted to hospital with significant pressure ulcers, or if any bruising was noted.

Incident reporting

Nursing staff told us about how they reported incidents. However, the majority of matrons or ward sisters told us they did not receive further analysis of the incidents they reported, for example, in order to identify any trends. Staff

were not clear about their ward performance in relation to data on the NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing patient care), including infection control, hand hygiene, pressure sores or falls. As a result of the lack of information staff received about their ward's performance, we found very few examples of where incidents had been learned from.

Equipment

There were some shortfalls with the availability of equipment in order to meet patients' needs. Matrons and ward sisters told us that, although they had enough equipment to meet patients' needs, they felt more equipment was needed to provide a more effective service. We found that some wards shared equipment such as hoists which meant there may have been a delay in some care being provided. On some wards, there was not as much equipment as staff felt was needed. For example, one ward had one blood sugar monitoring machine, but the sister felt around three were needed. On another ward, there was a lack of adequate drip stands, and we found drips were hung inappropriately on other equipment. Staff told us they had been asked to provide the trust with a 'wish list' of equipment they needed and the trust was in the process of purchasing more equipment. Staff told us that the maintenance of equipment was ongoing and they were able to quickly source more common items such as pressure relieving mattresses when they needed them. On some of the wards we visited we checked resuscitation trolleys and found that all the necessary equipment was available, and equipment checks had taken place daily on the majority of wards.

Medicines management

We checked the management of medication on some wards we visited, including the arrangements for obtaining, storing, recording and the administration of medication. We found the management of medication was appropriate on each of the wards where we checked this. The arrangements for the storage of medication were appropriate and we found medicines were stored in locked treatment rooms and in locked cupboards. Only authorised staff had access to medication rooms and we found the temperature of refrigerated medicines had been monitored daily.

Infection control

We were unable to assess the performance of each ward in relation to infection control and prevention due to the lack of information available. Some matrons and ward sisters were able to tell us when their last acquired infection had occurred and we found infection control audits had taken place on some wards, such as hand hygiene checks. The majority of our observations of staff infection control raised no concerns, and we found the availability of alcohol hand gel and hand-washing facilities was good.

Staffing

Nursing staff levels were appropriate in order to meet patients' needs. On each of the wards we visited we found that nurse and healthcare assistant staffing levels had increased since the trust took over the management of the hospital. Staff we spoke with and rotas we looked at confirmed this. As a result of increased staffing levels, they felt they were able to deliver better care to patients. For example, healthcare assistants told us they were able to complete comfort rounds and reposition patients at the frequency that was needed.

Despite the increase in staffing levels, we found on the majority of wards we visited that there was a reliance of bank (overtime) and agency staff to cover shifts, although some recruitment had begun. For example, the night cover for one ward had only one permanent nurse planned, and the remaining three positions – one nurse and two health care assistants – were bank or agency staff. Ward sisters told us they tried to use consistent bank or agency staff. Bank staff received a ward induction when they worked on a ward they were not previously familiar with. Bank staff told us they were managed by NHS Professionals and therefore their mandatory training, despite the changes at the trust, had remained up to date.

Medical cover

The level of consultant cover on each of the medical wards we visited was good, and medical staff reviewed their patients daily. However, we spoke with a number of junior doctors who told us that they felt they worked too many hours; they were too busy and, as a result, were under significant pressure. In addition, we found in some areas that, although medical cover was available, junior doctors were sometimes not experienced enough to provided appropriate cover when consultants were away.

Medical care (including older people's care)

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

We found some effective systems and processes in place to ensure patients received the care and treatment they needed. The majority of patients were admitted to a medical ward following a short stay on the Emergency Admission Unit (EAU)

During their time on the EAU, patients' needs were assessed to ensure they were transferred to the most appropriate area of the hospital where they could receive care that met their needs. Due to the hospital's problems with capacity and patient flow, we found patients could not always be admitted to the most appropriate specialist ward. However, medical staff oversaw the care patients on outlying wards received. For example, we found eight medical outliers on a surgical ward who received daily consultant input relevant to their area of medical need. We found that the EAU assessments accompanied patients to their long-stay ward so staff did not have to duplicate paperwork.

Information sharing/handovers

Across each of the wards we looked at there were effective systems in place for information sharing between staff, and from staff to patients. We observed a number of handovers which took place on wards, including the EAU and on elderly care wards. Handovers included consultants, junior doctors, nursing and therapy staff. Meetings were consultant-led and focused on whether or when patients might be fit for discharge and the steps needed to achieve this. We spoke to the specialist medical registrar about the arrangements for consultant cover at night and found that that an on-call system was in place where 11 different consultants covered areas of the hospital from home, including A&E, surgical and medical wards.

Stroke performance

Princess Royal is in the second quartile of performance in the latest Stroke Improvement National Audit Programme (SINAP), which means although they are performing below their London counterparts, nationally they are above average. In addition the trust was introducing the use of telemedicine so consultants could assess patients remotely to ensure decisions were not unduly delayed.

Consent/Mental Capacity Act

There were effective processes in place to ensure patients were provided with information and supported to make decisions about their treatment. Patients were consulted about their care at daily medical ward rounds. Staff told us that they asked patients for their consent before they assisted them with any intimate care and we saw examples of this happening. Nursing staff, including those on the dementia and elderly care wards, told us that consultants assessed patients' mental capacity if there were any doubts about patients making decisions for themselves, such as whether to receive specific treatment. Staff told us the hospital's social work team carried out assessments of a patient's capacity if a decision was required about ongoing care or discharge arrangements. Staff we spoke with were aware of the need to assume capacity and to make best-interest decisions on patient's behalf if their capacity was assessed to be lacking.

Staff support

Staff were appropriately supported, but had not all received an appropriate induction or ongoing training.

The majority of staff we spoke with, including junior doctors, nurses and healthcare assistants, told us they felt appropriately supported in their role, and most told us they felt comfortable to raise any concerns with their senior colleagues. However, we found that the majority of staff had not received an induction since the trust took over in October 2013, and mandatory staff training had not been implemented. We found that the lack of refresher training had impacted on care delivery and we heard one example of an ongoing legal case involving poor moving and handling practice by a member of care staff who had not received updated training. Ward staff we spoke with were not aware of when mandatory training might begin and the trust had not communicated any clear plans to staff to indicate when this might be.

Audits

Staff we spoke to on medical wards, including matrons and ward sisters, had limited information about their ward's performance in audits such as the NHS Safety Thermometer. The trust was unable to provide us with ward-specific audit performance data, which was due to problems prior to the acquisition. Although action is being taken, at the time of our inspection we were unable to establish how effective each ward was with auditing and learning from any identified issues.

Medical care (including older people's care)

Are medical care services caring?

Patient feedback

There was very little data available to inform us about patient experience but patients were generally positive about their experience.

We spoke to a total of 36 patients and three visitors across each of the acute medical wards we visited. The majority of patients we spoke with told us they were happy with the care they received, and most patients were happy with the staff who cared for them. Although most patients were happy, some we spoke with told us they were not always involved in how their care or treatment was planned, and others said they did not always receive regular information about their medical condition from doctors or nursing staff.

Observations of care

On each of the medical wards we visited we found patients were cared for by staff who were compassionate and attentive to patients' needs. Our observations of the care patients received were generally positive. For example, in order to avoid isolation and to promote social stimulation, staff on the dementia care wards created a lounge environment by the nurses' stations and invited patients and their families to sit and chat with each other in this area as opposed to by the bedside. The staff-to-patient interactions we witnessed were generally good and we found a relatively calm environment was created on the majority of wards.

Meal times

Patients were appropriately supported and their preferences respected during meal times. We asked patients about the food they received and their responses were mixed. Some patients enjoyed the food, and others did not. We found patients were able to make a choice at each meal time and appropriate options were available to patients with specific dietary or cultural needs. Our observations of one meal time found that patients were appropriately supported to eat their meals. The hospital operated a 'red-tray' policy to indicate how patients' meals should be prioritised and support given if needed.

Environment

Patients received care in a suitable environment which, in most cases, promoted their privacy and dignity. During our inspection we found patients received care in single-sex accommodation despite the pressure on beds. Staff we spoke with on some wards, for example the stroke wards or the EAU, told us that their accommodation needed to remain flexible and where possible where possible they tried to accommodate patients in single-sex bays. We found that patients received personal care behind closed doors or behind curtains in order to maintain their privacy and dignity. However, we found one privacy and dignity issue in the discharge lounge where one patient used a bottle to pass urine in front of other people without being offered a privacy screen.

Some wards did not have appropriate arrangements to accommodate bereaved family or friends in the event of a death. For example, during our visit to one ward, we were told that one patient had passed away several hours earlier. There were no bereavement facilities on the ward and the patient's family had to stand waiting in the corridor. Some wards had rooms which could be used for this purpose, but not all.

Patient information

Patients' preferences were respected. On some wards where patients had difficulty communicating, signs had been created by their bedside to inform staff how patients wished to be addressed by name. We found signs also communicated patients' needs – for example, one bed had a sign above it to inform people that the patient was blind. Other notices explained if patients were 'nil by mouth' or gave staff instructions on how to feed patients if they had swallowing difficulties. We found that patients on some wards were given information about who their consultant and staff nurse were in case they had any concerns they wished to raise.

Independence

Patients were encouraged to maintain their independence where possible and were supported to do this through physiotherapy and occupational therapy input. Some wards had their own physiotherapy rooms with specialist equipment to rehabilitate patients. Some patients told us that they were due to receive input following their discharge in order to ensure they were appropriately supported to prevent re-admission. This included some patients being discharged to a local intermediate care unit, and some elderly patients received support from the post-acute care enablement (PACE) team to ensure they fully recovered and to avoid re-admission.

Medical care (including older people's care)

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

Patient flow
The systems in place to manage patient flow through the hospital were not adequately responsive to patient's needs due to bed availability and delayed discharges. We found that most patients spent a short time on the EAU before being moved to a medical ward to ensure their needs were adequately assessed. Although some patients moved to a ward appropriate to their needs, some had to move to other wards due to the lack of beds available on specialist wards. For example, we found eight medical outlier patients on a surgical ward. The trust had opened a winter pressures ward for elderly patients, and this was at full capacity at the time of our inspection.

Discharge
Patients and staff consistently told us that delays with discharges were experienced primarily due to transport problems and difficulties obtaining take-home medication on time. Ward staff we spoke with told us that discharge planning usually began when patients started to show signs of improvement. We found discharge discussions took place at daily multidisciplinary ward meetings and included input from relevant staff, including therapy teams. However, ward staff told us about problems with booking transport and obtaining medication in time which meant patients sometimes had to stay on a ward longer than was necessary. This in turn meant that patients being admitted could not always go to a ward which specialised in their medical need. For example, staff told us that transport did not arrive at the time specified when it was booked, which meant staff did not always have time to arrange patients' medication before the transport arrived. Delays with transport were included in feedback from Bromley Healthwatch. Although the transport booking system had changed the week prior to our inspection, difficulties were still being encountered.

Ward staff also told us that they had difficulties when discharging patients who lived outside of the London Borough of Bromley. They told us this was because it was more difficult to obtain social services input from other boroughs. Patients who lived in the London Borough of Bromley received input from the hospital's own social work team if they needed social care services following their discharge. Patients and their visitors we spoke with told us that they had been involved in discharge planning and were invited to state their preferences.

Complaints
Patients were not always supported to make a complaint or to provide feedback about their experience at the hospital. On the medical wards we visited, we found limited information available to patients or visitors about how to make a complaint or provide feedback. Prior to our inspection we found that NHS Friends and Family test results showed extremely low response rates. Therefore, the trust had limited information on patients' experiences and were unable to identify areas of the service which might need improvement. We spoke to matrons and ward sisters about complaints that had been received and we found they had been involved in coordinating an investigation and responding to complaints. The majority of ward staff were unable to provide us with examples of improvements they had made in response to complaints. However, we heard two examples where nursing and care staff had met with complainants as a group to discuss specific cases and to hear each other's perceptions of the situation which lead to a complaint.

Are medical care services well-led?

Ward-based leadership
On the majority of medical wards we visited we found there was appropriate medical cover from consultants and good ward-based nurse leadership from matrons and sisters. On the majority of wards there were named consultants who oversaw the medical input of patients on the ward and any outliers on other wards. Consultants and nurse managers were knowledgeable about the area in which they worked and they were open and transparent about the difficulties their ward and the hospital faced. Each person we spoke with was optimistic about the future of the hospital since the trust had taken over in October 2013. Ward staff told us about some changes that had already been implemented by the trust, such as increased staffing levels on medical wards. Staff we spoke with, including nurses and healthcare assistants, told us they were happy with the management they received on the ward and they felt well supported.

Medical care (including older people's care)

Trust leadership

We found on each ward that leadership was visible and nurses wore uniforms appropriate to their grade so they could be identified. We spoke with the Head of Nursing and the Director of Nursing about their roles and their plans to implement improvements. The trust had a site management team in place, which was supported by the Deputy Director of Nursing. The Head of Nursing told us they received a good level of support, and matrons and ward sisters also told us they were well supported and able to raise concerns if they needed to. Senior staff knew about the areas on their wards that needed improvements and they felt they were getting some support from the trust to address these areas. For example, ward staff had been asked by the trust to provide an equipment 'wish list' to ensure wards had the equipment they needed, and some staff recruitment had been authorised.

Governance

On each of the medical wards we visited, we found appropriate governance arrangements were not in place to ensure that audits were completed, and learning from incidents, feedback and complaints were implemented. The majority of staff we spoke with told us that, although reporting of incidents was good, not all wards had received information about trends in incidents, and not all ward managers knew about how their ward had performed in recent audits. This meant that systems were not yet in place to ensure that where shortfalls were identified appropriate learning was taking place.

Surgery

Information about the service

Overview

The surgical division incorporates a range of services, including trauma and orthopaedics, urology, general surgery, gastrointestinal and gynaecological. There are 130 beds for surgical patients.

On the second floor in the north wing, there are six main operating theatres, including one theatre dedicated to treating emergency patients. Day surgery patients are treated in a separate unit external to the main hospital. They are assessed, operated on and discharged within a day. The day surgery unit has six operating theatres.

Day surgery patients are treated in a separate stand-alone building on the hospital site. They are assessed, operated on and discharged on the same day. The day surgery unit has six operating theatres.

Patients whose surgery requires hospital admission are cared for in the main hospital building. They visit the pre-assessment clinic currently based on Farnborough ward up to six weeks before their surgery.

On the day of surgery, patients come to the surgical admissions lounge on the second floor before going along to theatre for their operation. After the operation, patients are monitored in a recovery ward before being transferred to a ward or discharged home

Patients whose surgeries are unplanned are seen in A&E, and then taken to theatres. They are monitored in recovery before going to any ward in the hospital.

We spoke with 20 patients, three visitors and 32 staff, including senior and junior medical staff and nurses, pharmacists, physiotherapists, domestic staff and administration and clerical staff. We visited the pre-operative assessment clinic, surgical admissions unit, theatres, recovery, the day surgery unit, anaesthetic department and all the surgical wards. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed the performance of the service.

Summary of findings

Patients told us that they were satisfied with the care and treatment they received during all stages of their surgery. They praised the staff for being caring and kind.

The service was not responsive to all the needs of patients. Operations were often cancelled due to beds not being available. In the last three months, 142 operations had been cancelled. Sometimes patients who were well enough to leave hospital didn't because their discharge hadn't been planned.

The World Health Organisation (WHO) surgical safety check list was complete in all the notes we reviewed. Clinical governance structures were not embedded and there was no evidence that learning and improvements from incidents, complaints, audits and performance data. Performance data such as a 'dashboard' (a performance reporting and tracking system) was not shared with all staff or visitors to the hospital, therefore staff did not know about some aspects of their service – for example, the last time a person had a fall on their ward, or when a patient developed a pressure ulcer.

Surgery

Are surgery services safe?

Safe procedures

Staff in theatres used the WHO surgical safety checklist to ensure that patients had the necessary checks documented before, during and after surgery. We reviewed eight patients' medical records and found in all cases the WHO surgical safety checklists had been fully completed. This meant measures were in place to reduce the risk of patients having unsafe surgery.

Minimising risk

Some patients who required surgery could be at risk of developing deep vein thrombosis (DVT) due to their restricted or limited mobility. Data from Dr Foster Safety Indicators shows that the hospital had a higher-than-average number of patients developing a DVT after surgery. Nursing staff told us all patients were risk assessed for blood clots or venous thromboembolism (VTE). We looked at two nursing assessment records that were kept by the patients' beds and saw they had been risk assessed for VTE.

Pressure ulcers

The wards had processes in place for preventing pressure ulcers. We saw that every patient had their skin integrity monitored and recorded on a daily basis. Nursing staff told us they discussed any pressure ulcers during handover of nursing shifts twice a day and we saw this was recorded on their own notes. Staff were unclear when the last hospital-acquired pressure ulcer grade two or more had been reported in the surgical service, as there were no systems in place to share this information. For the last 12 months the hospital had been higher than the national average for all new pressure ulcers. In October 2013 the hospital recorded 4.22% of patients had new pressure ulcers, compared with the national average of 1.09%.

Infection prevention and control

Patients told us they thought the hospital was clean and they saw staff cleaning the floors. One patient had been an inpatient several times and told us, "It's always very clean". We saw that all clinical areas were visibly very clean and cleaning checks were carried out and recorded daily.

In general, staff adhered to infection prevention protocols. For example, in theatres, staff immediately challenged and explained the need for inspectors to wear personal protective equipment (known as 'scrubs') before entering theatres. However, some staff on some of the wards did not use the alcohol hand gel, were not bare below the elbow and wore jewellery. This meant there was a risk of spreading infections. The rates of avoidable infections methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C.diff) for the trust were low; however, information about instances of these infections in specific surgical services was not available, so staff were not aware of the infection control rates for the area they worked in.

The layout of the wards did not promote infection prevention as four wards (surgical wards 3, 5, 7 and 8) could only be accessed by walking through surgical wards 4 or 6. Posters were displayed to inform visitors to use the alcohol hand gel. However, we saw visitors and staff walking through these wards without washing their hands or using the available hand gel, increasing the risk of spreading infections.

There were not enough sinks for hand washing on the wards. We were told this had been identified as a risk and was on the risk register for the surgical service. However, we did not see this on the register provided to the inspection team.

Medicines management

We saw pharmacy staff attending to patients and discussing their medication needs. Patients told us they had discussed their medications and were aware of their purpose. Medicines were stored at the correct temperatures. On some wards, before and after surgery, pharmacy staff were available to ensure patients received their required medicine. However, we were told, and saw recorded, that sometimes medicines were not ready and this had delayed discharge for some patients. There was no effective system for completing in-patient drug charts for the elective surgical patients before surgery either in pre-operative assessment or in the surgical admissions unit.

Reporting and learning from incidents

Some staff reported that there had been an increase in reporting incidents as a new system had been introduced. Up until recently, senior nurses had oversight of incidents in their areas but there was no mechanism in place to cascade this information to staff. Some staff we spoke with had worked at the hospital for a number of years but could not recall reporting an incident or having feedback about incidents. The clinical governance meetings that were being started were intended to address this.

Surgery

On the day surgery unit, theatre lists which started late were reported as incidents. There was no evidence that any action had been taken to prevent this from happening. If the operations started late, patients who were scheduled later on the list were sometimes cancelled.

In September 2012, there was a cluster of seven serious untoward incidents reported for surgery. From talking with staff, it was unclear if the hospital had investigated further to find out the causes and to prevent them happening again. Since 1 October 2013, the trust was taking action on this matter.

Staffing

All patients we spoke with felt the hospital was well staffed, although they would like to spend more time with nurses. Patients were able to speak with staff when they needed with minimal delays.

Staffing arrangements enabled safe practice. On the day surgery unit, a matron post had been unfilled for a number of years. Since 1 October 2013, a matron had been in post and was providing leadership on the unit. Staff from the Denmark Hill site had transferred to the PRUH to ensure staffing levels were safe. Observations in theatre recovery showed adequate staffing levels to enable one to one care.

Staff felt there hadn't been safe staffing levels in the past but they managed by working extra hours. In October 2013, there was a high staff vacancy rate (16.2%) for the hospital. However, a system had been introduced to assess the staffing levels based on the needs of the patients, and senior nurses were completing this assessment daily. Recruitment had started and interviews for band 5 nurses and band 3 support workers had taken place and more were planned.

Record keeping

Staff on the day surgery unit and at pre-assessment reported they had no concerns with ensuring they kept patients' records. We saw that records were kept securely. Nursing records were kept separately at the end of the patient's bed and we saw nurses updating the records when care and treatment had been delivered.

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

Clinical management and guidelines

The national hip fracture database showed that the hospital was better than other hospitals for ensuring best practice for treating patients with hip fractures. One area for development was ensuring patients received orthopaedic care within four hours. Only 19.1% of patients requiring orthopaedic care were admitted to a dedicated ward. This is lower than the national average of 50.2%. There was a dedicated orthopaedic ward, but, because of the pressures on bed availability, not all orthopaedic patients were placed on this ward.

The pre-operative assessment for elective surgery was nurse led with one anaesthetist. A small nursing team worked closely together for the benefit of the patients. However if patients were assessed as being at high risk of complications, the patient notes were reviewed by an anaesthetist, and in some cases were contacted by phone by an anaesthetist, or reviewed in clinic on an ad hoc basis. The pre-op assessment nurses stated that they felt they ran an effective service as it was rare to cancel patients on the day of surgery due to a clinical reason.

Some specialities had clinical nurse specialists who provided continuity of care as they saw patients in follow-up clinics after they were discharged from hospital. There had been an increase in the number of clinical nurse specialists, ensuring the right expertise was accessible to patients.

Audit participation varied across the service but we were told that, due to the increase in staffing since 1 October 2013, more staff time was being freed up for identifying improvements to benefit patient outcomes

Consent

Patients we spoke with at different stages of their surgery told us that staff had checked they were ready to proceed and were well-informed to give consent. We checked the documentation for eight consent forms and found in all cases they were completed and signed by competent staff who were responsible for making the decisions about the care and treatment given. Appropriate arrangements were in place for patients who did not have the capacity to consent to surgery.

Surgery

Multidisciplinary working

Patients told us they interacted with a range of staff, including doctors, nurses, physiotherapists and domestic staff. We saw consultants leading ward rounds with junior doctors but these were not multidisciplinary because of the availability of other staff. Patients did not always receive a collaborative approach in their care and treatment.

We saw, and were told about, the good team working and strong support for each other within staff groups although lack of ward meetings may have contributed to the apparent lack of multidisciplinary working. In addition there was no clinical lead for clinical governance or infection control which hampered the start-up of clinical governance meetings.

Are surgery services caring?

Staff in surgical services were caring. We observed nursing staff interacting with patients in a kind and compassionate manner. All the nursing staff we spoke with demonstrated a commitment to providing care and treatment with kindness to all patients. There was limited data available about patient experience.

Patient experience

Many patients had a poor experience because they had their operations cancelled or postponed but they felt satisfied with the care and treatment they had received. One example from a patient was, "I wish my operation hadn't been cancelled so many times, but it's done now and I'm happy".

Patients reported that staff were attentive during the day and night. They described the staff as "lovely" and "marvellous".

All patients we spoke with told us they would recommend the service. Information about the NHS Friends and Family test was displayed, although it had a low response rate. Since 1 October 2014, the current trust has introduced its own survey, 'How are we doing?' The survey includes the Family and Friends test questions. The results of the October 2103 How are doing survey and the Family and Friends Test survey had been shared with staff. Senior staff told us they believed there had been positive results for November 2013. However, the results were unavailable when requested at the time of our inspection.

Patients and carers involved in their care and treatment

Patients and carers were involved in their care and treatment. We observed that staff made themselves understood and explained things in lay terms and checked that patients and relatives had no unanswered queries. When patients having planned surgery were initially referred to the hospital, it was identified at pre-assessment if they required an interpreter.

Patient dignity and respect

At the pre-assessment clinic, patients were assessed by a nurse in private rooms. We saw staff knocking on doors before entering and closing curtains when discussing care with patients on wards. We observed patients being escorted to theatres and being cared for in recovery. Staff treated them with kindness and ensured their dignity was protected.

Patients were cared for in single-sex bays. In the day surgery unit, children were cared for in a separate bay area to adults.

Food and drink

Patients we spoke with were satisfied with the food and drink. They were given a choice of meals in the morning to order their lunch and dinner. Staff were aware of who needed support during meal times as they were identified by a having their meals served on a red tray.

Wards attempted to protect meal times, allowing patients to enjoy their meals in peace while providing support to those who needed it. However, due to the layout of the wards, we saw that protecting meal times was difficult to enforce as patients needed to access other areas of the hospital by walking through the wards.

During pre-operative assessment, patients were informed when they must stop eating and drinking to enable their surgery to go ahead. We saw in recovery that staff assisted patients with sipping water as soon as they were ready. However, we were told of one incident where a patient who was admitted through A&E was not given any food or drink for 24 hours as their operation was moved to allow for more urgent patients. The patient was not informed.

Surgery

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

Surgery services were not responsive to patients' needs as planned operations were often cancelled. Some patients also experienced delays in leaving hospital.

Responding to patients' needs
Patients reported getting swift care that met their needs. We saw staff responding to patients and giving them the clinical attention they needed. Call bells were hardly used as staff were visible in the bays. However, a patient who had used the call bell reported that staff responded to her quickly. We saw patients with dementia had one-to-one care from a nursing assistant.

Pain management
Patients reported their pain management needs were attended too. If required they spent time talking with anaesthetists before their surgery to prepare them for managing their pain after surgery. One patient appreciated the anaesthetist being detailed about activities they should avoid post-surgery.

Theatres
Theatres were well managed. The theatre lists were planned according to patients' clinical needs. For example, at pre-assessment patients with diabetes were identified and placed first on the theatre list. Patients were collected from the surgical admissions lounge and taken to theatres. The surgical admission lounge had three rooms that were used to prepare patients for theatre. There were normally four theatres in use for planned patients. Therefore theatre staff had been using the recovery area for preparing patients for surgery.

Recovery
During our inspection, due to a lack of beds patients were admitted from the A&E department to recovery overnight. The recovery environment was not set up to be used as a ward and did not have ward facilities – for example, toilets, single-sex bays, access to food and drink. This also had an impact on preparing the recovery area for post-operative patients the following day. Recovery being used as a ward overnight impacted on getting recovery prepared for post-operative patients the following day and this led to cancellations of cases. However, patients told us they felt well looked after as there were plenty of staff caring for them

Leaving hospital
Doctors reviewed their patients daily to monitor their recovery and to ensure they were discharged when medically ready. During our inspection we spoke with two patients who were ready to leave hospital but there were delays with their discharge. Some of the common reasons for delays were: the right community support not being available; transport not being available; and medication not being ready. The post-acute enablement (PACE) team were responsible for ensuring patients had the right support. However, they only had the capacity to manage eight patients a day.

Out of hours care
There was sufficient cover from medical staff on call. For example, there was a critical care outreach team who were available for support with very unwell patients 24 hours a day, seven days a week. Staff we spoke with knew how to contact them and told us the team were responsive when needed.

Junior doctors felt supported by their consultants. Some nurses felt there could be more senior presence on the ward. However, some consultants' offices were based on the ward which enabled them to be more present.

Cancellations and postponements of elective operations
During our inspection, on the second day all elective operations were cancelled as there were no recovery or ward beds available for after surgery. Staff told us cancelling elective operations was common. In the last three months 142 operations had been cancelled, 48% of cancellations were due to beds not being available. We spoke with several patients who shared with us their distress and upset at having their operations cancelled in the days just before surgery or on the day of surgery. Being cancelled more than once was reported by a number of patients.

Concerns and complaints
Patients we spoke with were positive about the care and treatment they received once their operations had gone ahead. They were not intending to make any complaints and the majority praised the staff, in particular the nurses.

Surgery

One patient told us they had used the Patient Advice and Liaison Service and found it helpful. We saw on the day surgery unit that comments received by the service were promptly shared with staff and displayed in a public area. One patient told us, "I choose to come here as all the staff are great".

There was insufficient evidence that the hospital acted on concerns and complaints and learned from them. We asked for examples where the service had learned and improved following a complaint, and staff were not aware of any cases. Concerns and complaints were not discussed by all staff and the numbers of compliments and complaints were not displayed on the wards. On the day surgery unit, thank you cards and comments were displayed. From April to October 2013, the hospital had received 233 written complaints. Of these, around 33% (78) related to the surgery and anaesthetics service.

Are surgery services well-led?

Due to the recent changes in management, the leadership structure and managing quality and performance had not been embedded into services.

Leadership

Staff we spoke with felt that the recent changes in management had encouraged them that the service was going to be better-led. The majority of staff felt that the trust was listening to them and that changes to improve the quality of care for patients were going to happen. The majority were positive about the management changes that had occurred since October and many had seen changes already – for example, the increase in staffing.

Clinicians told us they felt the service was making decisions based on the quality of care for patients. For example, they felt that, although cancelling planned operations was disappointing, it was better than operating on patients and then not being able to care for them properly after the surgery.

The line management structures were unclear and work was ongoing to ensure one-to-ones and clinical supervisions were carried out regularly. All staff we spoke with told us they knew their matron and saw them visible on the wards. They would be happy to talk with their matrons directly while the line management structures were settling into place.

Managing quality and performance

Clinical governance meetings for discussing incidents, patient safety, performance, complaints and workforce issues were not being held until recently. This meant that not all levels of staffing were aware of their services' performance or important information about improving the service. It was unclear how information about the service was being escalated to management, as there was no process in place to enable this communication. Since 1 October 2013, processes were starting to be established.

Staff did not have access to quality performance data that are usually seen on reporting and tracking dashboards. There were no mechanisms in place to inform staff how well they were doing or to identify areas for improvement in delivering care.

Intensive/critical care

Information about the service

The critical care service at PRUH incorporates the critical care unit (CCU) providing general adult intensive care, the critical care outreach team and the critical care follow-up clinic. There are 10 beds in the CCU, seven arranged in an open-plan layout and three single cubicle rooms. Around 65% of patients come to the unit unplanned, for example, through the A&E department or from wards. There were 249 patients admitted from April to October 2013.

The critical care outreach team assists in the management of critically ill adult patients across the hospital.

We talked with two relatives and 11 staff, including nurses, doctors, pharmacists, consultants and managers over the course of our two-day inspection. We observed care and treatment and looked at medical records in CCU. We spoke with the critical care outreach team and staff who used their services. We reviewed performance information about the service.

Summary of findings

There were enough specialist staff to meet patients' needs and ensure they had appropriate 24-hour care and treatment.

Patients received care and treatment according to national guidelines. Patient diaries were completed so they could keep up to date with treatment and be involved in planning their recovery. The critical care service's performance is in line with other units across the country, with a similar, expected mortality rate. There was a clinical governance and performance monitoring framework in place and staff were kept involved through regular meetings and newsletters.

Patients and relatives reported a caring, supportive environment with information-sharing and input from families and patients so that care was holistic. Patients' feedback reflected this, with 100% saying staff were friendly.

The service was not responsive to patients' needs. There was a lack of available beds in the hospital which meant there was a risk of treatment being delayed and also that some patients could not leave the unit when they were well enough to do so due to lack of space on other wards.

The critical care service was well-led. Staff at all levels felt well supported and senior staff were visible on the unit.

Intensive/critical care

Are intensive/critical services safe?

Patient safety

The service and leadership were focused on safety and the individual needs of each patient. We observed a staff multidisciplinary team meeting with most staff present. Meetings were held twice daily for day and night staff, and staff reviewed falls, pressure ulcers, medication incidents, infection control, nurse staff levels, and management of patients' conditions. This gave staff an opportunity to look for ways to improve the patient experience together.

Incident reporting

Staff learned from reporting incidents. One recent example involved the unavailability of specific monitoring equipment. The incident was reported and quotes were being obtained to purchase or hire the equipment. In the meantime, staff were managing using alternative equipment.

Clinical governance meetings were held monthly. Meetings had multidisciplinary involvement and incidents were reviewed and discussed.

Hospital-acquired infections and hygiene

The most recent Intensive Care National Audit & Research Centre (ICNARC) data showed that the number of infections acquired while patients were on the CCU was very low. Patients and families told us the CCU was clean and staff were noted to wash their hands before touching patients. We observed staff wearing personal protective equipment such as gloves and aprons. Hand-washing facilities were available in each patient area. Visitors were encouraged to wash and gel their hands and staff were observed to follow recommended hygiene policy of being bare below the elbows in clinical areas.

Cleaning

Patients were cared for in a clean unit. The CCU was visibly clean on the days of our inspection. There was a dedicated member of staff on the unit who carried out all the cleaning duties. Nursing staff cleaned the beds and equipment between changeover of patients and daily as part of their infection control and prevention processes.

Meeting patients' care needs

Staff recorded patients' vital signs and care and treatment given in patients' electronic records at the bedside. All patients who were at risk of developing pressure ulcers had this documented. If a patient was high risk, a specialist mattress would be obtained. Recently a tissue viability nurse had been appointed and the CCU matron had found their input very useful to ensure that staff were meeting the needs of patients.

Staff were trained in managing pressure ulcers and all patients were turned every two to four hours to prevent the development of pressure ulcers. Data indicated that the number of hospital-acquired pressure ulcers was high. However, staff on the unit told us this was not representative of the unit.

Some policies and guidelines, for example, the resuscitation policy were out of date and needed to be reviewed. Staff were aware of, and were following, the old policy while new procedures were being developed. The equipment on the resuscitation trolley was checked daily to ensure it was in working order.

Staffing

Relatives were satisfied that there were enough staff to care for patients. The CCU provided one-to-one nursing or one nurse to two patients, depending on specific patient's needs. Each patient had a named nurse responsible for their care who was the main contact with family and friends. Bank (overtime) and agency staff were used on most shifts. However, recent recruitment meant they were being used less, helping to ensure that patients were cared for by a consistent staff group.

The CCU had a low vacancy rate and there had been a recent recruitment to posts, for example, band 5 nurses and a service manager.

The medical team was available 24 hours a day. Dedicated intensive care consultants were present in the day (six in total were employed by the hospital) plus one on call at night and at weekends. Junior doctors told us they were well supported.

Medical equipment

Each bed area had sufficient working equipment to safely meet the needs of patients. Senior nursing staff told us the medical physics team were responsible for the maintenance of medical equipment in CCU and provided a responsive service. Staff told us, and we saw first-hand, that they were trained and confident in using the equipment.

Intensive/critical care

The environment

The environment was safe for patients, staff and visitors. Access was by monitored admission only. There was a waiting room for visitors and separate private interview room that allowed discussions in private.

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

Clinical management and guidelines

Patients received care and treatment according to national guidelines and this was monitored. We discussed the audit programme which focused on quality improvement and developing better processes to ensure that patients were cared for in the most appropriate environment. It was hoped that the increase in staffing since 1 October 2013 would mean staff could focus on improving the quality of the service. One example was the patient diaries used in accordance with the National Institute for Clinical and Health Excellence (NICE). The diaries were completed for all patients by trained staff and patients' relatives in easy-to-read language.

Patient mortality

The threshold to get into the unit was higher than the national average; this could mean patients who might benefit from ICU are not being admitted. Delayed discharges would contribute to this. Once admitted to the unit outcomes were within the expected range. The ICNARC Case Mix Programme (an audit of patient outcomes from adult, general critical care units) reported a standardised mortality rate, similar to peer units across the country.

The unit was rated as having very good quality of complete data for the most recent ICNARC. Staff were engaged in taking part in the audit and presented the data regularly at clinical governance meetings where they also discussed areas for improvements.

Critical care outreach team

On discharge from the CCU, patients were supported by the critical care outreach team. Every patient who had been in CCU for more than 24 hours were visited by the team within four hours of their discharge.

Patients on the wards whose conditions deteriorated were provided with prompt care. All the nurses on the critical care outreach team had worked in intensive care areas. They helped staff to care for any other adult patients in the hospital. The team was nurse led and supported by anaesthetic and ICU trainees and consultants when requested and provided a 24-hour service. In conjunction with the primary medical team, they visited patients who were unwell, examined them, took observations and determined what the next actions should be.

The team also attended cardiac arrests in other clinical areas with specialist doctors and other nurses. All clinical staff had undertaken life support training appropriate for the role. Although cardiac arrest audit forms were completed, there was no evidence of formal reporting and collating of this information.

Are intensive/critical services caring?

Patients' and relatives' feedback

The unit's results from the NHS Friends and Family test from April 2013 to date showed that 100% (26 out of 26) patients found that staff were friendly. Patients' feedback was sometimes displayed on the unit and was always shared with staff in unit meetings and staff newsletters. One comment we saw stated, "All staff explained treatment, current and proposed, clearly and in a reassuring manner and were ready to answer any questions. Thank you."

Relatives told us they were well supported and cared for on the unit. Staff gave them an information leaflet and explained the contents. The leaflet also contained the Friends and Family questionnaire.

Patients' privacy and rights

We observed nurses, doctors and other health professionals caring for and treating patients in a kind and friendly way. Staff explained procedures, sought consent and provided reassurance. Patients were cared for in mixed-sex bays which is within national guidelines for this type of unit for patients requiring critical care. Privacy was maintained by the use of curtains around each bed space or in the three single rooms on the ward.

Food and drink

Nutrition and hydration were considered and provided for each patient, with daily support from a dietician. We saw that specialist foods were supplied to meet the individual needs of patients. Support was provided for patients who were unable to eat and drink while they were critically ill. Staff recorded patient's food and fluid intake.

Intensive/critical care

Follow-up clinic

The CCU follow-up clinic was available for patients to attend following their discharge. The clinic gave patients and their relatives an opportunity to discuss their experiences in CCU with a clinical nurse specialist. It provided therapeutic support to patients as they recovered from a critical illness.

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

(for example, to feedback?)

Admission to the CCU

Intensive care national audit and research centre (ICNARC) data showed that 10% of admissions to critical care were patients who had received cardiopulmonary resuscitation (CPR), which is higher than other hospitals. This meant that patients had to experience a significant deterioration in their condition, or have a higher illness severity than similar units before they were admitted to the CCU. The same data also showed that it was difficult to admit patients to the CCU due to the pressure on beds available, and delayed discharges back to the wards

Bed occupancy

The average bed occupancy from April to October 2013 was 80.9%. This is lower than the national average of 83%, indicating that occupancy levels did not affect the quality of care provided. Staff told us they were protective of beds to ensure availability for patients who needed them.

Leaving the CCU

Due to the lack of available beds on the wards, staff told us there were, at times, patients in the CCU who were well enough to be cared for on a ward. For example, in July 2013 there was a patient on CCU "for months" and a bed could not be located on the wards because of the patient's high nursing needs. From April 2012 to April 2013, 237 CCU bed days were used for patients medically fit to be cared for on inpatient wards. The ICNARC data also showed about 12% of discharges were made out of hours when there was risk that the right ongoing support was not in place. About 9% were reported as early discharges when patients were not deemed well enough to leave the CCU.

Since 1 October 2013, staff at all levels reported they had seen improvements in the management of beds. For example, the matron attended the daily meetings to discuss beds and updated and circulated reports on bed availability three times a day. Staff we spoke with recognised that a robust action plan for bed management throughout the hospital was required to ensure that patients were cared for in the most appropriate clinical environment.

Patient feedback

Patients' feedback was requested when they were well enough. An opportunity was also provided for reflection at the follow-up clinic. Patient experience information, complaints and compliments were reviewed and discussed at the weekly unit meetings.

We saw that patients and relatives had written to the unit with thanks following their discharge.

Complaints

There was a process for review and investigation of complaints in the unit. We heard that these were reviewed at the weekly unit meetings. There had been two complaints about the service in the last year. They related to patient movement within the hospital and were not specific to the CCU. Patients were informed about how to contact the Patient Advice and Liaison Service.

Are intensive/critical services well-led?

Leadership

The critical care service was well-led. Junior staff felt well supported and matrons and consultants were visible on the unit. We saw the daily running of the unit over two days with the nurse in charge and consultants working well together to promote safe, good quality care and treatment for all current patients, as well as prospective and past patients.

Culture

We spent time on the unit and saw good working relationships. Staff understood their roles and interacted with different staff groups to ensure they met the needs of their patients.

Managing quality and performance

The service monitored the safety and quality of care and action was taken to address identified concerns at weekly and monthly meetings. There were links with external services so that benchmarking with peer units was undertaken. There was a designated member of staff who led on carrying out audits.

Intensive/critical care

Support for staff

Staff reported good support in ensuring they were equipped to carry out their roles. Practice development nurses had recently been employed to provide practical support and training.

Maternity and family planning

Information about the service

We inspected the maternity services for the trust at the PRUH. The services comprised an early pregnancy diagnosis unit, antenatal outpatients, a day assessment centre, combined antenatal and postnatal ward of 30 beds, the Oasis birthing centre, and delivery theatres.

Summary of findings

We talked with 11 women and three family members. We also spoke with 25 members of staff, including matrons, midwives, doctors, student midwives, a clinical nurse specialist, catering staff, nursery nurses, senior managers and support staff. We visited the early pregnancy diagnosis unit, antenatal outpatients and the day assessment unit. We also visited the antenatal/ postnatal ward, the delivery suite and the Oasis birthing centre. We looked at treatment and care records and reviewed documentation that was provided to us by the trust.

We found that improvements were required in relation to the five areas we assessed. Although patients found that, generally, staff were caring and communicated well, there were times when they were not responsive to women's needs regarding medicines, pain management, explanations of conditions and meal provision.

The maternity areas were clean and safe and had good security measures in place to protect women and their babies. Some parts of the service did not enable privacy and respect for confidentiality to be fully addressed by staff because of the area design. Equipment was generally readily available, although there were shortages at times. Some checking processes had not been carried out as routine, and therefore some equipment may not have been safe to use.

Most of the women we spoke to told us they had had a positive experience and felt confident in the midwifery and medical staff who cared for them. However, some felt that staff were sometimes under pressure, particularly on the antenatal/postnatal ward.

Staffing levels had been increased, but there were insufficient staff with supervisory skills and expertise to support midwives as well as insufficient staff for the ratio of births to midwives. Staff could not tell us what the current ratio had improved to. Staff did not always have access to training, because there was not enough staff cover, and also because current procedures did not always identify when it was necessary to attend training.

Maternity and family planning

The governance arrangements had not been fully communicated to all staffing levels and therefore staff did not always get information about or learn from incidents and complaints. Risk registers did not identify the actions to be taken with time lines or designated persons responsible. It was not known if some identified risks had been resolved or when they were likely to be.

Are maternity and family planning services safe?

We found, overall, that the safety of women using the maternity services required improvements.

Staffing

The midwife to birth ratio was 1:38 and this is low when compared to what it should be, which is 1:28.

Staff told us the early pregnancy diagnostic unit was busy, seeing 12 to 14 women a day and was staffed by only one clinical person and a receptionist. This meant that staff could not be freed up to attend training and we were told that staff had not completed any mandatory training for some years. Within the outpatient antenatal clinic, teams reported being short-staffed and they felt there was a risk that mistakes could be made, as staff had to complete the detailed referral role while dealing with patients attending the clinics and answering the telephone.

Staff told us that the service was midwifery-led, but that medical help could be requested as needed, although it was harder to get at weekends. They said, “We can contact consultants on their mobile and they are willing to give advice”. Staffing levels were said to be based on two midwives running the service from 8:30am to 4.30pm, Monday to Friday and 9am until 2pm on a Saturday. Staffing was said to be generally good, although staff from the antenatal clinic had been called in on rare occasions.

Staffing arrangements in the Oasis birthing centre were based on one-to-one care during delivery. Core staff from the hospital and community midwives were on duty each shift. Occasionally, staff said that they would need to call in extra community midwifes if four women were in labour at the same time. Midwifery staff said that obstetric staff were not always readily available, as they were often busy with elective surgical lists. We saw that there were sufficient staff on duty to meet the needs of the women on the unit and that midwives were supported by healthcare workers who had undertaken, or were in the process of completing, additional training for their extended roles.

A midwife on the antenatal/postnatal ward commented that staffing had improved more recently, with newly qualified midwives and more senior staff now working at the hospital. Four midwives were now on duty, with a ward

manager not counted in the staffing numbers. New staff were said to be supported through mentoring and supervision, as well as formal and local induction, and a period of not being counted in the numbers of core staff.

On the delivery suite, staff reported that there was greater use of agency staff but that as far as possible they tried to have a higher number of contracted staff on each shift. Student midwives were also on duty, but were not counted in the numbers. Students were assigned a mentor and were supervised. The use of a daily capacity sheet enabled staff to be informed of activity in the whole maternity unit. A midwife told us that it was a busy area and that, at times, they were short-staffed, although four new staff had started recently.

Records

Two out of the six medical records in the maternity outpatients department did not have information about allergies adequately recorded on the front cover of the file. We asked a midwife, who told us that it was an omission. One patient at the same clinic told us that the doctor or the midwife they saw did not fully complete all entries in their maternity book. This meant that patients were at risk of receiving inappropriate care because not all of the medical records kept were up to date and fit for purpose.

Risk

Three risk registers for maternity services were provided to us for the periods August, October and November 2013. We saw that these identified the risk by title, with an initial risk rating score and a description of the concern. The August register identified that there were vacancies of 13.5 whole-time equivalent midwives. In November, we saw that 18 midwives had been recruited, and 28 midwives had planned maternity leave, although it was not clear if they were all for the PRUH. Although it was recorded that this would challenge the service, there was no detail about how this would be addressed.

The risk register recorded a concern that the maternity theatre at the Princess Royal University Hospital was staffed by midwives. The national recommendations were that midwives should not scrub for caesarean deliveries. We could not see any information on the risk register to indicate what measures would be used to resolve this issue. Midwives were on the rota for elective caesarean section deliveries and the midwives from the delivery suite when it was an emergency in the second theatre. We were told that the hospital was intending to recruit theatre staff to take over the elective theatre sessions but they were unsure of how the recruitment was progressing. When we interviewed the Director of Nursing she confirmed they would be recruiting theatre staff.

Staff told us that there were nine consultants available weekdays, working 8am until 8pm and two working on weekends but only between 9am and 1pm. On-call consultant support was available after 8pm. Elective caesarean births took place Monday to Thursday, with three per day in a dedicated theatre.

Safeguarding

Records reviewed on the antenatal/postnatal ward showed that arrangements were in place to safeguard vulnerable babies. Staff were knowledgeable about the safeguarding process and we heard discussions taking place about arrangements for one individual. Staff told us about the Safeguarding Lead and said that there were monthly safeguarding meetings that worked well. In relation to mental capacity assessments, the Safeguarding Lead arranged any required meetings and shared information with the relevant staff who needed to know. Information was recorded in the notes within what was described as a 'ghost' file. This was a file that was not taken out of the hospital.

Equipment

Staff were aware on the day assessment unit that there were higher numbers of obese women attending for their pregnancy and that more suitable equipment was required, such as couches. Despite this, they said they were not limited by the available resources and they were able to purchase items to get their job done safely.

On the antenatal/postnatal ward, we found that some of the required checks had not been carried out. For example, bedside checks of oxygen, suction and call bells had not been completed for 2–3 December. A kit used for managing an emergency situation called post-partum haemorrhage had not been checked for a number of dates in November, although checks had been completed for the days of December up to our visit. Similarly, we saw that the pre-eclampsia (a medical condition where the blood pressure is high and there is protein in the urine, which can lead to seizures if untreated) equipment had not been regularly checked and it was not known if the kit was ready for use. We saw that emergency resuscitation defibrillators had

been checked and that emergency drug kits used for allergic reactions were in date. Weighing equipment had been labelled as needing re-calibration in 2012 and it was not clear if this had been carried out.

Equipment in the Oasis birthing centre, including resuscitation equipment used for the care of babies after delivery, had been checked each day in accordance with the department's requirements.

Risk management and safety

Staff on the day assessment unit told us about the risk assessment that could be used for pregnancies as well as other patient needs, including assessments about the environment and looking after women who were obese. Staff had not had recent risk assessment training and they were not sure if junior staff undertook this as part of their development. They were aware of the reporting process for incidents and said that the system for doing so was easy to use, making it accessible to all staff. Risk assessment meetings took place weekly and these were attended by all levels of staff, with general feedback received at supervisor team meetings.

We were told about the cardiac procedure and emergency obstetric alarm system for women who were unwell. Staff said that any concern could be referred to the labour ward from the day assessment unit.

Staff on the antenatal/postnatal ward were aware of the reporting systems for incidents and adverse events. They explained how they used an early warning system to monitor the condition of mothers and their babies but we did not see any forms in the notes we reviewed. In addition they assessed risks such as the chances of developing a blood clot. When we looked at patient records for this ward, we saw that the risk assessments had not always been completed. For example, one woman who had been treated for a blood clot did not have the risk assessment completed on admission. This person may not have been managed in accordance with recommended practices and therefore, their safety could have been compromised.

Midwifery staff told us that there was a strict referral criteria for the Oasis birthing centre and that staff had to balance choice with safety. A midwife on the antenatal/postnatal ward explained that high-risk women came to the ward before and after delivery but that low-risk women could go to the Oasis birthing centre. This included those women who were likely to be discharged early after their baby's delivery. The midwife said an early warning tool was used to ensure the safety of women and their babies.

The key performance indicators for October 2013 in respect to risk management did not include information about reported data for serious incidents and complaints. We were unable to ascertain if there had been any incidents during the month, although we could see data for July, August and September.

Doctors told us that they had monthly peri-natal meetings as part of a multidisciplinary group and there were separate meetings for Audit and Risk Staff were not generally aware of the governance arrangements in the hospital and that there was no quality dashboard in use in maternity. Staff seemed aware of the complaints process and said they would be involved in the investigation if the complaint related to their own actions.

The service has had one Never Event – a serious, largely preventable patient safety incident – where a lady had a swab retained in her abdomen following caesarean section. Staff we asked were not aware of this and had not received any information about the event, the investigative process or any required actions to avoid a similar event happening in the future.

Infection prevention and control

All clinical areas, including the outpatients, Oasis birthing centre, maternity wards and theatres were suitably clean and maintained. This was confirmed by women who had been using the ward. One person said, "The hospital is clean and tidy". There were designated domestic personnel to undertake cleaning duties in accordance with a schedule. Equipment used for cleaning followed the national colour-coded recommendations for minimising cross-contamination. We noted that equipment used for monitoring the health and wellbeing of women and babies was cleaned by staff in between use. Equipment in the day assessment unit was noted to be clean, as were clinical areas and bed spaces.

Staff had access to personal protective equipment, including gloves and aprons in all the areas we visited. Theatre staff had special clothing and protective equipment designed to minimise risks during the delivery of babies. There was access to hand-washing facilities in all areas where care was provided. Hand sanitisers were

provided in some areas on the ward, although these were not available outside of all the rooms used by women pre and post delivery. Signage for promoting hand hygiene was not visible in all areas and we were told by women who used the service that they saw medical and nursing staff put gloves on but not always wash their hands.

On the day assessment area, the hand sanitiser was provided on a table near the entrance but this was not prominent and, therefore, was not used by any of the women we saw attending. Staff were seen washing their hands in accordance with best practice guidance in this area. Hand sanitisers, hand-washing and drying resources were available in consultation rooms in the assessment unit and in the antenatal clinic.

The immediate bed areas on the wards and in the day assessment unit and Oasis birthing centre were enclosed by fabric curtains and it was not known when, or how often, these were changed. Although, the staff told us said they were changed regularly. The hospital produced an environmental technical audit report, which included checks by estates, nursing and cleaning personnel. Information recorded from this assessment included equipment cleanliness and curtain checks. For April 2013, the achievement rate overall was reported to be 93% and 98% for 27 June 2013 but, we noted that checks on the curtains had not been reported for both these dates. Where action was required, this was assigned to the relevant department to be addressed. Similar environmental audits were carried out in the special care baby unit (SCBU) and we saw 98% compliance for 5 September 2013.

In the day assessment unit there was a lead for infection prevention and control and also a link person in the delivery suite. They said that hand-wash audits had been carried out as well as spot checks about the dress code, use of cleaning equipment and follow-up of cleaning protocols. We were told that infection prevention and control training was annual and staff would be followed up to ensure they attended. We did not see any detailed information to confirm this as we were told that training records were not sufficiently detailed on the current electronic system.

People who spoke with us in the Oasis birthing centre commented on the cleanliness of the environment, with comments expressed such as, "Everything is spotless". Clinical and domestic waste was managed safely and that sharps bins were available in all areas we inspected.

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

Care and treatment

One woman attending the day assessment unit said that staff, "Communicate effectively and I don't have to tell them the same information over again". They added, "It is good that they seem in control and update one another. They really make an effort to keep the next person looking after me informed. I am definitely involved in discussions and they explain options and are supportive". This same person also commented on their recent admission to the antenatal ward and said, "Felt like I was a small component in what was going on. Staff seemed confused and didn't know what was going on".

Information was available to support new mothers, such as breastfeeding noticeboards, and there was a complaints process. Staff said that women were seen by doctors during each ward round. Staff tried to make sure antenatal and postnatal women were separated out in the ward. Postnatal women had access to the support of the infant feeding coordinator.

In the six treatment and care records we looked at on the ante/postnatal ward we found that notes were not always completed fully and in accordance with the hospital's policy (provided via intranet). For example, there was an absence of information recorded about why monitoring babies' heart rate had been stopped, and by whom. Risk assessments, such as those related to pressure ulcers, had not been completed, even though this was required. Neonatal records were not always filled in and information about transfers to the postnatal ward had not been completed. Timings for skin suturing was not always recorded and so it was not known if the patient had waited an overly long time for this to be done. It was not always possible to clearly read names and signatures of doctors and midwives and doctors were not always recording their general medical council number for their entries.

We found that one person's notes were misplaced inside another person's 'ghost' notes, and there were no main hospital notes on the ward for one person. Staff told us that, when a woman was admitted to the antenatal ward and then discharged, all their notes, including cardiotocographs (recordings of the fetal heart rate and

uterine contractions-CTGs), were sent home with them. A summary letter related to their admission was placed in the 'ghost' file. Notes were seen to be easily accessible at times, with lack of attention by staff to their storage and confidentiality.

Waiting times

Information provided to us showed that 82.99% of women had their first antenatal booking appointment by 12 weeks plus 6 days gestation, which is line with the national recommendation.

Discharge planning

A support worker told that they would go through discharge planning information with patients. Pre-discharge checks, such as blood pressure, would be carried out, and there would be a discharge talk, with information about registering a baby's birth, and midwife visits. In-depth discussion was held usually in a group, where this enabled questions to be raised. Breastfeeding was discussed by the specialist. A discharge information pack was given to each person, including breastfeeding information, contact numbers and leaflets about screening. This pack was not available in other languages, which meant that some people may not have had access to all the available information.

Midwifery supervision

Midwifery staff in various areas told us that they needed more staff to be trained as supervisors but that this was a long process involving selection and training which could take a year. One staff member said that three candidates had been identified and, "The trust are supportive of this". They also said that a new consultant midwife was being inducted and that this person was a supervisor too. The ratio of midwives to supervisors was 1:32 but this was reduced to 1:20 when using supervisors of midwives from other hospitals that are part of the current trust. The national recommendation is 1:15.

Monitoring performance

There were key performance indicators (KPIs) for maternity services at the hospital, which used a traffic light system with green for 'on target', amber for 'potential problems' and red for 'action required'. We reviewed the KPIs for October 2013 and found that, in relation to quality, there were actions required with regard to the percentages of normal vaginal deliveries. For example, the target was to have more than 65% of births by normal delivery, but the year to date showed that the level achieved was at 57.3%. The total caesarean section rate was set as less than or equal to 24%, although October's figures indicated they were at 29.2%. Emergency caesarean section rates were on target, achieving 16.5% against a target of 17% or less. The indicators did not identify any targets in relation to pain management and we could not see if there had been any complaints or issues communicated by women about their pain management.

Audit

The hospital was participating in the audit by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK).

Are maternity and family planning services caring?

Overall, we found that people's care needs were not always met and there were areas for improvement related to pain management and medicines.

Involvement of women

We spoke with three new mothers and two fathers in the Oasis birthing centre. They informed us that they had been involved in decision-making processes and given choices about the birth of their babies. People who spoke to us praised the level of treatment and care, as well as the staff who had looked after them. New mothers said the level of support for breastfeeding was very good. They told us that the midwives helped them and provided reassurance and encouragement.

Care records and birthing plans for women who were on the Oasis birthing centre contained details of all aspects of the pre-birth arrangements up to the aftercare of the newborn infant. Information showed the full involvement of the mothers and that their choices and preferences had been fully considered and acted on as far as possible.

We heard mixed views from women about their experience. One woman who had been admitted to the maternity ward from A&E said she had not been given an explanation by anyone as they were all busy. She said that the staff were very kind and dedicated." With regard to maternity care, the woman said she had been fully involved in planning her baby's delivery. On medication management, we were told that one dose of antibiotics was given two hours late and, as for pain relief, "You get these when they are ready".

Maternity and family planning

Another woman told us that their experience had been very good and their complex history meant that they elected for a caesarean section. They said they "had excellent care and continuity of care, from the consultant in particular". She said the consultant kept her informed and explained things fully so she could understand. Family present also spoke highly of the care and treatment. We also reviewed positive feedback received via email, in which comments were expressed about individual midwives and the medical staff.

We received more positive comments from two other women and generally midwives were reported to be good at communicating and women felt they received good cared especially from doctors.

Food services

One woman said she had been newly diagnosed as having gestational diabetes and that she didn't know what she could or couldn't eat. This person said she did not get any advice or information from staff and told us, "It would help to have information. I got nothing and had to 'Google' and use the internet". She added that she had missed an appointment with the dietician and was expected to know what to choose from the food trolley.

Staff said that, in the evenings, catering staff went around the ward and identified food requests. We were informed that there were challenges at breakfast where only cereal, bread and jam was available, a selection which was not necessarily suitable for diabetics. Discussion with three women confirmed the limitations of breakfast choices.

Discussion with staff provided different opinions of being able to meet the cultural dietary needs of women. Clinical staff reported that cultural meals were readily available, whereas catering staff said it often took several hours to arrange Halal meals. Catering staff told us that they expected midwifery staff to inform them if any mothers required a special diet. They also said the choice of food on the wards was not as good or as fresh and they often ran out of "favourite" things.

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

We found that there were aspects of the service that did not demonstrate responsiveness to people's needs and so require improvement.

Accessibility

Staff told us that 3,800 women were seen in the early pregnancy diagnosis unit last year and that, because of this high activity level, women could wait for hours to be seen. Staff said the situation would be improved by having another doctor on the unit. It was very difficult to get a translator at short notice and that, in general, they asked women to bring someone with them or they had to book a translator which could mean waiting for a couple of days.

People told us that, by 8.30am, the car park was often full. The antenatal clinic was based in the outpatient area of the hospital. Staff told us that letters asking women to attend the clinic gave incorrect details for the entrance to the department, which meant that women were often late or got lost. There was poor signage directing people to the antenatal service.

One woman admitted for a planned induction said there had been good communications between the consultant, her GP and midwife. However, communications were not as good between different doctors in the hospital. For example, conflicting information had been given with regard to medicines management. She said her partner "was encouraged to be involved". The delivery process had been explained and she felt prepared.

Confidentiality

The antenatal clinic was found to be very small with a lack of space to ensure confidential discussions. We observed that polite interactions took place with women coming to the desk and on the phone, although we could hear the conversations from the very small waiting area.

In the day assessment unit, the bay area was designed with only fabric curtains in between for privacy and, while staff spoke quietly to people their confidentiality could not be guaranteed. In the day assessment unit, a list of names of women attending for blood tests was left on a table for each person to tick off as they arrived. This did not promote confidentiality or privacy. One woman said she needed to have a bigger room as the facilities were not well-designed. She said, "They do well despite this to keep privacy and make sure I feel comfortable".

We heard conversations taking place in the bay area in the Oasis birthing centre, as a result of the cramped area, despite curtains being closed for privacy.

Maternity and family planning

Environment

The outpatient antenatal clinic environment was small with a capacity that often meant high activity levels. The waiting area was small with only 15 chairs, so if a partner or children accompanied someone they may not have had anywhere to sit as it became crowded. There was a limited range of toys available to help distract children.

The Oasis birthing centre had been designed to enable low-risk deliveries to take place in a choice of rooms. This included water births in one of the three available pools. Delivery rooms were spacious and included suitable facilities for relaxation and movement around the room during labour. We saw that additional freestanding heating had been put in place in rooms which were at the far end of the unit but, despite this, these rooms were not very warm. After delivery, new mothers went either to the bay area or a single room. The four-bed bay area was cramped and there was little room to manoeuvre around the bed. There was limited seating for partners or visitors, especially if the new mother was using the arm chair.

On the Oasis birthing centre that people had access to a wide choice of food from a menu, including choices for those who had cultural or medical dietary needs, which was in contrast to maternity and SCBU. One woman on the SCBU said that, by the time she got her lunch, only salad and a baked potato was available.

Complaints

We reviewed the number of reported complaints for outpatient maternity services and saw six identified. These related to a delay in outpatient or cancellation, the attitude of staff, clinical care and communications. There had been 17 complaints made in regard to maternity and obstetrics, of which 11 related to aspects of clinical care, two about the attitude of staff, three about communication and one about discharge or admission arrangements. We did not see the finer detail of these matters or the investigative process or if action was required to minimise further complaints.

Are maternity and family planning services well-led?

While improvements had been made and staff felt that leadership was visible and present, there were areas that required improvement in relation to the support of staff, supervision, and governance. We found that governance arrangements were not fully embedded at all levels of the service.

Leadership

Comments from staff included “different feeling to previous mergers.” One staff member said, “It has been a more pleasant process and I have been asked my opinion”. They said that they were not aware of any specific audits and no recent questionnaires had been given out. They were aware of the NHS Friends and Family survey but said it was too early for any feedback. However, measuring the quality of care was part of the day-to-day role.

Staff in the Oasis birthing centre said they felt very well supported by managers and that they had more power to request resources since the changes in leadership. Midwifery staff said they could go to the Matron for support but they were also looking forward to having a consultant midwife. Staff told us that there was what they termed a ‘Just 5’ informative communication session each day and that this was used to cascade information, such as outcomes of investigations or changes in practice.

Doctors commented positively on the merger, with one saying that it was making a positive difference and that the hospital was moving forward. Consultants were said to be approachable but were not always present on the labour ward, which prevented teaching, particularly for caesarean sections. This would improve safety and compliance with the Royal College of Obstetricians and Gynaecologists guidelines and also improve training opportunities for junior doctors.

Staff on the delivery ward said that there was good team work and morale was “OK”, although at busy times this could be affected. They felt positive areas were the staff’s ability to deal with emergencies, the open culture and encouragement to discuss or raise concerns, and the debriefing after unexpected events, such as a still birth.

Training and development

Doctors told us they had access to teaching sessions which were held on a Friday. They had an educational supervisor and also participated in a clinical teaching group once per week. These sessions were said to be multidisciplinary but staff reported that midwives did not always attend or know how to arrange to attend. Discussion with the lead for training informed us that doctors and all other staff were

expected to go through induction and undertake mandatory training. We were told that the current system for recording training was not able to identify exactly what sessions had been attended by staff as part of mandatory training but that a new system was in development. It was not known if all staff were up to date with their required training, although some staff had a formal record that they managed in respect to recording training attended or planned.

Midwifery staff spoke about some of the new training that had become available, such as blood transfusion training. Support staff said they had been enabled to complete external training and that, while previously agreed courses had been cancelled, they were being supported to undertake a diploma related to their role. Senior staff told us that they had access to a leadership day for band 7 and 8 personnel and this was part of team building. Some staff said they had supervision but not all staff we spoke with had their performance formally reviewed.

Governance and quality assurance

Midwifery staff told us about the various governance and risk management meetings that were held for maternity services. This included peri-natal mortality meetings, which were said to be held monthly and provided an opportunity to discuss issues, such as the re-admission of a baby, with representatives from obstetrics, paediatrics, midwives and students. There were also weekly risk meetings and incident review meetings. When we reviewed the trust's Maternity Service Clinical Governance and Risk Management Strategy dated 6 August 2013, we saw that these meetings reflected what was outlined in the document. The strategy was detailed and included information about various aspects of the trust's approach to governance and risk management. However, as there was no reference to the PRUH, we were not able to confirm how the strategy applied to the hospital.

Services for children & young people

Information about the service

Princess Royal University Hospital provides Children's services which includes a dedicated A&E facility, a special care baby unit (SCBU) with capacity for 12 newborn babies delivered at 30 weeks and above. The hospital also provides surgical and medical treatment for children and young people up to the age of 16 years. There are 18 inpatient beds on the single children's ward, of which only 12 were currently staffed. Outpatient services are provided at a separate location.

We spoke with children and parents while visiting the children's ward, and spoke with parents on the SCBU. We made observations in areas where children and newborns received treatment and care, and spoke with members of staff. We also reviewed medical records and care plans.

Summary of findings

Overall, children who were admitted to the ward received good care and on the SCBU in environments that were suitably designed and laid out to support the various needs of children, neonates (those less than four weeks old) and infants. However, a lack of nursing staff trained to care for children requiring high dependency care meant that children arriving in the A&E who were very unwell had to be kept in the A&E until transferred to another hospital or kept in the A&E if deemed safer to do so than transferred to a ward. Sometimes children could not be admitted to the children's ward as staffing levels were not sufficient to open additional beds. This meant they had to be transferred to another hospital. On occasions, children had to wait in the A&E department for ward beds to become available. Staffing levels were improving but more nurses, including those with high dependency skills, were required.

Planning for elective procedures is disjointed and communication between surgeons and paediatricians is not clear. There was no process for planning elective surgical lists by taking into account bed availability and we were told that as a result, children's surgery was sometimes cancelled on the day.

Staff were enthusiastic about their roles and enjoyed working as a team, with good communication and support from one another. Children and their parents on the children's ward were generally happy about their experiences, although sometimes children were not always involved in decisions about their care, which included the consent process. Staff used various risk assessments to ensure that children were cared for safely. Arrangements were in place to safeguard vulnerable children.

Infection prevention and control practices were in place and all areas where children and babies received care were clean, as was the equipment used for their treatment and care. Staff, overall, followed best practice guidelines for hand washing, though on occasion, support staff needed to be prompted to wash their hands after coughing and sneezing into them when transferring a child to theatre.

Services for children & young people

Staff on the ward said new equipment had been purchased but there could be insufficient equipment available when children were being nursed in isolation. This meant staff spent time undertaking additional cleaning so that items could be shared.

Equipment on the SCBU was in good working order and was sufficient to meet the care and support needs of neonates and infants.

Are services for children & young people safe?

The staffing skills and expertise within the children's ward meant that it was not always possible to care for children who required high dependency on the ward and they had to be transferred to another hospital.

Staffing

At the time of our visit to the children's ward, 12 beds were being cared for by the staff from the ward and two beds were being used for children who needed allergy tests and so were looked after by a separate allergy specialist nurse. The number of staff on duty determined the number of beds that were open and this was reviewed on a daily basis.

The ward was increasing staffing levels, with the aim of being able to support the use of 15 of the available beds. Some recruitment had already taken place and further interviews had been arranged. Staff said the ward had improved since a change in leadership and increased staffing levels. Comments included, "It's brilliant having a matron".

The ward sometimes used regular agency staff to supplement staff. The staffing levels aimed to have paediatric qualified staff always but, on occasions, staff had neonatal intensive care unit qualifications or were midwives.

Staff said there were enough doctors, although more were at junior level. Despite this, staff said the consultants were very visible and available to provide advice, support and treatment. One comment made by a doctor in relation to the availability of medical support was, "[There is] good support, I am very happy" and, "There is always someone available".

We saw a number of doctors undertaking ward rounds and that busy nursing staff were able to participate in these as needed while attending to the care needs of children on the ward. There were separate staff available to support children's play and education. Relatives told us the play therapist provided activities for their children and that they saw the doctor every day. Positive comments made by parents included, "I couldn't ask for better staff" and, "The staff here are brilliant".

Services for children & young people

Staff told us they had a formal induction to the service, as well as to the ward. A local induction record had been developed for use by temporary or agency staff. We asked for mandatory training records and were advised that the system for recording training did not necessarily identify all the areas that had been covered by staff but, that the system was being updated. A member of staff said they had opportunities for supervision and discussion with their line manager, although they had not had their performance formally reviewed.

Children's safety

Staff used a range of risk assessments and management tools, such as for cot sides and bed rails to identify and minimise adverse events from occurring. An early warning monitoring tool was used by staff to assess each child's condition, such as their heart rate, temperature, pain levels and general responsiveness, although the tool in use did not provide specific direction about the action to be taken when scores fell outside the safety levels. Children who had undergone surgery had checks carried out in accordance with safe surgery practices, and this was seen in their treatment records. Risk management processes included reviewing incidents at group meetings. Staff were able to describe the process for reporting adverse events and how they may be involved in the investigation of such matters. Staff said they would get feedback where actions were required to minimise or avoid a similar situation arising. Staff told us of an example where they received safety information about the use of codeine in pain relief for children.

Safeguarding children

Information was available to support staff in identifying and responding to a potential or actual safeguarding concern in the form of a hospital policy. This was available on the hospital's website and intranet and was subject to review every three years. Children were assessed at admission for their overall safety and wellbeing. We saw that staff had a safeguarding prompt to follow and there was access to a designated lead nurse practitioner for safeguarding. We also saw that information was provided to staff where a child was known to be on the at-risk register as part of the arrangements with the local authority. Staff were very knowledgeable about the importance of safeguarding vulnerable children and gave examples of how they had acted on concerns.

High dependency care

The children's ward was not able to care for children who needed high dependency support, as most of the staff did not have the required skills and competencies. Children arriving in the A&E who required this level of care were kept in the A&E department while transfer arrangements were made. They were sometimes kept in the A&E if it was deemed safer to do so than transfer them to the ward. Children who became unwell on the ward were cared for on the ward unless they required intubation, when they were transferred to another hospital. Arrangements were in place to transfer children to other services, either by external retrieval teams, although this could take some time due to bed availability. There was also the possibility of transferring an unwell child to King's College Hospital. We saw that a formal procedure for the latter arrangement was in the process of being agreed**.**

Care needs provision on the SCBU was available for up to 12 babies, with 11 cots in use at the time of our visit.

Equipment

Ward staff said new equipment had been purchased but that sometimes insufficient items were available when children were being nursed in isolation. This meant staff spent extra time cleaning items so they could be shared between isolation rooms. We saw that equipment had been safety checked and was easily accessible to staff. Staff were trained in the use of medical devices by the medical engineering and physics department. Equipment in the SCBU had all been checked.

Staff said they had been trained in managing emergency situations, such cardiac arrest and there was access to suitable equipment on the ward area.

Equipment available on the SCBU included special cots with warming devices and the facilities to make distinguishable times of day and night. Emergency equipment was accessible and staff said they were trained as a minimum in basic life support

Infection prevention and control

The ward areas and SCBU were clean and domestic staff had access to a cleaning schedule, which outlined the required standards, frequency of cleaning and methods. Cleaning materials used by domestic staff reflected the recommended guidance. Clinical staff told us that a formal meeting took place to review the environment.

Staff had good access to hand-washing facilities, hand sanitisers and paper towels. There was a good supply of personal protective equipment, such as gloves and aprons. Staff carried out safe practice in regard to hand washing between patient contact and activities.

Waste was managed in accordance with best practice and safety guidance. There was provision of sluice facilities and designated areas for preparing medicines and storage of clinical equipment. Equipment used for monitoring children was found to be clean.

Single rooms enabled staff to nurse children in accordance with safe isolation guidance and signage was used on doors to alert people. On the SCBU, there were warning notices asking people not to visit if they may have a virus or other infectious disease.

Staff told us they had received infection prevention and control training as part of their induction. They had access to policies and procedures, as well as a lead person for advice and guidance.

Are services for children & young people effective?
(for example, treatment is effective)

Older children were not always involved in making decisions about their treatment or care as part of the consent process.

Communication
Information was available to people coming onto the ward in the form of a booklet titled, Welcome to the Children's ward at the Princess Royal University Hospital. New staff were also provided with information about the ward to help them understand the area and expectations of their roles. A range of leaflets on various conditions such as asthma were available to children and parents. We saw a leaflet Sharing information about your child: A guide for parents and carers. Information about the complaints process was available and on display with contact details for the Patient Advice and Liaison Service.

A parent of an infant being cared for on the SCBU said she had been provided with a range of written information and there was an opportunity to talk to relevant staff prior to the birth of her child. She also had the chance to book in with the breastfeeding clinic in preparation for managing this part of her baby's care. This same person explained that their husband had been able to visit the SCBU prior to the baby's birth, and they had seen the doctor who explained the level of monitoring their baby would require after delivery.

Staff told us that they made sure children and their parents or families were involved in discussions around the treatment and care planned. Doctors were said to provide information about the treatment plan and nursing staff would follow this up by checking understanding and additional explanation. Relatives who spoke with us said that they were kept informed by the doctors about what was happening in regard to admission to the ward as well as treatment. One comment made to us by a relative was, "The doctors are able to answer any questions".

We observed effective communication between doctors and nursing staff during the ward round and in relation to the care and treatment of children. Handover took place at change of shifts. There was also a handover book in which the ward sister wrote relevant details about each child, including appointment times. This book noted details about any new admissions and discharges. Each staff member had a handover sheet with relevant information to refer to. Three medical handovers took place between doctors at 8.30am, 5pm and 9.30pm.

Consent
Consent forms were in place and had been signed by the parents of two children whose records we reviewed. One relative told us that the doctor who saw their older child was not a paediatric doctor. The parent told us, "Things were inadequately explained". The child said they were told nothing: "I was worried and frightened that something serious was wrong that they didn't want to tell me". Another older child said they were involved in some discussion but "Mum signed the form this time". They added that, at another hospital, they had signed all the forms themselves but said, "Mum would not have signed if I said 'no'". Feedback from one child was that, "the anaesthetist was really nice and explained everything and was very funny".

Staff were aware of the process for making decisions in the best interests of children. They told us there was training available about obtaining consent. They said that consent involved the provision of information and checking

children's capacity to make decisions. There was access to interpretation services and to people who could use the Makaton sign language system to communicate with patients.

Pain management

Two older children told us that staff "were good" and asked them about their pain. One parent commented that, because staff were busy, they sometimes had to wait and the child agreed. Staff monitored children's pain and that they had an appropriate pictorial chart to help with assessing the child's level of pain. Medicine charts were in place and these had been completed when medicines had been given or treatment had been reviewed. Medicines were seen to be managed safely and securely.

Treatment and care planning

Staff were expected to use a personalised care plan for each child on the ward but, of the three records viewed, one record had not been completed. The absence of such information indicated to us that staff may not have been fully aware of the child's needs, their preferences and choices.

Support services

The lack of some on-site support services, such as laboratories, had caused delays in commencing treatment. Certain samples, such as urine and special blood tests, were sent off site, which involved the doctor having to arrange a taxi to take the samples to the laboratory. They also had to alert the staff at the receiving end to expect the sample. Staff said that, on occasion, samples had been lost or delayed which, in turn, caused delays in discharging children and causing bed blockages.

There was access to other specialist support services for the effective treatment of children. For example, dietician and diabetes nurses. In some areas of treatment support, such as physiotherapy and speech and language therapy, was provided by adult-specific staff.

Are services for children & young people caring?

Children's experience

There was limited data available from children and parent about their experience

Results from the NHS Friends and Family survey was displayed on the ward, although information had only recently been gathered and therefore it was difficult to see any comparative information or trends.

Personalised care

Staff commented that they had time to care. They said, "We work very well together as a team, with good communication". They added, "We are good with families and at involving them". We observed staff to be caring and responsive to the needs of children. Staff were kind and approachable and used age-appropriate language and communications, in a range of languages to support children and their families.

A range of information including breast feeding and storage of milk was available for women.

Discharge arrangements

Staff told us that the review of children was improving as this was taking into account planning of discharges around theatre activity. We saw that arrangements were being made for the discharge of a child from the ward and that relevant information was documented by staff. Families received a copy of the discharge summary. Staff told us that, in general, there were no issues around arranging the discharge of children, although complex cases could take a little longer, such as for adolescents with mental health needs.

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

(for example, to feedback?)

Children sometimes experienced delays in being admitted to the ward or had their surgery cancelled. Parents felt that the food provision varied and that, on occasion, food was not healthy or could not be provided to meet children's needs.

Admission arrangements

Children who were listed for elective surgical procedures, such as ear nose and throat (ENT) had the opportunity to attend a pre-assessment clinic. Children's needs were assessed, including special needs, by staff with the right skills and experience. Staff said that children up to the age of 16 in full-time education stayed on the ward, as well as those with special needs, up to the age of 19 years old.

Services for children & young people

Children who came through the A&E department sometimes had to wait for a bed to be available on-site or external to the hospital, if the need for transfer was identified. Children were not always seen by a specialist doctor in the A&E department.

A health play specialist was available to help make the clinical environment as non-threatening as possible and to help prepare children for theatre. This specialist covered all acute patient admissions, including the A&E department.

Procedural cancellation

Staff expressed their concern that children's surgeries were sometimes cancelled on the day, with no advance notice. Surgeons from different specialities did not always working together for the benefit of children using the service. There was no process for planning elective surgical lists by taking into account bed availability and we were told that as a result, children's surgery was sometimes cancelled on the day. Treatment plans or discharge of children was sometimes delayed because some investigative tests required analysis at the off-site microbiology laboratory

Cultural and religious needs

Staff were aware of the need to fully consider and respect the cultural and religious needs of children and their families. Examples given were provision of preferred foods and having a notice to alert if a parent needed to cover their head or be able to take time for prayer. Care records recorded children's religions.

Age-appropriate environment

The children's ward was spacious with some single rooms and two four-bed bay areas. Children had access to a play room and school room, both equipped with resources to provide effective play and educational support. Staff said there were portable DVD players and games machines for older children. Parents had their own day room and facilities for those parents who wished to stay with their child. Staff told us they ensured that the bays were made single-sex.

The layout in the children's A&E department was conducive to a positive working environment. The environment and waiting area had been specifically designed for children. The resuscitation area had four bays, one of which was a children's bay. We found that the children's bay was frequently occupied by adults. However, there was a dedicated high dependency area within children's A&E where a child from the resuscitation area could be moved to if necessary.

Relatives who spoke with us commented on the availability of activities to support their children. One relative said, "Activities are great and there is always something going on, including sensory toys". Another relative said about their child, "She is having a great time here, and won't want to come home!"

Food

Relatives told us they did not have access to any food on the ward but could have tea and coffee. Concerns were expressed to us about the availability of suitable foods for some children. For example, there were no foods suitable for one child with specific health problems, which meant that food had to be cut up by the parent to enable the child to eat. Another parent said the food was good, while another said there was limited choice and what was available was not always healthy. Another parent said the food was fine for their child.

Parents staying on the SCBU commented about the range of options but lack of quantity, as well as limited access. For example, if they did not get up early enough, people could miss out on choices. They also said the canteen was not open very late during the week or early on a Saturday so people were not always able to get food when they wanted it.

Gathering people's views

There was a 'graffiti board' for staff to use for comments and suggestions for improvements. There was also a monthly 'what you told us' and 'what we did' newsletter.

Information on complaints was available to people using the ward and SCBU. Staff told us that any complaints raised would go for investigation to the Matron who oversaw both clinical areas.

Are services for children & young people well-led?

There was positive feedback about the leadership on the ward and the changes that had started to take place. Systems to monitor the quality of care provided were being put in place, but further work was required to embed them.

Services for children & young people

Management support

At department and ward level, we found that children's services were well-led. Staff said that things had changed for the benefit of children, their families and the staff themselves, as a result of having a visible leader. We found that staff were enthusiastic and passionate about the care they provided. They were keen to embrace the challenges ahead but said that they had noticed improvements in areas such as equipment provision, training and support. While staff said they hadn't had the opportunity to have their performance formally reviewed, they had supervision and could access their line manager at any time to discuss issues or development needs. Staff said they felt the ward was safer and that there were clearer pathways to support them in their roles. Another staff member said there had been "a shift in culture and understanding". They added, "There has been lots of support". They said that information was available via emails and shared at ward meetings. We were told that changes in policies and procedures had been discussed directly by the line manager and we saw a range of communications about changes displayed on the ward.

Monitoring quality and safety

Except for the recent results of the Friends and Family survey feedback, we did not see any visible information displayed which would inform staff and people using the children's services of any outcomes from the feedback and quality monitoring systems.

Senior staff were aware of the arrangements for monitoring the quality of services but other staff were not, except for local audits such as infection control practices.

We were told that, for children's services, a quality monitoring tool had not been put in place. However, staff said there were weekly risk management meetings and we saw terms of reference for the child health risk management group, which indicated that monthly meetings were the aim for practice. Staff told us there were combined hospital paediatric clinical governance meetings and we reviewed minutes of these which showed that various areas were discussed by attendees. This included, for example, the completion of patient records, incident reports and risk management. A report on serious incidents included lessons learned. It was noted that in the minutes of the August and October 2013 meeting, under-reporting of incidents at the PRUH was discussed. We saw that staff attended a paediatric clinical improvement team meeting, which also addressed incident reporting and risk management, as well as complaints.

Medical staff confirmed they participated in meetings where incidents and audit information were reviewed, related to the use of specific medicines. Clinical staff at senior level explained how they had developed a ward action plan and we saw that this had identified various risks, how they would achieve compliance, the support required and a time line for resolution.

End of life care

Information about the service

The trust has a small palliative care team at PRUH consisting of nurses and one part time consultant. The service usually receives about 900 referrals per year, with an average stay of 7.5 days.

The team provides palliative care support for patients and education and guidance for the trust's staff. Support is also provided by clinical nurse specialists and nursing staff on wards. The trust also has a bereavement team and a multi-faith service.

We spoke with one patient who currently received support from the team. We also spoke to 12 members of staff across the trust about end of life care. They were from a range of backgrounds, including the bereavement team, the palliative care team, the chaplain, the mortuary staff, clinical nurse specialists and nurses on the wards which included the oncology ward.

Summary of findings

We found that staff were caring and where possible were responsive to patients' needs. There was generally a good working relationship between the different support services that were available. We received positive feedback regarding end of life care from a patient and from many of the professionals involved.

We found that the trust was working towards improving support for people at the end of their lives. However, at the time of inspection there were insufficient staff and inadequate systems for monitoring the quality of the service. The trust was not ensuring that the paperwork for patients assessed as not requiring resuscitation was always fully completed. Patients were at risk of receiving inappropriate care or treatment as staff did not always record their wishes not to undergo cardiopulmonary resuscitation. The palliative care notes were frequently neglected and patients' signatures were often missing.

The palliative care team worked under pressure and staff told us the staffing levels were insufficient to meet the number of referrals. The trust recognised this issue and told us that there was a plan to provide a seven-day service.

In line with national recommendations, the hospital was no longer using the Liverpool Care Pathway for end of life care. This had been rapidly phased out by the previous trust and had caused confusion among the staff. The trust was in the process of replacing their care planning tool and reviewing other procedures used for providing palliative care options for patients.

End of life care

Are end of life care services safe?

Staffing levels

The trust had a small palliative care team consisting of one 0.8 whole time equivalent consultant and two part time consultants. Four clinical nurse specialists work part time, making the equivalent of 2.6 whole time equivalent staff. We were told that, over the past 12 months, the pressures had increased significantly in proportion to a significant increase in number of referrals while staffing levels remained unchanged. Staff told us that occasionally they were required to work long days or visit patients on their rest days. Occasionally they were unable to complete records as they did not have the necessary administrative support. We noted that this was highlighted as a risk by the team. The trust told us that they were planning to employ a social worker and an administrative support person who would work with the team.

Recording of decisions

We found failures in the systems for patients' 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions to be made, communicated and reviewed. On several wards we visited we found that patient information boards or handover records stated that some patients were for resuscitation although they had a DNACPR form in place, or vice versa. Some DNACPR forms had not been adequately completed, including missing information about how patients or their families had been involved in the decision making or reasons why they had not been involved. We did not see any evidence that the decisions had been reviewed. DNACPR decisions had not been reviewed at appropriate intervals. For example, one person's decision had not been reviewed for four weeks

Records

DNACPR forms were often incomplete. There was no evidence that any we looked at had been reviewed. We also found that decisions were not always reviewed by consultants. This put patients at risk of receiving inappropriate care. Hospital guidance and policies relating to end of life care were out of date or contained irrelevant information. For example, the 'do not attempt cardio-pulmonary resuscitation' policy had not been reviewed since January 2011. In addition, staff told us that some of the medical records were kept off-site and they occasionally had difficulties obtaining them in time.

In the mortuary, there were clear systems in place to ensure that relatives viewed the correct body and that the correct body was released for burial.

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

End of life care pathway

The trust was no longer using the Liverpool Care pathway for end of life care, in accordance with national guidance. Staff told us that "they worked in a vacuum" for few months as the previous trust did not instruct staff what to use as a replacement. At the time of inspection, the palliative care team were guided by the 'Principles of Care for Dying Patients'. This included brief sections on how to provide care, manage symptoms and provide psycho-spiritual care.

Clinicians on different wards used the palliative care team referral form which helped the team prioritise urgent cases. There was also and end of life care plan identification form which prompted staff to complete end of life care plans. We were presented with a Specialist Palliative Care Team Operational Policy which contained different referral forms from those being used by the team.

Staff told us that another set of guidance was available via an intranet page. However, they said they found it difficult to access as the system was newly introduced and they told us it was not "user friendly". Staff were also using an Advance Care Plan which was developed in partnership with Macmillan Cancer Support which was used by some patients to help them make informed choices about how they would like to be cared for at the end of their life, and with funeral arrangements, organ donation, and life-sustaining treatments.

Communication

We saw that the multidisciplinary team members met weekly. These meetings involved palliative care clinical nurse specialists, chaplaincy team, occupational therapist and consultants in palliative medicine. This meant that patients' cases were reviewed fully and with a holistic approach.

Occasionally the communication between the palliative care team members and staff on different wards was not effective. A member of the palliative care team told us that there was a lot of inconsistency on the wards and that staff sometimes did not follow their advice, saying "they often

know better." This led to inconsistent support being offered to people at the end of their life. We were made aware of two incidents when contradicting advice had been provided by staff on the wards.

Pain management

There were protocols for appropriate medications and dosage levels to use in managing pain. However, we noted that, in one case, a pain control patch had not been changed for a patient for three days. A member of staff explained that occasionally nurses or consultants on individual wards did not have the relevant knowledge related to opioid pain relief medication. In addition, this patient had been wrongly assessed as being able to communicate verbally and staff had ignored their symptoms of pain. We saw that staff reported this incident on the trust's internal incident reporting system and it had been investigated.

Are end of life care services caring?

Feedback from patients and relatives

One patient who was receiving support from the palliative care team told us that, "It's a very good service I'm getting. They look after me very well". We saw that staff provided patients with information on how to contact the team and where to obtain additional support and information. We noted that staff were mostly dedicated, compassionate and knowledgeable.

Facilities for supporting patients and their relatives

We visited a few of the wards, including a ward for oncology patients, the bereavement suite, chapel and the mortuary. We found that the trust had appropriate facilities for supporting people at the end of their lives.

Feedback from staff

Staff were compassionate and caring to patients and their relatives when people were at the end of their lives. All of the staff we spoke with were clear about their role in ensuring people received quality support at the end of their lives. All described the importance of respecting people's wishes. However there was limited information about patients and relatives experience of the service.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Identification of support needs

The trust told us that they were introducing a new system to support identification of all end of life patients so staff could support patients in a more systematic way. We noted that the hospital reported an estimated 1,337 deaths in a period of 12 months. The palliative care team received about 900 referrals during a similar period of time. This meant that some patients who may have benefitted from the service had not been referred. We were told that patients might "slip through the net" if there was no previous community team involvement.

Multidisciplinary working

Staff organised weekly multidisciplinary team meetings where they discussed stages of patients' pathway and their clinical circumstances. A member of staff told us that they concentrated on a holistic approach, discussing physical, psychological, social and spiritual issues. These meetings involved occupational therapists, clinical specialist nurses and consultants as well as the chaplaincy team. In addition, staff reported that they had a good working relationship with the local hospice. Out-of-hours support was offered by the local hospice's palliative care consultants.

The trust did not provide counselling support, but patients and relatives were given information on how this could be accessed. When a relative collected a death certificate from the bereavement office, they were given an information booklet 'for bereaved relatives and friends'. The trust employed bereavement specialists including a dedicated bereavement support midwife working in the antenatal outpatients clinic.

There was a working procedure which listed responsibilities of the person who took the lead role in coordinating patients' care and promoting continuity and access to advice and information. However, we were unable to assess if this procedure was fully operational and effective due to the limited contact with patients and relatives of the people who died at the hospital.

Staff told us about occasional problems they experienced in communicating between different teams. For example, opioid pain medication could be prescribed by either the prescribing nurse or the consultant and occasionally there had been a difference of opinions and lack of clarity on

who was to take the final decision. A member of staff told us that they also experienced communication difficulties when there was more than one consultant involved. Sometimes the support and advice offered "felt chaotic" as different decisions were made by different people. The current trust has responded that any differences of opinion are fully discussed and a final decision reached jointly. Some prescriptions are changed when patients are reviewed.

Are end of life care services well-led?

Management

Staff were positive about the recent changes and said they felt motivated. They told us they were looking forward to working with their colleagues from other sites managed by the trust and that they had already noticed some positive changes following the takeover by the King's College Hospital NHS Foundation Trust. Staff also had confidence in the new management.

Staff development

Systems to support staff development were in development. The current trust has confirmed that supervison for nurses was being explored and appraisals for nursing staff, although out of date, were being explored. This meant that at the time of the inspection there were limited opportunities for staff to discuss their development.

Although we noted that the palliative care team had attended training relevant to their job – including acute oncology, advanced communication skills or introductory training to psychology and counselling – there was insufficient general training in end of life care for all staff. This had been highlighted as an area for improvement in the National Care of the Dying Audit and the palliative care team provides a study day for all staff every six to 12 months. Staff told us that one training session had been organised at the beginning of November 2013.

Quality monitoring

There was only limited evidence that the trust had adequate systems for monitoring the quality of the service. For example, most of the records reviewed during the inspection were only partially completed. This meant there was a risk that patients' wishes would not be adequately respected. We noted that the medical record for one patient who had been recently readmitted to hospital was missing. Comments from staff included "it takes a lot of time to find things [records]" and that it often was "an absolute mess". The trust did not have effective systems in place to audit medical records. In addition the previous trust did not take prompt actions in response to external audits such as the National Care of the Dying Audit undertaken in 2011, or other risks highlighted by members of staff, such as occasionally missing records.

Outpatients

Information about the service

The trust runs a wide range of outpatient services for children, young people and adults. The main outpatient department is located within the hospital.

As well as the general outpatient clinics, we visited oncology clinics, haematology clinics and cardiac and endoscopy clinics.

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

We talked with 17 patients and 25 members of staff. We also looked at the computerised appointments system and reviewed patients' records.

Summary of findings

Patients told us that they found staff friendly, professional and caring and that they were mostly happy with the services provided by the trust. Patients also told us that they felt involved in their care.

Patients were not always protected against the risk of unsafe or inappropriate care and treatment and their individual care needs were not always met. This was because some records were not accurate and did not always includeall the information related to their treatment. Patients' paper records were not always kept securely.

Patients were not protected from the risk of unsafe care and treatment because the trust did not have effective systems designed to enable them to regularly assess and monitor the quality of the services and identify and assess risks relating to health, welfare and safety of patients. Although the current trust is putting arrangements in place to obtain feedback from patients, limited information was available about patients' experience.

Staff were not always supported to deliver care and treatment to patients safely. They did not have annual appraisals, communication was not always effective at all levels and staff were not clear on management structures and the responsibilities of other team members.

Outpatients

Are outpatients services safe?

Records availability and storage

Clinicians did not always have access to patients' medical records for their appointments. Staff told us that paper records were kept off-site and they were delivered daily once the appointments schedule was confirmed and shared with the team responsible for medical records delivery. We noted that, in one of the clinics, 12 out of 42 records did not arrive on the day, and in another clinic, 18 out of 54 records failed to be delivered on the day. Nurses and healthcare assistants told us that every day they spent a substantial amount of time "chasing records". Staff told us they had not kept a note of how many sets of records were not delivered but informed the management regularly that it was a problem. This meant that some patients were undergoing fairly complex/ involved procedures such as colonoscopies without clinicians having reference to their notes which put them at risk of receiving unsafe care. One manager told us this has been a problem since June 2012 when the record storage facilities had been reorganised under the previous trust.

Since 1 October 2013, the current trust has taken some action and has further plans to improve records management. Actions taken include recruiting more staff and improving arrangements and capacity for preparing notes, but these have not yet translated into improvements in practice. Further actions are in progress.

Doctors told us that GP referral letters were often missing and that they frequently created a temporary set of notes and that "it is the exception, not the rule to have all the old notes available in clinic". The current trust inherited a system that did not effectively track the number of medical notes patients had. This was still the situation at the time of the inspection. Clinicians did not have access to full information in regard to previous treatments and were unable to review patients' progress effectively. Staff told us that occasionally, if they could not obtain a patient's medical record, they cancelled their appointments. This meant that patients were at risk of having their treatment delayed. In addition, we saw that patients' records in two of the clinics were stored on trollies in corridors and could be easily accessed by unauthorised people.

There were many unlocked filing cabinets of patient notes in corridors in public areas in the cardiology outpatient area. We asked the lead nurse in the outpatients regarding this who said a 'business case' had been made for new/lockable storage solutions for patient notes.

Environment

The premises we looked at were clean and staff were aware of infection control procedures. There were adequate seating facilities and all clinics could be easily accessed by people with mobility difficulties. We noted that sharps' boxes and clinical waste bins were not overflowing and staff had access to personal protective equipment.

Staffing

In some clinics there were vacant posts filled by temporary staff. The trust reported that over 16% of posts were vacant, but they were unable to provide us with information about how this affected individual outpatients' clinics. Staff told us that the trust had started to recruit more staff and we noted that there was a plan to address this issue.

Responding to incidents

We found that there were some mechanisms in place to capture incidents and identify risks. However, these were not always used as a learning tool. For example, one manager told us that they had frequently recorded incidents related to missing medical records on the trust database but there was no adequate response or action taken. The manager told us that they had recorded about 400 incidents since June 2012. Two patients told us that they did not feel the trust had suitably investigated incidents when they complained about the service and the response received was very impersonal. A manager of one of the clinics was unable to tell us what response had been made by the trust to another complaint or how this was communicated with the team members to improve the services.

Staff were aware of how to respond to safeguarding concerns and what constituted abuse. Clinics had a safeguarding lead and staff knew who they were.

Outpatients

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

Patient experience

Patients told us that they were mostly happy with treatment outcomes. They felt that clinicians attended to their immediate medical needs promptly, although, they had not always provided a holistic approach. We saw some examples of good multidisciplinary team involvement. However, shared pathways were not always effective and, occasionally, when external agencies were involved, the communication was not effective. There were some delays in written communication exchanged between services. One patient said that they had been waiting for eight weeks for the letters to be exchanged between their clinic and another hospital involved in their care.

Once the hospital became part of the King's College Hospital NHS Foundation Trust, many acute urology patients from neighbouring hospitals were transferred to the PRUH urology services. Doctors told us that this process was not well managed and caused delays in patients' treatment as the urology department had limited capacity to accommodate additional patients. This meant that doctors worked under pressure and patients were at risk of errors being made regarding their diagnosis.

Mental Capacity Act 2005

Staff understood their responsibilities in relation to the Mental Capacity Act (2005) and knew how to provide adequate support if a patient's capacity to consent to treatment was in question.

Are outpatients services caring?

Patients' feedback

Patients told us that they found staff friendly, professional and caring and they were mostly happy with the services provided by the trust. Patients also felt involved in their care. Most of them told us that they were provided with information regarding their treatment and that doctors explained what their treatment options were. There was no data available about patient's experience.

Privacy and dignity

Consultation rooms were private and comfortable and patients could ask to be assisted by a trained chaperone if there was a need. We noted that the open reception area did not always allow adequate privacy. Staff told us that patients could ask to talk to a receptionist in a private area. When a patient did not speak English, staff accessed interpreting services available over the phone or in person. There was limited written information available for people who had difficulties communicating in English. One person, who was unable to speak English, told us that staff had asked if they wanted to use an interpreter and that they had been supported by their partner on two occasions.

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

Waiting times

Patients' appointments were prioritised according to their clinical needs. We found that most of the clinics ran late, and staff told us that many of the clinics over-ran daily by up to two hours. Despite this being an ongoing issue, the trust had not taken any action to minimise the inconvenience to patients. We noted that there was no information available regarding waiting times in individual clinics. Patients told us that waiting times varied between 40 minutes and three hours. This made it difficult for them to plan around their appointments. Many patients' complaints were related to parking facilities as it was difficult to find a car parking space within the hospital grounds. When patients used the hospital car park, they were required to pre-pay, which meant they frequently under- or over-paid as they did not know how long the space would be needed. Many had been required to use the local supermarket's car park and this was particularly inconvenient to people with mobility difficulties who received treatment at the hospital.

Appointments/referrals

Consultations

Some of the clinicians told us that they felt under pressure and they did not always have sufficient time allocated to each patient. This meant that there was a risk that patients' treatment needs would not always be suitably assessed. Allocated clinic slots are generally 20

minutes for new patients and 10 minutes for follow-ups, which are subject to variation. However, we noted that clinics were regularly overbooked and the appointment times were about 10 minutes long (five-minute appointments were allocated at the fracture clinic). One doctor told us that they did not have adequate consultant supervision. Another specialist registrar confirmed that the clinical supervision was minimal and that their patient lists were not protected to ensure they had adequate time to assess a patient. They said, "I saw 19 patients this morning, and 10 minutes is not enough for adequate consultation as many of my patients are cancer patients". And also, "Double bookings are made which means that there is often five minutes to diagnose a new cancer patient". The current trust has commented that overbooking of cancer patients in clinic slots generally occurs following agreement with the clinician responsible for that clinic.

Once the hospital became part of the King's College Hospital NHS Foundation Trust, many acute urology patients from neighbouring hospitals were transferred to the PRUH urology services. Doctors told us that this process was not well managed and caused delays in patients' treatment as the urology department had limited capacity to accommodate additional patients. This meant that doctors worked under pressure and patients were at risk of errors being made regarding their diagnosis.

The trust had also reported delays in referrals for cardiology and ophthalmology clinics and frequently cancelled appointments on the day because of lack of availability of medical records.

Staff told us that the trust ran additional clinics when they were likely to exceed the national 18-week target set by the Department of Health (the maximum time it should take between when a patient is referred by a doctor or GP to the start of their non-urgent treatment). However, we noted that not all of the managers were aware of how they performed in relation to that target. There was no system in place to allow the provider to monitor routinely how they performed, which meant that they were unable to take prompt action.

Complaints

The trust reported that 17% of the complaints received were related to appointment delays or cancellations. Although they responded to patients' complaints, there was no evidence of any learning from them. Staff were not aware of what the response was and how to use it to improve the service. Two patients told us that they did not feel the trust had investigated their complaints adequately and they did not feel that they sought to improve the service in response to complaints.

Are outpatients services well-led?

Communication

There was only minimal communication across the organisation and staff did not share information about problems and solutions related to quality of the service with other team members. A member of staff told us that communication between the team and the senior management was marginal. Another person said the trust did not communicate with nurses and healthcare assistants sufficiently. They said "communication top-down doesn't always work. It has been a bit quiet recently".

We noted that small teams working within one clinic had limited opportunities to share knowledge and discuss challenges they faced in their day-to-day work with other teams. One person told us, "We work a little bit in a bubble here". Another person (from another team) said that they felt there was inconsistency in the way different teams performed the same task.

Monitoring performance

The trust used an administration system which detailed all patient contact with the hospital, both outpatient and inpatient. This system was also used for monitoring how individual clinics performed in relation to the targets set by the Department of Health. Local managers had limited access to this system and received limited information on how they performed. Incidents and accidents were recorded with the use of another computer system which allowed risk patterns to be identified and monitoring of actions taken in response to incidents and accidents. Managers told us that they had not been provided with summary information related to complaints or incidents so were unable to take any action in response to learning from incidents.

Staff told us that the trust often shared communication with them via email. However, they said that many staff had not activated the email address allocated to them, meaning that communication was not always effective.

Outpatients

Staff training and development

Staff told us that they felt positive about recent changes and the involvement of the King's College Hospital NHS Foundation Trust. They told us they were happy with the support offered by their local managers and we noted that most of the staff were caring, well-motivated and knowledgeable. However, we found that teams were only informally supported at the local level. There were inadequate systems in place to support learning, development and open communication at all levels.

Nursing and medical Staff had not been having regular appraisals. They told us that they did not receive formal one-to-one supervision. Staff received adequate mandatory training and this was managed and monitored at the local level. We spoke with a manager of one of the clinics who showed us a record of staff statutory training and told us what training was scheduled in near future. The trust was in the process of reviewing the training offered to staff and we were told that an online training programme had been arranged. Some of the staff told us that they had problems with accessing the online training as they did not have access to the system. One of the managers explained that information on how to access it was sent via email but not all of the staff had access to their email account.

New staff – permanent or temporary bank overtime) staff – were given an induction by their local manager. A manager of one of the clinics showed us the form used and told us about the process. However, we noted that there was no formal induction procedure for staff who transferred between clinics. One bank staff and one healthcare assistant who transferred from another department told us that they did not think they received adequate induction and they were just showed around the premises. The manager confirmed this.

Leadership

Staff did not have a clear overview of the management structures and responsibilities of the senior management team members. There was no system in place to monitor the quality of the service and the trust did not take appropriate action to address continuing failures. For example, the trust did not take prompt action in response to ongoing issues and identified risks related to medical records not being delivered on time. In addition, staff reported that clinics were consistently overbooked but there was no evidence that action had been taken to address this issue.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice within the trust:

- Use of patient diaries in the critical care unit for patients who have been unconscious for a long time. They aid patients' recovery by helping them understand what happened while they were unconscious.

Areas in need of improvement

Action the hospital MUST take to improve

- Engagement and support of all senior medical staff.
- Ownership for improvement must be embedded at every level in the hospital.
- The trust must address its discharge planning and patient flow problems and ensure all action is taken to minimise the risk of elective surgery being cancelled and improve capacity
- The trust must take action to urgently address the long waiting times in the A&E department.
- Problems with accessing and availability of medical records must be addressed urgently.
- Nursing documentation, including fluid balance charts, must be accurately completed.
- Decisions related to a patient's resuscitation status must be regularly reviewed and accurately recorded and shared with staff.
- Develop and embed systems for monitoring performance, quality and safety of care at all levels in the hospital.
- Ensure staff use the alcohol hand gel.
- Training, appraisals and support for all staff
- Appropriate training and sufficient staff to provide care for children who require high dependency care and improved planning for elective surgery for children
- Recruitment of new staff should continue to ensure that reliance on bank (overtime) and agency staff is reduced, and this should be prioritised by areas of greatest need.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Assessing and monitoring the quality of service provision** The provider did not have effective systems in place to monitor the quality of the services provided. Regulation 10(1)(a) 2(b)(i)ion 9(1)(b)(iii)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Cleanliness and infection control** Services were not protected from the risk of a health care associated infection because staff did not always follow infection control procedures and sufficient alcohol dispensers were not available in all inpatient areas. Regulation 12 (1)(a) Regulation 12 (1)(b) and Regulation12(1)(c) Regulation 12 (2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not enough qualified, skilled and experienced staff to meet the needs of patients. Regulation 22

This section is primarily information for the provider

Compliance actions

(1)(b)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have appropriate arrangements in place to ensure that all staff had appraisals, supervision and training to ensure they were able to deliver safe and up to date care and treatment. Regulation 23 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have appropriate arrangements in place to ensure that all staff had appraisals, supervision and training to ensure they were able to deliver safe and up to date care and treatment. Regulation 23 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Improvements are needed in respect of the documentation of patients' care, including their resuscitation status and the management of medical records to ensure they are availalabe for outpatient and inpatient care episodes.