Ashford and St. Peter's Hospitals NHS Foundation Trust

Ashford Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Our findings

Overall summary of services at Ashford Hospital

Requires Improvement 

Ashford Hospital is in Surrey and is situated to the West of London and close to Heathrow Airport.

The hospital provides a wide range of medical and mainly day surgical services, outpatients services, ophthalmology, inpatient rehabilitation, and includes the Ashford Walk-in Centre (run by a different provider). The majority of planned care, like day surgery is provided at Ashford Hospital.

Services include:

- Day-case surgery
- Elective Surgery
- Ophthalmology
- Outpatients (including pediatrics) and diagnostics; X ray, ultrasound, and MRI scans
- Inpatient Rehabilitation

We carried out this unannounced focused inspection of surgery because we received information of concern about the surgery service across the hospital from staff whistleblowing to the CQC.

We inspected surgery and focused on the safety and well led key questions as the information we received related to these key questions.

We rated surgery as good in both key questions.

Our rating of this service stayed the same. We rated the core of service of surgery as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- The majority of staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- A minority of staff did not feel respected, supported and valued.

Our findings

- A minority of staff were not bare below the elbows in clinical areas.
- Staff told us that divisional leaders were visible. However, staff perceived that the trust's executive team were not visible.
- Not all staff were up to date with mandatory training including safeguarding training.

How we carried out the inspection

We spoke to over 40 members of staff including; doctors in training, consultants, nurses, health care assistants, a student nurse, and allied health professionals. We reviewed a variety of data, meeting minutes and nine patient records.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Surgery

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff but due to pressures during the Covid-19 pandemic not all staff had completed it. Medical staff compliance was well below the trust target.

Data provided by the trust following our inspection showed across all staff groups except medical staff within the service overall compliance with mandatory training was 84%. The trust target was 90% compliance. Medical staff were not up to date their mandatory training; the overall compliance was 61%.

Staff and leaders told us it had been challenging to complete all mandatory training as face-to-face training was cancelled or run with reduced numbers due to Covid-19. During the surges in demand during the Covid-19 pandemic the majority of mandatory training was paused to allow staff to work clinically.

There was a program to address the deficit in mandatory training. The data we reviewed showed that compliance was improving month on month. In addition, within departments and wards there was a number of staff on long term sickness which also adversely impacted on overall compliance.

The mandatory training was comprehensive and met the needs of patients and staff. It was delivered by a combination of on-line and face to face training.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, the trust was in the process of transferring data from one digital system to another and completion data did not always reflect actual completion rates.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse and compliance amongst medical staff was well below the trust target.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. However, not all staff had received adult or child safeguarding training. Safeguarding training compliance amongst allied health professionals including Operating Department Practitioners was 70% for adult safeguarding

training and 74% for child safeguarding training. Amongst nursing staff, compliance was 69% of adult safeguarding training and 75% for child safeguarding training. Amongst support staff compliance was 69% for adults and 70% for child safeguarding training. The lowest level of compliance was medical staff with 56% compliance for adult safeguarding training and 50% of child safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could identify the safeguarding leads and knew how to contact them for support when required.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. A minority of staff were not bare below the elbows in clinical areas.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas. The service undertook audits to ensure staff were using PPE correctly, which showed good compliance. There was sufficient access to antibacterial hand gels, as well as handwashing and drying facilities. However, a minority of staff were not bare below the elbows which was not in line with trust and national guidelines.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Domestic staff followed daily work sheets to complete cleaning activities. We reviewed a variety of cleaning schedules which were fully completed.

Rooms had been risk assessed for maximum occupancy to ensure social distancing was maintained.

Patients underwent infection screening (such as Covid-19 and MRSA) prior to admission. Patient records confirmed this. Patients identified with an infection were not treated at this site in order to maintain its green status. Green hospitals are for patients who have been assessed as having no current infection risks to minimise the risk of cross infection. This was important due to the nature of the operations performed such as joint replacements. Whilst in hospital patients underwent daily Covid-19 swab testing.

Staff worked effectively to prevent, identify and treat surgical site infections. The service undertook monthly surgical site infection meetings, attended by department and ward leads where any surgical site infections or trends were discussed. We saw examples of changes to practice as a result of these meetings. For example, a pilot was currently underway for patients undergoing surgery when body hair needed to be shaved this was now done in the anaesthetic room rather than in theatre, minimising the spread of any germs within the theatre.

The service performed well for cleanliness. Infection prevention and control (IPC) audits showed that staff had knowledge of IPC processes and used PPE appropriately. The service conducted a monthly IPC audit which captured observations on many different aspects of IPC which included hand hygiene, waste and sharps management, indwelling devices such as urinary catheter and availability of hand sanitisers. If there were any areas of non-compliance an action plan was produced and followed up by department and ward leaders. All areas had an average score of over 95% for the three months preceding the inspection.

Surgery

We saw the service undertook regular clinical wash hand basin audits to ensure they were compliant against Health and Building Notes guidance. Commode audits were undertaken monthly to ensure they were cleaned correctly and safe to use. An audit undertaken in September showed 100% compliance.

The service undertook yearly infection control audit feedback tool audits. These showed mixed compliance in some areas. These had remedial actions identified with a responsible person assigned and a deadline for completion. The majority of actions had been completed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service performed well for cleanliness in audits. All areas we visited had an average score of over 95% for the three months preceding the inspection.

Patients could reach call bells and staff responded quickly when called. The service completed audits to check that patients could reach their call bell by asking patients. For example, for October 2021, 100% of patients in the day surgery unit said their call bell was always in reach.

The design of the environment followed national guidance. Staff were clearly able to describe fire safety process and evacuation routes in the event of a fire.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys had tamper evident tags. The contents of the trolleys were checked in line with trust policy and records were complete.

Anaesthetic machines, and specialist equipment in theatres was checked in line with trust policy and records confirmed this.

The day surgery unit and main theatres were in need of modernising and updating and there were plans for this to be completed. Changes had been made to ensure they were compliant with infection prevention and control.

The service had suitable facilities to meet the needs of patients. On Dickens ward a preadmission area had been created for a better patient experience. There was enough bariatric equipment available to meet the needs of patients. Bariatric refers to patients with a high body mass index.

The service had enough suitable equipment to help them to safely care for patients. Equipment was serviced by the trust's maintenance team using a planned preventive maintenance schedule. All equipment had a sticker indicating when it last underwent an electrical safety test, so staff knew it was safe to use. All equipment we checked had undergone electrical safety testing in the last 12 months.

Staff in theatres and the day surgery unit told us that there had been investment in equipment and the environment. Patient trolleys, operating tables and a microscope had been purchased and the staff rest room refurbished.

Staff disposed of clinical waste safely. We saw that waste was separated appropriately and sharps bins were assembled correctly and not overfilled.

Surgery

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Patients had to be carefully selected for operations at this hospital to ensure their needs could be met. There were clear processes and standard operating procedures to support the selection of patients. These were clear, based on national guidelines and included inclusion and exclusion criteria.

Staff completed risk assessments for each patient on admission or arrival using a recognised tool and reviewed this regularly, including after any incident. Staff consistently completed assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks..

We received information that large numbers of operations were cancelled due to poor pre-operative assessment. The hospital undertook an audit in September 2021 to look at the reasons for patients having their operations cancelled on the day of or the day prior to their surgery for clinical reasons. The audit covered the time period from 01 October until 31 March 2021 and included 205 cases of cancellation. The audit reviewed all of the 205 patient records. Ophthalmology performed the most operations at the hospital therefore this speciality saw the greatest number of cancellations. However, when expressed as a percentage this was in line with other specialties (6% of all cancellations). The second highest number of cancellations was for chronic pain procedures (5% of all cancellations).

The same audit showed 81% of patients had a pre-operative assessment. The majority of the patients who did not have pre-operative assessment were for minor procedures under local anaesthetic in ophthalmology, maxillofacial/oral surgery or chronic pain. It was standard practice not to complete a pre-operative assessment for these patients. There were three cases that did not receive a pre-operative assessment where it would be expected. These were all ophthalmology patients. In two cases it appeared that notes may have been missing or not scanned into the electronic clinical record as there were no clinical notes for the whole episode. The third ophthalmology case was a patient having a cataract procedure on their second eye. It was usual that a checklist would be completed to confirm that there were no changes since pre-operative assessment for the first eye, but this was not present.

The same audit showed of the patients who had a pre-operative assessment, 80% (133) did not meet criteria for needing an anaesthetic review, 17% (29) were referred for review by pre-operative assessment staff. There were five cases where patients met the criteria for referral for anaesthetic review, but this did not happen. All of these were day cases for a general anaesthetic with an American Society of Anaesthesiology (ASA) grade 3 or above. Both the day surgery integrated care pathway (ICP) document and anaesthetic suitability for day surgery guidelines state that patients with an ASA of 3 or above should have an anaesthetic review. Therefore, the service could not be assured that patients were suitable for their procedure at the hospital and had their needs met. ASA is a system to assess patients' suitability for surgery pre-operatively based on their physical health.

The trust told us that there had been considerable investment in the pre-operative assessment team who were an essential component in ensuring patients were fit for surgery at the hospital and for any issues to be picked up and resolved. This included a new pre-operative assessment unit at the hospital with increased anaesthetic consultant input. The service now contacted patients one week ahead of their planned surgery date. This had started towards the end of October and provided an opportunity for any patients where there has been a change of circumstance to be cancelled a week before and not on the day of surgery. It also provided an opportunity to book a substitute patient into the released theatre slot and thus ensure theatre sessions were well utilised. All cancellations on the day were reviewed by the pre-operative team, including the anaesthetist, to identify causes and avoid reoccurrence. Staff completed risk based pre-operative assessments in line with pre-operative assessment guidance.

Surgery

The service ensured compliance with the World Health Organisation (WHO) five steps to safer surgery surgical checklist. Our observations confirmed they staff completed them appropriately. The service monitored compliance through a record and observational audit. Data showed between 97% and 100% compliance between August 2021 and October 2021.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used NEWS2 to identify deteriorating patients. Patient observations were recorded electronically and escalated when triggered. Patient records confirmed that patients who triggered were escalated and interventions completed.

The service undertook monthly audits to monitor if patients observations were when scheduled. For example, audit data for Dickens ward between March 2020 and October 2021 showed 100% of patients had observations completed and between 70% and 85% had them completed on time. None breached the time parameters set by the trust relating to the time the observations should be completed.

The hospital provided elective care for patients only. The service transferred any patients who deteriorated or needed to go back to theatre by ambulance to the trust's acute hospital. Staff said there was sometimes a long wait for the ambulance unless it was a patient who was very unwell and required a blue light ambulance transfer.

There were 24 incidents reported from 01 May 2021 to 31 October 2021 when patients were transferred from Ashford hospital to the acute hospital across both surgical divisions. Staff reported 11 of these as being due to patient deterioration. The service graded one incident as moderate harm, relating to a patient who suffered significant blood loss requiring transfer. The service was investigating this incident as a serious incident.

The service had a policy which defined local safety standards for invasive procedures. This was in line with national safety standards for invasive procedures.

Staff knew about and dealt with any specific risk issues. We saw a good example in theatres of staff reviewing a patient's risk factors for a VTE and prescribing medication for the patient to take home to reduce this risk.

Staff understood how to identify the signs of sepsis and the management of sepsis in line with national guidelines. A patient's records which confirmed this.

We observed and multi-disciplinary handover meeting and saw staff shared key information to keep patients safe.

The site management team were trained in advanced life support. They were on site 24 hours a day seven days a week and responded to any emergencies.

The trust had a virtual reality training and education resource. The innovative equipment allowed the user to experience and respond to clinical situations they may experience in a safe and educative environment. The system transported users to a variety of settings with 360° imaging within the suite providing an all-round multi-sensory experience for learning. The system trained users were to prepare for real life emergencies.

Surgery

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The ward manager could adjust staffing levels daily according to the needs of patients. This was done by escalating through divisional leadership team and additional staff could be moved across the two hospital sites. There were regular staffing review meetings held throughout the day where staffing numbers were reviewed, and staff allocated to support areas that were short staffed to best meet patient need.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The number of nurses and healthcare assistants matched the planned numbers in the areas we visited. Data showed that between August 2021 and October 2021 planned staffing generally matched actual staffing. In the previous six months staff reported only four incidents relating to short staffing within qualified staffing..

Operating lists were staffed to the Association of Perioperative Practice (AfPP) guidelines. From August 2021 to October 2021, all operating lists were staffed to AfPP guidelines. Staff also confirmed operating lists were always staffed in line with these guidelines.

When there were nursing vacancies or absences, the service filled these gaps with agency staff. Staff reported that all the agency nurses used by the hospital had significant experience of working at the service. Bank and agency staff received a full induction. All the staff we spoke with were happy with the current nursing staffing levels in theatres and wards.

The trust had a staffing succession plan. There were a number of “grow your own” initiatives including apprenticeships, nursing associate training, student nurses and ODP training. The matron in day surgery said they tried to retain staff by facilitating flexible working and offering further accredited educational courses for staff.

A team of practice educators facilitated training for international staff that had been recruited. In preparation for obtaining their nursing registration they were taught 10 different skills. Over 100 staff had completed the training from January 2021 to date with 99% of staff passing their exams to obtain their nursing registration in the UK. Staff going through the training were all positive about the learning programme.

Main theatres had recruited 10 international nurses, these all undertook a three-monthly rotation through all the different specialties to gain skills, knowledge and experience. They were not counted within the staff allocation to ensure they received the support and teaching they required.

The service assessed and monitored any impact on safety when carrying out changes to the service and staffing.

The service had low vacancy rates in some areas. For example, the day surgery unit and theatres had no vacancies. Other areas had minimal vacancies. Operating Department Practitioners (ODPs) had the highest number of vacancies, with 14 whole time equivalent vacancies. ODP’s worked across both the hospital sites.

The service had low turnover rates. Some areas had no turnover of staff the highest level of turnover was within main theatres and was 16%.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service underwent Anaesthesia Clinical Services Accreditation (ACSA) accreditation two weeks prior to our inspection. The service was assessed against ACSA standards derived from the Royal College of Anaesthetists (RCoA) "Guidelines for the Provision of Anaesthetic Services"; These are evidence-based and accredited by the National Institute for Health and Care Excellence. The service was compliant seven standards of the standards relating to staffing and not compliant with four. The anaesthetic department had submitted a business plan to achieve compliance in all standards relating to staffing.

The majority of consultants worked across both hospitals.

The hospital employed a resident medical officer from an agency to mainly cover the enhanced care ward 24 hours a day. All resident medical officers were given a full induction. The was a consultant anaesthetist on call to also covered the enhanced care ward out of hours.

A junior doctor in training was allocated to each ward during the daytime. One reported they could sometimes be very busy but help and support was always available. Managers regularly reviewed and adjusted staffing levels. An additional junior doctor was sourced during the inspection as one of the wards was very busy.

Doctors completed daily ward rounds and planned patient care and treatment accordingly. Patient records confirmed all patients had received a post-operative review by a doctor.

In the previous six months staff reported only one incident relating to medical short staffing.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were a mix of electronic and paper records. Pre-admission notes were recorded electronically, theatre and recovery notes were paper-based, and the ward used a mixture of paper and electronic notes.

Patient notes were comprehensive. Staff recorded all necessary information. We reviewed eight patient records, and all had dates, times or notes about patients' preferences or wishes. Staff could find the most up-to-date information about patients when they needed it.

Patient records were stored securely in locked trolleys. When patients transferred to a new team, there were no delays in staff accessing their records.

Patient records showed that staff carried out nursing and clinical assessments before, during and after surgery and documented them correctly. Staff reviewed and updated patient risk assessments regularly in line with trust policy. Care plans were person-centred.

Surgery

The service carried out an audit of 40 patient records in July 2021. The results were rated red, amber and green against each of the 51 questions asked. There were nine questions rated as red and, the majority of these related to records of medicines. Staff developed a comprehensive action plan to address the areas of non-compliance.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were fully completed including any allergies to medicines

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. Controlled drugs stock levels were correct and the controlled drug registers were completed correctly.

Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antibiotics to identify and minimise the incidence of prescribing errors and to ensure antibiotics were used appropriately.

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely. The service undertook monthly Medicines Audit Quality of Care Inspections to monitor a variety of compliance with medicine optimisation. These which generally showed good compliance in the safe management of medicines.

Staff learned from safety alerts and incidents to improve practice. The trust held medicine huddles and produced weekly medicine safety messages that were circulated to staff. Safety alerts were shared with staff regarding the incorrect dose of antibiotic being given to patients. The trust had completed investigations into patients receiving the wrong dose of medicine for pain relief. All had any learning and remedial actions identified and actions had a person assigned to them. This was in line with the Royal College of Surgeons guidelines. The pharmacy team developed a variety of actions to prevent a reoccurrence and these had been shared with staff.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicine fridges and storeroom temperatures were monitored in line with trust policy and there was a clear escalation process if the temperatures were outside of defined range.

The pharmacy at the hospital had recently re-opened. Staff were extremely positive about this and said it had a big impact on efficiency and safety of medicines use. Previously Dickens ward was issuing over 300 paper prescriptions for patients take home medicines a month this had reduced to zero. Take home medicines were ready within one hour of prescribing, meaning patients could be discharged quickly.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. Staff gave us examples of incidents they had raised and the feedback they had received.

Surgery

There was evidence that changes had been made as a result of learning from incidents. The division developed patient safety message documents they shared to communicate learning from incidents. For example, one which informed staff of an incident when a patient was given the wrong dose of a medicine for pain relief, which included a procedure for the use of this medicine.

There was a serious injury when a patient had a major bleed and there was a delay in obtaining blood products for the patient from the trust's other hospital site. As a result, a number of changes were made to stop reoccurrence. These included every patient having a laparoscopic procedure (keyhole surgery) having a group and save blood sample and a dedicated motorcycle and motorcycle driver to transport blood samples and blood products between the two hospital sites to reduce any delays. A group and save blood test is taken for pre-transfusion compatibility testing. The hospital had purchased an electronic blood issuing machine. This allowed for the selection and issuing of blood for patients without the need of a group and save sample and could be issued in as little as 10 minutes. Major haemorrhage drills were undertaken with the involvement of transfusion staff. This ensured staff knew what to do in the event of a patient having a major bleed.

Managers investigated incidents thoroughly. Staff reported an incident and a root cause analysis completed for every patient that had to be transferred to the trust's other hospital site. This helped identify any areas where patient care could be improved, and lessons learned to minimise the risk of reoccurrence.

Incidents were managed promptly. At the time of our inspection there was no incidents that were overdue awaiting a handler or awaiting final approval.

Staff reported serious incidents clearly and in line with trust policy. The trust's central governance team investigated serious incidents with input and support from the speciality where the incident occurred. We reviewed a sample of serious incident investigations and found them to be comprehensive, with learning clearly identified, any actions allocated to a responsible person and completed in a timely way.

Managers ensured that actions from patient safety alerts were implemented and monitored. We saw patient safety alerts displayed and staff were able to tell us about one involving a piece of equipment which contained a strong magnet that could affect patients with pacemakers.

Managers shared learning with their staff about never events that happened elsewhere. Staff in theatres were able to tell us the learning from a never event that happened at the trust's other hospital site.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw confirmation of this within a sample of root cause analysis we reviewed.

Managers debriefed and supported staff after any serious incident. The service provided debriefs for staff by psychologists. These were undertaken within a root cause analysis we reviewed.

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service collected safety data which was displayed on wards for staff and patients to see. The service continually monitored and discussed safety performance. There were monthly harms free care meetings and Harm Free Care and Scorecard Oversight meetings, meeting minutes showed data was reviewed and action taken.

Surgery

Staff used the safety data to further improve services. On Dickens ward we were given two examples on how the data had improved patient safety, both related to reducing patient falls on the ward. One involved having the floor marked in bathrooms and toilets on the floor where waste bins should be located because staff had identified a trend in patient falls within bathrooms as walking aids were getting stuck on waste bins.

Between April 2021 and October 2021, there were five venous thromboembolism cases associated with the surgical wards being the admission point for the patients at this hospital.

In the same time period, there had been 12 patient falls, nine of these were on Dickens ward, one on Eliot ward and two in the day surgery unit. All falls resulted in no harm or low harm to patients.

In the last six months period there had been no hospital acquired pressure ulcers or urinary catheter acquired infections on the surgical wards at this hospital.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service we inspected sat within two different divisions. These were the general surgery, anaesthetics, critical care and theatres division, specialist surgery and musculoskeletal division. Both divisions were led by a divisional director, divisional chief nurse and an associate director of operations. This leadership style is referred to as a triumvirate. The triumvirate were responsible for services at Ashford Hospital and St Peter's Hospital.

Ward managers, supported by matrons, provided local leadership on each ward. All staff knew who their local leaders were and felt supported. The trust told us that during the Covid-19 pandemic the executive team did not carry out their usual walkabouts to visit staff, because of the infection risk. However, the executive team spoke to staff in monthly trust wide live "Virtual Team Talks". The trust told us these sessions were well attended by staff. However, despite these measures staff told us they felt the executive team were not visible.

Leaders understood and managed the challenges the service faced. They were visible and approachable in the service for patients and staff. The divisional leadership team facilitated a team talk and feedback session for theatres and anaesthetic to discuss and address the whistleblowing concerns raised to CQC.A comprehensive action plan had been developed to address the concerns raised by staff that was reviewed regularly. A number of other initiatives had been developed in order to address concerns, improve communication, learning from incidents and giving staff a voice and to be heard.

Surgery

Leaders understood the challenges to quality, sustainability and managing change and could identify actions needed to address them. Leaders had previously identified staffing as a challenge and had taken a number of different innovative strategies to improve staffing levels. Some areas such as main theatres and day surgery now did not have any vacancies. These included international recruitment, "growing their own", apprenticeship and enhanced roles.

The service supported staff to undertake additional qualifications and develop to take on different roles and support retention of staff. For example, in theatres staff were supported to complete additional roles such as in anaesthetics, recovery or pain management.

Leaders had relevant skills, knowledge and experience. Leaders at all levels of the service demonstrated relevant skills, knowledge and experience to run the service. All leaders we spoke to understood the challenges the service faced and had achievable plans on how to overcome the challenges and improve the service for patients. Leaders involved staff in any decisions that impacted them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff knew the trust's values which were; patient first, personal responsibility, passion for excellence and pride in our team.

In some departments staff had also developed values. For example, day surgery had their values as: strong teamwork, courage, compassion, communication, commitment and competence.

The service had recently had divisional restructure. They currently did not have a formalised strategy for the two divisions. However, during the pandemic period and since the restructure the service had been following the trust strategy.

The vision and strategy for the divisions were embedded in the trust's vision. The trust had a clear vision and a set of values, with quality and sustainability as the top priorities. The trusts vision was "to provide an outstanding experience and best outcome for patients and the team".

The trust had robust and realistic strategic objectives underpinning these visions which prioritised quality and sustainability. For example, "quality of care" and "modern healthcare".

The general surgery, anaesthetics, critical care and theatres division had an interim strategy which was based on the prevention of harm, patient care, safety and infection prevention. The specialist surgery and musculoskeletal division had an interim strategy to keep patients safe and focused on the 'North Star' trust objective around infection prevention. A 'North Star' objective is a long-term, high-level aspiration goal to motivate staff.

The main strategy of the service was the transfer of elective activity to Ashford hospital. The main specialties driving the change were upper gastrointestinal, gynaecology, trauma and orthopaedics and colorectal. This would provide an

elective site to maximise efficiency, reduce cancellations and provide a better patient experience. The plan was thorough, explored different options, the risks involved, additional staff required, additional equipment requirements and infrastructure changes. It followed a timescale with check points throughout reviewing what was going well and any areas requiring improvement.

The strategy for Ashford hospital was fully embedded in the wider local plans. The development of the elective centre at Ashford hospital was a key part of the response to the Covid-19 pandemic and delivering on the NHS Long Term Plan objective of separating elective and unplanned care. The trust were in the process of developing collaborative plans to enable the facility to benefit the wider population by supporting the recovery of elective backlogs.

Culture

The majority of staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had commenced a programme to further support equality and diversity in daily work. All staff were provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

In response to whistleblowing concerns raised by staff with the Care Quality Commission, the trust had developed an extensive action plan to address the concerns raised by staff. Actions included a safety culture survey for theatres and anaesthetics undertaken in September 2021.

We did not identify any widespread issues of poor culture within the service. There was a minority of staff who did not feel respected, supported and valued. The majority of staff told us that morale was good, they were happy, felt supported by their colleagues and managers and were fully focused on the needs of patients. Staff told us that there were many opportunities for career progression.

Staff told us that there were some behaviours of a few individuals that were not in line with the trust's values. We were given examples of when these behaviours had been challenged by managers and in the majority of cases, these behaviours had improved.

The trust had also launched an inclusive culture programme; this had four main workstreams within the programme. These were; improving people practices, improve diversity and inclusion, improving people relationships and improving leadership processes. The service had only recently launched the programme, so it was not possible to show any impact yet.

There were initiatives to help staff support each other. In the day surgery unit, there was a notice board for staff to leave individual staff comments to help others. Also, in the day surgery unit every morning briefing undertaken by the manager ended with a quote of the day to inspire staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance systems to support the functions of services across surgery.

There was an effective process to share governance outcomes and updates with staff. Ward and department managers had monthly meetings with the divisional chief nurse to provide updates. Actions were added to a log with lead individuals assigned.

The divisions had divisional governance matters meetings with staff. Ward managers and department managers and matrons met each month as part of a divisional harms meeting review. The purpose was to discuss harms data and share learning. We reviewed a sample of meeting minutes which followed a set agenda, were comprehensive and well attended. Learning identified from these meetings was fed back to staff during ward and department team meetings. We saw meeting minutes which confirmed this

Leaders from each division met monthly for a divisional board meeting. We reviewed a sample of meeting minutes for both divisions, these were comprehensive and were focused on safety and quality of the service. Actions were identified and recorded on a log with a lead individual assigned. Meeting minutes showed that actions were followed up at the following divisional board meeting.

The service followed the trust's learning from deaths policy. The service held regular mortality and morbidity meetings, by speciality, to discuss learning from deaths. However, these were in the form of presentations and were not minuted, attendance was not recorded, and learning actions identified did not have a person assigned to them. This was not in line with the Royal College of Surgeons guidelines. Learning from mortality reviews were seen at board level through a quality of care committee board report presented to the board.

The service showed good governance in its management of development projects. One of the service's goals had been to open the enhanced recovery area (ERA) in December 2020 but was delayed due to Covid-19 to April 2021. Service changes, including cover and staffing, were incremental as patient acuity and volume increased. The service increased junior and senior cover both in and out of hours (including weekends). The service held regular reviews of staffing in line with activity since the unit officially opened. The service published a fully developed standard operating procedure and established a multi-disciplinary governance oversight group limited to this project which met monthly and included discussion and investigation of incidents and safety concerns.

There was a variety of other committees and meetings which supported the overall governance of both divisions. These included: speciality clinical governance meetings, mortality review group, quality of care committee, hospital acquired thrombosis review group and educational half days in theatres.

The service had systems to support the delivery of the strategy and good quality services. Staff of all grades were clear about their roles and what they were accountable for and to whom.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Both divisions had risk registers. The general surgery, anaesthetics, critical care and theatres division risk register had six risks there was one high risk, but this did not directly relate to this service, all other risks were graded as moderate. The specialist surgery and musculoskeletal division risk register had nine risks, and all were graded as medium risk. Each risk was rated and had a named manager responsible for overseeing it. There were details of the actions taken to reduce the risk and updates provided as the risks were reviewed. The risk register was reviewed and updated at the clinical governance meetings. Service risks sat within the division responsible for the service.

Surgery

The division had monthly divisional management board meetings, which followed a set agenda which included risk, incidents, performance, vacancies and audit findings. Each speciality also had monthly meetings which followed the same format. Meeting minutes showed the meetings were well attended any learning identified and actions had a person assigned to them.

There were effective processes to monitor patients waiting for surgery and performance against the post Covid-19 recovery plan. There was a patient tracking list, and managers reviewed this at weekly meetings. Clinical specialists reviewed clinical urgency to ensure that patients were prioritised in line with clinical need. Capacity issues were highlighted, and managers told us capacity issues were addressed by utilising this hospital as an elective centre.

The divisional triumvirate leadership teams had oversight of patients waiting for appointments and referral to wait performance and these were used to plan access for patients. These were discussed in divisional meetings. They in turn reported waiting times and plans to reduce them to the trust board.

The service used a quality assurance dashboard report to monitor performance information including waiting time to referral, theatre utilisation and length of stay. The dashboard provided a real time indication of performance and was comprehensive.

Each ward and department had their performance reviewed during a monthly divisional harms meeting. Performance issues were escalated during this meeting and the ward or department manager was required to produce an action plan when performance was poor.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff received training on information governance as part of their mandatory training.

Information stored electronically was secure. Computer access was password protected and staff logged out of computer systems or hand-held devices as they completed tasks. Staff had access to a trust intranet system which provided a range of internal and external resource material to assist staff in their daily work.

Staff used multiple systems for recording patient care, including paper and electronic records. The trust was transferring to an electronic patient record system in 2022.

The trust had systems to ensure external notifications of incidents causing harm to patients were reported in line with national requirements.

The hospital used a cloud based real time inspection and reporting tool for healthcare quality inspections. This eliminated administration by capturing inspection results directly onto mobile electronic devices which provided automated reporting.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Surgery

The trust was in the process of refreshing their strategy in consultation with the public and stakeholders. The Together We Care Trust strategy comprised of our mission, vales and aims. The strategic objectives were; Quality of Care, People, Modern Healthcare, Digital and Collaborate. The strategy was launched in 2018, since the Covid-19 pandemic healthcare had transformed. Therefore, the trust was engaging with the public and stakeholders by asking them to complete a survey to understand if the objectives were being met effectively and communicated and whether there are areas to consider changing.

The trust were developing plans alongside the local authorities to ensure that transport was available for those affected by the move of services from St Peter's hospital to Ashford hospital and this was part of a wider strategy of making services more available in community locations.

Feedback from some staff included that they people did not feel their voice mattered. The trust's executive and divisional leadership teams were committed to creating an environment where staff felt they could contribute to changes and that plans were not already set by the time they were informed. The divisions and trust had a focus on effective communication with staff which included monthly divisional newsletters, daily trust news bulletins, trust kindness and culture committee and "unmask your stories". "Unmask your stories" was a staff engagement software tool and provided staff within the division the opportunity to share written narratives anonymously and freely anytime they wished to express their experiences and thoughts describing what it was like to work within their division.

Staff were involved in the planning of services. As part of the development of an enhanced recovery area a separate operational committee met bi-weekly to oversee and co-ordinate operational matters with multi-disciplinary representation from both surgical divisions. Both committees had wide representation from all staff groups and aimed to highlight, understand and manage demand, acuity and safety in line with staffing numbers, skill mix, training needs and pressures.

There was a strong emphasis on the safety and well-being of staff. There was a range of interventions available to support the emotional and mental health of staff. These included psychological incident debriefs and psychologists.

People's views and experiences were gathered to shape and improve the services and culture. The service engaged with patients through compliments and complaints. Complaints data was reviewed at the monthly divisional harms meeting. When complaints were above average the ward or department, they had to complete an action plan to identify learning or service improvements.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff had a good understanding of quality improvement methods and the skills to use them to make changes. We were given examples of staff using quality improvement methods to make changes.

For example, there were interventions aimed at preventing patient falls. These included patients at risk of falls being given a yellow blanket and socks to act as a visual aid for staff. All patients had a standing and lying blood pressure taken prior to their surgery and the first time they mobilised after their surgery. In conjunction with the pain team and pharmacy, pain relieving medication had been reviewed for patients post-operatively, so patients were not too drowsy for the medication and risked falling. There were notices everywhere to remind patients of what might increase the risk of a fall and reminding them to take their time and think about every step before they take it.

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Another quality improvement project was “gloves off”. Staff identified that some were using gloves inappropriately and when they did not need to. The aim was to reduce glove usage and only use them when necessary.

The creation of the admissions lounge on Dickens ward and the reopening of the pharmacy on site were also quality improvement projects.

Managers engaged with staff about quality improvement ideas to help improve the service and supported them throughout the process.

Theatres and day surgery had implemented surgery crisis resource management (SCRM). SCRM clearly defined leadership, situational awareness, anticipation of the next step, clear closed loop communication, distribution of workload and allocation of attention to tasks of importance. It included standardised cards with instructions on managing a variety of medical emergencies. At the theatre briefing a member of the team was allocated to be the reader of the card in case of an emergency, they wore a badge to easily identify them to other staff members. This was consistently applied.

The service participated in research which was communicated to staff. For example, during the morning briefing staff were advised in a change in practice to see if it reduced surgical site infections.

Outstanding practice

We found the following outstanding practice:

The service had introduced a wide range and a number of different innovations to reduce patient falls. The service had a system that meant all patients received a follow up call the day after their surgery to check they had everything they needed, and their pain was controlled, and to discuss any concerns they had.

Theatres and day surgery had implemented surgery crisis resource management (SCRM) so staff could respond effectively to emergency situations.

We saw examples of staff responding to patients’ individual needs and beliefs whilst mitigating any risks to the patient.

The service had developed an effective support package for newly recruited international staff that enabled them to gain UK registration.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve divisions.

Action the trust SHOULD take to improve:

- The service should ensure all staff are up to date with their safeguarding adults and safeguarding children training (Regulation 13).

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- The service should ensure staff complete their mandatory training and each module meets their compliance targets (Regulation 12).
- The service should ensure that all staff are bare below the elbows in clinical areas (Regulation12).
- The service should consider a formalised way to record mortality and morbidity meetings.

Our inspection team

The team that carried out the inspection comprised a lead inspector, two other CQC inspectors and two specialist advisors. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.