Imperial College Healthcare NHS Trust

St Mary's Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St Mary's Hospital is part of Imperial College Healthcare NHS Trust. It is an acute hospital and provides accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people's services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

St Mary's Hospital is a 484-bed general hospital based in London. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&38;E department and outpatient services.

The team included CQC inspectors and analysts, doctors, nurses, experts by experience and senior NHS managers. The inspection took place between 2 and 5 September 2014.

Overall, we rated this hospital as 'requires improvement'. We rated effective and caring as 'good' but safety and responsive as 'requires improvement' and well led as 'inadequate'.

We rated critical care, maternity and family planning, children and young people's services and end of life as 'good' but 'requires improvement' for medical and surgery services, and inadequate for A&38;E and outpatients.

Our key findings were as follows:

Safe:

- The principles of the 'Five steps to safer surgery' checklist were not embedded in theatre practice at St Mary's Hospital.
- Wards and departments were not always staffed in line with national guidance. Nurse staffing levels had been assessed using an acuity tool, and in some areas, were regularly reviewed. However, in some areas nurse staffing levels were below national standards. Action had been taken to mitigate the risk of inadequate staffing levels but was sometimes impacting on patient care. Services were consultant-led, although consultant cover was below national recommendations in some areas.
- The standards of cleanliness of the premises and equipment were poor in some clinical areas. Most staff followed the trust's infection control policy, but there was an inconsistent approach to being bare below the elbows and observing hand hygiene. Hand hygiene audits were undertaken by the ward staff but there was no peer review as these were undertaken by the ward's own staff.
- Staff had access to a range of mandatory training and attendance was monitored electronically and on paper. There was low compliance with mandatory training in some clinical areas.
- The introduction of the new electronic record-keeping software at the trust had resulted in problems with booking outpatient appointments for patients. The trust was taking action to resolve these issues.
- Medicines were not always stored securely to ensure that unauthorised personal did not have access to them.

Effective:

- Staff were encouraged and supported with their continual professional development and there was a range of opportunities for staff to develop their skills, including completing degree and master's level studies.
- The majority of care was delivered in line with best practice guidance. Staff participated in a range of local and national audits. Outcomes for patients were similar or above the national average for a number of surgical specialties.
- There was a high rate of patients who did not attend their outpatient appointment or surgical procedure. Action was not being taken to identify the reasons for this or to address the causes.

Caring:

- Staff were caring and treated patients and their relatives with dignity and respect.

Summary of findings

- Patients commented positively about their care and treatment. The results from the NHS Friends and Family Test in many areas of the hospital were better than the England average, and a high number of patients would recommend this hospital to their family and friends.

Responsive:

- The trust was not meeting some of its targets; these included sending out appointment letters to patients within 10 working days of receiving the GP's referral letter, and not getting patient discharge summaries to GPs within target times.
- Capacity in some areas did not meet demand; this had resulted in a backlog of more than 3,500 patients waiting for surgical intervention and a lack of level 2 high dependency beds. There were no plans to address this issue. There was a lack of bed capacity, particularly for level 2 patients stepping down from the intensive care unit (ICU) after brain and spinal injuries.

Well-led:

- The trust had a vision and clinical strategy to improve health and to support innovation in healthcare that had been shared with all staff. The new chief executive of the trust was visible and had already made a positive impact on staff morale by listening to their concerns.
- There was a lack of consistent governance arrangements – for example, the ICU and the rest of the level 2 beds in the hospital were not aligned.
- The trust had a major incident procedure which most staff were aware of. Some staff had participated in training on how to respond to major incidents.

There were poor areas of practice where the trust needs to make improvements.

Importantly, the trust must:

- Increase the number of cases submitted to the audit programme for the World Health Organization (WHO) surgical safety checklist to increase compliance with the 'Five steps to safer surgery'.
- Develop and implement systems and processes to reduce the rate of patients who do not attend their outpatient appointment or surgical procedure.
- Review the level of anaesthetic consultant support and/or on-call availability to ensure it is in line with national recommended practice.
- Review the arrangement for medicines storage and ensure medicine management protocols are adhered to.
- Ensure all staff are up to date with their mandatory training.
- Ensure all equipment is suitably maintained and checked by an appropriate person.
- Ensure adequate isolation facilities are provided to minimise risk of cross-contamination.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.
- Review the provision of the paediatric intensive care environment to ensure it meets national standards.
- Review the provision of services on Grand Union Ward to ensure the environment is fit for purpose.

In addition the trust should:

- Improve the handover area for ambulances to preserve patient dignity and confidentiality.
- Ensure that there is a single source of up-to-date guidelines for A&38;E staff.
- Seek ways of improving patient flow, including analysing the rate of re-attendances within seven days.
- Improve links with primary care services to help keep people out of A&E.
- Ensure that all patients who undergo non-urgent emergency surgery are not left without food and fluids for excessively long periods.

Summary of findings

- Review the literature available to patients to ensure it is available in languages other than English in order to reflect diversity of the local community.
- Ensure same-sex accommodation on Witherow Ward to ensure patients' privacy and dignity are maintained.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Develop a standardised approach to mortality review which includes reporting to the divisional boards and to the executive committee.
- Review patients' readmission and length of stay rates to identify issues which might lead to worse-than-average results.
- Review the arrangements for monitoring compliance with statutory and mandatory training to ensure there is a consistency with local and trust-wide records.
- Review the double-checking process for medication to ensure that staff are compliant with trust policies and procedures.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Review the provision of adolescent services and facilities to ensure the current provision is able to meet the needs of patients.
- Ensure that there is sufficient capacity to accommodate parents/carers while their child receives intensive care support.
- Ensure that the children and young people's service has representation at board level.

Follow up inspection November 2014

At the follow up inspection in November 2014, we found that significant improvements had been made in the accident and emergency department in response to the warning notice we served in September 2014.

Our key findings were as follows:

• The trust had undertaken a significant amount of work since our last inspection and addressed the issues outlined in the warning notice we served to resolve the breach of the regulation.

• There had been investment to improve the environment and plans implemented to minimise disruption to both patients and staff during this refurbishment.

• Staff followed the trust's infection control policy, including being bare below the elbows and observing hand hygiene and using personal protective equipment as necessary.

• Daily cleanliness, infection control and hand hygiene audits were undertaken.

• The A/E department was visibly clean and clutter free.

• The hospital had implemented monitoring arrangements for the standards expected in the A/E department which included reporting arrangements to the executive committee.

• Cleaning schedules including the frequency and the time specific areas should be cleaned were displayed in the department and monitoring of cleaning in line with the schedule took place.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	At inspection in September 2014 we found the standards of cleaning and maintenance of some equipment was inadequate. The department had some issues with patient flow because of the A&E department's physical capacity in relation to the number of patients it could accommodate. There was a lack of bed capacity for those who needed admission. We also had some concerns about the leadership in the A&E department and the lack of drive to improve patient experience on this site for the next five years. Care was generally satisfactory and there were sufficient staff. Staff worked well as a team. The department provided a prompt and safe service for trauma patients. Safeguarding arrangements, particularly for children, were effective. At our follow up inspection in November 2014 we found the hospital had taken action to address the breach of the Health and Social Care Act 2008 in relation to infection control in the A/E department. The standards of cleaning and maintenance of equipment had improved. The refurbishment programme in the department was almost complete and had resulted in a positive impact on the environment and facilitated protecting patients against the risk of infection.
Medical care	Requires improvement 	The trust was unable to maintain adequate nursing staffing on some wards to meet patients' needs. We found patients were treated with compassion, dignity and respect. Staff were motivated and focused on providing a good experience for patients. We found that equipment was readily available but not all of it was suitably maintained and checked by an appropriate person. The trust on occasions was unable to provide adequate isolation facilities to reduce the risk of healthcare-associated infections. There was no written information available in languages other than English. The storage and management of medicines were not in line with trust policy. Some medicines were

stored incorrectly. Not all staff were up to date with their mandatory training. We saw examples of multidisciplinary team involvement and national audits demonstrated that the hospital was achieving good clinical outcomes when compared with other hospitals.
Teamwork was evident and line managers were supportive and visible to staff.

Surgery

Requires improvement

The trust has a known backlog of patients waiting for elective surgery however, they did provide trust-wide plans to demonstrate how they planned to reduce the backlog and manage patients who had experienced long waits for their surgical interventions. There was evidence of good outcomes for patients who underwent surgery. Preoperative assessment for some surgical specialties was not managed effectively, which often led to cancellation of elective procedures. Data submitted by the trust showed that surgery cancellation rates were higher than the national average.
The trust had not taken sufficient steps to ensure that the 'Five steps to safer surgery' checklist was embedded in practice. Procedures and treatments within surgical services followed national clinical guidelines. Pain relief was effectively managed and most nutritional needs of patients were assessed and provided for. Nursing skills mix was regularly reviewed and there were low numbers of nursing vacancies with very few agency staff used. The majority of staff received mandatory training and further specialist training was available. Infection control procedures and practices were adhered to and regularly monitored.
Patients spoke positively about their care and treatment at the hospital. Results from the NHS Friends and Family Test were better than the England average, and a high number of patients would recommend this hospital to their family and friends.

Critical care

Good

The critical care and high dependency areas were generally well-run. The main areas of risk were the lack of bed capacity and different governance arrangements over the level 2 beds outside of the ICU. However, the leadership team were aware of these concerns and had taken action to address

Summary of findings

these. Patient feedback was positive. There were some concerns relating to staffing levels as these were not always in line with national guidance. Mandatory training had not been completed by all staff.

Maternity and gynaecology	**Good**	At the time of our inspection, the risk of unsafe care because of inadequate midwifery staffing had been mitigated by prioritising the needs of women in labour. However, the quality of care on postnatal wards was sometimes compromised. The business case for additional staff had been accepted and recruitment to these posts was underway. Evidenced-based care was promoted and there was an audit programme to assess compliance with best practice. There was an embedded multidisciplinary approach to learning from incidents and complaints. Staff at all levels were able to raise concerns and these were addressed. Specialist clinics assessed the needs of women with medical conditions. Specialist midwives and caseload midwives (midwives who deliver one-to-one care for an agreed number of women) supported women who were at risk. Women were encouraged to make a choice about the type of birth that was best for them and their babies. The community midwifery service provided local women with continuity of care. There was training for midwifery staff and trainee doctors and opportunities for professional development. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued.
Services for children and young people	**Good**	While there were areas of innovative thinking, we found that children were being cared for in environments which were not fit for purpose and posed a potential risk to their safety and wellbeing. Areas including paediatric intensive care, children's outpatients and the Grand Union Ward were not of sufficient size or design to effectively provide care to children in an era of ever-increasing reliance on technology. Bed spaces and cubicles were cramped; there was a lack of effective isolation facilities and a shortage of accommodation for parents/carers who wished to be near to their child or new-born infant while they receive intensive care therapies.

Summary of findings

The division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Parents and children were complimentary about the care and treatment provided. Parents felt that staff across all disciplines were compassionate, understanding and caring. Where children and/or parents/carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future. There was a strong and embedded approach to multidisciplinary working across the various specialities.

The senior management team was cohesive and all those working in this division were passionate about influencing the care and treatment for children and young people. There was a lack of progress made on risks which had been identified within the division. Some risks had existed for more than five years; there was little or no evidence to suggest that these risks were being addressed in an effective way. In addition, there was no representation of children and young people at board level.

End of life care

Good

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the majority of the organisational indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The specialist palliative care team (SPCT) were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive

Summary of findings

to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.
There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

Outpatients and diagnostic imaging	**Inadequate**		The hospital had not increased capacity to respond to the gradual increase in outpatient attendances. Patients were waiting longer to be given an initial appointment and also experienced waits in clinic. The hospital was not meeting its target of sending out appointment letters to patients within 10 working days of receiving the GP's referral letter. On average, appointment letters were being sent to patients between five and six weeks after the GP's referral letter had been received. Some patients were either not receiving their appointment letters or received this after the date of their appointment. Doctors consistently turned up late for clinics without explanation. There was a lack of process in place to monitor performance and identify improvements required. Staff felt supported by their local clinical managers but considered that senior managers were unaware of how the department operated. Staff met with their local managers to discuss performance and concerns on a regular, informal basis only. There were enough nursing and medical staff in the department and patients were treated with compassion, dignity and respect. Patients were positive about the care they received.

Requires improvement

St Mary's Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to St Mary's Hospital

St Mary's Hospital is one of the five registered acute hospital locations of Imperial College Healthcare NHS Trust. The trust also provides services from Hammersmith Hospital, Charing Cross Hospital, Queen Charlotte's & Chelsea Hospital and the Western Eye Hospital. St Mary's Hospital is in Paddington, central London, and is a general acute hospital which provides accident and emergency (A&E) services, medical and surgical services for adults and children; it has a critical care unit and a maternity unit and provides specialist care in areas including paediatrics and sexual health. The A&E department is one of London's four major trauma centres.

The trust had 1,342 inpatient beds across the five locations, of which 484 are at St Mary's Hospital. The hospital sees more than 349,432 outpatients each year. In the last 12 months there were more than 40,715 A&E attendances.

The chief executive officer and medical director had both been appointed to the trust board in the last 12 months.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, MRCP FRCR

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission (CQC)

The team of 35 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics and palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses, a student nurse and experts by experience.

The follow up inspection November 2014:

Our inspection team was led by:

Inspection manager: Fiona Wray, Care Quality Commission (CQC)

The team included a CQC inspector and doctor.

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 inspected the following eight core services at the St Mary's Hospital:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Prior to the inspection we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor, Health Education England; General Medical Council (GMC); Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

Detailed findings

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in White City, London on 2 September 2014, when people shared their views and experiences of Imperial College Healthcare NHS Trust.

We carried out an announced inspection visit on 2 and 3 September 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, dieticians, physiotherapists and pharmacists.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

The follow up inspection November 2014:

At our inspection in November 2014 the inspection team inspected only the Accident and emergency (A&E) at St Mary's Hospital to assess if action had been taken to address the breach of regulation :

Prior to the inspection we reviewed the action plan submitted by the trust in response to the warning notice served. We carried out an unannounced inspection visit on 25 November 2014. We spoke with a range of staff in the hospital, including nurses, doctors and domestic staff. We observed the environment in which people were being cared for in.

Facts and data about St Mary's Hospital

St Mary's Hospital is one of the five registered acute hospital locations of Imperial College Healthcare NHS Trust.

Context

- Approximately 484 beds
- Serves a population of around 158,700
- Employs around 3,153 whole time equivalent (WTE) members of staff

Activity

- Around 349,432 outpatient attendances per annum
- Around 112,452 attendances per annum.
- Around 3,674 births per annum

Key Intelligence Indicators

Safety

- One Never Event (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) in last 12 months – a retained swab in maternity services
- One serious untoward incident (April 2013 to March 2014) – misplaced nasogastric tube (NG tube)

Effective

- Hospital Standardised Mortality Ratio – 80.25 (better than the national average)

Caring

- NHS Friends and Family Test:
  - 77% average score for both inpatients and A&E are better than the national average for 2012/13
  - 37% response rates for both inpatients and A&E, similar to the national average for 2012/13

Responsive

- The A&E's four-hour target was met in 95% of cases in the previous 12 months
- Referral to treatment times: The trust met the admitted and non-admitted pathways
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met the national target
- Cancer: 62-day wait – did not consistently met the national target

Inspection history

The hospital had one previous inspection in July 2013 prior to the publication of ratings and one comprehensive inspection in September 2014 at which the hospital was rated as 'requires improvement' and a warning notice was served.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Urgent and emergency services

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

Information about the service

The A&E department at St Mary's Hospital is open 24 hours a day, seven days a week and is one of four designated major trauma centres in London providing specialist care and treatment for people who have been involved in accidents involving trauma. It provides a service to people mainly from the London Boroughs of Hammersmith and Fulham, Westminster, Kensington and Chelsea, Ealing, Hounslow, Brent, Hillingdon and Harrow. Around 2,500 patients a year benefit from the trauma service.

The department, including the urgent care centre (UCC) sees about 113,000 patients a year (adults and children). Of these, 48,000 are adults with serious illness or injury, and about 25,000 are children. The facilities and staffing in the department increased slightly during September 2014 following the closure of the A&E department at the trust's Hammersmith Hospital, which saw 22,000 patients in 2013. The children's emergency department is a purpose-built and child-friendly environment.

The UCC is open 24 hours a day, seven days a week, and sees about 39,000 people each year for minor injuries or to be reviewed by a GP. It is staffed by emergency nurse practitioners employed by the trust with GPs provided by London Central & West Unscheduled Care Collaborative.

There is a single point of access reception for patients who come in independently. Staff at the reception direct patients to either A&E or the UCC.

During our inspection, we spoke with one clinical and two nursing leads. We also spoke with 16 other clinical and 11 non-clinical staff. We undertook observations within all areas of the department and reviewed documentation, including patient records. We spoke with five patients and 16 relatives/carers.

During our follow up inspection in November 2014, we spoke with clinical and non-clinical staff. We undertook observations in all areas of the department and reviewed documentation, including executive committee reports and training records.

Urgent and emergency services

Summary of findings

At inspection in September 2014 we found the standards of cleaning and maintenance of some equipment was inadequate. The department had some issues with patient flow because of the A&E department's physical capacity in relation to the number of patients it could accommodate. There was a lack of bed capacity for those who needed admission. We also had some concerns about the leadership in the A&E department and the lack of drive to improve patient experience on this site for the next five years.

Care was generally satisfactory and there were sufficient staff. Staff worked well as a team. The department provided a prompt and safe service for trauma patients. Safeguarding arrangements, particularly for children, were effective.

At our follow up inspection in November 2014 we found the hospital had taken action to address the breach of the Health and Social Care Act 2008 in relation to infection control in the A/E department. The standards of cleaning and maintenance of equipment had improved. The refurbishment programme in the department was almost complete and had resulted in a positive impact on the environment and facilitated protecting patients against the risk of infection.

Are urgent and emergency services safe?

Requires improvement

In September 2014 we found the service did not sufficiently protect patients, staff and visitors from the risks of infection because it was not consistently clean. There was complacency about cleanliness among clinical staff, and an absence of effective systems for maintaining hygiene in the department. The department was poorly lit in the corridors and some equipment was dirty or damaged which could impact on the standard of care provided to patients. We observed poor practice by clinical staff with regards to hand hygiene, the use of personal protective equipment to protect staff and patients (e.g. gloves and aprons) and in the prompt disposal of clinical waste.

At our follow up inspection in November 2014 the department had been refurbished and the flooring replaced and lighting in the corridors improved. Damaged and broken equipment had been removed. All of the instruments we saw were visibly clean; however, we noted that two of the eight laryngoscope blades in the adult resuscitation area had been left open and uncovered ready for use.

Action had been taken to ensure patients, staff and visitors were protected from the risks of infection. The environment and the majority of the equipment in the department was visibly clean and dust free. There were systems and processes in place to monitor and maintain hygiene in the department.

Incidents

- There had been 4 serious incidents in A&E at this site since 2013. Two were still under investigation and the other two had been thoroughly investigated and learned from.
- The top five categories of reported incidents were slips, trips and falls, pressure ulcers, medication, infrastructure, patient abuse towards staff and patient transfers. There had also been a serious near miss of appendicitis and instances of mental health patients absconding.
- Staff told us the hospital's incident reporting system was easy to access and they usually received feedback on incidents reported.

- Wider learning from incidents was circulated to staff through the A&E digest and through teaching sessions. Emails to A&E staff were also used to share learning following incidents. Significant changes following incidents were also included in the 'Team Read' file, which clinical staff were required to sign to show they had read the documents. From signatures seen, too few staff at this site had signed to indicate that they had read the file. For example, five nurses out of 40 and three out of 10 doctors had read a recent document in the file.
- Staff told us about learning from an incident that had changed practice. A psychiatric patient had absconded and fallen from a gantry. Since then, relevant patients' assessment cards had been required to contain a basic description of the patient's appearance to help staff identify anyone attempting to leave the premises.
- Mortality and morbidity meetings were held regularly and there were debriefs after the treatment of major trauma patients to review whether anything could have been done differently.

Cleanliness, infection control and hygiene

- At our previous inspection in September 2014 we found numerous areas of the A&E department and some equipment to be visibly dirty and staff had not taken action to address these issues.
- We previously observed that there was a lack of personal protective equipment and few clinical staff washing their hands or using hand gel before and after caring for patients. We did not see staff wearing gloves or disposable aprons when it was appropriate to do so.
- We saw almost all the spill wipes containers were empty. Many of the anti-bacterial hand gel dispensers were also empty, including those for paramedics bringing in ambulance patients, and one beside trolley in the adult resuscitation bay. There was also a lack of hand-washing sink in the department.
- We saw instruments that were not clean, and clean instruments left open and uncovered ready for use. some sharps bins that were open for use were full and there were some overflowing rubbish bins.
- At our November 2014 inspection we found the A/E department was visibly clean and clutter free. The cubicles we visited had all been refurbished, they had sharps bins that were less than half full, there was wall mounted personal protective equipment (PPE) including aprons and disposable gloves.
- The hospital had implemented either daily or weekly monitoring arrangements for the standards expected in the A/E department against nine key performance indicators (KPIs). These KPIs covered hand hygiene, decontamination, facilities check, PPE, sharps bin, linen, curtains, standard of cleanliness and estates issues. The monitoring results were reviewed and collated by the divisional managers who were responsible for submitting the results and remedial actions of any failed standards weekly to the executive committee.
- The shift team leader or matron completed daily cleanliness and infection, protection and control audits looking at six key areas including PPE and sharps bins. These were undertaken at random times of the day and action taken to address any shortfalls identified. Maintenance issues identified during daily audits were escalated to the business manager and reported to the estates' department.
- Hand hygiene was audited daily with the nurse in charge observing three 10 minute episodes, this took place in the morning, afternoon and at night with a minimum of 10 hand hygiene observations per day. The department had achieved a 90% compliance score in the week ending 23 November 2014.
- We saw the weekly audit results for the five weeks preceding our inspection demonstrated that compliance with these KPIs had improved week on week and all were over 90% compliant. The rating was green for all nine KPIs for the week ending 23 November 2014.

  • Executive directors had carried out spot checks in the department as an additional level of oversight and feedback. These checks were not documented but feedback was provided to staff at the time of the spot check.

  • The training records we saw showed that as of the 10 November 2014, the majority of clinical staff had completed aseptic non-touch technique training.

  • The trust's cleaning contract had changed providers on 26 October 2014. There was a service level agreement that outlined the expected standards. These included there being a minimum of two dedicated domestic staff based in the A/E department 24 hours a day, seven days a week, with a supervisor present between 6.00am and 10.00pm daily. During our inspection we observed there were three

members of the cleaning team plus a supervisor in the department. There was access to an out of hour's domestic team who were responsible for 'deep cleaning' if required for example if a patient with an infection had used the cubicle.

• Cleaning schedules which included frequency and the time specific areas should be cleaned were displayed in the department. Following a review of the roles and responsibilities for cleaning specific equipment, the trust's cleaning policy had been updated on the 14 October 2014 and included a list of equipment and the cleaning responsibilities of individual staff groups. For example the new commodes were cleaned daily by domestic staff and in between patients by nursing staff. We observed that these were clean and labelled as ready to use.

• Cleaning checklists were displayed in each cubicle to confirm the three times a day schedule cleaning had taken place. Records seen showed that cleaning had been completed as a minimum twice a day and domestic staff signed to confirm they had completed all the cleaning tasks. We also saw that in between these regular checks, when a patient was discharged from the department a cleaning check list was completed to demonstrate that the cubicle had been cleaned. The matron confirmed the standard expected was at least twice daily recording.

- There was a cleaning escalation policy and flowchart including who was responsible for escalating issues. We saw several cleaning checklist records where the cubicle was recorded as in use and could not be cleaned and this had been escalated to the supervisor and nurse in charge.

• There were arrangements in place for staff to access a rapid response domestic team if necessary to ensure admissions were not delayed due to cubicles not being cleaned in a timely manner.

• There were arrangements in place for quarterly deep cleans of the department; an initial deep clean had taken place following our last inspection.

• All domestic staff were expected to complete a competency checklist that was signed off by their supervisors to demonstrate they had the necessary skills to undertake specific tasks. We saw signed training records for domestic staff working in the department to show they had received training and had been assessed to carry out the required standard of cleaning within the colour coded cleaning areas (red, blue and yellow).

• The majority of the equipment we saw in the department was clean and had a signed label identifying the date it had been cleaned and by whom. However, a portable x-ray machine in one of the x-ray rooms was labelled as clean, but had a thin covering of dust in the lower part.

• All of the instruments we saw were visibly clean; however, we noted that two of the eight laryngoscope blades in the adult resuscitation area had been left open and uncovered ready for use. These were removed when pointed out to the nurse in charge.

• Throughout the department soap, towels and hand sanitising gel were available at all hand wash basins. Anti-bacterial hand gel dispensers were available at all entry and exit points and when entering and leaving clinical areas in the department. We noted they were all dispensing gel and were replenished as needed.

• Additional sinks had been installed to facilitate hand hygiene. For example there was a recently installed hand-washing sink in the sluice. The theatre, which was regularly used as a treatment room, was having a new hand washing sink installed on the day of our inspection.

• A/E staff observed the standard principle of 'bare below the elbow' and washed their hands or used hand gel before and after caring for patients.

- We saw that soiled linen was stored in laundry bags. Staff told us that new style laundry bags were now used, which were stronger and larger reducing the risk of splitting and rested on the base of the trolley which prevented overfilling. There was a daily linen check as part of the monitoring audit carried out at midnight and the department had achieved a 100% score for the week ending 23 November 2014.

• Disposable curtains around the cubicles were clean and stain free with a date when they were next due to be changed. Staff were aware of when and how these should be changed and we saw staff changing curtains which had been noted to be soiled.

Urgent and emergency services

Environment and equipment

- At our previous inspection in September 2014 we found issues relating to the physical environment including corridors that were dimly lit and some of the lights were broken and worn flooring and some walls were damaged.
- The airway trolley had not been checked in the month prior to our September 2014 inspection and there was no GlideScope® (an instrument used give a clear view of a patient's airway). Some equipment was noted in September 2014 to be broken.
- At our November 2014 inspection we found the trust had undertaken a refurbishment programme in the department, which was still on going. This had resulted in the A/E department environment being improved and the new ceiling and lighting made the corridors brighter. All broken lights observed at our last inspection had been replaced.
- The majority of the flooring in the department had been replaced and was clean. The floor in the resuscitation area had been cleaned and repaired since our last inspection and was no longer lifting in the gap between the door and floor. This flooring was on the refurbishment programme to be replaced however the department was still assessing how best to arrange this piece of work and still provide the service.

  • The chipped plaster on many of the walls observed at our last inspection had been repaired and we noted that protective, wipeable wall coverings had been installed, making it easier to clean and maintain.

  • The psychiatric place of safety room had been cleaned, new flooring laid and the damage to the walls repaired. Staff told us the mental health team from the trust who provided this service were due to visit the department during the week of our inspection to advice on changes to the room to ensure it was fit for purpose. Once the assessment had been completed a business case would be prepared to obtain funding for the necessary work and any additional equipment or furniture required.

  • The matron told us there had been a 'general clean up' in the department to remove excess equipment and supplies to clear corridors and free up space. This was evident at our inspection and corridors were clutter free.

- Supplies and equipment had been lifted off the floor in the clean and dirty utility rooms to enable floor cleaning. We saw domestic staff moving equipment to clean and equipment and PPE had been placed into wall mounted holders and other clinical supplies were secured in lock top storage boxes which could be easily moved for cleaning purposes.

  • All patient toilets in the department had been refurbished and hand dryers installed to replace paper towels which had been identified as a contributing factor to the toilets becoming blocked.

  • Work had been completed to improve the paediatric A/E department; this included replacing the curtain in the assessment room with a frosted glass door, removing a wall to make the reception area open plan improving visibility and removing the numerous posters and stickers on the walls, which had been repaired. There were plans to replace the plain curtains around the cubicles with printed ones to make the environment more child friendly.

  • The seating areas in the paediatric waiting room was damaged, we were told that the hospital was waiting for replacement cushions for the seating and for the damaged wood to be repaired.

  • In one of the two paediatric resuscitation rooms, an anaesthetic machine had been out of order since 18 November 2014; it was unclear if this was the same pieces of equipment that we had noted was out of order at our last inspection. The senior nurse we spoke to was unsure when this equipment would be repaired.

Medicines

- Medicine was stored appropriately and checked by pharmacy technicians. Fridges were locked and temperatures were accurately maintained. Patient notes recorded medication prescribed and administered appropriately.
- Drug fridges were locked to ensure safety and security of medicines.
- We saw evidence that medication audits were carried out; for example on controlled drugs management.

Urgent and emergency services

Records

- The 15 sets of patient notes we looked at were of acceptable quality. However, the patient notes audit found that patients' identifying information such as their name or hospital number was not always recorded on every page, and nursing documentation was sometimes not completed. For example, one record said observations were "not done as patient seen by doctor". In that instance the patient had been seen by a doctor 90 minutes after arrival so the patient observations should have been taken as part of the initial assessment and within 15 minutes under College of Emergency Medicine Guidelines. This was not a one off occurrence as during our visit we overhead doctors asking nurses why tests had not been done. The final review and treatment plan was not always recorded on notes.
- We noted that a number of notes in the department were overdue to be sent for scanning and retention. We also saw from the risk register that there were concerns about the quality of scanning and storage of A&E records which was a risk in the event of complaints or legal challenge.
- Storage of pro-formas for specific conditions was poorly organised and consequently, relevant pro-formas were not always in patient notes. For example, renal colic pro-formas were missing, but in the filing area where they should have been stored were guidelines for nosebleeds and emergency gynaecology.
- A digital camera containing patient images was in an unlocked cupboard. This posed a breach of confidentiality risk, as the camera was potentially accessible to unauthorised persons

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had been trained on how to support people who lacked capacity or had mental health needs. We saw 'Top tips for dementia patient care' displayed on the wall in the staff area. However, we did not observe this knowledge being put into practice. We saw an agitated patient using inappropriate and abusive language, who was asked by another patient's relative to stop swearing because this was upsetting. There was no active staff intervention, even from the registered mental health nurse observing the abusive patient at the time.
- The Mental Health Act 1983 was used for holding patients while awaiting assessments from the psychiatric liaison team.
- If there was more than one mental health patient, we were told the second patient might experience a long waiting time.
- The mental health service had recently started to assess 16 and 17 year-olds in the adult Majors area.

Safeguarding

- We saw evidence that all paediatric staff had completed safeguarding training. Staff we spoke with showed an understanding of safeguarding children and vulnerable adults and knew how to recognise signs of abuse and how to report it.
- There was a safeguarding clinical nurse specialist based in the children's A&E as well as St Mary's Hospital liaison health visitors. The nurse specialist spent time working with staff day to day in the department (70% of her time) and providing training (30% of her time).
- The nurse specialist described a clear and effective process to ensure that potential safeguarding concerns were escalated, and said there was ready access to a senior member of staff for an opinion for child welfare issues.
- There were safety nets to alert staff to potential abuse or neglect of children presenting to the A&E. This was done through staff observations, the health visitor review of patient notes and a weekly family support meeting attended by the liaison health visitor, social services, paediatrics and A&E staff, the Child and Adolescent Mental Health Services (CAMHS) liaison nurse, drug and alcohol worker and named nurse for safeguarding. The nurse specialist reviewed all referrals to social services.
- Paediatric guidelines were shared between A&E and the children's ward to ensure a consistent approach.
- A health visitor liaison referral form was automatically completed for every child aged under one year and any child with possible non-accidental harm, or with a parent with a history of domestic violence, drug or alcohol issues.
- The trust alert system ensured that A&E staff were aware when a child was known to social services, and there was a clear system for keeping this list up to date to ensure that any child known to be at risk or subject to a child protection plan was identified and appropriate action was taken.
- The children's A&E had access to senior paediatric advice and second opinions 24 hours a day.
- CAMHS guidelines had been reviewed in September 2013 and children's safeguarding had been updated in

July 2014 to reflect the Pan London Child Protection Procedures 2014. The adult safeguarding policy had last been updated in September 2013, which meant that it had not been reviewed in the light of the Supreme Court judgement in March 2014 on deprivation of liberty processes.

Mandatory training

- Mandatory training was integrated with statutory training. It was provided in different formats, including e-learning by computer and allocated time was given for this.
- Nurses were responsible for their own training portfolio but there were alerts in the system to remind them.
- The target for compliance with statutory and mandatory training was 95%. We saw evidence to demonstrate that this had not been achieved. Nurse compliance was 63% at 31 March 2014. We were told that work had been undertaken to improve this.

Assessing and responding to patient risk

- The national early warning score (NEWS) system was used effectively and clinical observations were entered into patient notes. A given score would alert clinicians to any deterioration in a patient. The escalation processes were clear.
- Senior managers were aware that bed pressures were leading to delays in finding beds for patients quickly enough. 830 patients spent between four and 12 hours from decision to admit to admission between July and September 2014. Between 19 and 22 medical patients were admitted each day.

Initial assessment

- Patients who came in to the department independently were registered at reception, given a number and were then called for a streaming interview in a private room. Those needing emergency treatment were taken to the A&E waiting room. Others waited for minor injury treatment or a GP consultation. Patients were seen in order of arrival unless their condition clearly warranted more urgent treatment.
- Children were triaged in a private room in the paediatric area after registration at the main reception.
- The paediatric waiting room had a glass surround enabling staff to observe family interactions and identify any attempted unauthorised access.
- There were trauma care pathways and consultant-led specialist teams were available 24 hours a day to deal with admissions of people with multiple serious injuries.

Nursing staffing

- A band 8 matron was in charge of the department and a band 8 nurse consultant worked across the three acute hospital sites in the trust.
- Staff we spoke with considered there were enough nurses. We found the department was adequately staffed during our inspection, although we noted four reports of incidents related to inadequate staffing in July 2014.
- Staff told us there was potential increased activity from 10 September after Hammersmith Hospital and Central Middlesex Hospital A&E departments had closed. An additional nurse had been added to both the day and night shifts. We were told that managers would be monitoring activity levels.
- A new workforce planning tool named baseline emergency staffing tool (BEST) had been introduced two weeks before our inspection which identified any disparity between nurse staffing levels and workload. The tool enabled calculation of nurse-to-patient ratios against patient dependency and could be used to provide a skills mix breakdown. The results of this were being monitored by the matron and referred upwards to trust management.
- During the day, there were 10 or 11 nurses on duty, depending on the time of day, and at night there were nine nurses in the adult Majors area.
- There were always trained children's nurses in the paediatric A&E, including two at night.
- Staff reported there were vacancies for two band 7 posts and healthcare assistants, despite repeated advertising.

Medical staffing

- St Mary's A&E department is a major trauma centre with 24-hour consultant trauma cover. The trauma consultant did not cover non-trauma A&E patients. Trauma patients were later transferred to the trauma ward that was not part of the A&E department.
- The adult A&E department had 7 whole time equivalent (WTE) consultants at the time of our inspection, which was fewer than the 10 recommended by the College of Emergency Medicine. There was consultant presence on site from 8am until 10pm at night, Monday to Thursday and until 9pm on Friday. Six hours of consultant cover was provided at weekends. The department did not

therefore provide the recommended 16 hours of consultant presence a day, but said they had approval to appoint six more consultants. However, at the time of our inspection, this recruitment had not taken place.

- There was 24-hour cover from a specialist registrar. Middle grade and junior doctors were on duty overnight and a consultant was on call. A rota of two specialist trainee 3 (ST3) doctors worked shifts from 8am to6pm, 11am to 9pm and 1pm to 11pm.
- The children's A&E had one or two consultants on weekdays from 8am until 8pm three days a week, and on call outside those hours. There was 24 hour medical cover by paediatricians. Handovers took place between nurses and doctors together at a board round in the morning.
- We were told that locum doctors were employed but that they were known to the department, had received an induction and were familiar with procedures and protocols.

Agency and Bank

- The department's vacancy rate was 12.5 % for all staff. Agency and bank staff use for all staff was 10.4% in July. The sickness rate for the past 12 months averaged 4.4%.

Security

- There were security staff on duty 24 hours a day. Staff said they felt safe and supported.
- Staff working in the department followed National Institute for Health and Care Excellence (NICE) guidelines on restraint One member of staff told us that while hospital security staff were used for restraining patients and visitors they were not trained in management of violence and aggression
- We observed security staff working effectively alongside the police where needed.

Major incident awareness and training

- There was a major incident plan and we were told that the hospital ran simulations. However, we noted that the plan had not been updated to reflect the fact that Charing Cross Hospital was no longer a trauma unit.
- There were three well-stocked major incident cupboards.
- Staff told us the annual Notting Hill Carnival had its own staffing plans based on previous years' experience.
- We saw an up-to-date business continuity plan.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Policy and protocols were underpinned by national guidance. However, some guidelines did not reflect current trust policies. There was an active audit culture but less attention was paid to reflection on practice and making changes post audit. Staff made regular checks to ensure that patients' basic needs were met. The department had a high readmission rate to A&E which had not been closely analysed to determine the reasons for this.

Evidence-based care and treatment

- Trust policies were based on up-to-date guidelines, stored electronically in a file called
- 'The Source'. However, the A&E department had some systems of its own outside this trust-wide system. Trainee doctors used a USB storage drive containing separate guidelines written by A&E seniors; those guidelines on the USB storage drive were different to those on the intranet and some were out of date. For example we saw one from 2002 and a listing of phone numbers from 2005. We noted the audit of USB drive use did not include use of the guidelines accessible from this drive.
- The third set of guidelines was from the A&E manual. Paper printouts were found filed in the handover room. We noted that there was often more than one protocol for a given condition and guidelines contained different referral routes. This presented a risk that patients might receive treatment which did not reflect current best practice.

Pain relief

- A review of recent patient notes showed that pain was assessed at streaming (where patients are assessed and directed to the most appropriate department). This was noted on the front sheet for patient referrals to the urgent care centre and on the nursing assessment sheet for those referred to Majors. There was an appropriate choice of pain relief for patients, which was given in a timely manner. If patients used their own pain relief medication, this was documented in their records.

Urgent and emergency services

Nutrition and hydration

- Hot drinks and water were available for patients and relatives in the A&E. Patients told us that food was offered to those with longer waiting times.
- Patients in the clinical decision unit said they had been offered drinks and food when required.

Patient outcomes

- The hospital had taken part in the College of Emergency Medicine audits. They had used the results to review the effectiveness of the department, although we did not see evidence of significant changes being made as a result.
- Outcome data from the National Trauma Audit and Research Network showed that St Mary's Hospital had an extra two survivors to every 100 patients treated, when compared to the UK average.
- The College of Emergency Medicine recommends that the unplanned re-attendance rate for A&E should be between 1–5%. The rate at St Mary's was 7.5% but they had not analysed the underlying causes or how this rate could be reduced.

Competent staff

- Appraisals of staff performance were undertaken annually. The current rate was approximately 82%. Nursing staff spoke positively about the more rigorous process that had recently been introduced, whereby staff salary increments depended on achieving competencies rather than being automatic.
- Band 7 staff had one day per month allocated for staff management and team appraisals. Nurses considered their managers to be supportive.
- Emergency nurse practitioners rotated through urgent and acute care to develop skills in both areas. We saw a nurse training spreadsheet documenting competencies for emergency care.
- There were early morning training sessions for nurses one day a week to share learning and for regular teaching in A&E skills such as suturing and triage.
- Junior doctors told us they felt well-supported and had access to training. There was protected time allocated for teaching.

Multidisciplinary working

- We observed a structured handover of care at the midday shift involving a consultant, doctors, and the nurse in charge. Although this was meant to be multidisciplinary, there was no occupational therapist or drug and alcohol nurse present. Patient confidentiality was protected as no names were used and attention was paid to the welfare and medical needs of patients. We noted that the nurse in charge was on the telephone or attending to other matters and not giving the handover full attention.
- Staff told us that the trauma team worked effectively across all divisions in the hospital, but that internal cross-divisional networks for non-trauma patients needed improvement.
- There were multidisciplinary meetings four times a day, including occupational therapists, nurses and doctors.
- There was an alcohol/substance misuse liaison team which could be accessed for support and staff told us they made a number of referrals to that service.
- There was access to psychiatric input from the psychiatric liaison service 24 hours a day.

Seven-day services

- The A&E services for adults and children and the urgent care centre were open 24 hours a day, seven days a week.
- There was on-call consultant presence out of hours.
- There was imaging and pharmacy 24 hours a day, seven days a week.

Are urgent and emergency services caring?

Requires improvement

The privacy and dignity of adult patients was compromised, especially those admitted by ambulance. Staff in the A&E department were providing a caring service in the paediatric A&E. Parents mentioned that children had a long wait in the evening. Some adult patients told us they felt staff were rushed, and they did not know who was caring for them or who they were due to see. Although the department scored above the national average for the NHS Friends and Family Test, the low return rate did not make the data reliable.

Urgent and emergency services

Compassionate care

- We observed episodes of compassionate care delivered by nurses and doctors to patients, particularly to children. For example, a child needing an x-ray was pushed on the trolley with her mother lying beside her to give reassurance.
- Ambulance patients were triaged in a corridor, with no privacy for the patient, opposite both the waiting room/ discharge area from A&E and cubicles with patients. Although we were told that confidential exchanges would take place in a side room, we did not observe this happening at the handovers we saw. The ambulance handover area did not adequately preserve patient privacy, dignity or confidentiality.
- Patients reported kindness and reassurance from staff. A number of patients mentioned they would appreciate more information about how long they had to wait, and to know the names of staff they were seeing or due to see.
- Patient feedback was collected through the NHS Friends and Family Test. The response rates had been consistently low over the past year, rarely reaching 25%; in June 2014 it was 8% compared with an average response rate of 20.8% nationally. It would not be reasonable for the trust to solely rely on these scores as a measure of patient satisfaction because of the low return rate.
- We observed one incident in which staff did not show respect to a patient staff were observed talking over the head of a patient with spinal trauma about a different suicidal patient.
- People's privacy and dignity was sometimes compromised by curtains being open in cubicles. Also, the handover area for those arriving by ambulance was visible to many other patients and staff.

Patient understanding and involvement

- Most patients told us they felt informed about the processes in A&E and we saw posters explaining the patient journey, although these were not in every cubicle. Patients said that once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- A parent who attended often because of their child's condition said that assessment was fast and made her feel "safe".
- Parents commented positively on the knowledge of the staff treating their children.

Emotional support

- We observed staff providing reassurance to patients and relatives waiting for news on people receiving resuscitation.
- We heard about an example of guidance being given by a senior member of staff on breaking bad news following an x-ray.

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

(for example, to feedback?)

Requires improvement

The A&E department was managing to deliver treatment and provided an adequate service for patients attending the department but was not taking enough account of their views to improve the service. The signage in the hospital was unhelpful and confusing.

Service planning and delivery to meet the needs of local people

- We found the signage in A&E difficult to follow because there were too many signs. This was confusing to patients and we observed many patients asking how and where to book in. In other areas there were too few signs, for example, to help find the lifts or the way out.
- Information about the Patient Advice and Liaison Service (PALS) was available but not always in areas where patients or relatives were most likely to see them.
- In response to the closure of two other local A&E departments, on 10 September 2014, some infrastructure changes were in place to cope with additional pressures. These included an additional cubicle in the Majors area and a new area to which a less seriously ill patient could be safely moved from the main resuscitation area to free up a bed in the main resuscitation area. The ambulatory care area was to be moved to another location.
- Other changes were being made to slightly increase capacity in St Mary's Hospital A&E, including the addition of an assessment cubicle and more resuscitation trolley spaces. There were also plans for an

extra 22 beds on the St Mary's Hospital site. These changes had not been effected at the time of our inspection, but the aim was to enable St Mary's Hospital A&E to offer patients the same level of service, even though the number of people using the service would increase.

- There was information on the screens in the waiting room about other services people could contact if they had non-urgent conditions. There was a very small waiting room for relatives, although there were also some chairs along a corridor that we saw being used. The only reading matter in the waiting area on the first two days of our inspection was a leaflet on organ donation. One relative told us this seemed insensitive. This room had been restocked with a wider range of health promotion leaflets on the last day of our visit.
- Staff photographs, for example, to identify the trauma team leaders and staff were not fully up to date which limited their usefulness to patients.
- Staff told us patients could be given information about their condition on discharge, but we did not see this happening, and no patients we spoke with mentioned this.
- Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated, discharged or admitted within four hours. Data showed that, year to date, the trust as a whole was meeting this target. However, the trust was doing slightly less well for type 1 patients, cases that are potentially life threatening. Of these patients, 90.8% were treated within four hours for the year to date. All children were treated within four hours.
- There had been eight breaches of type 1 cases, the most seriously ill patients. Staff told us that the reasons for this were most frequently due to the lack of available beds in the main hospital. Bed occupancy in the hospital was often high, for example 98% on 1 September 2014, which impacted on patient flow through A&E.
- Since April 2014, on average 5.4% of the most acute patients had been in A&E for over six hours which is higher than the England average.
- Around 2.1% of A&E attendees left without being seen, which is within the national quality threshold of less than 5%.
- We saw that patients were assessed at triage, and intervention was timely for trauma patients.
- Approximately 3% of patients admitted waited between four and 12 hours from the decision to admit to admission. National standards recommend that all patients should be admitted, transferred or discharged within four hours of arrival to the A&E.
- A number of measures have been introduced to help reduce the pressure on A&E and ensure that patients were treated at the most appropriate location. A medical telephone referral service had been set up for GPs to give advice and arrange referrals to appropriate wards. Patients with long-term conditions for example, known haematology, cardiac or renal patients were being given 'patient access' cards with a number to call if they needed urgent treatment or to give to the London Ambulance Service.
- When there was a shortage of beds, the unit moved to a 'treat and transfer' model. A drug chart was written up and the patient was transferred to Charing Cross or Hammersmith Hospital, depending on the treatment required. At present any service could do this when St Mary's A&E was full.
- We observed some procedural inefficiency. We overheard a senior doctor ask why a patient had been in the department two hours without having any tests at all. Similar points about tests not being done in a timely way were seen in patient notes.
- Patients who had sustained injuries associated with trauma, such as road traffic accidents, were rapidly assessed in the A&E by the specialist consultant and trauma team, and scanned to assess the extent of their injuries before being taken to the trauma theatre. Most of these patients were later transferred to the specialist trauma ward.
- Some processes were slow, (for example, blood diagnostics) and this had an impact on patient delays in A&E. There were challenges for patient discharge, particularly for the elderly, in part because of the different responsiveness of the five main London boroughs the trust worked with.
- Senior staff told us there was a lack of clinical engagement with the clinical commissioning groups and the trust had not reached the right arrangements with GPs to reduce the number of patients who attended frequently. A new telephone line had been introduced to help GPs with referrals to specialist acute

medicine or the acute medical unit appeared to be welcomed by GPs. The intention was to take some pressure off the A&E department but it was too early to judge the success of this.

- There was poor documentation of consultant involvement in cases and fewer patients than average were reviewed by consultants before discharge. The College of Emergency Medicine's 2013 audit of consultant sign-off showed that St Mary's Hospital was in the bottom 11% of hospitals where sign-off was by a consultant, although in the top 75% for sign-off by a senior trainee in emergency medicine – specialist trainee 4 (ST4) or above. The department was close to the national average for cases discussed with a consultant or senior trainee doctor after patient discharge. Such reviews are important both for patient care, as a chance to identify any patient discharged inappropriately and as a learning opportunity for trainee doctors.
- A registrar was usually available for rapid assessment but was not always supported by a nurse.
- In response to recent Ebola concerns, patients presenting at the A&E were asked to identify themselves at reception if they had recently travelled from a specified list of countries and had certain symptoms. There were 'Ebola kits' for high-risk patients in the streaming room, the paediatric office and the ambulance base.
- There were health promotion leaflets, and drugs and alcohol information in areas where patients could see them. Parents attending during the day experienced shorter waits and said they were usually informed about how long they might have to wait. Parents attending in the evening said the wait was long and staff did not keep them informed about waiting times. A child told us the department was "child friendly".

Responding to the needs of children

- The waiting area had toys for children to play with and a television. There was a small room where teenagers could spend time away from younger children.
- There was a play specialist every day in the children's emergency department, although not out of hours. Part of their role was to distract younger children when they were having treatment.

Caring for people with mental health needs

- The department had a dedicated place of safety room for people who had or may have mental health needs. The room was, in the main ligature free and had panic buttons, but the heavy chairs were free-standing which presented a risk and could potentially be used to cause harm.
- There was always a registered mental health nurse on duty. Their role was not to assess patients but to manage the individual until the psychiatric liaison team could assess them.
- There were approximately 124 acute psychiatric attendees a month. The median time they spent in the emergency department was two and a half hours. However, we saw one patient admitted at midnight on 2 September 2014 who was still on a room in A&E at 2.45pm on 3 September 2014, even though they had been assessed by the mental health team as needing admission.
- The psychiatric liaison team was employed by another NHS trust and had one or two nurses on a shift at the hospital 24 hours a day. They aimed to see patients within 30 minutes. However, they were not able to show evidence of meeting this target when we asked for this. Incompatible computer systems meant the service could not access historical mental health treatment records from other trusts, which led to delays in assessing patients.

Working with the ambulance service

- Ambulance turnaround time did not meet the national target of handover within 15 minutes for 95% of cases. 83% of handovers at St Mary's were within 15 minutes, although 96.2% were within 30 minutes in the week of 11 August 2014. There had been no 'black breeches', ambulances waiting over 60 minutes to hand over a patient during 2013/14 or in the current year to date.

Meeting people's individual needs

- Reception staff told us that a translation service could be accessed if required. The only information in other languages that we saw was a notice asking patients who had visited one of a long list of countries recently to inform reception. This was in Arabic and French.
- The number of staff not wearing uniforms as well as the inconsistent use of name badges made it difficult for patients to identify the staff who were treating them. We observed more consistent wearing of uniform on our visit on Friday 5 September 2014. We were told there was no budget for 'scrubs' clothing for doctors.

Urgent and emergency services

- We saw 'Top tips for dementia patient care' displayed on the wall in the staff area. However, we did not observe this knowledge being put into practice. On the first evening, we saw a patient living with dementia wandering around for a considerable time, accompanied by a carer, and randomly approaching other patients. We saw no staff engagement with this person.
- Entry or exit from the children's A&E required access to a button high on the wall. This was unreachable for adults of small stature or those in wheelchairs. There was no sign about how to obtain help with this.
- Referrals to drug and alcohol services were widely displayed and streaming nurses told us they regularly gave people information about these services.
- Chairs in the waiting room were not comfortable and there were no higher chairs which elderly people might find more comfortable.
- There was a plentiful supply of hot drinks and cold water for patients and carers in the adult area of A&E. In the children's area we noted on two occasions there were no cups by the water machine.
- There were three desks for booking in and adults were given a ticket number, which was used to call them for streaming where a nurse would make an initial assessment of the person's condition, and place them in a queue either for the A&E or the UCC. One desk was low to suit people in wheelchairs.
- There was a clear information screen in the waiting area showing information about services, including waiting times. There was also a leaflet explaining the patient journey through the A&E department and giving information about alternative sources of medical help, such as walk-in centres, alcohol advice and counselling services or sexual health.
- An ambulatory care facility was due to open shortly. At present around 15 patients a day were seen as ambulatory care patients in an inadequate, small treatment area.

Learning from complaints and concerns

- There were approximately five written complaints a month.
- We were told the top complaints were about communication, for example, staff roles rather than staff names being given to patients. The failure of all staff to wear name based demonstrated that the department were not sustainably addressing this complaint. Other complaints included that communications with GPs were not detailed enough, and that patients had long waits for cubicle space or for a speciality doctor.
- An example of concerns that were acted included the case where people had found the glass surrounding reception staff in the adult waiting room intimidating; this was subsequently removed.
- Staff had been trained in diffusing situations, and there had been no recent incidents.
- Staff said they were free to raise concerns to their managers.
- PALS was promoted in leaflets, but we did not see the leaflets being actively given to people.

Are urgent and emergency services well-led?

Inadequate

Leadership was not visible in the department and not aware of what was happening on the front line. The department's vision was not underpinned by detailed, realistic objectives and plans, it was focused on the aspirations for a new building to solve problems rather than come up with solutions for improving patients' experience now and in the years before a new building was ready.

We had concerns about cleanliness and equipment and the department was not well-led to varying degrees in these areas. There was management oversight by a senior member of staff from another directorate that brought an external view but was not effective in achieving the desired results in improving leadership in the department.

Vision and strategy for this service

- The department's long-term vision aligned with the national vision for centralising emergency care services so that those patients with more serious or life-threatening conditions were treated where there was the best expertise and facilities to maximise patients' chances of survival and full recovery. Achieving this vision required a new building. There was an outline, costed business case but this remained unfunded.

Urgent and emergency services

- Staff did not have a clear vision or understood how their roles contributed to improving the quality of patient experience now and until and if a new A&E department was built. Staff just accepted that the environment looked less than ideal and looked "tired".

Governance, risk management and quality measurement

- The A&E was part of the medicine division. The medical division management board met monthly and key performance information on issues such staffing, training, incidents and risk was reported to the board.
- The risk register for the A&E was part of the register for medicine. Those risks identified and placed on the risk register had mitigating actions documented.
- A daily situation report was distributed to A&E managers summarising the department's activity and performance and summarising the previous day's activity to enable them to oversee key indicators and monitor safety and effectiveness. Weekly summaries were circulated to all A&E managers.
- Audits were used to assess performance. Examples of learning from audits were the recent introduction of a new form for admissions to the clinical decision unit, and better use of coagulation blood tests which had saved £7,000 in a year. The audit information about poor documentation of consultant involvement in notes had been placed in the 'Team Read' folder to encourage improvement.

Leadership of service

- The leadership of the A&E service was not sufficiently visible to staff and patients. We observed some poor communication, for example, doctors being unsure which patient was in which cubicle in the A&E department.
- Many staff spoke positively about the new chief executive officer for the trust and believed that they would make a difference to the trust.
- Managers spoke highly about the commitment of their staff.

Culture within the service

- Clinical staff were complacent about the low standards of cleanliness, untidiness and patched-up equipment.
- There was a strong academic learning culture and a number of nurses had articles published in journals.
- Clinical staff said they enjoyed working in the department and thought that teamwork was its strength. They felt well-supported by senior staff and valued the training opportunities they were offered.

Public and staff engagement

- Staff were aware of a planned rebuild sometime in the future but not of detail or timing.
- General staff and departmental information was disseminated through a monthly newsletter, A&E Digest.
- Patients and relatives to whom we spoke in waiting rooms and around the hospital site were uncertain about the implications of the publicity about A&E services changing. People we spoke with in the waiting room did not understand the different types of health services available: A&E, urgent care, minor injuries and walk-in clinics. Attempts to gain insight from patients to improve patient experience were weak and staff seemed unaware of the potential value of patients' views.

Innovation, improvement and sustainability

- The service did not model best current A&E practice in either its premises, its times for test results, speed of access to specialist opinion or analysis of other bottlenecks which would have the potential to improve flow through the department.
- Work with GPs and commissioners on an integrated approach to delivering optimal care services across primary and hospital care was at a very early stage, for example, work to ensure that fewer elderly people came to A&E.
- The flexibility of emergency nurse practitioners working in minor injuries to support the emergency department in times of pressure was valuable at times of pressure.

Medical care (including older people's care)

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

Information about the service

Medical services at St Mary's Hospital included a wide range of inpatient wards such as general medicine, older people, stroke, respiratory medicine, gastroenterology and endocrine.

During our inspection, we visited 11 medical wards and spoke with 30 patients, five of their carers and relatives, 56 members of staff including doctors, nurses, allied healthcare professionals, ward managers, senior staff and other support staff such as cleaners or ward clerks. We reviewed patient and medication records and observed care being delivered on the wards.

Summary of findings

The trust was unable to maintain adequate nursing staffing on some wards to meet patients' needs. We found patients were treated with compassion, dignity and respect. Staff were motivated and focused on providing a good experience for patients. We found that equipment was readily available but not all of it was suitably maintained and checked by an appropriate person. The trust, on occasions, was unable to provide adequate isolation facilities to reduce the risk of healthcare-associated infections. There was no written information available in languages other than English.

The storage and management of medicines were not in line with trust policy. Some medicines were stored incorrectly. Not all staff were up to date with their mandatory training. We saw examples of multidisciplinary team involvement and national audits demonstrated that the hospital was achieving good clinical outcomes when compared with other hospitals. Teamwork was evident and line managers were supportive and visible to staff.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

There were limited isolation facilities for patients who required nursing in a single room to prevent cross-infection. All wards apart from Witherow Ward provided single-sex accommodation for patients.. Staff knew how to report concerns related to alleged abuse or neglect if needed. Procedures used for reporting errors, incidents and near misses were effective.

Patient safety was compromised as some wards were inappropriately staffed. Medicines were not always managed safely. We found that patient records were appropriately completed and fit for purpose. Patients were asked appropriately for their consent prior to procedures being carried out. There was adequate equipment available to respond to emergencies and unforeseen events.

Incidents

- There were no Never Events reported by the trust which involved medical services at the hospital. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Staff had access to an online incident reporting form and knew how to use it. However, some staff working on acute medical wards told us that, on occasions, they had no time to complete the record appropriately. A nurse also told us that they had been reprimanded by their line manager for reporting an incident through the system. They were told that not all incidents needed reporting and some could be addressed informally. We were concerned that no learning could be facilitated if incidents were not reported formally.
- Reported incidents were assigned to an appropriate service lead for investigation. A matron told us that the senior management team reviewed every incident report to ensure that the issue had been addressed. The completed report was automatically sent back to the person who had reported the incident so they received feedback. We were provided with examples of learning from incidents. Nurses told us that incidents were discussed at the ward meetings and improvements were made in response.
- There had been 47 incidents reported within the medical division through the Strategic Executive Information System (STEIS) in 2013/14. These included 24 incidents related to grade 3 pressure ulcers, six to healthcare-acquired infections, three to unexpected deaths and one to communicable diseases (outbreaks of infection that involve presumed transmission within healthcare settings). There were also two delayed diagnoses reported on STEIS.
- Divisional mortality and morbidity meetings took place at speciality level and senior member of staff told us that issues or concerns were reported through the directorate committee meetings. There was no standardised approach to mortality reviews or standard written records from those meeting.
- Safety alerts were monitored and staff we spoke with were aware of the most recent critical safety alerts relevant to their specialities.

Safety thermometer

- Information related to the NHS Safety thermometer, used for measuring, monitoring and analysing patient harms and harm-free care, was displayed on most of the medical wards.
- The medical wards had reported 253 pressure ulcers in 2013/14. We observed that the number of these incidents had reduced since March 2014.
- There had been 115 falls and 69 catheter acquired urinary tract infections within the medical division during 2013/14.
- We were told that the completion of the venous thromboembolism (VTE or blood clot) risk assessment forms was one of the trust's commissioning targets. More than 95% of patients were assessed for VTE risk within 24 hours of admission to hospital, which was in line with their target.
- All patients who had a hospital-acquired VTE had the cause investigated through a formal root cause analysis with the responsible clinician. There was an identified VTE lead for the trust.
- There was a medicine division safety committee at which patients' safety was discussed and actions agreed when required.

Cleanliness, infection control and hygiene

- We observed all wards, toilet facilities and waiting areas we inspected to be visibly clean.

Medical care (including older people's care)

- The patient-led assessments of the care environment (known as PLACE) carried out between March and May 2014 reported that all the areas visited, including medical wards in the hospital, were clean.
- Cleaning services were outsourced to a third-party provider. The staff responsible for cleaning knew what actions they should be taking to reduce the prevalence of healthcare-associated infections.
- Patients at greater risk of acquiring or passing on healthcare-associated infection were mostly nursed in side rooms. However, staff felt there were insufficient isolation facilities and that on some occasions they were unable to isolate patients who had been admitted with, or had acquired infections such as MRSA. The lack of isolation facilities was highlighted as an area of risk for the trust.
- We noted that one patient with MRSA had been treated on an open ward for a period of three weeks. A nurse on that ward told us that this was in line with the trust's policy of giving priority to patients with suspected or confirmed infectious diarrhoea. An infection control nurse and matrons from other wards told us that all MRSA patients with prolonged infections should be treated in single rooms and were moved to one when it became available. However, due to a lack of facilities it was not always possible to isolate patients in a timely manner.
- The MRSA screening compliance rate across all medical wards in the hospital was approximately 83% between April 2014 and our inspection. Only 50% of patients who were identified as requiring MRSA screening on Almroth-Wright Ward had been screened. While Witherow Ward and Grafton Ward reported 100% MRSA screening compliance for the same period.
- Staff followed appropriate hand hygiene practice. There was a sufficient number of hand-washing basins and hand gel was available in corridors and near each patient bay. We saw that weekly hand hygiene and cleaning audits were undertaken and the results displayed on the individual wards. When non-compliance with hand hygiene protocols were found, feedback was given to the individual staff members.
- Personal protective equipment, such as gloves and aprons, were available for staff to use when necessary.
- The trust undertook real-time reviews of all Clostridium difficile cases and monthly MDT clinical reviews were undertaken for all cases.
- The trust had reviewed the C. difficile and diarrhoea policies to ensure they reflected guidance from Public Health England on prompt isolation of patients with suspected or confirmed infectious diarrhoea within two hours of diarrhoea commencing. The trust was working towards achieving the Department of Health's C. difficile target of less than 65 cases across the trust in 2014/15. We observed that all patients with suspected or confirmed infectious diarrhoea were isolated in a single room.
- Staff told us that wards were visited by an infection control nurse to monitor infection prevention and control practice and environment issues. We were told the outcomes of those visits were shared with the matrons by email and discussed at staff meetings.

Environment and equipment

- Not all equipment was properly maintained to protect patients from use of unsafe equipment and risk associated with it. Staff told us they had access to equipment and there were arrangements for the repair and maintenance of equipment on all wards. However, we noted that repairs had not always been attended to in a timely manner. For example, a broken bedside lamp next to an occupied bed on Witherow Ward was out of order for over three weeks. A fridge on Thistlewaite Ward had been waiting to be installed by an engineer for three weeks.
- All equipment was visibly clean and was labelled to indicate that it had been disinfected and was ready to use to minimise the risk of contamination with healthcare associated infections. However, not all of the equipment was appropriately checked by a qualified technician to ensure it was fit for purpose. This included some pumps used for administration of intravenous medications and fluid delivery. Although these were clean and ready to use, they were not serviced regularly. We observed intravenous pumps on Thistlewaite Ward which had labels that indicated they had not been serviced since 2011. Nurses told us that equipment should be checked annually. There was also evidence that other portable electrical equipment used on the wards had not been routinely tested to ensure it was fit for purpose placing patients at potential risk due to equipment not functioning effectively.
- The oxygen cylinders and fire safety equipment we checked was noted to be in date and ready to use in case of an emergency.

- All disposable equipment, such as sterile cannulas, intravenous infusion sets and bags of intravenous infusion were in date and appropriately stored.
- Some of the facilities did not fully respond to patients' needs and were not suitably designed to allow staff to provide care and treatment effectively. There were inadequate storage facilities on Witherow Ward, resulting in equipment being stored in inappropriate areas. For example, we saw four shower chairs and commodes stored in patient toilets, while other equipment was stored in the staff office resulting in limited facilities for staff to take breaks during their shifts.
- Staff on other wards told us that there were limited facilities for staff to take a break during their shifts.

Medicines

- Emergency medication and resuscitation trolleys were checked daily on all of the wards we visited.
- The pharmacist visited all wards daily. Staff told us the pharmacy services were readily available and they could contact the pharmacist whenever required.
- Pharmacists undertook six-monthly audits of controlled drug management on all clinical areas that stocked controlled drugs. All wards were expected to achieve 100% compliance with each of the individual standards audited. The audit reported that common themes identified were crossing out or correction fluid used on records, specimen signature lists not always up to date and controlled drug requisitions not always complete.
- The audit recommended actions to be taken by ward managers to raise awareness and importance of controlled drug management locally. We found limited evidence to indicate that these recommendations had been fully implemented.
- Medication was not always stored securely. Rooms where medicines were stored were not always locked. For example on Thistlewaite Ward, the room used to store medication was kept open and we observed that a medicine classified as a controlled drug and other drugs were kept on an open shelf on this ward and were accessible to unauthorised personnel.
- We noted that some rooms where medicines were stored were very warm and there was no routine room temperature monitoring to ensure all stock was stored in line with manufacturer guidelines.
- Medicines requiring refrigeration were not always kept at the right temperature. On Witherow Ward, the drug fridge temperatures were not recorded daily. On Manvers Ward the recorded maximum temperature reading was 25 degrees for one month. On Thistlewaite Ward the recorded maximum temperature was 23 degrees for more than six weeks. No prompt action had been taken to address temperatures that were above the maximum upper limit. One matron told us that a new fridge had been ordered and delivered three weeks prior to the inspection; however, it was still waiting to be installed.
- Patients were not always provided with secure storage for their own medicines. We observed that a patient on Manvers Ward kept their medication box on top of their locker which was accessible to other patients and visitors.
- On Thistlewaite Ward staff we spoke with were not aware that three patients on the ward were self-medicating. They had limited knowledge of the protocols they would follow to support these patients.
- None of the staff we spoke with were aware of insulin passports which were used to empower patients with diabetes to take an active role in their treatment with insulin.

Records

- Observation and fluid charts were kept at patient bedsides and their medical records behind the nurses' station. Staff were aware of confidentiality and data protection procedures.
- The patient records we looked at were appropriately completed and fit for purpose. These included risk assessments for falls, manual handling and skin care.
- On Thistlewaite Ward the confidential waste bin stored in the corridor was full. Documents containing patients' personal information could easily be removed from the bin by unauthorised persons. The matron told us the bin would be disposed of on the day of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy, including guidance for medical staff on best interest decision-making when patients lacked capacity.
- At the time of our inspection, there were no patients who had been subject to depravation of liberty safeguards. Staff on the wards we visited were aware of the safeguards for patients and the procedures they would follow to initiate deprivation of liberty safeguards.

- Patients were asked appropriately for their consent before procedures were carried out. They told us that staff always spoke to them about any procedure before carrying it out.
- Patients over 75 years old were routinely screened for dementia to ensure appropriate support was provided and any potential issues relating to capacity to give consent were identified.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Safeguarding

- Staff told us that they had received training in safeguarding vulnerable adults. Nurses had completed level 2 safeguarding training.
- Staff were aware of who the safeguarding lead for the trust was and how to report concerns related to alleged abuse or neglect.
- A senior nurse told us they had access to a local authority's social work team and they felt they had established an effective working relationship with them.

Mandatory training

- Nurses told us that they had access to training and the majority of staff stated they were up to date with their mandatory training which included basic life support, safeguarding, information governance, mental health awareness or health and safety.
- The trust's target for mandatory training compliance was 95%. This target was not always achieved. The trust told us that qualified nurses working in cardiology and oncology had completed their mandatory training. Compliance levels reported for other specialities varied between 0% of nurses working in dermatology, 25% for rheumatology and above 50% for nephrology, endocrine and elderly medicine department. We were told that all unqualified nursing staff working in nephrology, acute and elderly medicine were due to complete refresher courses. Others working in oncology, endocrine or cardiology had completed all required training.
- Data provided by the trust showed that between 67% and 86% of doctors working within medical specialities such as dermatology, rheumatology and elderly medicine had completed their mandatory training.
- There was a standardised induction procedure that all permanent and temporary staff were expected to complete when they commenced employment.

Assessing and responding to patient risk

- Individual risk assessments for patients were up to date and reviewed when required. This included falls assessment, use of bed rails or pressure ulcers risk assessment.
- The national early warning score (NEWS) system was used across the hospital to assist staff in the early recognition and escalation of a deteriorating patient. We observed that NEWS documentation was appropriately completed.
- The Situation-Background-Assessment-Recommendation (SBAR) framework was used to support staff in escalating concerns in a clear and concise manner. Staff were aware of how to use these tools and how to escalate concerns related to patients' wellbeing.
- There was appropriate patient observation, for example, where one-to-one support was offered to patients because of the risk of falls, the reasons for it was clearly documented in their notes. There was timely escalation if a patient's condition deteriorated. Patients received specialist input when needed.
- We observed that patients had emergency call buzzers within their reach and these were responded to in a timely manner.

Nursing staffing

- More than 50% of healthcare assistant posts were vacant in the medicine division at St Mary's Hospital. Senior nurses and matrons told us that they had been able to fill some of the vacant nursing posts in a recent recruitment campaign but many of the healthcare assistant posts remained unfilled.
- A senior nurse told us that the issue of insufficient numbers of healthcare assistants on Thistlewaite Ward had been escalated to a senior manager but the issue had not been resolved resulting in some patients not being appropriately supervised.
- Nurses on one ward told us that, on occasions, they were required to cover shifts on other wards. They said that this had put additional pressures on their colleagues and potentially impacted on the level of care provided to patients.
- Failure to fill shifts with temporary staff, particularly at short notice, and the high vacancy rate were included as moderate risk on the divisional risk register. Matrons

were encouraged by managers to book bank (overtime) shifts as far in advance as possible. The trust was also pursuing other initiatives to reduce the vacancy rate across the division.

- We were told that elderly medicine was the speciality with the highest nurse vacancies, with a 32% vacancy rate. Specialist medicine had a vacancy rate of 20.4%.There were no vacancies in the renal or cardiology areas.
- For June 2014, the agency WTE used as a % of the operating WTE was 1.45% in acute medicine, 0.59% in elderly medicine, 1.34% in specialist medicine, 0.82% for stroke.
- Senior managers we spoke with felt recruitment was unnecessarily long and that improvements were required to streamline the procedure.
- Stroke, oncology and dermatology departments had absence rates of 9.85% (June 2014), 22% and 18% respectively, combined for both nursing and healthcare assistants.
- Senior nurses and matrons told us that, provided all shifts were covered, they had enough staff to provide safe care and treatment. Overall the trust reported a fill rate of approximately 95% for nursing and healthcare assistants, both on day and night shifts in May 2014 and approximately 90% for June 2014.
- Staffing requirements were not fully met in June 2014 on the acute medical unit with 7% of nurses and 14% of healthcare assistants' day shifts left unfilled.
- Senior nurses told us they mitigated any risk to patient safety by using supernumerary staff to cover shifts, reducing the number of admitted patients when possible and redeploying staff from other areas.

Medical staffing

- We observed that 50% of the doctors employed by the trust were specialist registrar doctors who were supported by consultants (30% of all doctors). The number of middle grade doctors was higher than the England average of 39%. The number of junior doctors employed by the trust was lower than the national average. Only 18% of all doctors were junior grades compared to the England average of 22%. We were told that this was because of the high degree of specialisation provided by the trust.
- The medicine division employed significantly fewer middle career doctors (at least three years at 'senior house officer' level or a higher grade within their chosen speciality) when compared with England average (2% against 6%).
- There were no consultant vacancies in the medical division.
- The pre-inspection submission to the CQC stated that there were no vacancies for trust/training grade doctors as at 30 June 2014.The highest locum doctor usage (3%) was in neurology, while all other medical specialities used between 0% and 2% locum doctors to cover consultant and trainee grades in between.
- We noted low absence and sickness rate among doctors for all medical specialities.

Major incident awareness and training

- The site-specific major incident plan had been reviewed in November 2012. It clearly listed call-out and communication procedures as well as command and control teams.
- Action cards had been developed to assist various grades of staff in taking control and coordinating actions in the event of major incident.
- Staff were provided with contact details for local emergency services and neighbouring hospitals.

Are medical care services effective?

Good

Care pathways for the assessment and management of patients' medical conditions were informed by appropriate national guidance. Clinical audits demonstrated that outcomes for patients after heart attack and stroke were better than the England average.

Patients were given information about pain and offered pain relief when needed. Patients' nutritional needs were assessed and monitored appropriately. Staff were competent and knowledgeable. There was effective communication and multidisciplinary team working between all staff involved in patients' care and treatment.

Evidence-based care and treatment

- Audit tools informed by the National Institute for Health and Care Excellence (NICE) guidance for the assessment and management of patients' medical conditions were

used. In autumn 2013 the service participated in the British Association of Dermatologists audit to assess the treatment of patients with psoriasis which resulted in national guidance being produced.

- The service audited compliance with NICE guidance in a range of areas, including (in November 2013 on a specialist ward) compliance with the implementation of NICE guidelines for orthoptic involvement in post-stroke visual impairment. This audit demonstrated that staff were not always aware of the guidelines relating to stroke and orthoptic services. We saw actions had been taken in response to improve patients' outcomes and staff awareness of the NICE guidelines related to management of patients with stroke for long-term rehabilitation.
- The National clinical guideline for stroke published by the Royal College of Physicians and NICE guidance for the prevention of occlusive vascular events informed the trust's stroke prevention and management guidelines.
- There was a process for reviewing out-of-date clinical guidelines. Any updates to procedures and clinical guidelines were discussed at the medicine division safety committee prior to implementation.

Pain relief

- The pain measurement tool used was part of the assessment process for patients with dementia when they were admitted and during their hourly checks by ward staff.
- Patients we spoke with had been given information about pain and staff regularly checked to make sure they were comfortable and were offered pain relief when needed.

Nutrition and hydration

- The patient-led assessments of the care environment (known as PLACE) carried out in March to May 2014 showed that the food served on medical wards had been flavourful and served warm. It was noted that, where meals consisted of more than one course, all courses were served at the same time resulting in some meals being cold by the time the patient was ready to eat them.
- As indicated by the PLACE assessment, patients were not always offered the opportunity to clean their hands prior to their food being serviced and sometimes patient areas were not prepared for the meal service. The trust took actions to address the findings of this assessment.
- We observed that patients were offered snacks between meal times and that drinks were available at all times. Some patients commented that there was a long period of time between dinner and breakfast.
- Staff told us that it was difficult to accommodate patients' requests for increased or smaller portion size. This was because all main meals were served in individual pre-prepared trays of standard size.
- We observed that patients who had mobility difficulties had water and food within their reach.
- There was a catering service's folder available on each ward setting out the full range of catering services available and how to access them.
- Patients' nutritional needs were monitored appropriately. Food and fluid intake charts were accurate and up to date.
- We saw that menus catered for the cultural preferences of patients.

Patient outcomes

- The findings from the Myocardial Ischaemia National Audit Project (MINAP) found that treatment provided to patients with a heart attack where the supply of blood to the heart was only partially blocked (NSTEMI) was better than the England average.
- The hospital performed better than the England average in the National Diabetes Inpatient Audit (NaDIA) completed in September 2013 in 11 out of 21 measures. We observed that, overall, diabetes patients' satisfaction had dropped significantly when compared with 2012 results and fewer patients felt able to take control of their own care.
- The hospital participated in the National Heart Failure Audit 2012/13 which collected data on patients with an unscheduled admission to hospital who were discharged with a primary diagnosis of heart failure. The audit showed that 99% of patients had input from a specialist and in all cases patients were diagnosed with a use of echocardiography. The hospital also performed better than average in relation to discharge planning and referrals to heart failure liaison services.
- Only 16% of cardiac patients were treated on specialist wards, which is worse than the national average of 50%. Fewer-than-expected patients were referred to cardiology for follow-up services.
- Hospital Standardised Mortality Ratios were better than expected for October 2012 to September 2013 for both week days and weekend admissions.

Medical care (including older people's care)

- There were no identified in-hospital mortality risks for all specialities, including gastroenterology, nephrology, endocrinology, respiratory medicine, neurology and cardiology.
- The number of elective cases who had an emergency readmission was lower than the England average, meaning fewer patients returned to hospital within 28 days post-discharge. However, more respiratory medicine and endocrinology patients were readmitted within 28 days.
- For non-elective treatments in general medicine (115), neurology (111) and gastroenterology (106) the readmission rate was slightly worse when compared with England average (100, 101 and 100 respectively). The head of speciality and a general manager told us that readmission rates reflected the nature of specialist treatments offered to patients and complex cases treated at the hospital.

Competent staff

- Staff we spoke with were competent and knowledgeable. They were clear about their responsibilities, aware of patients' individual progress and were observed to answer patients' questions in a confident manner.
- Supervision and one-to-one meetings for nurses and healthcare assistants were organised on a 'when required' basis, there was no regular schedule for these meetings.
- There was a teaching programme for staff development and staff told us the trust supported training.
- There was a competency framework that all new staff were expected to complete within the first three to six months in post.
- We saw evidence that 73% of all doctors working in the medical division had been appraised between April and August 2014. Trainee doctors told us they were generally satisfied with the support they received and that there were sufficient learning opportunities to develop their professional skills and knowledge.

Multidisciplinary working

- We saw some examples of effective multidisciplinary team involvement. We observed during daily ward rounds that allied health professionals discharge leads were involved in discussions about individual patients to ensure that the delivery of care was appropriate and effective.
- We saw evidence in patient records of appropriate, timely input from members of the multidisciplinary team. This included input from the dietician, speech and language therapist and tissue viability nurse.
- Nurses told us that there was adequate access to physiotherapy and occupational therapy.
- Therapists we spoke with felt there was good communication across all staff involved in patients' care and treatment.
- There were multidisciplinary team meetings held weekly on most wards.

Seven-day services

- Pharmacy services were available out of hours to facilitate prompt discharge. There was a pharmacist available on site from 10am to 2pm with on-call support provided after 2pm.
- Junior doctors and nurses told us that they had adequate support from consultants or specialist registrars out of hours.

Are medical care services caring?

Good

We observed that staff were caring and spoke to patients in a dignified way. Patients told us that nurses and doctors were friendly and they treated them with respect and compassion. Patients felt involved in decisions about their care and treatment.

Compassionate care

- We observed patients being treated with compassion, dignity and respect. Patients told us that nurses and doctors were "helpful and very friendly" and "always polite".
- We observed that the nurses and healthcare assistants spoke to patients in a dignified way. They greeted them, introduced themselves by name and explained what their role was and any procedures they were to support the patient with.
- Results of the NHS Friends and Family Test for 2013/14 demonstrated that six of out of 10 wards scored better than the England average, including Manvers Ward

which was among the highest-rated wards. Grafton, Rodney Porter and Almroth-Wright wards all scored worse than the England average for more than seven out of 12 months.

- The response rate for the Friends and Family Test on some wards was below 20%. The trust was working towards improving the response rate to 40% across the hospital by March 2015.
- The trust was among the lowest 20% of all trusts participating in the national Cancer Patient Experience Survey 2012/13. In response, the trust told us they reviewed the services provided to oncology patients. Only 63% of participating patients were given written information about the type of cancer they had; 50% were told about treatment side effects that could affect them in the future; and 61% found it easy to contact a specialist nurse.
- Staff used a tool called 'iCare' which ensured that a number of checks relating to physical health needs were completed on an hourly basis, including an assessment of pain levels.

Patient understanding and involvement

- Most patients we spoke with felt involved in decisions about their care and treatment. One patient told us that staff were "very informative, they keep me informed about my progress".
- Staff were attentive to patients' needs, and we saw them speaking reassuringly to patients explaining their treatment and seeking patients' consent.
- Patients knew who was in charge of their care and were informed of the names of staff on duty.

Emotional support

- There were patient and carer support groups associated with the hospital. These included the diabetes support group which met once a month at the neighbouring NHS walk-in centre.
- The stroke support group met monthly to provide an informal forum for all stroke survivors and patients with transient ischaemic attacks (mini strokes), their family, friends and carers.
- There was also a breast cancer support group for people who have or knew someone who had breast cancer.

Are medical care services responsive?

Requires improvement

There were shortfalls in how the needs of different people are taken into account, for example dementia care plans were not fully implemented in the hospital. There was no written information available in languages other than English. Complaints were not always used as an opportunity to learn, as there was no record of informal complaints received by staff on wards which would assist in identifying trends and inform learning.

There was effective cross-divisional working to manage bed capacity issues. There were very few medical patients who were provided with treatment on non-medical wards due to lack of beds availability. However, not all medical patients were cared for on their speciality ward.

Service planning and delivery to meet the needs of local people

- Senior managers and nursing staff told us that the hospital could not always offer a bed on the right speciality ward to patients. For the period of 1 April to 31 August 2014; bed occupancy for medical level 1 patients was 93.38% and for levels 2 & 3 was 93.23%.
- There was a plan for the management of bed capacity. Site operation's managers were the identified lead for capacity and site issues; they worked in close partnership with the senior site nurse practitioner.
- Approval to open an escalation ward to provide additional beds was given by the chief operating officer and head of clinical site operations and divisional directors of operations and nursing. This approach ensured all alternative options had been considered and there were appropriate staff to provide care on this additional ward.
- There were no escalation wards open at the time of our inspection. The number of patients who were placed in other clinical areas outside the medical division, known as medical outliers, due to lack of beds had decreased in the last 12 months from 62 patients in July 2013 to five in June 2014. Nurses told us they felt all patients placed on other wards had received appropriate support coordinated by an appropriate consultant.
- Staff said that side rooms were not always available and matrons were required to prioritise patients' needs in order to mitigate risks.

Medical care (including older people's care)

Access and flow

- A patient flow coordinator worked with the head of site operations, site operations manager and site nurse practitioner to address any patient flow and bed capacity issues. There were conference calls three times a day organised across the three hospitals to address bed capacity issues; the frequency of this call was increased as necessary.
- Staff told us patients who needed to be transferred to another ward within the hospital were generally transferred during the daytime. However, between June 2014 and August 2014 there were 26 internal out-of-hours inpatient transfers, occurring between 10pm and 7am. These included nine gastroenterology, six general medicine and four respiratory medicine patients. There were also 12 patients transferred to other hospital out of hours. During the same period, 20 patients were discharged out of hours, mostly from gastroenterology and respiratory medicine departments.
- The average length of stay for patients receiving care in gastroenterology, neurology and respiratory medicine in 2013/14 was shorter than the England average for elective cases. However, the average length of stay for non-elective cases was slightly longer than the England average for respiratory medicine patients, but similar for general medicine and neurology patients.
- In July 2014 the trust did not meet the 92% target for patients waiting to start treatment within 18 weeks. Overall 88.5% was achieved across all specialities with 85% in elderly medicine, 84% in general medicine, 89% for rheumatology and 91% in cardiology. The trust achieved this target in neurology, gastroenterology and respiratory medicine. The trust had also failed to meet the 90% target for patients who completed their care pathway and started admitted treatment within 18 weeks as they scored 86% overall. The trust met the 95% target for non-admitted pathways.
- The trust had implemented plans and aimed to achieve all three referral to treatment time standards by October 2014.
- The trust had consistently met all but one target related to urgent referrals across 2013/14. More than 15% of the urgently referred patients for suspected cancer were waiting over 62 days to begin their first definitive treatment following a GP referral. The target was 85%, and the trust achieved 79%.
- We were told the most common reasons for transfer delays were problems with arranging nursing homes placements or when other non-acute care needed to be arranged.
- There was no discharge lounge at the hospital. Patients waiting for transport home had to wait on the ward or in the transport lounge. Patients told us that occasionally they were required to wait up to four hours for the transport to arrive. This service, contracted by the trust, was managed by an external company.

Meeting people's individual needs

- We saw that there was written information available for patients and their families relating to support services, various medical conditions or how to minimise the risk of infection. This information was up to date, clear and concise. However, there was no information available in languages other than English. Similarly, food menus were only available in English and no other formats, such as pictorial versions, were available to support people with limited communication.
- Staff told us they had access to translation services and were able to communicate with patients who did not speak English.
- The PLACE assessments carried out between March and May 2014 showed that signs directing patients and their families to areas of the hospital such as wards, outpatient's areas, emergency departments or pharmacy were not clear. The needs of people with visual impairment had not been assessed and some signs were not positioned at eye level for easy, close-up viewing. Both internal and external steps lacked high visibility markings.
- The trust had a dementia care team which included dementia specialist nurses who worked across the hospital sites in the trust and provided information and consultation to staff members who needed additional support relating to dementia care.
- The hospital aimed to screen at least 90% of patients aged 75 or over who were admitted as an emergency for 72 hours or more for cognitive impairment. The hospital had achieved this target in 2013/14.
- The hospital had an older people's assessment and liaison team which was a consultant-led team available 24 hours which ensured that older people's needs were specifically identified on admission.
- The hospital used a care pathway known as FAIR (Find, Assess, Investigate and Refer) which was one of the

targets identified by commissioners. It helped to ensure that patients who might have been at risk of displaying cognitive impairment on admission were provided with care, treatment and onward referral through their stay in hospital.

- An audit of carers of patients living with dementia had been piloted on five wards across the trust: 73% of the relatives who participated in this survey stated that they felt supported by the hospital and were involved in discharge planning.
- The trust had introduced the 'This is me' tool, a document filled out by a patient or relative, to share information about their likes and dislikes and their social history and background. We noted that staff had limited awareness of the tool and it was not fully implemented in the hospital.
- Staff told us there were no reported mixed-sex breaches, (when male and female patients were cared for in the same bay on a ward), since April 2014. However, we noted that Witherow Ward was a mixed gender ward where male and female patients shared the same bay. However, male and female patients were on opposite sides of the bay and did not share bathrooms or toilets
- . However, there were separate toilet and washing facilities.
- There were no day rooms or quiet rooms were patients could spend time with their relatives on the wards we visited. We noted that some patients were admitted for long periods of time with limited access to day activities or entertainment such as television or radio. On one ward, one patient was admitted for 37 days, while another patient on another ward had been admitted for 51 days.
- Patients on Grafton Ward told us that visiting times were between 3pm and 8pm. They felt it was unsuitable for families who travelled from outside of the city. We were told that staff were flexible and made exceptions to allow visitors outside these hours.
- There was an admission and discharge pathway for people with a learning disability, developed in collaboration with the Westminster Learning Disability Partnership.
- The department of spiritual and pastoral care covered a range of faiths including Anglican, Catholic, Free Church, Jewish and Muslim and were available to provide patients and their families with emotional support. Representatives of other faiths could be contacted as required.

Learning from complaints and concerns

- Staff knew how to handle complaints on the medical wards.
- Leaflets were displayed on all wards informing patients how to raise concerns and providing them with information on the Patient Advice and Liaison Service (PALS). Complaints information was also available on the hospital's website.
- Staff told us they tried to resolve issues informally at ward level whenever possible, but a record of these informal complaints was not kept. If staff were unable to resolve the informal complaint they were encouraged to direct complainants to PALS.
- There were very few formal complaints received by the trust from medicine patients in 2014. The majority of those received related to poor clinical care, nursing care and ineffective communication with a patient.

Are medical care services well-led?

Good

Staff were aware of the service's vision and strategy. There were governance and risk structures in place with a range of groups and committees at which risks were discussed and learning shared.

Staff were kept informed of developments at trust level and felt listened to by their line mangers and able to express concerns. Staff worked as a team and line managers were supportive and visible to staff. Senior managers were aware of issues that impacted on the quality of care but action had not been taken to address all known issues.

Vision and strategy for this service

- There was a strategy and vision for the medical division, Staff we spoke with were aware of how the service would be developed.
- Staff were aware of the chief executive officer and some of the board members. They confirmed they had been kept informed of developments at trust level through emails and newsletters.
- Staff had been asked to participate in reviewing the trust's vision and strategy.

Medical care (including older people's care)

- In July 2014 the chief executive and executive and divisional directors hosted all staff meetings where the clinical strategy and service transformation plans had been discussed.
- There was a staff newspaper where the trust vision and objectives had been publicised.

Governance, risk management and quality measurement

- The trust had established speciality steering boards chaired by the medical director to oversee the improvement plans. For example, there was a cancer steering board which was tasked with addressing improvements in services provided to cancer patients.
- There were regular medicine division safety committee meetings attended by the managers from the three sites (Charing Cross, Hammersmith and St Mary's Hospitals) and representatives of different specialities. Risks that related to different specialities were discussed at the meeting and outcomes shared with at the trust's quality and safety committee.
- There was a range of other meetings held by safety groups from medical specialities. The outcomes from these meetings were shared with the medicine division safety committee.
- Not all senior nurses we spoke with were aware of their local risk register or which risks were, or should be, included.
- All staff we spoke with supported the new divisional structure which had been implemented in 2013. They thought this helped the hospital to improve governance and communication across the division and increase senior managers' visibility.
- In response to the controlled drugs management audit completed in May 2014, the ward managers had taken action to raise awareness of controlled drug management locally. However, we found limited evidence to demonstrate that all the recommendations from this audit had been addressed
- Senior managers we spoke with were aware of the lack of isolation rooms and the impact this had on patient care but did not provide us with evidence of how these issues were being mitigated.
- Senior clinicians were aware that the average length of stay for respiratory medicine patients and the readmission rates were worse than expected.
- Lack of compliance with MRSA screening was a known issue in the division; however, there were no plans to address the causes of this and to increase compliance rates.

Leadership of service

- Staff told us they could discuss issues with their line manager and were often able to contribute to the running of their department. Staff felt their line managers were supportive and visible.
- Senior nurses on the wards told us they had felt involved in the management decisions that affected their wards. They felt consulted on issues regarding service delivery.

Culture within the service

- Staff we spoke with were focused on providing a good experience for patients. They were patient-centred and aimed to provide a better service.
- We observed that staff worked well as a team and spoke of how they supported each other.
- We observed that the majority (80%) of trainee doctors were satisfied working for the trust. The key findings from the national training survey carried out by the General Medical Council in 2014 highlighted that the culture in the service was good.

The NHS Staff Survey 2013 found that staff felt more satisfied with the quality of work and well-motivated at work when comparing with other trusts. They also felt that their role made a difference to patients. However, a slightly higher than average number of staff said that they suffered work-related stress (40% vs 37% nationally) and the job satisfaction score of 3.52 was slightly worse than the average for England (3.6 out of 5).

Public and staff engagement

- Patients were able to provide feedback by using the 'I track' electronic survey devices that allowed wards to collect patient feedback and review their results. Information on how to use the system was available on all wards.
- The 2013 NHS staff survey 2013, found that staff felt engaged in their work. More staff than in the previous year felt that they were able to contribute towards improvements at work.
- The trust told us that over 25% of all staff chose to be actively engaged with shaping the trust's clinical strategy designed to improve clinical outcomes and patient experience.

Medical care (including older people's care)

Innovation, improvement and sustainability

- In December 2013, the trust became the first centre in the UK to undertake a new type of brain scan which facilitates more accurate diagnosis of Alzheimer's disease and other dementia conditions.

Surgery

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

Information about the service

St Mary's Hospital provides a range of surgical services, including gynaecology, ear, nose and throat (ENT) and maxillofacial surgery, vascular surgery, general surgery, bariatric (weight loss) surgery, trauma and orthopaedics. Emergency surgical services also provided a major trauma centre for adults and children and acute surgery. Elective surgical services include neurosurgery, vascular surgery, trauma and orthopaedics, plastic surgery, upper and lower gastrointestinal surgery, breast surgery, plastic surgery and general surgery. At this site, 44% of cases were day case procedures, 26% were elective and 30% were emergency cases.

There are 14 theatres across St Mary's Hospital, with nine specialist theatres, including a designated major trauma theatre in the main suite in the Queen Elizabeth the Queen Mother building. The major trauma centre at St Mary's Hospital sees over 2,500 major trauma calls per annum, around a third of all London trauma patients. The service is a nationally recognised specialist centre for major trauma and a regional service for vascular surgery and bariatric surgery. The main theatres carried out emergency and trauma surgery and operated 24 hours a day, seven days per week.

There are 121 surgical beds in the designated surgical wards, approximately 40 of which are designated for day case procedures. As part of the inspection, we visited the surgical rehabilitation ward (Albert Ward), the general surgery ward (Charles Pannett Ward), the orthopaedic ward (Valentine Ellis Ward), the short stay surgery ward which is the location of Imperial College's Surgical Innovation Centre for breast, bariatric and general surgery, (Paterson Wing), the major trauma ward and the vascular and the gastrointestinal and a vascular ward (Zachary Cope ward). Private patients were treated in the Lindo Wing.

We spoke with 15 patients, observed care and treatment and looked at 12 care records. We also spoke with 48 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Surgery

Summary of findings

The trust has a known backlog of patients waiting for elective surgery however, they did provide trust-wide plans to demonstrate how they planned to reduce the backlog and manage patients who had experienced long waits for their surgical interventions. There was evidence of good outcomes for patients who underwent surgery. Preoperative assessment for some surgical specialties was not managed effectively, which often led to cancellation of elective procedures. Data submitted by the trust showed a higher –than-national-average cancellation rate for surgery.

The trust had not taken sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice. Procedures and treatments within surgical services followed national clinical guidelines. Pain relief was effectively managed and most nutritional needs of patients were assessed and provided for. Nursing skills mix was regularly reviewed and there were low numbers of nursing vacancies with very few agency staff used. The majority of staff received mandatory training and further specialist training was available to a wide variety of staff. Infection control procedures and practices were adhered to and regularly monitored.

Patients spoke positively about their care and treatment at the hospital. Results from the NHS Friends and Family Test were better than the England average, and a high number of patients would recommend this hospital to their family and friends.

Are surgery services safe?

Requires improvement

The trust had not taken sufficient steps to ensure that the 'Five steps to safer surgery' checklist was embedded in practice across St Mary's Hospital. While recently introduced audits focused on improving the overall process and considered a range of human factors, they were only introduced in April 2014 and reviewed a very small sample size of cases and there had been limited improvement in compliance. There had been a recent serious incident involving a retained swab which involved incomplete or ineffective use of the World Health Organization (WHO) surgical safety checklist. Furthermore, two Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) had been reported at the trust's two other hospitals in the preceding 18 months. Therefore, we were not assured that risks associated with surgical procedures were sufficiently managed.

There was a consistent approach to clinical incident reporting and feedback mechanisms in the division. All serious incidents were investigated, we noted that between January 2013 and July 2014 there had been 26 falls on surgical wards which had not been specifically addressed. We were not assured that there were sufficient proactive initiatives to reduce the high number of falls.

Surgical wards monitored the delivery of care and clinical standards for patients relating to falls, pressure area care, risk of venous thromboembolism (VTE or blood clots), nutritional support as well as other safety measures such as incident themes and complaints trends. Staff highlighted concerns relating to the delivery of pressure-relieving mattresses and with delays in responses to requests to the estates department when equipment or structural repairs were required.

Incidents

- There was a process for investigating Never Events and patient safety incidents, including serious incidents requiring investigation.
- The theatre and surgical ward staff we spoke with told us they all had access to the electronic incident reporting system, and were clear about incidents that needed to be reported.

- Staff told us learning from incidents took place through weekly and monthly multidisciplinary meetings and bi-monthly audit meetings. In addition, staff on the surgical wards had feedback in weekly briefings, as well as via regular newsletters. Staff were able to describe recent incidents, including those that occurred at other hospital locations within the trust, where learning was shared to aid improvement.
- Divisional managers told us that mandatory training for all staff at senior manager grade and above included a module in investigation of incidents and complaints. However, some staff we spoke with at this level were unaware of this training. We requested evidence that this training had been delivered to all staff, however, the evidence provided did not demonstrate this training had been delivered.
- We were also told that most trust staff had received training in having difficult conversations, including discussing incidents. Despite asking for evidence that this training had been delivered to all staff, the trust did not provide this to us.
- The trust reported one Never Event in theatres at St Mary's Hospital in the preceding 18 months.
- Data provided by the trust showed a better-than-national-average reporting rate of harm-free incidents. Staff also told us that they felt confident in the trust's reporting systems, demonstrating that they worked in practice.
- 1 July 2013 and 30 June 2014, 35 serious incidents were reported trust-wide within the surgical division, 14 of which were attributable to care received at St Mary's Hospital. We were told this information was collected and reported on a trust-wide basis and therefore could not identify where in the surgical division these incidents had occurred with the data provided.
- Learning from incidents were fed back in a variety of ways to all staff, including a monthly clinical governance newsletter, a summary report to divisional leads and a Safety matters bulletin.
- Incident investigations and learning focused on human factors – the relationships between human behaviour, system design and safety – involved in these cases.
- Data provided by the trust showed that between January 2013 and July 2014, a total of 26 pressure ulcers at grades one to three were recorded for surgery. Staff told us they risk-assessed patients at risk of developing pressure ulcers, reported incidents when pressure ulcers were detected and were supported by the tissue viability team. It was not clear that the actions from investigations of reported incidents were embedded.
- Although all serious incidents were investigated, we were not assured that there were sufficient proactive initiatives to reduce incidents such as the high numbers of falls. Trials of falls prevention equipment, such as alarm mats, were being discussed, but had yet to be put into practice.
- Mortality and morbidity meetings were varied in quality and frequency. Meetings took take place at a speciality level, with reporting to the quality and safety committee by exception. We found some specialties, such as orthopaedics, reviewed mortality and morbidity bi-monthly at the end of the surgeon's audit meetings. We were told by clinical staff that some actions and lessons arose from these meetings, but as there were no action plans produced, we were unable to determine who was accountable for any actions or learning, or what improvements had occurred as a result.

Safety thermometer

- The NHS Safety Thermometer – a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care – was used in the surgical wards. This included information about all new harms, falls with harm, new VTE, catheter use with urinary tract infections and new pressure ulcers.
- Safety Thermometer information was clearly displayed in prominent places on the surgical ward areas during our inspection, and showed high rates of compliance with harm-free care. Zachary Cope Ward was involved in a trial of displaying this information electronically on monitor screens in front of the nurses' station, and we saw these were used in discussion with patients, families and carers.
- On all surgical ward areas, the trust's performance was better than the England average. Results from the harm-free care report for July 2014 for the surgery, cancer and clinical haematology division, covering all surgical ward areas, showed overall infection control scores at 94.7%. The score was 90.4% for nursing indicators overall and 92.1% for compliance with intentional rounding. The division was 96% harm-free overall. The investigative sciences and clinical support division, which includes operating theatres and anaesthetics, were 100% harm-free overall.

- Lead nurses submitted nurse-sensitive quality indicators to the trust database, which was reviewed by heads of service. We were told that these were 'exception reported' at lead nurse meetings. Most surgical ward areas were compliant with these indicators at the time of our inspection.
- We noted that risk assessments for inpatient harms were being completed appropriately on admission and patient records confirmed plans were in place to mitigate risks.
- VTE risk assessments were being completed and the trust had measured the compliance rate. Data reported to the board showed that financial and quality targets were being met for the Commissioning for Quality and Innovation (CQUIN) framework.

Cleanliness, infection control and hygiene

- We found local and national guidance for infection control was being followed and implemented at the trust.
- The trust infection rates for Clostridium difficile (C. difficile) and MRSA were slightly worse than the average range for England, even taking into account the trust size and the national level of infection. All cases were investigated and senior managers told us that most actions to address root causes of each case of C. difficile or MRSA had been implemented.
- Following any surgery performed on a patient with a known infection, the theatre was deep cleaned to reduce the risk of cross-infection. These patients were placed at the end of a surgical list, if possible, to minimise the risk of infection.
- Data gathered prior to the inspection showed there was a low number of catheter acquired urinary tract infections.
- During our observations and when speaking with patients in surgical ward areas, we saw that all areas were visibly clean and tidy. Monthly cleaning audit results showed compliance was over 90% across all ward areas in the preceding 12 months.
- Hand hygiene compliance was audited monthly by staff in each surgical ward area. Scores were routinely 95% and above across all areas, and across the division was 97.7%.
- The theatre complex (equipment and environment) was visibly clean and equipment stored to enable effective cleaning. Walls were washed weekly, stock was stored in closed cupboards and theatre kits were clean.
- Theatres at St Mary's had undergone a programme of renovation to upgrade ventilation. The theatres we inspected were visibly clean and well-maintained. Daily and weekly cleaning checklists were displayed in each area and these were complete and up to date. Monthly cleaning audit results showed compliance was over 90% in the preceding 12 months.
- We observed that staff regularly washed their hands and used hand gel between attending to patients. They followed 'bare below the elbow' guidance and were aware of current infection prevention and control guidelines. Gowning procedures were adhered to in the theatre areas and in ward areas staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- The dedicated infection control team for the trust included a senior nurse who worked with ward staff to reduce the incidence of surgical site infections. Data provided by the trust showed that surgical site infection rates for total hip replacement, knee replacement, neck of femur repair and reduction of long bone fractures were better than the England average for operations carried out at St Mary's Hospital.

Environment and equipment

- The theatre department had commenced using a barcode system for tracking and tracing surgical equipment to accurately ensure required surgical equipment was in place.
- We were told by staff that there were delays in requesting equipment on some surgical wards and in theatres which sometimes led to delays. Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff in each theatre team were responsible for checking equipment on a daily basis and any equipment failures or issues were logged as incidents.
- We checked resuscitation equipment in surgical ward areas and in theatres and found emergency drug packs and the defibrillator were checked daily and were ready for use. However, we saw a resuscitation trolley on Valentine Ellis Ward had been checked weekly instead of daily. We raised this as a concern with the trust during our inspection.
- A risk regarding the safety of ventilation in theatres had been identified in 2013 which resulted in upgrades to each theatre across all sites, which had been

completed. Capital funds had been used to upgrade theatre lighting and anaesthetic machines. This work was in progress at St Mary's Hospital and was due to be completed by December 2014.
- Staff on some surgical wards at St Mary's Hospital spoke of difficulties accessing air mattresses to enhance pressure area care. Senior staff told us this may have been because the supply was managed by an external company.

Medicines

- Medicines were stored securely in locked cabinets within the surgical wards.
- Medicines were only prepared when required, with the exception of medicines for use in emergency cases, which was in line with trust protocol.
- All staff received a competency-based assessment before administering medication. We were told that, when a drug error was identified, staff were required to complete another drug competency assessment to ensure safety.
- On the wards and in theatres, medicines were stored correctly in cupboards or fridges where necessary. Fridge temperatures were checked daily to ensure medicines were stored appropriately and safely.
- Controlled drugs were checked twice a day.
- Pharmacists were allocated to each ward area to review medicines charts as well as providing patient-specific advice and support timely provision of discharge medication.
- Processes to check progress with ordering and dispensing take-home drugs were in place on surgical wards by nursing staff, to expedite patient discharge.

Records

- Patients had their care needs risk-assessed on admission. When their needs changed, this was noted in patient records in all the clinical areas we visited.
- Patient records showed that staff carried out appropriate checks for consent and medical history prior to starting a procedure.
- Trust reported data showed 95.9% of all diagnostic screening was reported within 48 hours at St Mary's.
- Staff on surgical wards described ongoing difficulties they faced since the introduction of an electronic patient administration system, Cerner, in April 2014. Staff spoke of difficulties with patient information being sent to wrong patients, difficulties in tracking notes and locating test results and letters. The trust had recognised this as a trust-wide issue and implemented a series of actions. Staff told us that they had recognised this was slowly improving.
- Ward matrons told us they did 'walk rounds' on wards to review care, including regular reviews of pressure area documentation. We were not provided with evidence of these reviews or the action taken when issues were identified.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In patient records we reviewed we saw documented evidence of preoperative risk assessment which included establishing informed consent by speaking to patients about their understanding of their surgery and recording consent appropriately.
- Staff demonstrated knowledge of the Mental Capacity Act 2005 and the implications of this to protect patients' rights. Through a review of patient records, we saw that staff had assessed patients' capacity to make decisions and when patients lacked capacity, staff sought advice from professionals and others as appropriate so a decision could be made in the patient's best interest.
- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent and had access to a simple device, accessible via mobile a phone app for training in the Mental Capacity Act and its related deprivation of liberty safeguards. Staff told us this was useful awareness training but that more detailed training dealing with specific cases would be beneficial.
- An annual consent documentation audit against the trust consent policy was undertaken. Results in October 2013 showed improvements in documentation including notes on best interests, though some areas had dropped below the standard, including documenting of consent for tissue retention and dating of consent by the patient.

Safeguarding

- Systems were in place for staff to report on safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all of the ward staff we spoke with had undertaken safeguarding adults training and safeguarding children's training at level 3.

Surgery

Mandatory training

- The staff mandatory training records on the wards we visited showed that between 69% and 95% of staff in surgical ward areas at St Mary's had attended mandatory training at the time of our inspection. However, ward matrons told us that this data was not always accurate, and felt that rates were higher than stated. They told us this was because completion of the online training modules was often not recorded. We were informed that the trust had an action plan to ensure that all staff received their mandatory training during the current financial year. Ward matrons told us they were now asking staff to demonstrate completion of each module in person.
- There was a worse-than-average completion rate for mandatory training among consultant medical staff, at only 43%. We were not made aware of what was being done to address this low rate of compliance.

Assessing and responding to patient risk

- The surgical wards used the national early warning score (NEWS) system for standardising the assessment of acute illness severity. The trust started using this tool trust-wide in 2013. We found clear directions for escalation and staff were aware of the appropriate action to be taken if patients scored higher than expected. Completed charts we looked at demonstrated that staff had escalated correctly, and repeat observations were taken within necessary timeframes.
- Staff described their roles and could identify the necessary steps to take in the event of a clinical emergency. They were able to identify the location of emergency equipment and describe the steps outlined in the hospital's emergency policy.
- We were told the nursing leads attended their allocated ward areas at 7am every day to ensure that deteriorating patients were escalated proactively to consultants. Staff spoke about using clear communication, prompted by a recognised tool called Situation-Background-Assessment-Reasoning (SBAR) to improve escalation.
- Although staff reported no concerns about accessing medical input when required, we noted that outreach services at St Mary's Hospital operated from 8am to 8pm. Outside these hours, staff could access support from trust site managers.
- Where patients were pre-assessed by the centralised specialist team, we saw they were risk-assessed in line with national guidance on preoperative assessment. We could not be assured of the approach to risk management used by the specialties who managed their own preoperative assessment processes.

Use of the 'Five steps to safer surgery'

- We observed two theatre teams undertaking the 'Five steps to safer surgery' procedures, (related to the WHO's surgical safety checklist). The theatre staff completed safety checks before, during and after surgery and demonstrated an understanding of the procedures.
- The trust had started to carry out WHO surgical safety checklist audits in April 2014 including swab count. Two 'secret shopper' style audits were also undertaken weekly at St Mary's against compliance with the WHO checklist. Staff confirmed there were "observational" audits to verify staff adherence to the 'Five steps to safer surgery' procedures.
- These audits highlighted that some parts of the surgical safety checklist, including known allergy and surgical site markings had a low compliance. Results showed 60% compliance with briefing in June and 65% in July 2014, while there was 0% compliance with the debrief section. This had been identified on the division risk register, which stated that July 2014 audit showed improvement in some areas on the WHO audit, but the debrief was not occurring regularly enough. The August 2014 audit reviewed at the quality meeting demonstrated improvements in most areas.
- Swab count audits had been undertaken monthly since June 2013 on around 20 cases per month across all three sites. Continued low compliance with handling, labelling of swabs, 'pause for the gauze' policy, surgeon stopping while the first cavity count of swabs was being done, and consistency of staff members counting the swabs had not been addressed.
- Overall, the risk of unsafe surgery was not sufficiently mitigated. Although compliance with the 'five steps' was escalated to the divisional risk register and actions on this register stated that audits had mitigated the risk. The actions did not state that there was a very low sample size used in the audit or which cases were included and it did not highlight the very recent introduction of the 'Five steps to safer surgery'. There was, therefore, false assurance for surgical safety.

Nursing staffing

- Surgical wards used an Association of UK University Hospitals approved adult dependency acuity tool to

assess the needs for the number of staff on the surgical wards, which is completed every six months. Indicators of quality, including bed occupancy and level of care and wider measures such as number of incidents, drug errors and complaints, form part of the tool. We were told that, as a result of using the tool to review skills mix, a request was made to increase staffing numbers. We saw that, as of July 2014, Valentine Ellis Ward was awaiting approval by the trust board for one-to-one whole time equivalent (WTE) nursing staff, a need identified by using the acuity tool.

- We found surgical wards were appropriately staffed throughout this inspection. We were told there were only 12 vacancies out of 190 posts in nursing theatre. Vacant posts were currently being recruited to.
- Rosters showed that staff were rotated trust-wide. To maintain skills mix, staff were usually rotated within specialties in the same division and had to meet certain competencies. We found that the skills mix in the surgical division met the Royal College of Nursing recommendation of at least 65% trained nurses to 35% healthcare assistants.
- Nurses in charge, known as ward matrons, were supernumerary and, in line with Royal College of Nursing guidelines, were not assigned patients to care for when on shift.
- Data provided by the trust for St Mary's Hospital contradicted our findings during the inspection as it had suggested worse-than-average vacancy rates and use of agency staff. Ward staff told us the monthly data was not always an accurate reflection of staffing levels as changes occurred regularly.
- The staff sickness absence rate for nursing staff in surgery was 3.81%Senior nursing staff told us that these rates were monitored on a monthly basis.
- Exit interviews were regularly reviewed to monitor feedback from staff. Ward matrons told us there were no trends identified from exit interviews as most staff went on to promotions or other areas.
- We were told that staff working in a supernumerary capacity such as ward matrons could be moved to cover areas where there were shortfalls in staffing, with the exception of nursing students.
- The ward matron supported requests for healthcare assistants or extra staff to provide one-to-one care to ensure that patients' needs were met.
- Some staff told us they felt they needed more nursing staff at night. However, this was not confirmed by the most recent nursing acuity audit which showed that night staffing levels were appropriate to meet patients' needs.
- In theatres, we were told senior managers discussed bank (overtime) and agency use weekly and that the number of vacancies for scrub and recovery nurses was reducing, although anaesthetic support remained a difficult-to-recruit group.

Surgical staffing

- There was a 24-hour, consultant-led care model across the surgical specialties at St Mary's Hospital. The surgical specialties operated a consultant of the week model which meant a named consultant was responsible for care to surgical patient out of hours.
- Surgical handovers were carried out twice daily at which all patients were discussed.
- Consultant-grade staff made up 33% of the surgical workforce at St Mary's Hospital; 57% were registrar level; 8% were junior doctors; and 2% were middle grade. Staff on surgical wards and in theatres at St Mary's told us there were sufficient doctors at the appropriate grade available when required
- Guidance on safe surgical staffing was followed. For example, only doctors who were competent could carry out laparoscopic appendectomy procedures were on the on-call rota, which was in line with guidance from the Royal College of Surgeons. The trauma consultant of the week was taken from a range of specialties including vascular surgery and plastic surgery.
- Surgical staff told us there was good access to the medical team when required. There was a resident neurosurgery registrar at St Mary's Hospital 24 hours a day, seven days a week, whose primary responsibility was care of all patients admitted under neurosurgery. For patients needing other medical input, the on-call registrar grade doctors in these specialties provided this care.
- The rotas we saw showed that vacancies in registrar grade positions were being covered by locums. Trust data showed there was a 6.9% vacancy rate among this grade of doctors within the surgical specialties, which the trust management told us was in line with the national average.

Surgery

Major incident awareness and training

- There was a documented major incident plan which listed key risks that could affect the provision of care and treatment. We were told there was no specific policy for theatres and that staff followed trust guidelines.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of the plans and described the appropriate action they would take.
- We were told there was no specific major incident training for staff but surgical ward staff were aware of the policy.

Are surgery services effective?

Good

Outcomes for patients who had undergone major, orthopaedic and vascular surgery were better than the England average. The trust took part in national and local clinical audits. Staff used care pathways effectively. Pain relief was effectively managed and the nutritional needs of patients were accounted for.

Staff were competent to carry out their roles and worked well within multidisciplinary teams. While we saw many procedures and treatments within surgical services were reviewed against national clinical guidelines, the trust could not demonstrate the extent to which this was the case at St Mary's Hospital.

Evidence-based care and treatment

- The hospital participated in national audits. These included audits of surgical-site infections, hip fractures, bariatric (weight loss) surgery and lower limb amputation, emergency laparotomy and bowel cancer operations.
- National Institute for Health and Care Excellence (NICE) guidelines were managed corporately with a clinical lead assigned to each guideline, whereas national and local audits were managed by the divisions. Some specialties had audited their practice against NICE guidance. For instance, the orthopaedic service had reviewed service provision against the mobilisation and rehabilitation recommendations in the NICE guidelines CG124: The management of hip fracture in adults.
- The July 2014 governance report showed that the trust was compliant with 83% of NICE guidelines across the three hospital locations. However, the trust did not provide us with information to show to what extent this was the case for the specialties at St Mary's Hospital.
- Audit results were compiled and reported trust-wide. The hip fracture audit in 2013 showed that the trust performed better than the England average in six of the 10 best practice measures which included all patients having a falls assessment. The chief of service for the specialty recognised that 74% of patients were seen within 36 hours, which was below the trust's target of 90%.
- The trust performed worse than the England average rate for patients admitted to orthopaedic care within four hours: 33.2% against the England average of 51.6%.
- For the preoperative assessment of hip-fracture patients, the England average was 53.8%, but the trust achieved 38.7%. To address this we were told the hospital had recruited two orthogeriatricians who were in post at the time of our inspection. The hospital had also increased the number of trauma lists at evenings and weekends, made changes to the care pathway that included integration of rehabilitation and ring-fenced two beds for specialist care on Valentine Ellis Ward. We were told these changes were having an impact and performance was steadily improving, which would be assessed and demonstrated in the hip fracture audit results for 2014, which had been completed but not yet published.
- Senior staff told us that fractured neck of femur outcomes were in the top 25% in the country, though these results were not provided to us at the time of our inspection.
- The trust was in the bottom 20% nationally for the National Cancer Peer Review in 2013. The senior management team described changes that had been made to address these results, including workshops to engage staff and patients, involvement of patient representatives in the pathway redesign and the patient navigator's project to improve patient experience across the pathway.
- Results from the National Bowel Cancer Audit in 2013 showed that all patients were discussed at multidisciplinary meetings and 97.1% of patients had a reported computerised tomography (CT) scan, in line

with NICE guidance, which is better than the England average of 89.1%. However, only 63.6 % were seen by the clinical nurse specialist, which is worse than the England average of 87.7%.

- Data from the National Vascular Registry in 2013 showed that the trust performed better than the national average for non-emergency aortic abdominal aneurysm repairs with an unadjusted mortality rate of 0.8% and all operating surgeons had outcomes in the expected range given their level of activity. However, the trust was only reporting 75% of operated cases to be reviewed by the national vascular registry and did not provide us with an explanation for this.
- The trust participated in the National Emergency Laparotomy Audit. Information was marked as unavailable in the audit results for a number of areas requiring policies and protocols, including surgical and anaesthetic seniority and pathways for management of sepsis. The trust provided us with an action plan to address these findings.
- Data from the National Trauma Audit and Research Network showed overall outcomes for major trauma for North West London, which included St Mary's Hospital. The published results related to surgical intervention, specifically time to theatre for trauma patients – the trust's time was 1.8 hours which was better than the England average.
- Monthly audits of nursing quality indicators were undertaken for each surgical ward and these results were reported on the divisional quality scorecard.
- Surgical staff told us there was a strong focus on research at St Mary's Hospital, and a number of consultant surgeons were senior lecturers at medical schools and contributed to regularly published research in their areas of expertise.

Pain relief

- The trust employed a specialist pain team who provided direct support to surgical wards and undertook pain reviews, supported by the outreach team and on-call anaesthetists.
- We observed patients alerting nursing staff to their increased pain levels and saw their pain was addressed in a timely manner. Staff told us they had access to the dedicated pain team on a daily basis.
- The pain team worked to evidence-based protocols, and had developed local guidelines for patient-controlled analgesia for post-operative and acute pain.
- In April 2014, nurses in the pain service conducted an audit to assess how pain was managed for patients they did not normally see in medical and surgical areas across the trust's hospital locations. The audit showed a reduction in the number of patients reporting severe pain.
- The pain team lead was undertaking long-term research, reviewing prevention of chronic pain after thoracic surgery.
- A local audit of pain in April 2014 associated with epidurals concluded that a higher-than-expected number of patients experienced pain when moving and coughing with an epidural infusion. Recommendations to improve practice were identified such as training for ward-based staff and we were told this area would be re-audited in 2015.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- Patients who were able to eat and drink normally told us they were given a choice of food and drink.
- Where patients had a poor nutritional intake, they were risk-assessed and fluid and nutrition charts were used to ensure they received adequate food and drink. Where necessary, a dietician assessment was undertaken and specific interventions recommended.
- In 2013, a local audit of emergency procedures by the anaesthetic department on a sample of 25 patients showed that patients were waiting for significant periods of time post-admission for surgery before being offered a drink or intravenous fluids. In a few cases, the audits showed some patients waited up to 11 hours for fluids and 19 hours for food, which meant they were unnecessarily fasting for a prolonged period. The senior management team stressed that this was not representative of the number of patients who received emergency treatment at St Mary's Hospital, and that actions were being taken to improve the patient experience. We were told that the audit would be repeated by December 2014.
- Patient records we reviewed showed that risks of nausea and vomiting post-operatively were assessed and discussed with patients at pre-assessment and appropriate action taken.

- We saw that all patients living with dementia had a food chart and were given assistance at meal times to ensure their dietary needs were met. Fluid intake was also monitored most of the time, although we noted some inconsistencies in the quality of the recording.

Patient outcomes

- Performance in some national audits demonstrated that outcomes for patients were close to or better than the England average, particularly for major trauma and vascular surgery.
- The Hospital Standardised Mortality Ratio, which compares the expected rate of death in a hospital with the actual rate of death, at St Mary's Hospital, was 67.43 which is statistically significantly low, showing that fewer patients died than expected.
- The rate for readmissions for January to August 2014 was 11.9% for colorectal surgery, 8.6% for trauma and orthopaedics, 7.5% for general surgery and 7.0% for vascular surgery, which is the same or slightly worse than the national average.
- The relative risk of readmission was worse than average for non-elective general surgery and trauma and orthopaedic surgery. Revision rates submitted for St Mary's Hospital between 1 April 2014 and 31 August 2014 for hip operations was 17.1% and knee operations was 9.1%, which were both close to the national average.
- In the National Oesophago-Gastric Cancer Audit, post-operative outcomes were close to or better than the England average.
- Patient Reported Outcome Measures (PROM) showed that the majority of patients undergoing knee replacement operations and hip replacement procedures had reported improvements in their overall health following their treatment. However, reported results for groin hernia showed that this had worsened.
- The trust's results from the National Bowel Cancer Audit were similar to the England average.

Competent staff

- Junior doctors told us they were not asked to perform procedures unsupervised that they did not feel competent to do.
- The appraisal process was linked to incremental salary increases and trust values, therefore if staff did not achieve their objectives, they were not automatically given their annual increment.
- The trust funded a number of leadership programmes for staff, although they did not provide us with detailed information to demonstrate how many staff within the surgical areas and in theatres had applied for and had successfully undertaken these programmes.
- Non-medical staff told us they received regular one-to-one meetings with their manager, while nursing staff also received regular feedback from an assigned mentor.
- On Zachary Cope Ward, all band 6 nurses had participated in their annual appraisal and we were told that bespoke vascular high dependency competencies were used to monitor their progress in specific areas.
- Ward matrons monitored staff compliance with the trust's mandatory training programme. Attendance rates were slightly lower than the trusts expected standard of 90%, but we were told that this was difficult to monitor as some training modules were face-to-face and others were e-learning. Some ward matrons told us they had to witness staff members completing these modules in order to provide evidence that they had been done.
- A number of staff had attended specialist courses and master's programmes, and many told us that they were encouraged and supported to undertake further education.
- Anaesthetic outcomes were being monitored against the Royal College of Anaesthetists guidelines and results were available by consultant grade clinician. These were being used to inform the individual's appraisal and revalidation.

Multidisciplinary working

- Trainee doctors, nurses, physiotherapists and pharmacists told us they were well-supported. Allied health professionals worked effectively with ward-based staff to support patients' recovery and timely, safe discharge following surgery.
- Multidisciplinary team meetings were established to support the planning and delivery of

patient-centred care. The daily meetings, involving the nursing staff, therapists, medical staff as well as social workers and safeguarding leads, took place where required and ensured the patients' needs were fully explored and action taken to ensure their needs were met.

- Multidisciplinary trauma meetings were held daily and the major trauma ward was covered by a team of

physiotherapists, occupational therapists, dietician, speech and language therapist and pharmacist, ensuring best practice guidelines for trauma care were met.
- Occupational therapists and physiotherapists were assigned to specific ward areas. The physiotherapy service had been reduced, which in some cases meant that one physiotherapist was assigned to 50 patients, resulting in reduced time with patients requiring rehabilitation.

Seven-day services

- We were told by the consultants that they undertook ward rounds seven days a week. On weekends they reviewed only new patients. The consultants were on site from 8am to 5pm Monday to Friday and an on-call system operated out of hours and at weekends.
- Physiotherapy services were provided to patients on surgical wards at St Mary's Hospital seven days a week.
- Occupational therapy, speech and language therapy and dietetics were available 8am to 5pm Monday to Friday.
- Staff told us out-of-hours imaging and pharmacy support was available when required. The imaging directorate was available Monday to Friday, 9am to 5pm, with extended hours and weekends for magnetic resonance imaging (MRI), ultrasound and x-rays. Out-of-hours emergency services ran seven days per week and offered ad hoc sessions to address particular backlogs or peaks in demand.

Are surgery services caring?

Good

Patients and their relatives provided positive feedback during our inspection about the care provided. We observed that staff interacted well and did their best to make patients comfortable. Staff demonstrated a caring approach to their individual team members. NHS Friends and Family Test scores were better than the national average for almost all surgical ward areas.

Procedures were in place to gain informed consent and involved the patients at all stages of their treatment. Patients' privacy and dignity was afforded as male and female patients, often wearing theatre gowns, had separate waiting areas in the theatre reception.

Compassionate care

- The NHS Friends and Family Test results were better than the national average for St Mary's Hospital. Surgical ward matrons had received an analysis of the responses and told us they were not aware of any trends. We did note, however, that Charles Pannett (at 18%), Zachary Cope (at 21%) and Samuel Lane (at 31%) wards had lower-than-average response rates but staff did not tell us what action was being taken to address this.
- Throughout our inspection we saw staff deliver caring and compassionate care to patients.
- A patient we spoke to who was awaiting an amputation; they told us that staff provided clear explanations in preoperative assessment in a caring way, and said "they have told me everything I need to know".
- Frequency of intentional rounding (comfort rounds) was monitored which showed this was done 95% of the time across the surgical wards at St Mary's Hospital. However, some ward staff we spoke to were unclear about what intentional rounding meant.
- The patients and relatives were complimentary about the nursing and medical teams and the care they delivered.
- Patients and their relatives said they were treated with dignity and respect during their stay. We witnessed other patients and their loved ones being treated in this way.

Patient understanding and involvement

- On admission, patients were allocated a named nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients confirmed their consent had been sought prior to care and

treatment being delivered.

- Patients and their families were involved in and were central to, decision-making about their care and support. They had been given the opportunity to speak with the consultant looking after them.
- We found that relatives and/or the patient's representatives were also consulted in discussions about the discharge planning process.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed positive

interactions between staff and patients and saw staff providing reassurance and comfort to people

who were anxious or worried.

- Patients could be transferred to side rooms to provide privacy and to respect their dignity, though staff told us that the rooms were often occupied which mean they were not always available when required.
- Patients' privacy and dignity was afforded as male and female patients, often wearing theatre gowns, had separate waiting areas in the theatre reception.
- The clinical health psychology department had 18 staff working across the three hospital sites. The department supported specific patient groups, including those undergoing bariatric surgery and patients with cancer.

Are surgery services responsive?

Requires improvement

The surgical department had a significant backlog of patients who were awaiting elective surgery; however, the trust did provide us with plans to reduce the backlog and deal with patients who had experienced long waits for their surgical interventions. Referral to treatment times in some specialties had breached national targets on an ongoing basis.

The provision in theatres was satisfactory; the surgical admissions lounge provided a suitable environment in terms of the patient experience with respect to patient comfort, dignity and confidentiality. The clinical impact of cancellations and delays in surgery were not monitored and the information in the dashboards did not show breakdown by location of theatre use and productivity.

There was insufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. Bed occupancy was worse than the England national average and in order to meet the requirements of the alignments to the North West London 'Shaping a Healthier Future' strategy and the trust's clinical strategy, bed numbers had reduced in some specialties. Staff told us that patients were frequently cared for in inappropriate areas, such as in theatre recovery overnight.

Service planning and delivery to meet the needs of local people

- There was 24-hour cover for emergency operations. All theatres were available over the weekend and night for emergency surgery.
- Staff told us that patients sometimes experienced long delays in the recovery area after their surgery due to a lack of beds.
- Data showed that the trust had a higher number of operation cancellations compared to the national average. We were not made aware of the trust's plans to address this.

Access and flow

- Referral to treatment times varied in 2014 and were now close to the national average of 18 weeks. National operational standards required that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. However, the hospital was not meeting the standard for patients admitted for general surgery and trauma and orthopaedics. The rates were 87.9% for general surgery, 74.5% for trauma and orthopaedics and 89.1% for ENT – these were worse that the national average.
- The length of stay for non-elective surgery was slightly worse than average. The trust did not provide an explanation of why this was the case or what mitigating actions were being taken to address this.
- Theatre use was 74%, below the trust's target of 85%. Despite asking, we were not provided with an explanation for this.
- Bed occupancy averaged at over 90% on a number of surgical wards, including Charles Pannett and Samuel Lane at St Mary's Hospital in the preceding 12 months. Staff told us that there were daily difficulties in identifying an appropriate bed for patients.
- Between January and March 2014, 9% of patients whose operations were cancelled were not treated within 28 days, which was slightly worse than the national average
- The average length of stay for elective and non-elective procedures was close to the national average, with the exception of vascular surgery where the average was better, at three days compared to a national average of four days. While it was 4.9 days in vascular surgery, 4.8 days for major trauma compared to a slightly higher national average. In elective orthopaedics was lower than average at 2.2 days.

Surgery

- We were told that many patients started on an enhanced recovery programme from pre-assessment. Enhanced recovery programmes were in place for lower gastrointestinal surgery, and hip and knee replacement orthopaedics and being developed for upper gastrointestinal surgery. This work was supported by an enhanced recovery nurse specialist. However, during our inspection, we reviewed 12 patient records and could not find any enhanced recovery programme templates completed. Senior managers told us that the impact of these pathways was not being monitored across all areas, but was stated to be most effective on Albert Ward.
- There was a high rate of patients who did not attend their surgery appointments. To reduce this number, we were told that patients were being telephoned shortly prior to date of surgery to remind them, but this initiative had only started in late August 2014 and therefore we were unable to assess its impact at the time of our inspection.
- Cancellation rates for surgical procedures (17%) were worse than the national average (approximately 6%) at St Mary's Hospital. We were not made aware of the action being taken to address this.
- Staff told us they felt there was sometimes reactive management in relation to the unavailability of beds. Senior staff told us the amalgamation of the vascular services to St Mary's site had resulted in a 40% cancellation rate due to lack of beds in May 2014. As a result of the number of beds being reduced from over 50 to 26, there was a six- to eight-month wait for elective major surgery.
- Staff told us that incident reports were completed in relation to the lack of bed availability which resulted in a short-term increase to 31 vascular beds. We were advised that at least once or twice a week admissions of patients needing vascular surgery from other hospitals had to be delayed because of a lack of beds. As the number of beds is likely to be reduced again in the near future staff told us capacity issues were becoming unsustainable.
- Lack of bed capacity on vascular and surgical wards was recognised on the divisional risk register, though this was identified as a low priority.
- Capacity pressures in surgical areas at St Mary's Hospital was recognised on the trust's risk register and daily review with performance and bed management teams were required to manage the associated risks. The senior management team could not confirm whether this action was having a significant impact.
- The trust reported that more than 180 patients were being cared in non-surgical ward areas due to lack of bed availability in the preceding 12 months. We could not be assured that staff in these areas had the appropriate skills and competencies to provide care to surgical patients.
- Delays in transferring patients back to the wards from recovery post-operatively was an identified risk and was documented on the divisional and trust's risk register.
- Pre-assessment was recognised as a risk by the division and trust as contributing to the high rates of patients who did not attend, and the higher than the average referral to treatment times. To address this issue, preoperative assessment was gradually being centralised to reduce the number of patients who did not attend as well as the cancellation rate. Around 40% of preoperative assessments were undertaken at divisional level, whereas others were undertaken at specialty level.
- The increase in the backlog of patients who had been waiting more than 18 weeks represented a major performance issue which was documented on the risk register. Progress report on the effectiveness of the actions taken to address this issue indicated that this backlog had stabilised in the period March to August 2014. Performance data showed that more than 3,500 patients were awaiting treatment. Managers were unable to provide evidence of the actions they were taking to manage this issue or information about what procedures patients were waiting for during the inspection; however the trust did provide overarching plans to reduce the backlog in each specialty.
- Cancellation rates for elective procedures were worse than the England average. Data recorded on the trust's theatre database stated that 14,242 operations were carried out between 1 January 2013 and 31 August 2014 at St Mary's Hospital. During this period 2,363 operations were cancelled, around 17%. The most commonly recorded reason for this was that patients did not attend. Evidence provided by the trust and the managers during our inspection did not provide assurance that effective action was being taken to address this issue.

- Between April and July 2014, there were 4,000 electronic discharge summaries waiting for clinical input. The trust was not able to show us how many of these were attributable to surgical wards, so we were unable to ascertain if this meant a number of GPs were not receiving important clinical information about patients admissions.

Meeting people's individual needs

- We saw that Valentine Ellis Ward provided specialist facilities and individual support for patients living with dementia. This ensured that these patients had their complex care needs met 24 hours a day.
- The trust had dementia 'champions' who were available to provide support and guidance for patients and staff. Ward areas used the Butterfly Scheme for patients living with dementia. The scheme (a not-for-profit organisation) provided training and templates to staff to record information about the patient's likes, dislikes and choices and helped them manage care in a sensitive and person-centred way.
- The hospital had clinical and support staff who also worked as translators and were able to offer instant access to language support.
- The Major Trauma Ward had direct access to a registered mental health nurse to assist patients who had experienced acute deterioration in their mental health.
- Arrangements were made to ensure that patients were treated in single-sex areas throughout the wards and theatres we visited. There was an admissions lounge in theatres, eight consulting rooms, with separated male and female waiting areas.
- There were no dialysis facilities for patients accessing vascular services at St Mary's Hospital, which meant patients needing dialysis were spending up to three mornings a week on hospital transport, travelling to and from Hammersmith Hospital.
- Elective admissions were staggered throughout the day were possible to promote flexibility for patients, although most patients asked or were requested to arrive between 7am and 7.30am, the reason given was that this arrangement ensured the theatre list was flexible.
- Emergency patients admitted via A&E took priority and could be admitted at any time. Staff told us these emergency admissions resulted in surgical outliers – patients being placed on other surgical or medical wards.
- A noticeboard outlined the various multi-faith services available, with timings for specific prayers and services. Patients also had access to one-to-one support from the chaplaincy service.

Learning from complaints and concerns

- We saw information leaflets and posters about the Patient Advice and Liaison Service (PALS) and complaints from patients were displayed near the nurses' station in most surgical ward areas.
- Ward staff told us they received no formal training in complaints investigation.
- Staff told us how patient feedback about their concerns resulted in changes to extend quiet and protected meal times.
- We noted that there had been a monthly increase in complaints year-on-year between quarter one, April – July 2013 and 2014 in the division of surgery, cancer and cardiovascular sciences.
- In quarter one of 2013 the complaints trends on surgical wards were: poor clinical care, poor nursing care, appointments, delays and cancellations and ineffective treatment and admission, discharge and transfer arrangements. In quarter one of 2014, the trends were: poor clinical care, poor nursing care and ineffective treatment, appointment delays or cancellations, communication or information to patients (written and oral). The complaints about appointment delays and cancellations increased from 6% to 12%.

Are surgery services well-led?

Requires improvement

The leadership team had not taken effective action to manage risks such as the five steps to safer surgery, and they were unable to articulate the actions being taken in line with the overarching trust-wide plans to address the backlog of patients waiting for operations. There were governance arrangements for auditing and monitoring

services and evidence of actions or learning from clinical governance meetings, including accountabilities for change and development, however we noted that actions were not always followed through.

All surgical wards were well-managed by nursing staff and feedback about the nurse leadership was positive. Staff spoke of an open and candid culture in which problems and emerging concerns were escalated to senior management without hesitation. A learning culture was encouraged and successes were celebrated. Long-term plans for services at St Mary's Hospital had been articulated, discussed with staff in open forums and agreed with relevant stakeholders.

Vision and strategy for this service

- The trust had a clinically-led vision for surgical services at St Mary's Hospital and most staff we spoke to were aware of this.
- The trust had developed a clinical strategy for 2014, which described long-term plans for all trust activities. In relation to the surgical services at St Mary's this included identifying the movement of emergency neurosurgery, acute surgery and orthopaedics and plastic surgery from the Charing Cross site to St Mary's and day case surgery, except orthopaedics and gynaecology, from St Mary's to Charing Cross.
- We were told by divisional management staff that the strategic direction had been agreed with the local clinical commissioning groups and other stakeholders.

Governance, risk management and quality measurement

- The trust had restructured its governance arrangements within the last year and this meant that surgical ward areas were managed within a separate division, the division of surgery, cancer and cardiovascular sciences, while pre-assessment and theatres were now in the investigative sciences and clinical support division. Senior staff told us there was no impact on the running of services, although some staff told us of difficulties with arbitrary decisions as the two divisions had separate budgets.
- All specialty areas maintained their own risk register. Risks deemed to be the most significant were transferred to the trust's overall risk register. Ward matrons were aware of risks that had been escalated on this register and told us they were encouraged to identify and escalate risks.
- There were identified clinical governance leads at divisional level, with the heads of service being accountable at divisional level for clinical governance within their areas.
- There were bi-monthly governance half days, known as audit days, on the wards and in theatres. We observed one meeting in theatres at St Mary's Hospital, which was attended by more than 50 members of staff, including nurses, operating department technicians, porters and healthcare assistants. All staff on shift were expected to attend, and these meetings were scheduled in advance to ensure staff availability and provision for emergency theatre cases. Discussions were open and contributions from staff were encouraged and included 'Five steps to safer surgery' checklist, recently reported incidents, complaints and overall theatre performance.
- There were monthly clinical governance meetings on the surgical wards at which incidents, risks, audits and adherence to guidance was discussed, as well as joint divisional meetings for senior nursing staff.
- We were told by the divisional management teams that the medical director discussed serious and moderate incidents every Friday with senior management. However, these meetings were not minuted, therefore we were unable to identify what actions were taken.
- Lead nurses collated the monthly harm-free care report which identified nursing quality indicators and included a range of measures such pressure ulcers, falls, hospital-acquired infection, catheter-acquired urinary tract infections, complaints, compliance with intentional rounding (round-the-clock comfort rounds). Each ward was benchmarked and results were reported to the board on a monthly basis.
- Cost improvement plans were risk-assessed by the clinical team and reviewed at the quality committee before being agreed to ensure patient safety implications were considered.
- The July 2014 divisional complaints reports stated that complaint themes were not reviewed alongside incidents. Therefore, it was not clear how integrated learning from incidents was.
- When we spoke to managers about the risks relating to safety, particularly the five steps to safer surgery. They told us practice was safe as surgical safety was not a 'tick box exercise' and that human factors were embedded. However, they were unable explain why there were limited improvements in overall results, and did not see low sample sizes as a risk.

Surgery

- We asked managers about the risks relating to responsiveness, particularly the backlog of operations. They were unable to articulate specific information to demonstrate how this was to be addressed in accordance with the trust-wide back log action plans and how they prioritised these plans based on clinical risk.
- When we requested information to identify how actions plans were being progressed, in response to compliance with national guidelines and staff training, we were not provided with this information.

Leadership of service

- The leads for each clinical service area, or chief clinician, worked across the three locations of the trust promoting consistency.
- There was a strong leadership culture within nursing. Senior nursing staff and ward matrons led by example and demonstrated their personal accountability for the service and their staff. All the staff we met said they were proud to work for the trust, their ward, and in their specialism.
- Some consultants felt detached from senior management and decisions made by the trust were not communicated to them in a timely way.

Culture within the service

- Staff spoke of an open and candid culture in which problems and emerging concerns were escalated to senior management without hesitation.
- There were no whistleblowing cases open at the time of the inspection. Staff were aware of the trust's whistleblowing policy.
- Ward staff told us that senior staff were open and created a positive teamwork culture, with ward managers visited weekly by their managers.
- Junior and trainee surgical staff, who had started their rotations three weeks before we inspected the trust, told us they felt well-supported by consultants.
- However, findings from the 2014 General Medical Council trainee survey highlighted themes which had negatively impacted on surgical trainees, including induction, feedback, adequate experience and access to education resources. Specific bullying and harassment concerns in relation to the anaesthetics department at St Mary's were raised. The chiefs of service for each area told us they had implemented a range of actions to address these concerns and were monitoring feedback from trainees. We were unable to assess the impact of these interventions as the new trainees had only recently commenced in post.

Public and staff engagement

- There were weekly consultation meetings with staff over a two-month period in 2014 regarding the clinical strategy.
- Patients could provide 'real time' feedback with the 'I track' electronic survey devices. We were not made aware of how these results, or any actions, were monitored across surgical wards and theatres at St Mary's Hospital.
- The clinical health psychology department led a number of interventions to support staff and clinical nurse specialists, including Schwartz rounds – monthly sessions for staff from all disciplines to discuss difficult emotional and social issues arising from patient care.

Innovation, improvement and sustainability

- The surgical rehabilitation ward, Albert Ward, had been shortlisted for a national award by the Health Service Journal for orthopaedic surgery with regard to dementia care.
- Staff had developed a 'Joint School' programme for patients who were due to have elective surgery at St Mary's Hospital. A group support network for patients reviewed the whole care pathway, including advising on what to expect, the enhanced recovery programme and physiotherapy guidance.

Critical care

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

Information about the service

The critical care service at St Mary's Hospital comprised a 16-bed intensive care unit (ICU) which provided care to both level 3 (multiple organ failure or advanced respiratory support) and level 2 patients (single organ failure, post-operative care or high levels of monitoring), a medical high dependency unit (HDU) which cared for up to 10 level 2 patients, a number of level 2 beds in other parts of the hospital, such as surgical wards, and a critical care outreach service.

We visited all wards which delivered HDU or ICU care. We spoke with 10 patients including their family and friends, 40 members of staff including nursing, medical, administration/clerical and allied healthcare professional staff. The ICU treated nearly 1,000 patients so far in 2014, with HDU wards treating between 1,000 and 1,500 patients each. We checked 12 pieces of equipment and 12 patient records. We also observed care.

Summary of findings

The critical care and high dependency areas were generally well-run but there were some areas of concern. The main areas of risk were the lack of bed capacity and different governance arrangements over the level 2 beds outside of the ICU. However, the leadership team were aware of these concerns and had escalated and taken action to address these. Patient feedback was positive. There were also minor concerns relating to staffing levels and training.

Critical care

Are critical care services safe?

Good

There was a focus on safety within the critical care service and the use of safety indicators, such as the NHS Safety Thermometer, and infection control indicated that the service was continually improving in these areas.

The majority of national staffing level guidance was adhered to, although there were times when this was not the case. Staff were aware of how to respond to major incidents and safeguarding but they were not always aware of their responsibilities under the Mental Capacity Act. However, mandatory training rates were generally low but above the trust average and there were not always appropriate actions when learning from incidents.

Incidents

- There had been no Never Events in the critical care services at this hospital. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There had been 48 incidents in the sub-division of critical care, anaesthetics and pain reported between April and June 2014, all these had been graded as 'no harm', 'low harm' or 'near misses'.
- Most incidents were pressure ulcers, implementation of care and medicine errors, with some reports in infrastructure and equipment. In response to the issues relating to pressure ulcers a pressure ulcer group had been formed across the critical care units in the trust which included tissue viability nurse input to improve wound care practice and provide education at patients' bedsides. This had reduced the number of pressure ulcers.
- All staff were able to describe how incidents had been learned from, which included unit meetings where incidents were discussed. Root cause analysis was completed on serious incidents and investigations of other incidents such as pressure ulcers.
- The incident reports we looked at showed that actions had been taken to prevent the incidents recurring in the future. However, the actions being taken were mainly reminders to staff or increasing staff awareness of policies or practice rather than changes to procedures or protocols. The only incident staff described where there had been a change in practice was a Never Event that had occurred at another trust site which had resulted in a change in procedure for checking x-rays of nasogastric tubes (NG tubes). Therefore, there was a risk that the causes of incidents were not comprehensively dealt with.
- Staff were able to describe and show us how incidents should be reported using the trust's electronic reporting system. They told us they received feedback on incidents they reported.
- Mortality and morbidity meetings took place every two months at which staff discussed learning from each death within the critical care units.

Safety thermometer

- NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care) results were displayed in the HDU and ward areas that provided level 2 care, but not in the ICU, where only the infection rates were displayed.
- Recent results of the Safety Thermometer in the ICU showed better-than-national-average infection rates, one Clostridium difficile (C. difficile), six grade 1 and two pressure ulcers and three falls in the last three months. However, MRSA screening compliance was low at 74.7% and harm-free care was also low at 92.3% in these three months against the trust's targets. Similar or better scores were also reported in the HDU and level 2 bed areas.
- To address issues identified by the Safety Thermometer, several actions has been taken. There was weekly input from the microbiology and tissue viability nurses to manage existing and prevent further infections and pressure ulcers. An action plan was also in place to reduce blood infections from central venous catheters (CVCs) including having CVC champions, daily spot checks, and further training on CVCs for staff. Actions were recommended from each fall, although these were reminding staff to adhere to guidelines rather than any changes to systems and processes.

Cleanliness, infection control and hygiene

- All the areas we observed were visibly clean and tidy. Patients and their friends and family told us the units were clean. Cleanliness audits gave the ICU and HDU areas over 97.5% compliance.

Critical care

- We saw that staff observed infection control procedures such as wearing personal protective equipment such as aprons and gloves when providing care, and hand-washing when entering and existing different areas of the unit.
- All the equipment we checked had been cleaned and green stickers were attached to equipment to show it had been cleaned within the last 24 hours.
- Bins in the areas we visited were not overflowing and there were separate bins for sharps and medical waste. These were emptied at least three times a day.
- There was a low rate of MRSA and C. difficile infection rates in the units. On one unit where there had been two cases of C. difficile)since March 2014, actions had been taken to address this, such as new bedside equipment and ensuring staff were aware of and signed to confirm they had read the relevant policies.
- Isolation rooms were available in the ICU, HDU and on the wards. Signs were displayed if a patient with an infection was being treated in the isolation rooms.
- On the day we inspected, there had been three patients who acquired infections in the ICU, two vancomycin-resistant enterococcus (VRE) and one pseudomonas. These had been reviewed by microbiology experts and investigations were taking place but the results were not available at the time of our inspection.
- The May 2014 infection control audit reported that the ICU was 100% compliant with hand hygiene, 93.2% of patients were MRSA-screened, 90% of patients with cannulas were checked for urinary tract infections and 95% of patients with CVCs were screened for blood infections. The medical HDU performed similarly well, with a lowest score of 96% for hand hygiene compliance in the last six months. Another ward with level 2 beds had 100% hand hygiene compliance.

Environment and equipment

- The 12 pieces of equipment we checked were all maintained, and daily checks of the resuscitation equipment and intubation trolleys were fully complete. Oxygen cylinders were in date and appropriately maintained. Only one piece of equipment we checked had not been portable appliance tested.
- Staff were competent to use the equipment in the units as this had been covered as part of their induction.
- Only one of the three sluices and storage areas we looked at was not locked and all were kept tidy.
- The outreach team said they arranged a porter to bring a resuscitation kit when they were paged as there were some non-clinical areas of the hospital, including corridors and outside buildings, where there was no resuscitation trolley but they could be required to attend to provide urgent care to a patient.
- The ICU had both negative and positive pressure isolation rooms to safely care for infected or immunosuppressed patients to prevent cross-infection.
- Some staff said it could take time for estates management to undertake repairs such as broken doors. We saw that the ICU had a broken electronic door for an isolation room which had been on the risk register for two months but had not yet been repaired.

Medicines

- All the medication cupboards were appropriately locked and medicines were stored appropriately at the correct temperature, including those that needed to be locked in a fridge.
- We observed appropriate administration of medicine, including requesting consent. Medicine records were complete.

Records

- Ten of the 12 patient records we looked at were complete, including observation checks such as heart rate, and risk assessments such as skin integrity and venous thromboembolism (VTE or blood clots). In ICU, these were recorded on an electronic system called IntelliVue Clinical Information Portfolio® (ICIP) whereas the rest of the level two beds and HDU used paper records. There were concerns from nursing staff that they could not access the electronic ICU patient records and these had to be printed off.
- Across the trust, there was a patient record system called Cerner. Most staff commented that there had been issues with this system such as patients being sent to areas where they had not been admitted. However, staff stated that they had been trained to use the system and there were specific 'champions' to assist staff. There were also concerns that paper and electronic records did not always match and it was sometimes difficult to obtain paper patient records which meant transferring patients could be delayed or their records could not be fully completed.

Critical care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not always understand their responsibilities under the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards. Some staff were aware of best-interest assessments and the psychiatric liaison team, whereas others could not identify this team or what to do if someone did not have clear capacity. On the ICU, a mental health nurse came to the unit daily to help assess patients' capacity and support patients and families as needed.
- We saw staff obtaining consent from patients before commencing care. Best-interest assessments had been undertaken for patients who needed them.

Safeguarding

- Staff were aware of their responsibilities to safeguard vulnerable adults. They knew the safeguarding lead in the trust and how to report a concern to them. They were also able to show us the current safeguarding policy.
- Staff completed safeguarding training as part of their induction and mandatory training. However, we were not provided with the records of what level had been completed and the number of staff who were up to date.

Mandatory training

- Although staff told us they received mandatory training and this was kept up to date, staff records showed that levels were low. For example, immediate life support (ILS) training was at 76% in the ICU and 79% in the HDU. Overall mandatory training in critical care was 76%. We were told that, although there were a number of sessions for ILS, it was sometimes difficult for staff to attend. 89% of ICU nursing staff were competent in intravenous therapy. Only 70% of staff were epidural competent. Overall, mandatory training in one area where level 2 beds were located was at 68%. On another area of level 2 beds 80.77% had completed mandatory training. Medical leads and the nursing lead for the outreach team were trained in advanced life support level 3. Staff told us they had concerns that records were not being fully completed for those who had attended training.
- We were also told that some mandatory training was now only required every three years such as basic life support, patient safety, and manual handling, although others such as information governance, were still required yearly.
- Induction included some aspects of mandatory training such as intravenous therapy, aseptic non-touch technique, infection control, medicines management and calculations as part of the new staff starter pack.

Assessing and responding to patient risk

- National early warning scores (NEWS) were in use on the HDU and level 2 beds. These were completed and patients were escalated to the outreach team when appropriate, in line with the trust's escalation policy.
- The hospital followed the trust's policy for managing deteriorating patients and this clearly stated what score patients required before they needed more observations and escalating to either the medical team or outreach team.
- There was no formal pathway between level 2 and 3 beds due to the number of areas where level 2 beds were located. However, teleconferences took place daily between the areas with critical care beds to manage the bed space for those requiring escalating or stepping down.

Nursing staffing

- Staffing in the ICU was one-to-one for all level 3 patients, with two nurses being required for patients requiring multi-organ support, and one-to-two for level 2 patients in the HDUs and most medical wards when we inspected. However, there had been recent incidents reported and senior staff confirmed nurses had been required to care for some level 3 patients at a one-to-two ratio which was not in line with national guidance. One medical ward had a ratio of two-to-five for its level 2 patients which also did not follow national guidance. We were unable to confirm if the unit increased their staffing level beyond one-to-one for more complex patients as there were no patients in the ICU requiring this level of intervention at the time of our inspection.
- Staffing levels had been calculated using an acuity tool. This showed that there were no patients with complex needs in the ICU and we observed that this was the case. Discussions were held between the lead nurses at each ICU site twice daily to ensure there was adequate staffing.
- There were no healthcare assistants in the ICU with one band 6 practice development nurse who was supernumerary and one band 7 who was the lead nurse for the unit which was in line with national

recommendations. However, there was no clinical educator for the level 2 beds in the HDU or wards nor a band 7 which was not in line with national recommendations.

- There was a high use of bank (overtime) and agency staff at 17.5% in the ICU and 19.5% in the medical HDU, this was reported to be due to new staff being supernumerary for varying amounts of time depending on their competency. Therefore, the vacancy rate was much lower than the use of bank/agency staff at 5.9% in the ICU and 6.8% in the medical HDU. The service was continuing to recruit additional staff to reduce the use of agency staff even further.
- An induction and orientation programme was in place to ensure that agency/bank staff were familiar with the unit before commencing work and they were supervised by senior nurses, especially if they had not worked on the unit before. Senior staff estimated that at least one-third of bank/agency staff they used were regular with the critical care units.
- Nursing staff were rotated around the three hospital sites so if one site was short, staff could be moved if necessary. This was reflected in their contract terms and job description and was covered in their induction.
- The outreach team had three staff on shift, including a nurse consultant and were available 8am to 8pm during the week. The team included advanced nurse practitioners and senior nurses and were competent to provide outreach support. No ward raised any concerns with the outreach team failing to attend pager calls and none of the patient records we checked showed outreach access was a concern.

Medical staffing

- There was a middle grade airway trained doctor and junior doctor available out of hours with a consultant on call.
- Two consultants covered the ICU during the day which is a ratio of one-to-eight which met the national core standards for the unit. They undertook twice-daily ward rounds and ensured continuity of care as the same consultant was on shift at least four days in a row apart from weekends. These consultants rarely had any other clinical commitments. The lead consultants for the ICU had a clinical background in intensive care medicine and had completed airway management training.
- In the HDU and wards with level 2 beds, ward rounds took place at least once a day with tracheostomy patients seen twice daily. However, one ward reported that level 2 patients were only seen by junior doctors and not middle grade or consultants.
- The HDUs had medical cover; however, these doctors were not always airway trained so there was a reliance on the outreach team or staff from the ICU if a patient had an airway issue that required anaesthetic support.
- Medical handovers took place twice daily which involved all the medical staff for the shifts taking over. Handovers included a clear description of what medical interventions may be required on the next shift and what to do in the different possible clinical circumstances.

Major incident awareness and training

- As the hospital was a major trauma centre, staff were aware of the units' major incident plans. They were able to explain how they would react in an emergency, such as a terrorist attack or train crash, and how they would step down the least dependent patients so there was room in the ICU to take additional patients. They would also call in as many staff as possible and increase overall bed capacity. The situation would then be reviewed each shift.
- We were told an evacuation exercise had taken place a "few years ago" and the current policy for this was being reviewed at the time of our inspection.

Are critical care services effective?

Good

The majority of policies and guidelines were in line with national guidance. Audit results were positive, although there were areas for improvement. Data collected by the service demonstrated that patient outcomes were in line or better with the national average. However, the outreach team did not collect data to demonstrate the effectiveness of their service.

Staff were competent and had the necessary skills and knowledge to deliver safe and effective care. There was effective multidisciplinary working in the ICU, however, when critical care was delivered on non-critical care wards, this was not always effective.

Critical care

Evidence-based care and treatment

- The hospital complied with most National Institute for Health and Care Excellence (NICE) and Intensive Care Society guidelines and standards. Audits of these guidelines took place regularly, but recent audits showed only partial compliance of organ donation, preoperative tests, and depth of anaesthesia monitors. Business meetings were held weekly which included a discussion by consultants on any changes to guidelines.
- Staff felt the trust was sometimes ahead of national guidelines. A consultant gave an example of guidelines regarding the use of oxygen which the trust implemented in 2004 but had only become national guidance more recently.
- The trust's critical care policies such as catheter care, wound care, nutrition/food, bowel management, daily checks/nursing and risk assessments, admission documentation/property, discharge documentation, were up to date with current guidance.
- The audits of compliance with policies in the last two months showed 100% compliance with ventilated patient observations, peripheral access devices and pressure ulcers but 98% compliance with indwelling urinary catheter, central vascular access device care bundles, and 95% compliance with food and nutrition care bundles.

Pain relief

- All the patients and family and friends we spoke with told us they were happy with the pain relief received and said they were able to get pain relief when they needed it.
- A pain team visited patients with epidurals and patient-controlled analgesia daily.

Nutrition and hydration

- Patients and family and friends told us they were happy with the food and that drinks were always available and within reach. Patients were supported to eat and drink if needed.
- Patients who required intervention from a dietician were assessed by the ICU's designated dietician.

Patient outcomes

- Most of the Intensive Care National Audit & Research Centre (ICNARC) data for the hospital was around the UK average or better, such as mortality, and unplanned readmissions within 48 hours. However, although around 80% of patients were fully independent when they were admitted, only around 66% of patients were still fully independent when they were discharged.
- The ICU scored 77% against the critical care network quality measures in April to June 2014. It was stated that this low score was due to case mix and not participating in the patient survey. Issues raised were late-night discharges and unplanned extubation.
- The outreach team did not collect any data to show how their work improved patient outcomes. However, every member of staff we spoke with felt very well-supported by the outreach team.
- The critical care team were currently involved in a number of audits including a number from National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and ICNARC-related audits, sepsis, lung safe, stress ulcer prophylaxis, severe acute respiratory infection, central line care bundle, ventilator care bundles, peripheral cannula care bundle, indwelling urinary catheter care bundle, critical care pressure ulcer prevention, food and nutrition, VTE and falls prevention.
- Junior doctors were also involved in a number of audits, including fasting before surgery, decision-making involved in ICU referral, tracheostomy for trauma patients, ventilator-associated pneumonia rate in trauma patients, patient referrals to ICU, prescribed sedation scores, temperature management in traumatic brain injury and use of the anaesthetic thiopentone for stage 3 traumatic brain injury. We were told actions were taken by the trust from these audits such as capnography (measurement and display of CO2) extended to each bed space, establishing a critical care group, increasing the amount of bed space, having site manager meetings more regularly, relocating level 1 patients to side rooms to ensure there was not a mixed-sex breach, insertion technique for management of central lines being reviewed, changing fasting guidelines, a new tracheostomy system and a daily round by the senior nurse for skin integrity checks. However, we did not receive the results of these audits despite requesting them, therefore could not assess if appropriate action had been taken on their findings.
- The ICU participated in the National Cardiac Arrest Audit.
- The Actual and Potential Organ Donor Audit showed it was worse than the UK average for organs donated in

2013/14, with low approach and consent rates compared to the national average both after brain and circulation deaths. We were not provided any information on how this would be addressed.

Competent staff

- We found that staff had the necessary competencies to deliver care in the ICU, HDU and level 2 beds. Relevant senior members of staff had completed advanced life support training and consultants were trained in airway management. Nurses were also critically care trained, including those who were caring for patients in level 2 beds outside of the ICU and HDU. A specialist ICU course was also provided which had two intakes a year. Other courses included neuroscience, trauma and mentorships.
- Staff's competency in other areas of treatment, such as pressure ulcer management, was assessed by tissue viability staff to ensure they were competent to provide that treatment and care.
- Staff told us they had appraisals and that this was relevant to their role. The appraisal records we looked at showed that nearly all staff were up to date with their appraisal with only nine outstanding out of 54. One administrative and clerical staff member told us they had been put on a training course for a more senior position. There was a clear career progression pathway for nurses with additional competencies required at each stage such as mentoring and critical care specific courses. However, some staff members told us they did not get regular supervision meetings with their line management.
- As part of the induction process, each new staff member had an orientation which was signed off on a checklist. This included policies and procedures, IT access, equipment use, and patient records. This was done at each hospital site to ensure that staff could work across the trust. All mandatory and competency-based training was protected but additional studies had to be taken in staff's own time.
- Training and advice was provided by staff at the Stoke Mandeville National Spinal Injuries Centre ensure the hospital was able to stabilise and start rehabilitation on spinal injuries appropriately.

Multidisciplinary working

- The ICU had a multidisciplinary team that included anaesthetists/intensivists, critical care nurses, physiotherapist, a pharmacist, two dieticians, as well as input from speech and language therapists. The Situation-Background-Assessment-Recommendation (SBAR) framework was in use during these meetings.
- There was not always multidisciplinary team working when critical care was delivered on non-critical care wards. However, ward staff liaised with ICU staff and the outreach team when necessary for level 2 patients and outreach had provided training to ward staff on resuscitation and ventilation to reduce the amount of outreach calls.

Seven-day services

A consultant was available on call out of hours. There was no outreach service out of hours but an onsite team was available to deal with medical emergencies. This included a core medical trainee (level CT1) and a registrar.
Out-of-hours imaging was also available.

Are critical care services caring?

Good

Patients, their family and friends felt the service they received from critical care was caring and they were positive about privacy, dignity and empathy. Patients, their friends and family were kept involved in their care and were given the information they needed. Scores for patient experience were mainly positive.

Compassionate care

- All the patients, their family and friends we spoke with were happy with the care they received. Comments included, "everyone is wonderful, they always put patients first".
- We saw that staff ensured patients' privacy and dignity, for example, by closing curtains when providing personal care.
- The service provided us with patient surveys with former critical care patients and these were mainly positive about patients' experiences.

Patient understanding and involvement

- Patients, their family and friends told us they were kept informed and were involved in their care. They told us treatment was explained to them. One family explained

they felt they had been told everything they could possibly know. However, some families told us it was sometimes difficult to speak to a member of staff when they needed one.

- We were told by patients/families that leaflets had been given to them by staff explaining the facilities within the critical care units. One family said they had not yet been allowed to have their relation's records although they had only been in the unit two days and staff had explained this was due to wanting to provide a full prognosis first.

Emotional support

- Patients/families told us they were offered emotional support such as counsellors and bereavement support. Chaplaincy service was also available.
- There were specialist nurses for organ donation.

Are critical care services responsive?

Requires improvement

Bed capacity did not meet the needs of critically ill patients who were considered well enough to be stepped down from level 3 to level 2 and 1. This resulted in high bed occupancies, high lengths of stay and delayed discharges. Informal complaints were not always learned from. There was appropriate support for vulnerable people.

Service planning and delivery to meet the needs of local people

- Although patients were able to be escalated to the ICU if they deteriorated, this sometimes resulted in level 3 and 2 patients who were not quite ready to step down, being moved to other wards to create space in the ICU. This resulted in delayed discharges and high bed occupation levels.
- Some staff had concerns with the ICIP system as, when transferring a patient, they had to print patient records off the system so the information could be transferred to the patient's paper records. Staff felt these print-offs did not always detailed or clear enough to ensure the patient's care could be continued appropriately.
- The trust served a population of two million. The ratio for this size of population should be 11 critical care beds per 100,000 of the population according to national guidance. The trust had 44 ICU beds but an undetermined number of level 2 beds due to the various wards they were located in. Other trusts also served the same population in the North West London Critical Care Network so we were unable to determine if national guidance was being followed.
- Some patients said they had no call bell, although we did not witness this. We saw that patients had a call bell if they needed assistance from a member of staff.
- There were admission policies for the HDUs and areas requiring HDU support and we observed these had not been breached.

Access and flow

- On the day we inspected, the ICU had 10 patients out of 14 beds. However, bed occupancy had recently been at 93% in June 2014. However, overall bed occupancy in 2014/15 was 80.3% to date. Admissions during 2014 were around the national average or slightly below the previous two years, and the number of bed days was higher. Historically most people in critical care were trauma patients, but the case mix had been more varied in the three months up to June 2014.
- In the last three weeks, we noted that there had been rarely more than a bed free in either the medical HDU or the ICU at 1pm each day. The leadership of critical care said that, due to the lack of ICU beds, sometimes level 3 patients were cared for on the trauma ward and one such patient was being cared for there on the day we inspected.
- Delayed discharges from the ICU were worse than the national average at 67% since April 2013 to date. Additional bed capacity had been created at Hammersmith and Charing Cross hospitals and plans were in place to change the number of the HDU beds but this had not yet resulted in a decrease in discharge delays.
- The average length of stay in the ICU varied from 5.9 to 10.6 days over the last three months which is above the national average and had been increasing since 2013/14. However, the case mix was affected by the hospital being a trauma centre. Staff said this length of stay was also affected by not having a specific neurology HDU to care for brain injury patients after they stepped down from the ICU.
- The HDU beds had average length of stays varying between 2.3 and 4.7 days and bed occupancy was over 95% in the last three months. Staff told us this was due to a lack of level 2 and 1 bed space, such as neurology or spinal wards, due to the number of trauma patients the

hospital admitted. This resulted in patients remaining on the ICU or in level 2 beds longer than they needed, including level 1 patients. There had also been a number of outliers in the HDU beds, including 25 surgical patients on the medical HDU in the last year and 11 on surgical HDU beds. The additional bed capacity at other hospitals and configuring the HDU at St Mary's were part of the plans to address this.

- There was a plan for escalation to the general manager if there were concerns with bed capacity. The service leadership agreed that capacity was particularly a problem during the winter. However, there was a cross-site conference call twice daily between service leads to manage bed capacity.
- There was a plan for a designated 16 bed HDU at the hospital, but at the time of our inspection, the business case for this development had not been drafted or presented to the Trust Board. Staff stated that they expected the HDU to be ready to use within nine months. In addition, some patients complained to us they had been waiting to be discharged from the ICU or HDU with one saying the delay had been four days.
- The level 2 beds were located on a range of wards across the hospital and the medical HDU was located near the medical wards rather than the ICU. Therefore, logistically, it was more difficult for patients to be transferred between the HDU, level 2 beds and the ICU due to the acuity of the patient and the different floors the patient would have to travel.
- Out-of-hours discharges from critical care were worse than the national average at 11% with 69 transfers in the last 15 months. Most of these were as a result of the ICU bed being required for a trauma patient. However, there had only been nine delayed admissions from the ICU totalling 97 hours in the last 15 months and 17 readmissions within 48 hours (2.3% of all admissions) in the same time period. There were a total of six elective surgical patients cancelled due to a lack of critical care beds in July 2014, although there had been a total of eight cancelled between April 2013 and June 2014. There were three non-clinical transfers in the last four months. There were six mixed-sex breaches in the last seven months.
- The main inter-hospital transfer was for cardiothoracic patients from St Mary's to Hammersmith for the cardiothoracic-specific critical care unit.
- There was effective discharge liaison for the critical care beds and standardised transfer forms were in place.
- Patients that were stepped down from ICU were followed up daily by an ICU consultant.

Meeting people's individual needs

- Staff were aware of clinical nurse specialists such as the mental health nurse and how to access this support.
- Patients and family and friends told us that, although there were visiting times for the units, staff were flexible with these.
- A number of information leaflets were available, including organ donation, how to complete an electronic patient survey, ward/unit information such as facilities, staff, ward rounds, and visiting times, bereavement support, Patient Advice Liaison Service (PALS), and infection control. The critical care units had a leaflet available for parents with children explaining how to help children understand when relatives were in the unit.
- We observed call bells being answered in a timely manner.
- Dementia packs were available for carers and patients were appropriately screened for dementia.

Learning from complaints and concerns

- Senior staff told us complaints were dealt with informally by the service and they tried to prevent formal complaints. We found there was conflicting information about the number of formal complaints received. We were told that critical care had only received one formal complaint in the last 18 months, although we noted that 11 were recorded against critical care/anaesthetics/pain in the period April to June 2014. When we spoke with ICU staff, they told us the service had not received any complaints recently. We saw no evidence that discussions about informal and formal complaints took place during team meetings. Therefore, there was a risk that complaints were not always learnt from.
- When we spoke with patients and their family and friends, most were unaware of the formal complaints procedure, although leaflets were available in the reception areas.
- As part of the critical care patient groups, the service had started to provide ear plugs and eye shields due to concerns raised about noise and light.

Facilities and environment

- The medical HDU environment did not meet the needs of the patients. The lead nurse's office was being used

for storage. Each bay had two beds, however, these had originally been designed for four standard ward beds which meant the design was inefficient as there was not the room or layout to easily store the monitors and equipment for a high acuity patient.
- Patients' families and friends were given a phone number for the direct line to their relative's bed which meant they could directly contact the nurse in charge of their care. In addition, due to the size of the unit, visitors could be directed to a specific bed-space by way of an intelligent lighting system, therefore reducing risk of visitors becoming lost or disorientated within the unit.

Are critical care services well-led?

Good

Although some staff were unaware of the vision and strategy of the service, the leadership team had identified how the service needed to develop and improve, including where its risk areas were. There was a positive staff culture with encouraging feedback on engagement and leadership. The department's capacity issues had been escalated to divisional level and were an identified risk on the division's risk register.

Vision and strategy for this service

- Other than the reconfiguration of the hospitals, most ICU and HDU staff were unaware of the vision and strategy for the service and were unsure what the reconfiguration meant for them. However, nurses from band 6 upwards, were aware of the local vision and strategy, including what the focus of the department was both short and medium terms, such as reducing the cases of C. difficile.
- The critical care leadership team's vision included reviewing the outreach support at all sites considering Hammersmith did not currently have one. They also wanted to bring ICIP to all their trust sites and have a neurological specific critical care unit at St Mary's to treat trauma patients with brain injuries. Work had started to develop these but they were in the early stages.

Governance, risk management and quality measurement

- The medical HDU and level 2 beds outside of the ICU were not under the same governance structure as the ICU. In addition, the trust outreach teams were not part of the critical care department's governance arrangements, although they were part of the same division as the critical care service. There was also no parity between the two outreach teams at Charing Cross and St Mary's. The senior leadership of the critical care service felt this was not an appropriate situation and so were reviewing the outreach services as a whole.
- Clinical governance meetings took place weekly which discussed all incidents within critical care that week.
- The critical care services contributed to the ICNARC survey, took part in audits, monitored their performance using dashboards and the Symbiotix medical agency and were part of a critical care network.
- The service had an up-to-date risk register which included the risks of delayed discharges, lack of capacity and medical vacancies with mitigating actions either in place or in transit. However, the lack of level 2 beds had been on the risk register since 2008 with no estimated completion date.
- Monthly quality board meetings took place at divisional level and a new critical care committee had recently been set up to provide quality and governance management over the department.
- When we spoke with the leadership of the critical care department, they were aware of the concerns regarding the lack of level 2 beds, delayed discharges and recruitment but were able to explain that there were plans to address these.
- Clinical governance newsletters were sent by the division which included updates on guidance, learning from incidents, pressure ulcers, and complaints. There had been three of these in 2014.
- We were told that capacity issues had been escalated to the divisional managers and the issue entered on the department's risk register and there had been discussions about the medical division having HDU beds, however, at the time of our inspection a business case for these additional HDU had not be written, agreed or funded.
- It was unclear from the evidence provided how the service was working with other critical care units in the critical care network to address capacity issues to ensure critical beds were available for those patients who required them.

Critical care

Leadership of service

- Staff felt able to approach both their immediate line management and felt supported at executive level particularly the new chief executive office and chief operating officer. The leads within critical care said the service was more of a priority within the trust than it had been previously. They gave an example of how an issue was raised regarding junior doctor induction and it was dealt with by the chief executive almost immediately. However, some staff did not feel they got enough information about how the service and the trust was changing and performing. All members of staff we spoke with were particularly happy with the support by the general manager for critical care but felt there was not sufficient support from the divisional leadership.
- Administration and clerical staff had concerns they were not included in the leadership of the trust and the services.

Culture within the service

- Staff said there was good teamwork within the services, although staff on one ward said it was more medically led.
- The sickness rate was high, at 5.2% in the ICU, but low at 3.8% in the medical HDU.
- Staff within the ICU had been nominated by their peers for a trust award called an 'Oscar' which was awarded to teams of staff who demonstrated clinical excellence. There had also been other initiatives to improve staff morale such as having staff morale leads on the units, instant recognition awards and the 'Make a difference' scheme which was a trust wide scheme for individual members of staff for providing high standards of patient care.

Public and staff engagement

- Staff said they felt engaged with their services and their leadership. This included staff groups on issues within critical care such as tissue viability and pain management. Unit/ward meetings took place at least twice a week. A monthly In the Loop newsletter was sent to all staff. The staff engagement survey from 2014 showed that 39% of staff in the division which critical care was under was positive about staff engagement.
- Although one site used a patient experience system called 'I track', this was not in use at St Mary's. It had been trialled, but staff said it had not proved useful in providing feedback.
- There were quarterly patient focus group meetings which enabled the service to learn from patient experience and these fed in to the overall governance structure for critical care. However, only two families attended each of the last two meetings.

Innovation, improvement and sustainability

- The service was being innovative, including attempting to secure a welfare officer for patients, but we were not told what progress had been.
- Research projects were taking place, including improving patient care. These included projects in sepsis, hypothermia, hip fracture surgery, nutritional support of critically ill patients, elective surgery complications, high risk emergency laparotomies, and use of integrated care pathways. ICU consultants were also been published authors in a number of studies.

Maternity and gynaecology

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

Information about the service

St Mary's Hospital provides a range of maternity services: community midwifery services deliver antenatal and postnatal care for women in the area; a midwifery-led birth centre; antenatal clinics; a day centre; labour suite; antenatal and postnatal wards; and obstetric theatres. St Mary's is also a tertiary centre for women with complex needs and has a level 2 neonatal intensive care unit (NICU). There is a home birth service, which was provided to 42 women in 2013, and there is a consultant-led service for private patients. There were 3,674 births in 2013. Maternity services are part of the trust's women's and children's division.During our inspection, we spoke with 14 women who used the service and 30 staff, including maternity support workers, midwives, doctors, consultants, administrators and senior managers. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We inspected the areas where maternity services were provided, including a community midwifery practice, looked at care records, and reviewed information provided by the trust, such as audit and performance data.

Summary of findings

At the time of our inspection, the risk of unsafe care because of inadequate midwifery staffing had been mitigated by prioritising the needs of women in labour. However, the quality of care on postnatal wards was sometimes compromised. The business case for additional staff had been accepted and recruitment to these posts was underway.

Evidenced-based care was promoted and there was an audit programme to assess compliance with best practice. There was a well-embedded, multidisciplinary approach to learning from incidents and complaints. Staff at all levels were able to raise concerns and these were addressed.

Specialist clinics assessed the needs of women with medical conditions. Specialist midwives and caseload midwives (midwives who deliver one-to-one care for an agreed number of women) supported women who were at risk. Women were encouraged to make a choice about the type of birth that was best for them and their babies. The community midwifery service provided local women with continuity of care.

There was training for midwifery staff and trainee doctors and opportunities for professional development. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

There were processes to mitigate the inadequate midwifery staffing levels such as using bank (overtime) and agency staff and relocating staff to the labour ward. The recently revised escalation policy set out instructions for staff to follow when demand was high. The business case for increased staffing had been agreed and additional midwives and midwifery support workers had been recently appointed. Consultant obstetric presence was at the recommended level.

The process for learning from incidents was embedded. Staff said they felt able to raise concerns and that these would be addressed. There were effective processes to safeguard women and babies against the risk of abuse. The majority of midwifery staff had completed mandatory training. There was regular multidisciplinary simulation training to rehearse obstetric emergencies.

Incidents

- There was one Never Event in April 2014, when an intentionally inserted vaginal pack was not removed before the woman was discharged home. Never Events are serious, largely preventable patient safety incidents which should not occur if the available, preventable measures have been implemented. There was a full investigation and nine actions were identified, including, a revised swab-counting policy, the introduction of a coloured wrist band to be applied to women at the time a pack was inserted, and ensuring adequate handover between consultants at the end of their shifts.
- Staff of all grades said there was a focus on learning from incidents. Midwifery staff and trainee doctors said they were able to voice concerns by talking to more senior staff and/or by recording them on the incident reporting system. They told us about action that had been taken to address concerns.
- The risk midwife and the obstetric lead for risk at St Mary's worked together to investigate serious incidents, to support senior staff in investigating other incidents and to analyse trends in incidents. We were told that incident reporting had increased and staff were encouraged to report staff shortages when this had an impact on care.
- Incidents which had been 'near misses', when there had been no harm to women or their babies, were used for discussion and learning. We found there was an open culture with an emphasis on learning without blame.
- We looked at maternity incident reports and saw that action had been identified to reduce the likelihood of a recurrence of incidents. When staff had not followed best practice guidance they were encouraged to reflect on their practice with a senior colleague and/or to attend additional training. In addition, there were actions to enhance general learning, such as a workshop on the management of instrumental births for trainee doctors.
- Learning from incidents and complaints was disseminated. There was a monthly critical review meeting of serious incidents to which all staff were invited. Executive summaries of recently completed serious incident investigations were available on the intranet. Midwives told us about the Risky Business newsletter and we saw that the most recent issue included learning from serious incidents and actions arising from complaints.
- There was a monthly, cross-site perinatal mortality meeting attended by consultants and midwives from maternity services, a pathologist and a neonatologist to discuss contributory factors and any learning.

Midwifery staffing

- Inadequate midwifery staffing levels had been identified as the principal risk for the service and had been identified as a contributing factor in poor outcomes in the previous year, such as unexpected admissions of babies to the NICU. At the time of our inspection, the ratio of one midwife to 33 women was higher than the national average of one to 29. During the last 12 months, admissions to the labour ward had been suspended once and the service had been on 'amber' rating a few times when there was a risk of demand exceeding resource, and action had been taken to increase staffing and/or to limit admissions.
- Midwifery staff of all grades told us there were staff shortages at times. This had been particularly acute over the summer months when it had been difficult to fill vacant shifts with bank (overtime) staff. One-to-one

care during established labour was prioritised by bringing in additional staff to the labour ward, but it had not been possible to provide one-to-one care on several occasions in the previous year.

- Ward coordinators were instructed to escalate to the senior midwife (in working hours) or to the site nurse practitioner (out of hours), when staffing levels were below the planned level and this prevented safe care. Staff told us of various actions that had been taken to address shortages, including redeploying midwifery staff to the labour ward from other wards to ensure one-to-one care during established labour, requesting community midwives to work on the wards, cancelling non-clinical activity such as training, elective caesarean sections, and asking practice development midwives or risk midwives to work on the wards.
- The recommended ratio on postnatal wards was one midwife to six women, but we were told this had frequently been higher during August, and staffing had been below the establishment of five midwives, including the coordinator and two midwifery support workers.
- The senior midwife explained other action taken to mitigate the risks posed by midwifery staffing shortages. Expected deliveries in the coming months, based on the 20-week scan, were mapped against staffing and gaps on shifts identified, to be filled by bank staff when possible. An additional bank midwife was sometimes rostered on in advance, and stood down if capacity met demand. There was a weekly meeting with the agency providing bank and agency staff to identify any shifts that had not been filled and 48 hours prior to any possible shortfall, the use of agency staff was authorised.
- A business case to improve the midwifery ratio to one to 30 by 2015 had been agreed by the trust and the first phase of the plan had been implemented, with the recruitment of midwives, maternity support workers and scrub nurses, who would begin working from October 2014. There was further recruitment planned to take place in 2015.

Medical staffing

- There was 98 hours of consultant presence on the labour ward, in line with recommended practice, and a consultant was available on call at other times.
- Anaesthetic consultant support and/or on-call availability was not in place 24 hours a day and therefore not in line with national recommended practice. Anaesthetists on call in the private wing or in the surgical specialities were available in an emergency.

Safety thermometer

- The NHS Safety Thermometer (a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care) had been adapted to maternity services and audits were undertaken monthly. The results displayed on the wards and indicated that there had been harm-free care on maternity wards in recent months.

Cleanliness, infection control and hygiene

- The maternity wards at St Mary's were in an old building which required refurbishment, and this presented challenges to cleaning and maintenance. Nevertheless, the environment was visibly clean and tidy on the day of our inspection. A maternity support worker commented, "this is an old building and that could be better but we want to make it as good as possible for the women who are here – so I do my 'rounds', to keep things clean and tidy".
- There were regular, trust-wide audits of infection control and the World Health Organization (WHO) 'Five Moments for Hand Hygiene' in each ward monthly, with a reported compliance rate of over 98%.
- The trust was conducting a rolling programme of the aseptic non-touch technique competency.
- We observed staff using personal protection equipment, such as gloves and aprons. Hand gel was available at the entrance to, and within, the clinical areas.
- Midwifery staff were aware of cleaning and infection procedures for birthing pools and of the recent safety alert describing the procedures to follow when using a birthing pool.
- The fridges storing blood, expressed breast milk and food were clean and the temperature checks regularly completed.

Environment and equipment

- The adult and neonatal resuscitation equipment in the wards and in the birth centre were clean and regularly checked.
- The oxygen cylinders on the wards had sufficient content, were in working order and were regularly checked.

- Staff told us that if the lift was out of order and babies needed to be transferred to the NICU from the labour ward or the private wing, there was a pod to use to carry the baby.

Medicines

- The medicines management records on the post natal ward we looked at were up to date.
- The temperature of the fridge holding medicines was regularly checked.

Records

- We observed that women visiting the day unit had their hand-held records (the 'red book' showing records of routine tests and vaccinations).
- The introduction of the new electronic record-keeping software at the trust had resulted in problems with booking antenatal and postnatal appointments and in keeping records up to date. Staff told us these problems were becoming less frequent and there had been additional training. The community midwifery team had encountered particular problems and additional resource had been allocated to address these. There was a team making daily data quality checks and reporting weekly on progress.
- Midwives told us they had prioritised completing the manual records and there was variation in completeness of the electronic records compared to the hard copy notes. We also saw examples of information on the electronic system not included in the manual records.
- The three sets of records we looked at contained venous thromboembolism (VTE or blood clot) assessments completed at booking

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was part of mandatory training for midwifery and obstetric staff. Women who might lack capacity were identified early in the pregnancy and supported by specialist midwives.

Safeguarding

- There were processes to safeguard unborn and new-born babies. Caseload midwives provided care and support to women who were considered high risk. There was a cross-site midwifery lead for safeguarding.
- There had been a recent initiative involving the obstetric lead for mental health and the perinatal psychiatrist to improve antenatal assessment to identify women at risk because of mental health needs. The midwifery staff with responsibility for safeguarding women and babies had effective contacts with the local authority safeguarding staff, GPs and other health professionals in the community and attended safeguarding case conferences.
- Midwifery staff attended safeguarding Level 2 or 3 as part of their annual mandatory training. We found that midwives were aware of indications that a mother or baby might be at risk. They had also received training on identifying vulnerable adults at risk of abuse.
- Midwifery services had requested a safeguarding page on the new electronic patient record system and this has resulted in improved information-sharing about women and babies at risk.
- Women who had been subject to female genital mutilation were assessed to establish the risk to their female children.
- Electronic tags were available in the labour ward for babies who there was a safeguarding concern about. Alarms sound and doors sealed if the baby was detected near one of the exits where sensors were positioned.
- Following an incident when there were concerns that a mother might try to abscond with her baby, we saw the safeguarding midwife had arranged to meet with the trust security team and relevant agencies to discuss putting precautions in place to avoid a recurrence of such cases in the future.
- Midwives contacted the safeguarding lead and the maternity independent domestic violence specialist for advice when a woman disclosed that she had been abused.
- The safeguarding lead was setting up a support group for women whose babies were subject to protection orders.

Mandatory training

- There were mandatory education programmes for midwives and for maternity support workers, in addition to the annual statutory mandatory training day for maternity staff. The completion rate for midwifery staff was 90% for those who were required to undertake mandatory training in 2013. The figure for maternity support was 86.6%.
- A practice development midwife told us the comprehensive training meant that midwifery staff felt

adequately prepared to be flexible in response to high demand, for example, when community nurses were called into the maternity wards at times of high demand.
- Trainee doctors told us multidisciplinary simulation training took place regularly, with a room set aside for this. There were announced and unannounced 'skills drills' training to rehearse obstetric emergencies.

Assessing and responding to patient risk

- Midwives and trainee doctors said they felt able to discuss any concerns they had with the progress of labour with more senior staff, and would have no hesitation in calling a consultant out of hours if they needed their advice or presence.
- Mandatory training for midwifery support workers included recognising ill women, using the modified early obstetric warning score.
- There was one dedicated high dependency (HDU) bed for women needing additional postnatal care. A midwife working on the HDU said she received the training she needed to look after women who needed this care, and a local audit had found appropriate documentation of observations.
- Midwifery staff said they felt competent to provide safe care, and the women and their partners said they were confident in the staff. A father told us how his wife's labour had suddenly progressed rapidly while she was on the antenatal ward that morning, and she had given birth before being moved to the labour ward. He said a midwife "took control and stopped the panic" and the rest of the staff respected the midwife's command to work together to look after his wife and baby.
- We were informed of the recent reinforcement of the role of anaesthetists and surgeons in leading the three steps of the WHO surgical safety checklist in obstetric procedures. The surgeon was expected to lead sign-out, and to promote debriefing and learning. The recent trust observational audit of the use of the checklist had found 98% compliance with the sign-in step and 100% compliance with the time-out and sign-out steps of the checklist in obstetric theatres.

Major incident awareness and training

- The maternity staffing escalation policy had recently been simplified to clarify the responsibility of staff at all levels when there was a risk of staff shortages having an impact on safety. An 'amber' rating was initiated when midwifes were not able to provide one-to-one care to women or there was a risk of beds not being available to women coming to the labour ward unit or transferring from the labour ward. When the unit was full or staffing levels were inadequate to provide safe care, this was escalated to a 'red' rating, the head of midwifery was informed and possible actions included the closure of the unit.

Are maternity and gynaecology services effective?

Good

There was evidence of an ethos of learning in maternity services. National guidance was reviewed and disseminated and there was a coordinated audit programme to assess compliance with best practice. There were multidisciplinary meetings to discuss the results of these audits. Evidenced-based care was established for high-risk women, for example, those who were diabetic or who were overweight. Outcomes for women and their babies were within expected limits. However, the care for women and babies on the postnatal ward in the immediate post-labour period was not always in line with best practice because of midwifery staff shortages. The newly established community midwifery service was providing effective antenatal and postnatal care near their homes.

There was a training programme for midwifery staff and staff had opportunities for professional development. Trainee doctors were well-supported.

Evidence-based care and treatment

- Policies and protocols were based on national guidelines and standards. New guidelines were reviewed and disseminated.
- There was a trust process for discarding out-of-date guidelines, which had been fully implemented in the women's and children's division.
- There was a local audit programme, coordinated by obstetricians with responsibility for education, with results presented at a cross-site, multidisciplinary meeting. We saw information about these audits and noted that action from previous audits had been identified and monitored, with evidence of improvements as a result. Recent audits included the use of oxytocin in augmenting labour and a review of deliveries with third and fourth degree perineal tears.

- A midwife experienced in vaginal breech birth was part of a team undertaking a 12-month audit of maternity records to review the counselling offered to women about birth options when they had breech presentation. The aim was to improve choice for women who had a breech birth.
- The maternity service was working towards accreditation in UNICEF's Baby Friendly Initiative.
- The reconfiguration of community midwifery services provided continuity of support in the antenatal and postnatal periods for local women, close to their homes, in line with best practice.

Pain relief

- The full range of pain relief was available to meet the individual needs and preferences of women. These included epidural analgesia, opiates and nitrous oxide (gas and air), paracetamol and the use of water in birthing pools.

Nutrition and hydration

- Of the women who gave birth at St Mary's in 2013, 85% were breastfeeding their babies when they were discharged, higher than the national average.

Patient outcomes

- Maternity services held a number of consultant-led clinics for high-risk women, including those who were diabetic, obese, or having a multiple birth. Audits of records of these groups of women had found screening during antenatal care had been effective in identifying women at risk and that appropriate care had been provided throughout the pregnancy.
- Midwifery staff of all grades told us that staff shortages on the postnatal ward had been detrimental to the care of women and children. Midwifery staff told us they prioritised babies requiring additional care, transitional care, but we noted there had been incident reports of late doses of intravenous antibiotics. Midwifery staff who worked on the ward told us it was difficult to provide the support women needed, such as assisting with breastfeeding, and they consider that this impacted on how confident women felt looking after their babies.
- Caesarean section rates had been high at St Mary's in the past, but had reduced in recent years to 29%, slightly worse than the national average. Following a recent rise in the rate, there had been a review of 100 sets of mother's notes and action taken so that decisions about caesarean section would be escalated for consultant review. The rate had subsequently fallen.
- The number of neonatal and maternal deaths and readmissions to hospital were in line with expected rates.
- The vaccine to protect babies against tuberculosis was offered to 99% of families.

Competent staff

- There was an induction programme for new midwifery staff, which was being further developed by the practice development midwife responsible for recruitment. All new staff were assessed for basic competencies before they were allowed to work.
- The training programme for midwives and midwifery support workers was delivered by a mixture of workshops, on-the-floor training, for example, in the use of equipment, e-learning and assessment, which enhanced the safety and effectiveness of the care provided to women and their babies. There was an annual assessment of midwives' competence in interpreting cardiotocograms (CTGs) when monitoring the baby's heart rate and midwives who failed the assessment were not permitted to interpret CTGs on their own. Training had been adapted in response to assessments and the pass rate was improving.
- Midwifery staff told us that, in recent months, staff had sometimes been unable to attend training because of being asked to work on the wards to cover staff shortages.
- The midwives working for the new community midwifery service told us they had been well-prepared for their new role through a bespoke training programme, which included a clinical decision-making day, a home birth study day and team-building sessions.
- The training programme was changed regularly in response to new guidelines and expectations. The programme now included an additional breastfeeding training day as part of the Baby Friendly Initiative. There was a training programme, developed with pharmacy and paediatric staff, for midwives providing antibiotics for babies requiring special care (transitional care) on the postnatal ward.

Maternity and gynaecology

- Midwifery support workers and midwives told us the training provided was excellent. They said they had attended an appraisal in the previous year at which they discussed further opportunities for learning and development. Appraisal rates were over 90%.
- Midwives told us the midwives service prioritised continual professional development and they were well-supported by practice development and supervisors of midwives. The supervisor to midwives ratio was one to 15, meeting good practice standards. We were told supervision was well-structured and midwives knew who to go to for support.
- Trainee doctors said they received good support from consultants, who were always available if they needed advice. Teaching was prioritised by the trust and the service, and we saw evidence of regular teaching sessions and an audit programme. Consultants held the pagers to enable specialist trainees to attend training. The results of the General Medical Council survey of trainee doctors found that junior doctors did not have concerns about the way they were supported. There had been a negative response from trainee GPs working in maternity services in the past, and action was taken to address the concerns.
- Obstetric consultants in maternity had produced a booklet for trainee doctors about understanding serious incidents, which was to be used throughout the trust and had been taken up for wider distribution by the London deanery.

Multidisciplinary working

- Midwives and trainee doctors told us there was good multidisciplinary communication. We were given examples of when midwives had felt able to challenge trainee doctors who had not involved them in decisions about women they had been caring for.
- Handover on the labour ward was not multidisciplinary, and paediatric staff did not routinely take part in handover discussions. We were told that after the midwives handed over to the next shift in the labour ward, the consultant and/or other medical staff conducted a labour ward round and discussed each of the women with the allocated midwife. When there were indications that obstetric input might be required, medical staff would then talk to the woman. Midwives and trainee doctors told us this system was effective in understanding the needs of the women on the labour ward.
- The service was currently piloting a tool for use by midwifery staff to pass information to medical staff in a structured way.
- We were told there was effective working with paediatric staff, who were informed when they should attend a birth and responded rapidly when needed in an emergency. There were discussions with neonatal nurses about enhancing the care of babies requiring transitional care on the postnatal ward.
- The new community midwifery teams worked closely with other health professionals in the community to support mothers and their babies.
- We were told by nursing staff on medical wards that obstetric staff were attentive to women who had been moved to their ward to receive medical care.

The maternity service had introduced a code of practice for commercial companies offering women and families information that sent sales representatives to postnatal wards, to ensure that they would not ask for personal information without a full explanation about how this would be used. We observed a sales representative on a postnatal ward who did not follow these instructions and the women we spoke with said they had not been given an explanation. We reported this to the head of midwifery who said action would be taken immediately to deal with this breech of protocol.

Are maternity and gynaecology services caring?

Good

Women we spoke with said they had received good care. They said they were involved in making decisions about the birth. Bereaved parents were supported.

Compassionate care

- Women on the postnatal ward told us midwifery staff were caring. One of them said they were 'kind, pleasant and helpful'. We observed medical and midwifery staff communicating with women and their partners in a caring and respectful way.
- We spoke with a woman at a community midwifery service who said the care and support she had received had been reassuring. She said the midwives she had seen had been "caring and knowledgeable".

Maternity and gynaecology

- The results of the CQC 2013 Survey of Women's Experiences of Maternity Care for Imperial College Healthcare NHS Trust were similar to other trusts for most measures, such as being given appropriate advice and support when contacting a midwife and being involved in decisions about labour. The results were worse than the national average for length of time waiting for a response to using the call button. The results for involving the partner were better than average.
- The response rate to the NHS Friends and Family Test at the trust was better than the average. There had been a dip in the birth and postnatal scores in January and February 2014, but these had since risen to close to the average for England.

Patient understanding and involvement

- Women who were seeing a named community midwife discussed their birth plans and had a choice about where to have their babies. A woman on the postnatal ward said her community midwife had looked after her "brilliantly" in her pregnancy and had already sent a text to her about coming to see her when she got out of hospital.
- Women in the specialist antenatal clinic who had seen the midwife said they had received a full explanation about their medical condition. However, a woman who had only seen doctors at the clinic said she was given written information but no verbal explanation. She was having regular appointments at the clinic, but was not seeing a midwife. Women at the clinic, referred from outside the local area, were not receiving midwifery care.
- A woman on the antenatal ward whose labour was being induced said, "the staff are lovely and they care about me". She had been given the option to go home but had said she would rather stay at the hospital, and staff had been understanding about her choice.
- A woman on the postnatal ward said the staff had supported her choice. She said "they respect me and although I had had two emergency caesareans they were fine about me wanting to try for a vaginal birth…it didn't work, but they were good to me".

Emotional support

- There was a bereavement room for women whose baby had died which was furnished from funds raised by the bereavement midwife. The bereavement midwife was available to women who had lost a baby and visited out of hours if needed. This bereavement service was also provided to women with late termination of pregnancy because of foetal abnormality. The midwife gave training in bereavement to midwives.
- When the birth did not proceed as expected, the consultant talked to the women and their partners during postnatal ward rounds to explain what had happened. The consultant invited them to return if they had further questions.

Are maternity and gynaecology services responsive?

Good

There was a full range of maternity services and women were encouraged to make a choice that was best for them and their babies. The community midwifery service provided local women with continuity of care and supported women following the birth with services provided in the local children's centre of GP surgery.

Antenatal clinics for women with medical needs were crowded and women had to wait to see a doctor. Postnatal wards were sometimes short-staffed and it was difficult to provide a responsive service that met individual needs. Specialist and caseload midwives supported women with particular needs, such as mental health needs.

Service planning and delivery to meet the needs of local people

- The service had difficulty meeting demand and had presented a business case for increasing staffing levels, which had been accepted by the trust.
- We found there was an understanding of the needs of the local population and the needs of women who were referred from outside the area for specialist care.
- The Maternity Service Liaison Committees (MSLC) had been consulted about reorganisation of the divisions within the trust. The committee had not been active recently because of changes in membership, but there were plans to bring in new members.
- Maternity wards were in an old building which did not provide an optimum environment for women. The facilities in the antenatal and postnatal wards were poor, such as en-suite facilities, and the nearest toilet and separate shower were across the corridor from the wards. Staff worked hard to limit the impact of the

environment on the experience for women and their families. One woman told us, "of course it would be better if the building was modern – but the staff are great".

Access and flow

- Women in the local area could self-refer by telephone or by completing a form on the website. Referrals were also made by GPs and other health professionals.
- 96% of bookings for antenatal care in 2013 were made before the twelfth week of pregnancy.
- There had been problems with antenatal bookings since the new electronic record-keeping software had been introduced at the trust. This had resulted in some appointments not being made and delays when women attended antenatal clinics. We saw that steps had been taken to address these problems, but when we visited the antenatal clinic we saw that there were still long delays. Women were not informed of waiting times and this caused unnecessary anxiety, particularly for those who had another appointment or had a child at home.
- The new community midwifery practices based at children's centres or GP surgeries made access easier for local women. The service promoting continuity of care and support for antenatal and postnatal care by allocating a named midwife for women in the local area. A midwife was rostered on at weekends for essential visits. Community midwives said the referral routes worked well when they needed to refer to specialist midwives or clinics. They said they could contact an obstetrician for advice and refer women to the day unit. Some women preferred to go to antenatal clinics at the hospital and their preference was respected.
- Women from outside the area who were referred for specialist care were given a number to call if they had any concerns during pregnancy. Most women at the specialist clinics did not know about midwifery services in their home area and did not know what care they would receive postnatally.
- There was a day centre which women attended when they were beginning labour or when they had concerns about their pregnancy. The centre provided a triage service and referred women on when appropriate.
- There was an expectation on one-to-one care during labour. When demand outstripped resource on the labour ward, the consultant obstetrician and the ward coordinator assessed the women and allocated midwives according to the level of risk.
- There was a dedicated theatre available 24 hours a day, with an additional smaller theatre for use if necessary. However, women booked for an elective caesarean section sometimes had their procedure delayed, because midwives who acted as scrub nurses were moved to the labour ward at times of high demand. Dedicated scrub nurses were being recruited.
- Bed occupancy had been lower than the national average of 58% in 2013; this had risen in to the national average in 2014.
- Discharge was sometimes delayed when there were midwifery staff shortages on the postnatal ward. Midwives said they made sure the mothers' 'red book' (showing records of routine tests and vaccinations) was up to date before discharge. Information was given to women about who to contact after they went home.
- Women attending the termination of pregnancy service were treated in the gynaecology ward, or in the labour ward if in the later stages of pregnancy.

Meeting people's individual needs

- There was a full range of maternity services and women were encouraged to make a choice that was best for them and their babies. Low-risk women were able to give birth at the midwifery-run birth centre. The home birth service was available to a small number of women, and there were plans to expand this service.
- There was a dedicated midwifery-led birth centre had a non-clinical environment and always provided one-to-one midwifery care during labour. There were birth preparation sessions and women were seen at the centre every week in the later stages of pregnancy.
- Women on the labour ward had a choice of water birth. There were initiatives to facilitate vaginal births for women with high-risk pregnancies, and a consultant midwife met with women who wanted to give birth outside guidelines. The consultant midwife also ran a clinic for women with tocophobia, (fear of giving birth), to support these mothers.
- Interpreting services were available at the hospital and staff told us they also used the telephone interpreting service.
- The community midwifery practices were working with health visitors to provide child-centred care. There were breastfeeding support and drop-in sessions for women

to ask for advice. There were parent education classes with interpreters present, including at the weekend. There had been very positive feedback about these classes.

- There were specialist midwives for safeguarding, HIV and infectious diseases, and for women who had undergone female genital mutilation. Caseload midwives in the community midwifery teams provided one-to-one support for women at risk, for example, because they had a learning disability or mental health needs.
- All the women we spoke with on the postnatal ward said they had been well looked after. However, midwives and maternity support workers told us how difficult it was at times to provide a responsive service that met individual needs. We observed that there was a task-focused approach to providing care, which meant that all the necessary tasks were completed, but care was not focused on the woman and baby.
- There were no separate facilities for partners. However, the service had decided to allow partners to stay out of hours when they agreed to follow specific instructions while they were on the ward at night.

Learning from complaints and concerns

- We saw that action had been taken in response to complaints and information about complaints was disseminated to staff through the Risky Business newsletter.
- Staff told us they tried to address concerns early and provide an explanation and they felt this had resulted in a fall in the number of complaints. There was information on the ward about raising concerns and staff told us they explained the complaints process to women or their families when they were dissatisfied with the care.

Are maternity and gynaecology services well-led?

Good

Leadership was evident in the changes to the service, such as the introduction of community midwifery practices. Governance structures were in place and risks assessed. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued.

Vision and strategy for this service

- The changes in the women's and children's directorate as a result of the trust restructure had effectively been implemented.
- We were told that the new chief executive of the trust had already made a positive difference to morale by listening to the concerns of frontline staff. The director of nursing was also visible and reported to be approachable.
- The introduction of the community midwifery practices had been a key element in the strategy for the service. The thorough planning and incremental implementation of the seven practices was presided by the staff working in the practices. We found enthusiasm for its development and the enhanced focus on women and their babies and their individual needs.
- The business case made to the board for increased staffing had been successful. The case looked at the deployment of staff across all areas, including theatres, and examined the skills mix as well as numbers of staff.

Governance, risk management and quality measurement

- Risks to the delivery of high-quality care in maternity services were analysed and controls put in place. Key risks and actions were reported through the division's governance structure. The new executive team had introduced improved governance structures to assess and address risk at trust level.
- There was evidence that maternity services had processes to promote evidenced-based care, and to learn from incidents and complaints.
- Maternity services used a dashboard to monitor the safety and responsiveness of the service.
- The termination of pregnancy service was compliant with requirements relating to the access to this service.

Culture within the service

- We found a positive culture and optimism for the future in maternity services. Staff of all grades and roles felt a sense of responsibility for the quality of the service, and were also clear about when they should escalate concerns.

- Staff told us they felt valued by senior management and able to make a contribution to the development of services. Staff performance was recognised, and celebrated.
- The caseload midwifery team for vulnerable women had received the Royal College of Midwifery team of the year award in 2014 and the head of the community midwifery service had received the MAMA Midwife of the Year 2014 award for helping women to have the birth of their choice.

Leadership of service

- Staff with a variety of roles and grades, including administrative staff, reported that leadership in maternity services had markedly improved in the last two years.
- Midwifery staff told us they were supported by their ward managers. They reported that management at all levels were approachable. A midwife commented, "this is the sort of place you can talk openly. If you don't look happy, they ask you how you are".
- 'Back to floor Friday' had been introduced at the trust by the director of midwifery and nursing for women's and children's services, and subsequently rolled out to other parts of the trust. While we were at the trust we saw the director, the head of midwifery and matrons in clinical areas assisting staff. Senior managers also ran drop-in sessions on Fridays and told us of some of the suggestions that junior staff had made at these sessions, which had subsequently been implemented.
- We heard that some staff did not feel that they were treated equally when poor performance was identified. However, we found no evidence of this to be the case.

Public and staff engagement

- Action had been taken in response to feedback from women and their families about their experience on postnatal wards, which had resulted in improvements in ratings. A project team of ward staff of all roles and grades set out an improvement plan to support staff to embed changes in practice in the wards. There was an emphasis on valuing staff and creating a positive working environment, with a monthly 'staff member of the month' nominated by women on the ward.

Services for children and young people

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

Information about the service

St Mary's Hospital provides a range of secondary and tertiary care services to new-borns, children and young people. The 19-cot Winnicott Baby Unit provides level 2 neonatal intensive care for both pre-term and full-term neonates born from 27 weeks gestation. The paediatric intensive care unit (PICU) provides level 3 care to children aged from 0 to 18 years and is designed to operate between 8 and 10 beds depending on the time of year.

Grand Union Ward is a 14-bed tertiary haematology and infectious disease ward consisting solely of single rooms. Great Western Ward consists of 24 beds for emergency and elective admissions. At the time of the inspection, West Way Ward was closed due to a reduction in patient flow, however, this ward would host a range of day-case services ranging from elective surgery, ambulatory care and preoperative assessment clinics.

Between April 2013 and March 2014, the Winnicott Baby Unit admitted a total of 282 neonates, the majority of which (236) were born at St Mary's Hospital. The total number of care days for 2013/14 totalled 815 for babies requiring level 2 care, 1,031 days for babies requiring high dependency and 3,133 for babies requiring special care.

The PICU admits approximately 400 children to the unit each year; with 90% as emergency admissions. A total of 1,188 children were admitted for surgery in 2013/14, ranging from general surgery (285 cases), paediatric urology (296 cases), ear, nose and throat (510), ophthalmology (69) and dentistry (28). The total number of inpatient stays was 4,341 for 2013/14, a reduction of 1,469 on the previous year.

Children's outpatients hosted a total of 35,693 visits in 2013/14, an increase of 942 on the previous year.

In addition to the inpatient and day-case services, children's services at St Mary's Hospital also includes a range of specialist services, including but not limited to, paediatric immunology and allergy, neurology, nephrology, neuro-disability, child development, audiology and diabetes.

We talked with 14 parents and their children, 25 members of staff including nurses, student nurses, matrons, play specialists, doctors, consultants and support staff. We observed care and treatment being provided.

Services for children and young people

Summary of findings

While there were areas of innovative thinking, we found that children were being cared for in environments which were not fit for purpose and posed a potential risk to their safety and wellbeing. Areas including paediatric intensive care, children's outpatients and Grand Union Ward were not of sufficient size or design to effectively provide care to children in an era of ever-increasing reliance on technology; bed spaces and cubicles were cramped; there was a lack of effective isolation facilities; and there was a shortage of accommodation for parents/carers who wished to be near to their child or neonate while they received intensive care therapies.

The division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Parents and children were complimentary about the care and treatment provided. Parents felt that staff across all disciplines were compassionate, understanding and caring. Where children and/or parents/carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future. There was a strong and embedded approach to multidisciplinary working across the various specialities.

The senior management team was cohesive and all those working in this division were passionate about influencing the care and treatment of children and young people. However, there was a lack of progress made on risks which had been identified within the division. Some risks had existed for more than five years; there was little or no evidence to suggest that these risks were being addressed in an effective way. In addition, there was no representation of children's and young people's services at board level.

Are services for children and young people safe?

Requires improvement

The PICU and Grand Union Ward (bone marrow transplant and infectious diseases) were not suitably equipped to meet the increasing demands of the specialist services they provide. Within the PICU, while measures had been introduced to mitigate the risk to children, there remained a risk of the transmission of multi-resistant organisms likely to cause hospital-acquired infection among critically ill children. Immuno-compromised children admitted to Grand Union Ward were also placed at risk due to insufficient numbers of cubicles with en-suite facilities. Both of these clinical areas were found to be cramped with limited space around bed spaces; this further increased the risk to patients, specifically within the PICU.

Some clinical services were supported by a full complement of nursing and medical staff, while areas such as the Winnicott Baby Unit did not meet national staffing standards. During 2013, the overall staff attrition rate for children's services was reported as being as high as 35%. In response to the high turnover and high vacancy rate, a new rotational development programme had been created attracting 30 newly qualified nurses who were due to commence with the service in September 2014.

There was openness and transparency when things went wrong and information had been cascaded to frontline staff after multidisciplinary meetings. Themes from incidents were discussed at monthly quality and safety meetings. Medicines management and recording were overall found to be good. However, there were isolated anomalies and inconsistencies with compliance of the 'double-checking' process. There were processes to ensure that deteriorating patients were appropriately managed.

Incidents

- Children's services reported one Never Event (serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) in 2014. At the time of the inspection, this remained under investigation. However, provisional findings indicated that the guidance available to staff at the time of the event was not consistent with national best practice guidelines and, in fact, promoted unsafe practices.

- Following the event, the service took immediate action to ratify a new procedure which was in line with guidance issued by the National Patient Safety Agency (NPSA). A review of all divisional policies was also undertaken to ensure that prescribed practices were in line with national standards.
- Learning from the Never Event was disseminated to staff through the service's quality and safety newsletter, The Indicator. A summary of the event was included in the July 2014 edition, as well as detailing the action that had been taken in response. Six members of staff we talked to were aware of the event and were able to describe the actions that had been taken.
- A total of 1,149 incidents attributed to children's services were reported on the trust's electronic incident reporting system between April 2013 and July 2014.
- There was a system for ensuring that incidents reported as having a moderate, major or extreme impact on patients, were appropriately escalated and investigated and that action plans were devised and disseminated accordingly.
- Paediatric morbidity and mortality meetings took place monthly, however, it was not possible to determine from the minutes provided to us who attended those meetings.
- Cross-site neonatal meetings also took place. Attendees were recorded within those minutes, making it easy for the service to identify who had been present and who was absent, and so it was easy to identify who to disseminate information to ensure they remained updated with any developments resulting from the meeting.
- Both the paediatric and neonatal morbidity and mortality meetings listed action and learning points. The minutes from the meetings demonstrated that outstanding actions were followed up at future meetings, although it was noted that timescales were not set against each action.

Safety Thermometer & Harm Free Care

- Children's services routinely participated in the trust wide, harm-free care initiative (a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care).
- Data provided by the trust indicated that Grand Union Ward, Great Western Ward and the Winnicott Baby Unit all attained 100% compliance with harm-free care during April and May 2014. During 2013/14, both the Winnicott Baby Unit and Grand Union Ward had attained 100% for the whole year for harm-free care. Great Western Ward reported 99.4% compliance with harm-free care during 2013/14, with one pressure ulcer being reported.
- The PICU reported a 95.6% compliance rate with providing harm-free care during 2013/14; the unit reported one pressure ulcer and two catheter-associated urinary tract infections (new onset) during that time period.
- We noted that three pressure ulcers had been reported on the harm free care report for the PICU in May 2014, reducing their year-to-date compliance rate to 70%.

Cleanliness, infection control and hygiene

- The department had a range of equipment, which was seen to be clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned.
- During our observations of the immediate environment in which children and neonates received treatment and care, we found all areas to be suitably clean.
- Where cleaning took place, domestic staff were using colour-coded equipment items for different parts of the ward.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons. Staff routinely washed their hands both before and after patient contacts within the Winnicott Baby Unit and the PICU.
- Staff and visitors were observed to be washing their hands before they entered the Winnicott Baby Unit.
- The attending infectious disease consultant engaged with the hospital microbiology team on a weekly basis to discuss complex cases or where any infection risks or transmission risks had been identified within children's services. The hospital microbiology team and infection control team were supported by a range of multidisciplinary team members, ranging from specialist pharmacists, paediatricians, virologists and microbiologists.
- Children's services had an established antibiotic stewardship programme which was coordinated by the paediatric infectious disease team.
- There were systems for ensuring that the play room and toys were cleaned on a regular basis.

- Results from cleaning audits were displayed throughout the ward areas.

Environment and equipment

- Grand Union Ward consisted of 14 individual rooms, four with en-suite facilities. Patients and their parents/carers in the remaining 10 rooms were required to use wash room and toilet facilities located along the corridor of the ward. Staff reported that this was not ideal because some patients could be immuno-compromised; therefore, they felt that patients were being placed at risk due to a lack of en-suite facilities.
- We found some rooms on Grand Union Ward to be cramped; staff reported that this could be problematic, especially during emergency situations because cubicles could become congested with staff and equipment such as the resuscitation trolley.
- Grand Union Ward was equipped with two negative pressure cubicles. It was reported by the ward staff that the negative pressure system was currently faulty and, as a result, staff were using portable High-efficiency particulate air (HEPA) filter machines to manage the risk to immuno-compromised patients. Staff had no guidance on how they should maintain the filter machines and the frequency with which filters were changed. We were informed that the estates and maintenance team had been awaiting replacement components for the negative pressure system since 14 August 2014.
- As of 29 August 2014 one risk on the women's and children's clinical risk register was reported as the "potential risk of pseudomonas infection on the Grand Union Ward". Pseudomonas had been found in the water supply to cubicles seven and eight and was associated with "insufficient water flow creating an environment for the growth of pseudomonas and potentially other infectious agents". This risk was scored as a risk rating of 12. While there was evidence that temporary measures had been put into place to manage the risk, such as in-line water filters, there was no plan to resolve the issue long term.
- The PICU was cramped and was not fit for purpose. The service reported to us that the current bed space configuration was non-compliant with the Paediatric Intensive Care Society recommendations on the configuration and size of PICUs. They stated that the cramped conditions increased the risk to patients because of the risk of transmission of multi-resistant organisms.
- The women's and children's clinical risk register (as of 29 August 2014) reported a risk of multi-resistant organisms likely to cause hospital-acquired infection due to insufficient isolation cubicles within the PICU. This risk also stated "the unit does not comply with Paediatric Intensive Care Society standards 2010 – bed spaces are 50% less than required standards and there is only one designated isolation cubicle". A business case had been developed and submitted for board consideration for the re-development of the PICU.
- The PICU team reported in July 2013 the transmission of VIM-pseudomonas between two patients who were receiving treatment on the PICU.
- Equipment was found to be in date. Staff told us there was usually sufficient equipment available at all times. They would borrow from other wards when necessary.
- Staff were aware of who to contact or alert if they identified broken equipment or environmental issues that needed attention.
- Children undergoing surgery were received into a dedicated anaesthetic room and postoperative recovery area which were both located within the theatre department
- We noted that weekly and daily checks of the resuscitation trolley on Grand Union Ward were not always carried out. Staff informed us that, due to an increase in acuity and overall increased activity on the ward, they often did not have time to check the trolley. A review of the resuscitation checklist found that there were multiple occasions whereby the top of the trolley, including checking of the defibrillator, had not been carried out on a daily basis.

Medicines

- There were processes for ensuring medications were kept securely. Medication fridges were found to be locked. Fridge temperatures were routinely being recorded to ensure that medicines were stored as per the manufactures' recommendations.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs.
- The six drug charts we reviewed showed that medicines were prescribed by registered medical practitioners.

- There was a process for monitoring the risks associated with the storage, prescribing, preparing and administration of medications. Incidents were reported via the trust's incident reporting system.
- Children' services had a dedicated risk and audit nurse whose role, among others, was to review reported incidents to identify trends. The departmental risk newsletter, The Indicator, reported the number of incidents within paediatrics and neonatology. Where trends had been identified, actions had been taken to resolve issues.
- The paediatric anti-microbial stewardship team had developed an electronic app to assist staff responsible for selecting and prescribing antibiotics to children. The app supported staff to prescribe antibiotics while considering best practice recommendations from the anti-microbial stewardship group.
- There were policies and procedures to support staff with prescribing and administration of medications. Policies included "administration of medicines to patients who are 'nil by mouth'" as an example.
- Staff had access to national formularies such as the British National Formulary for Children and a local neonatal formulary.
- Staff working on the Winnicott Baby Unit had access to a total parenteral nutrition calculator to help ensure that infants were prescribed the correct intravenous nutrition which met their individual needs.
- Clinical areas were supported by daily and weekly visits from a paediatric pharmacist.
- We observed the practice of nursing staff preparing oral medications on Grand Union Ward. While the service operated 'double check' processes, whereby two nurses independently checked medication to ensure it had been prescribed, prepared and administered correctly, we noted that the approach to double checking was informal. For example, we observed one nurse prepare four oral syrup medications for one patient. The syringes were placed into a container and the bottles containing the supply of medication were left on the work surface. A second nurse checked each syringe and the expiry date of each drug. However, the syringes were not placed in any particular order; each syringe contained different volumes and so it was not possible to verify which syringe contained which medication. We could therefore not be assured that the double-check process was suitably robust to safeguard children. We raised these concerns with the nurses involved at the time of the inspection.
- The children's pharmacy team reported 271 interventions in pharmaceutical care during a five day audit period in 2013: 33 prescriptions were stopped; 58 prescriptions changed; 33 new prescriptions started; 69 prescriptions clarified; 13 prescriptions monitored; and 65 information requests. This meant that the pharmacy team had positively intervened to ensure patients were protected from the risks associated with medications.

Records

- The preoperative checklists we reviewed for children who had gone to theatre were completed following the trust's policy for pre-operative management.
- The three patients' care plans on the medical ward and two on the neonatal unit we reviewed were comprehensive and person-centred. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.
- During our inspection, we noted that records were kept securely.
- A review of incident reports showed that the children's outpatient department had experienced problems with having full sets of patient records being available to the medical and nursing team in time for clinics. A total of 136 incidents were reported between April 2013 and July 2014.
- Between 22 May 2014 and 2 September 2014, 432 patients were seen in the paediatric outpatient department with a temporary set of notes (5.4% of total visits). There were no reported incidents involving a lack of any patient notes at all not being made available. However, a review of the incidents indicated that, while temporary notes were made available, these often lacked relevant clinical information or referral letters and so hindered clinicians when reviewing patients.

Consent

- Staff obtained consent from patients and or their parents/carers appropriately. The staff explained how consent was sought and involved both the child and the person with parental responsibility.
- We noted that verbal and/or written consent was obtained for both medical and/or surgical interventions, with signatures to confirm.

- One of the parents told us that the staff had fully explained the proposed procedure and possible complications before they gave consent.

Safeguarding

- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.
- A policy relating to safeguarding children and young people was available and accessible and had been reviewed in July 2014.
- The hospital had a consultant lead, named nurse and named executive for safeguarding children.
- There were systems for referring children and adolescents to the local Child and Adolescent Mental Health Service (CAMHS).
- The areas within children's services were supported by a safeguarding nurse who we saw visit each clinical area on a regular basis.
- 96% of eligible staff had undertaken training for safeguarding children at level 1.
- 92% of eligible staff had undertaken training for safeguarding children at level 2.
- 67% (116 staff out of 172) of eligible staff had undertaken training for safeguarding children at level 3. The trust reported that the remaining 56 staff that were non-compliant for completing level 3 training were booked to attend an appropriate course by 30 December 2014.
- The service ensured that all children and young people, children's social care, police and health teams had access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. This was achieved by the on-call general medical consultant assuming this responsibility. About 75% of paediatric consultants had completed level 3 safeguarding children during 2013 and 2014.
- There were processes for ensuring that children who had not attended for an outpatient clinic were followed up. The nurse in charge for outpatients ensured that each child who had not attended was referred back to the consultant who would then consider whether the child should be discharged from the clinic list and referred back to the GP with a covering letter state that they had not attended, or be offered another appointment time, or whether a safeguard referral should be submitted.
- The service had a named consultant who was responsible for implementing learning from reviews following the death of a child.

Mandatory training

- There was a significant disparity between the mandatory training figures provided centrally by the trust and those provided by the senior nursing staff in the children's division. Local records on the wards highlighted that most staff had completed all their mandatory training but trust-wide data had conflicting levels of compliance.
- 85% of nursing staff on the Winnicott Baby Unit had completed their mandatory training and 75% had received an appraisal during 2013/2014s.
- 100% of nursing staff allocated to work on West Way Ward had completed their mandatory training and 72% had received an appraisal in the previous 12 months.

100% of staff allocated to work on Great Western and Grand Union wards had completed their mandatory training. 66.2% and 76.9% of nursing staff working on Great Western and Grand Union wards respectively had undergone an appraisal during 2013/2014.

Assessing and responding to patient risk

- The trust used a bedside Paediatric Early Warning Score (PEWS) system to ensure the safety and wellbeing of children. This system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required.
- Staff were aware of the appropriate action to be taken if patients scored higher than expected using PEWS; patients who needed close monitoring and action were identified and cared for appropriately.
- The sample of completed charts on Great Western Ward we looked at showed that staff had escalated issues correctly, and that repeat observations were taken within the necessary timeframes.
- At the time of our inspection, the trust was in the process of reviewing the effectiveness of the bedside PEWS to determine whether the tool helped to reduce the number of children admitted to the PICU.

- High dependency care was provided on Great Western Ward. Where capacity on PICU was limited, patients were transferred to Great western for 'stepped down' high dependency care.
- Patients whose condition may have deteriorated on the wards could be referred to the paediatric site practitioner and to the nurse in charge of the PICU for review and assessment.

Nursing staffing

- Information provided by the trust indicated that, as of September 2014, the establishment for the children's wards directorate (including PICU, outpatients, West Way, Grand Union and Great Western wards and the paediatric day haematology unit) was 141.39 whole time equivalent (WTE) posts, with an overall vacancy rate of 19.52 WTE (13.8%).
- The Winnicott Baby Unit had an establishment of 48.4 WTE with a vacancy rate of 6.94 WTE (14.3%).
- It was reported that the nursing establishment in the Winnicott Baby Unit meant it was not possible for the unit to meet the British Association of Perinatal Medicine standard for babies requiring one-to-one intensive care. This was listed as a risk on the divisional risk register and had first been entered onto the register on 1 December 2011. However, the unit was able to demonstrate that there were sufficient numbers of staff to meet the standards for babies requiring special care, the one-to-four (one nurse responsible for providing care to four babies) ratio and high dependency care of a one-to-two ratio.
- The Paediatric Intensive Care Society suggests that the minimum number of nurses required to staff one critical care bed is at least 7.01 WTE. This figure allows for a range of non-clinical duties including annual leave, supernumerary nurse in charge each shift, statutory and mandatory training and sickness and maternity leave. Until very recently, the widely accepted minimum number of nurses required was set at 6.7 WTE per critical care bed. Excluding winter pressure months, at which time, the number of beds increases to 10, St Mary's PICU operates eight critical care beds, 24 hours per day. By applying the Society's nursing standards of 7.01 WTE, the minimum number of qualified staff required would be 56.08 WTE to support eight beds or 53.6 WTE if applying the lower threshold of 6.7 WTE per bed space.
- The PICU at St Mary's has a current budgeted establishment of 51.3 WTE qualified staff. The current vacancy rate, as reported on 1 September 2014, was 7.94 WTE or 15.5%. Three band 5 staff and one band 8a matron were scheduled to commence on 22 September 2014, reducing the vacancy rate to 3.94 WTE or 7.7%. While the budgeted establishment was below the minimum recommended Paediatric Intensive Care Society standard, staff reported that bank (overtime) and agency staff could be accessed to help support the unit.
- Following the publication of the 2013 Royal College of Nursing guidance on staffing, the senior management team undertook a review of the nursing establishment across the service. The nursing establishment had appeared on the local risk register due to a shortage of qualified children's nurses being employed to support Great Western Ward in 2013.
- We were told that a large-scale recruitment drive had taken place in quarter one of 2014 which resulted in the appointment of 30 WTE nurses who were due to commence a one-year rotation programme on 29 September 2014. Ten nurses were allocated to Great Western Ward and Grand Union Ward respectively, and five nurses were each being allocated in the PICU and the neonatal intensive care unit (NICU) at Queen Charlotte's & Chelsea Hospital. We saw that a provisional band 5 rotation and development programme had been created by the practice educators so each of the 30 new staff was appropriately supported throughout their rotation.
- Staff working on Grand Union Ward raised concerns with us that, due to the increasing acuity of patients on the ward, it was often extremely busy and they felt that they could not always provide holistic care to patients.
- Specialist services such as the paediatric clinical haematology and bone marrow transplant service are supported by clinical nurse specialists.
- Each of the clinical areas was supported by a qualified paediatric nurse practitioner 24 hours per day.

2013/2014 Staff utilisation and vacancy rate per clinical area

Grand Union Ward

2013/14 year end bank/agency use : 17.9

2013/14 year end vacancy rate : 14.2

2013/14 year end sickness rate : 2.5

Great Western Ward

2013/14 year end bank/agency use : 18.7

2013/14 year end vacancy rate : 19.4

2013/14 year end sickness rate : 5.7

PICU

2013/14 year end bank/agency use : 15.6

2013/14 year end vacancy rate : 14.3

2013/14 year end sickness rate : 4.3

West Way Ward

2013/14 year end bank/agency use : 5.9

2013/14 year end vacancy rate : 4.5

2013/14 year end sickness rate : 5.3

Winnicott Baby Unit

2013/14 year end bank/agency use : 1.1

2013/14 year end vacancy rate : 17.5

2013/14 year end sickness rate : 5.4

Medical staffing

- The PICU was supported by eight specialist intensive care consultants who provide cover to the unit 24 hours a day (in-house and on-call).
- The PICU was further supported by five paediatric specialist trainee 3 (ST3), one adult intensive care ST5, six ST6, ST7 or ST8 trainees – this includes trainees from the Royal College of Paediatrics and Child Health, one clinical fellow in paediatric intensive care medicine and three additional paediatric intensive care fellows who help to support the Children's Acute Transfer Service.
- The Winnicott Baby Unit was supported by a team of 11 neonatal consultants and one academic neonatal reader, who rotate between the NICU at Queen Charlotte's and the Winnicott Baby Unit.
- General paediatrics was supported by eight consultant paediatricians.
- Following a serious incident in which a contributing factor to the incident was the rotation of the junior medical workforce, general paediatric consultants now provide double-consultant cover during the first week of junior doctor changeover.
- Surgical patients who were admitted to the ward were reviewed by the medical team to ensure that their health and care needs were being fully met.
- Concerns were raised by staff regarding vacancies within the paediatric haematology service. One middle grade post was reported as being covered by locum medical staff and one consultant post was reported as being vacant for about 18 months, therefore placing additional pressure on the existing three substantive consultants who were providing 24-hour, seven-days-a-week, on-call cover. Four incidents were reported between 20 May 2014 and 24 June 2014 because a registrar was not available to cover the paediatric haematology service.

Security

- There was a security system for entry to the wards. We observed staff politely challenging visitors to determine the reason for their visit.
- There was a child abduction and missing child protocol. While the service did not have formal rehearsals to test the protocol, the senior management team told us that it had been implemented in the previous 12 months when children with challenging behaviours had left the ward, Following one incident, the protocol was reviewed to ensure that it contained information relevant to patients who were being treated for mental health problems, including the use of physical restraint to safeguard patients from harm.

Major incident awareness and training

- Senior members of the children's team had received training and had engaged in major incident planning. I It was not clear from our discussions with more junior staff that any major incident training had taken place so that staff could rehearse the major incident protocol to allow them to become proficient with its use.

Are services for children and young people effective?

Good

Care was provided in accordance with evidence-based national guidelines from organisations such as NICE and the Royal College of Paediatrics and Child Health.

Staff followed specific care pathways and used pain assessment tools to ensure that patients received appropriate care and treatment and effective pain relief.

They ensured that patients' nutritional and hydration needs were closely monitored and maintained. The PEWS scoring chart was used to identify patients whose condition needed medical intervention.

The ward managers carried out appraisals for nursing staff, identified training and development needs and maintained records of staff training. However, we noted that there was some disparity between training records kept locally by ward matrons and those kept centrally by the trust.

A 24-hour, consultant-led service was provided across the clinical specialities. The service was supported by a range of clinical nurse specialists, allied healthcare professionals and paediatric site practitioners. Multidisciplinary working was an embedded concept across all areas of this service.

Evidence-based care and treatment

- Children's services used a range of guidelines which had been produced by NICE and the Royal College of Paediatrics and Child Health to define the treatment they provided.
- There were pathways and protocols for the management and care for various medical and surgical conditions. We saw documented evidence that these were used and updated appropriately if there were any changes in the national guidelines.
- The Winnicott Baby Unit was seen to use NICE clinical guideline 149: Antibiotics for early-onset neonatal infection.
- The Winnicott Baby Unit was accredited by Bliss, the charity for premature babies, as Bliss Baby Charter level 1, which is an audit of best practice levels of care for neonatal units looking after premature babies.
- St Mary's is accredited as a level 2 paediatric oncology shared care unit (POSCU) and currently engages with the acute lymphoblastic leukaemia and lymphoma (UK ALL) 2011 trial; a trial for the treatment of paediatric acute lymphoblastic leukaemia in the UK. Peer reviews of this service take place every 12 months to ensure the service is meeting the requirements to ensure they continue to remain an accredited unit.
- The paediatric allergy service has been attributed to the development of national guidance including the Royal College of Paediatrics care pathways for children with allergies.
- The paediatric allergy service reported that regular evaluations were undertaken against national standards set by NICE and the British Society of Allergy & Clinical Immunology (BSACI). Examples included the implementation of a standard operating procedure for the administration of Omalizumab (for treating severe asthma) and adrenal auto-injectors, which were derived from BSACI standards.
- There were processes for ensuring that clinical services complied with national standards. Examples included the review of the neonatal jaundice guideline against the standards set within the NICE clinical guideline 98: Neonatal jaundice. Action plans were generated where areas of improvement were required.
- The paediatric neurology team reported that they were not able to fully meet the standards for NICE clinical guideline 137: Epilepsies, because there was little or no access to a dedicated neuropsychologist. The department had established networks with external providers so that specific cases could be discussed and opinions sought. It was also in the process of developing a business case to resolve the issue.

Pain relief

- There was a process for ensuring that neonates received oral sucrose to reduce pain during procedures such as heel prick blood screening and lumbar punctures.
- We saw that the Winnicott Baby Unit used kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates.
- Children admitted to the ward had age-appropriate pain assessments, including a neonatal infant pain scale, a faces, legs, activity, cry, consolability (FLACC) assessment for children aged two months to seven years and a visual analogue scale for children aged eight years and over. A review of five care records demonstrated that staff routinely assessed children's pain levels.
- The department had access to a policy titled 'Pain Management in Children: Multi-professional assessment and management guideline' for the management of acute pain in paediatric inpatients (from age one year upwards). The policy was evidence-based and provided staff with guidance on managing varying levels of pain.
- There were numerous distraction techniques throughout the children's services to help reduce patients' pain and distract them from painful procedures. Play specialists and play assistants were available to assist the medical and nursing teams, as required.

- Staff reported that access to the paediatric pain team, which was facilitated by the anaesthetic team, had been problematic in the past, especially when the anaesthetist was required in theatre. This meant children presenting to the ward with chronic conditions or with a pain crisis, could not receive appropriate and immediate analgesia. A review of the pain management guideline was undertaken as a result, with the addition of intranasal diamorphine being included as a first line analgesic.

Nutrition and hydration

- We noted that drinks, snacks and an appropriate choice of food were available for children and young people. Multiple faith foods were available on request.
- Although the Winnicott Baby Unit did not operate a donor milk service, there were arrangements to source specialist donor milk from the Queen Charlotte's NICU as required.
- During quarter one of 2014: 73% of babies born at less than 33 weeks gestation were solely receiving maternal breast milk on discharge; And 87% of babies were receiving "some" maternal breast milk on discharge.
- Neonates, children and young people admitted to the children's wards, the NICU and PICU underwent nutritional screening assessments. Dietetic referral pathways were available for any child or young person identified as being at risk of malnutrition, or for children who had specialist requirements such as high-calorie meals, as an example.
- The service provided a monthly feeding clinic for children with behavioural feeding difficulties.
- Inpatient dietetic services received a total of 837 referrals, resulting in 3,706 clinical contacts during 2013/14. An additional 687 outpatient referrals were made during the same period, resulting in 2,741 clinical contacts.
- There is a multidisciplinary approach to children who required support with their long-term nutritional needs.
- The service employed 6.3 WTE specialist paediatric dieticians. Nutritional services were provided across the range of paediatric services, including neonatology, paediatric intensive care, allergy services, diabetes, haematology, oncology, bone marrow transplant and infectious diseases. The dietetic team reported that an increase in referrals was placing additional pressure on the team to deliver their service in a timely manner.

Patient outcomes

- There was no evidence of risk that the trust was an outlier regarding paediatric and congenital disorders and perinatal morbidity.
- Children's services submitted a range of data to national audit programmes. This included the National Neonatal Audit Programme, British Thoracic Society Paediatric Asthma Audit, Childhood Epilepsy Audit and the National Paediatric Diabetes Audit.
- The Winnicott Baby Unit is one of 29 UK-based neonatal units to submit their performance data to the Vermont Oxford Network, an international benchmarking tool which captures data from around 950 NICU's around the world.

National Neonatal Audit Programme performance

- Data from the 2011 National Neonatal Audit Programme listed St Mary's Hospital (Winnicott Baby Unit) as a positive outlier in two of the four questions selected for additional analysis.

MBBRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

- The trust is currently submitting data to MBRRACE-UK (a research collaboration based at the University of Oxford which investigates infant and maternal deaths) on a regular basis; however, no national performance reports have yet been released.

Paediatric Intensive Care Audit Network (PICANet) performance

- The PICU has routinely participated in the PICANet programme since 2003.

Year 2010: St Mary's PICU Crude Mortality Rate = 5.8; National Average Crude Mortality Rate: 3.8

Year 2011: St Mary's PICU Crude Mortality Rate = 5.5; National Average Crude Mortality Rate: 3.9

Year 2012: St Mary's PICU Crude Mortality Rate = 6.8; National Average Crude Mortality Rate: 3.8

- Between 2010 and 2012, the national average number of children admitted to a PICU who were subsequently discharged alive was 96.2% with crude mortality reported as 6.8% in 2012. This crude, unadjusted data suggests that the PICU has a marginally higher mortality rate when compared to the national average of 3.8%. The 2010 to 2012 Paediatric Index of Mortality 2r (PIM2r)

adjusted standardised mortality ratio for the St Mary's PICU was 1.00 (lower 0.77 and upper 1.27). The outcomes for this unit fall within the selected confidence limits and therefore St Mary's PICU can be described as having a case mix adjusted mortality rate that falls within the expected range.

National Paediatric Diabetes Audit

- The trust reported that 100% of diabetes patients received haemoglobin A1c (HbA1C) screening every three months and annual screening for thyroid and coeliac disease and retinal screening for children older than 12 years.
- NICE quality standard 6 for diabetes in adults recommends that patients with diabetes agree to maintain a personalised HbA1c target of between 6.5% and 7.5% and receive an ongoing review of treatment to minimise hypoglycaemia. This guidance is also considered as part of the National Paediatric Diabetes Audit. Data from the 2011/12 audit showed that the HbA1C rates for St Mary's hospital were worse than national average. For example, the percentage of patients who were managed with an HbA1c target of less than 7.5% was 11.9% of the total caseload, as compared with a national average of 17.4%. However, the trust provided us with additional data which suggests that the unit has made significant improvements in this area.
- It is also important to note that when considering the performance of this service against other services across the country, the paediatric diabetes team at St Mary's had submitted 100% of their caseload data to the 2011/12 audit; this compares with 3%, 1.5% and 6% of caseload data being submitted by the top three performing trusts. It is therefore difficult to fully compare and benchmark the department due to the inconsistent volumes of data submitted at a national level.

National Cancer Peer Review Programme – Level 2 core measures: POSCU

- When reviewing Cancer Quality improvement Network System (CQuINS) data for 2012/13, the St Mary's POSCU was placed in the lower quartile for overall unit performance when compared to national benchmarks. 2013/2014 suggests that the unit has improved in this area, and is now placed between the middle and upper quartiles.
- The POSCU was placed in the middle quartile for the standard of multidisciplinary team engagement during 2012/13. There had been an improvement in this area, with the POSCU now rating as being between the middle to upper quartile for this standard in 2013/14.

Competent staff

- The paediatric database reported that, as of April 2014, 90% of nursing staff had participated in an appraisal. The staff told us that they considered the appraisal system to be beneficial to their personal and professional development.
- Staff working in the various clinical settings had access to educational practitioners. Staff told us this was received positively and helped them to develop their competency.
- Children's services have access to a dedicated simulation training suite adjacent to the PICU. Twice-weekly, multi-professional simulation and teaching sessions took place. During the inspection we observed junior doctors undertaking a simulation session in paediatric life support.
- Ten consultants were accredited advanced paediatric life support instructors and eight consultants were accredited neonatal life support instructors.
- 23% of nursing staff working on Grand Union Ward had attended paediatric immediate life support training in the previous 12 months. No band 6 or 7 nurses had attended this training.
- Two senior nurses working on Great Western Ward had completed an advanced paediatric life support course in the preceding four years.
- Five nurses (19%) working on Great Western Ward had completed paediatric immediate life support training in the previous 12 months.
- During the last year 88% of junior doctors working within the Winnicott Baby Unit had undertaken neonatal life support training; 50% of the nursing and ancillary staff working on the Winnicott Baby Unit had undertaken this training in the preceding four years, and 15% of the nursing staff had last attended the training in 2009 and were therefore in need of an update.

Multidisciplinary working

- A range of weekly, multidisciplinary meetings took place allowing staff from across the various services to

discuss, plan and reflect on patients whose care does not form a standard treatment pathway. Examples of the weekly meetings included surgery, neuro-disability, complex care and nephrology.
- Parents shared with us examples of input their children received from physiotherapy, occupational therapy, dietetics and speech and language therapy.
- The trust provided a dedicated children's pharmacy team during normal working hours (9.10am to 5.30pm Monday to Friday). The pharmacy team were noted to be involved in many of the multidisciplinary team meetings that occurred.
- The medical wards had access to allied healthcare professionals and specialist staff as required and we observed care being provided by members of the multidisciplinary team during our inspection.
- Medical notes we reviewed had documentation from members of the multidisciplinary team involved in their care.
- Play therapists were available on the wards, including the PICU and provided valuable support to the wellbeing of the child. Parents and other clinical staff valued their contribution and spoke highly of them.
- Children and young people who were in need of mental health or psychological support had access to specialist input from the local CAMHS.
- The paediatric service was recognised as a POSCU, networking with tertiary cancer centres including the Great Ormond Street Hospital for Children NHS Foundation Trust.

Seven-day services

- Patients had access to allied healthcare professionals such as physiotherapists outside of normal working hours including weekends. In addition, staff were able to access radiology services 24 hours per day with urgent electronic reporting available overnight.
- Both the dietetic and occupational therapy teams had produced business cases to expand their service to ensure they could provide seven-day working for paediatric inpatient services.
- Two paediatric surgeons, two paediatric urologists and one adult/paediatric urologist undertook regular elective general surgery at St Mary's. An additional six paediatric surgeons provide an on-call surgical rota for paediatrics and neonates. A separate consultant was allocated to cover the paediatric surgical on-call rota for trauma cases.
- The ear, nose and throat on-call consultant was available to support complex paediatric cases and support the PICU, especially for complex airway cases.
- Paediatric anaesthetics support was provided by eight specialist consultant anaesthetists who provided 24-hour, seven-days-a-week support to all clinical areas providing care to children.

Are services for children and young people caring?

Good

People who used the service were positive about the way they were treated by staff. People said they were treated with compassion and respect. We saw staff ensuring that people's dignity and privacy were upheld.

People were mostly involved in making decisions about their care and treatment. Families and children were encouraged and supported to manage their own care where possible and to maintain their independence; the service adopted a family-centred care model.

Comments from children and family members collected through the trust's patient satisfaction questionnaires and surveys included: "An excellent team of caring professionals", and "Very personal, comforting, compassionate staff. Professional approach coupled with empathy is a major source of support".

Compassionate care

- Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect.
- We saw that doctors and nurses introduced themselves appropriately and that curtains were drawn to maintain patient privacy.
- All of the parents and relatives we spoke with were positive about the caring, friendly staff. They said the care they and their child received was kind, compassionate and supportive.
- We saw doctors and nursing staff introduce themselves to families and curtains were drawn to maintain patient dignity.
- Great Western Ward operated a same-sex policy whereby boys and girls were nursed in separate bays. Children on Grand Union Ward were all nursed in individual cubicles.

Services for children and young people

- Comments from patients and their parents/carers included: “The nurses, doctors, play and specialists have been great. They are all very friendly and helpful”, “The occupational therapy and physiotherapy team have been very good”, and “I would recommend this service to anyone who has a child”.
- The trust used a range of systems to seek feedback from children, young people and their relatives. This included an electronic patient tracker system which was located on the wards and outpatient areas. Information from the tracker system was fed back to staff on a monthly basis via the staff communication board.
- Children’s services engaged in the NHS Friends and Family Test. The Winnicott Baby Unit attained a composite score of 80 in January 2014, 100 in February, 38 in March, 100 in April and 60 and 69 in May and June respectively. Scores had been reviewed and the underlying factor to low scores was attributed to a lack of parent accommodation.
- West Way Ward scored 93 in July 2014; this was better than the national average of 73.
- Comments from patient and parent/carer feedback included: “An excellent team of caring professionals”, “Have more rooms available for parents as being away from your baby is hard”, “Very personal, comforting, compassionate staff. Professional approach coupled with empathy is a major source of support”.

Patient understanding and involvement

- The Winnicott Baby Unit provided outreach nursing support to parents/carers whose baby was scheduled to be discharged home after having received treatment in the unit.
- We observed consultant ward rounds taking place in the Winnicott Baby Unit. Parents were present for the handover; the consultant spent time speaking with the parents and provided many opportunities for them to ask questions about the care and treatment plans for their babies.
- Children’s outpatients had a process for supporting older children and adolescents to speak with a clinician or parent without having a parent present. This process was supported by a mobile phone app which had been developed by the outpatient team.

Emotional support

- We saw children and families being reassured by the nursing staff and heard explanations of their care being given.
- A range of clinical nurse specialists were employed to support children and their families. The parents we spoke with were highly complementary of the nurse specialists.
- The Winnicott Baby Unit provided an outreach service that further supported parents/carers by offering bereavement support.
- There were processes for supporting the parents/carers and siblings of children receiving palliative care.
- There were support mechanisms and care plans to meet the individual needs of children receiving oncology therapies such as chemotherapy and radiotherapy.
- Having considered patient feedback, the paediatric oncology service introduced psychology support to children and their families at the time of initial diagnosis.

Are services for children and young people responsive?

Good

The service maintained good communication and good relationships with local GPs, local authorities and other healthcare providers. There were examples of innovative programmes to improve the health and wellbeing of children, as well as programmes to reduce hospital admissions.

Both the PICU and NICU were unable to meet the demands of its patient population. It was widely accepted by the senior management team that both services could be expanded and business cases had been developed to this affect.

Service planning and delivery to meet the needs of local people

- The service had systems for monitoring the care delivered as well as considering the services’ needs for the future.
- Paediatric site practitioners had been employed to oversee the day-to-day operation of the service, having input into the admissions and discharges of each clinical area.
- Twice-daily unit meetings took place allowing the nurse in charge from each clinical area to discuss their bed occupancy, upcoming discharges, elective and emergency admissions.

Services for children and young people

- We observed the nurse in charge from the Winnicott Baby Unit liaise with the medical and nursing team located at the Queen Charlotte's NICU via video link. This enabled the team an opportunity to discuss discharges and admissions across the service, as well offering the team an opportunity to discuss operational issues such as staffing issues.
- So the department could meet the current demands of the service, an initiative titled 'Connecting Care for Children' had been developed. This initiative was designed to assist in the integration of child healthcare across primary, secondary and tertiary services. As a three-component programme, the intention was to provide primary care providers with access to specialist paediatric advice by the hospital team delivering community-led surgeries incorporating education, training, professional support and outreach clinics. In addition, GPs could access consultant paediatricians via telephone and email, with a same-day response to help reduce the use of unscheduled services such as the A&E and general children's ward. The final component of Connecting Care for Children was designed to empower patients and their parents/carers to self-manage their own care, to provide peer support to others and to engage with local general practitioners and primary care nursing staff by acting as practice champions.
- The paediatric allergy service was heavily engaged in North London's 'Itchy, Sneezy, Wheezy' project. Findings from the initiative were presented at the 2014 Royal College of Paediatrics and Child Health conference. The concept of the collaborative programme was to deliver a multidisciplinary approach specifically to children with allergic conditions. More than 200 healthcare professionals had been trained in the recognition and management of children with allergies. More than 200 children have been assessed and treated in primary care allergy outreach clinics as compared to being referred to the hospital's already oversubscribed outpatient service.
- We noted that young people up to the age of 18 were cared for within the children's and young people's service and saw evidence that their transition into adult services was managed effectively. This was especially noted for young people with diabetes, allergies, haemoglobinopathies and rheumatology conditions. However, it was reported that there was a lack of dedicated space within the children's outpatient department and the wards for adolescents and young people. There was, however, a standard operating procedure for nursing and medical staff caring for adolescents on adult wards, to seek advice and support from the children's nursing and medical teams. This included a robust safeguarding protocol.

Access and flow

- It was widely accepted by the children's services senior management team that the PICU was not fit for purpose. The current PICU did not meet the Paediatric Intensive Care Society standards for bed space, patient isolation and unit ventilation facilities. In addition to this, the PICU had long-standing capacity issues. During 2012/13 the PICU refused a total of 233 patients who had been referred to them via the North London Children's Acute Transport Service. The service refused 199 patients during 2013/14.
- Data provided from the trust indicated that the PICU operated at greater than 85% occupancy during January and February 2014, despite the unit opening an additional two winter pressure beds spaces. It is generally accepted that, when bed occupancy rates are higher than 85%, there is a potential for there to be a negative impact on the quality of care provided to patients.

PICU Bed Occupancy Rates January – June 2014

January 2014; PICU occupancy Rate: >100% (based on 10 beds)

February 2014; PICU occupancy Rate: 86% (based on 10 beds)

March 2014; PICU occupancy Rate: 87.5% (based on 8 beds)

April 2014; PICU occupancy Rate: 87.5% (based on 8 beds)

May 2014; PICU occupancy Rate: 75% (based on 8 beds)

June 2014; PICU occupancy Rate: 75% (based on 8 beds)

- A business case has been proposed to refurbish the existing PICU and to expand the service to some 15 beds, of which four bed spaces would be dedicated to the provision of high dependency care.
- The Winnicott Baby Unit received 282 admissions (excluding readmissions) between April 2013 and March 2014. This was slightly lower than the previous year's

admissions when the unit admitted 320 babies. Combined with the unit's sister department at the Queen Charlotte's & Chelsea Hospital, NICU services at Imperial College Healthcare NHS Trust refused a total of 65 babies during 2013/14: 59 in-utero refusals (12 were from the local North London Neonatal Network and 47 from outside the network); and six ex-utero refusals (three from the network and three from outside).

- It was acknowledged by the neonatal team that the service had scope to expand its services to meet the demand for specialist neonatal intensive, high dependency and special care cots.
- Overall rates for children's outpatients not attending appointments during 2013/14 were reported as 19.2%.
- The highest rate of non-attendance was in paediatric dentistry (28.8% of combined new and follow-up appointments) followed by paediatric ophthalmology (26.4% of combined new and follow-up appointments).
- To address the high non-attendance rates, the outpatients department had considered a range of initiatives, including the re-launching mobile phone text reminders. Administrative staff had also been employed on a temporary basis whose sole role was to contact families by phone to remind them of their up-coming appointment.

Meeting people's individual needs

- The wards operated flexible visiting times to allow for families to support the parents/carers whose children were on the wards.
- Translation services were available for patients and families who did not speak English as their first language.
- Information boards were sited around the hospital and in the relative's room, providing a range of information.
- While parents on Great Western Ward were offered fold-away beds or chairs so they could remain with their child overnight, there was very limited parent accommodation across the service. Parents/carers whose children were receiving treatment on the PICU and NICU were required to stay in a local hotel, with the Children of St Mary's Intensive Care (COSMIC) Charity providing financial support to families to enable them to stay near the hospital. In 2013, COSMIC reported spending more than £18,500 on parent accommodation alone.
- It was further noted that there were delays in discharging babies from the Winnicott Baby Unit because of a lack of "rooming in" facilities. A further business case had been proposed to expand the Winnicott unit so that additional parent accommodation could be developed.
- There were limited inpatient facilities available for adolescents staying in hospital. The hospital did not have a dedicated adolescent unit. Adolescents were usually admitted to the inpatient wards and placed, if possible, together in bed bay areas or in cubicles. Great Western Ward did not have a specific adolescent area where they could relax. This issue had been listed as a risk on the directorate's risk register on 26 January 2009 and there remained no defined plan of action to resolve the issue.
- The paediatric outpatient department was observed to be busy and congested during the inspection. Staff reported that, during busy clinics, there were not always enough seats for people to sit on.
- The neuro-disability team reported that, while there had been an increase in the number of patients requiring spasticity management in line with NICE guidance: Spasticity in children and young people, there had not been an increase in the number of formal spasticity clinics being provided. Consultants were there to provide ad-hoc clinic appointments to children and their families to ensure they could access support and treatment in a timely manner.
- The adolescent transition team held after-school outpatient clinics, although it was reported that the team did not have a dedicated space in outpatients and so capacity within the clinics was limited.
- Despite a lack of formal space for adolescents, the service had developed a range of standard operating procedures and treatment pathways for 16-17 year olds. These pathways included a young person's sexual health service and teenage pregnancy service.
- Children requiring support for mental health conditions were routinely nursed on a one-to-one basis. Staff told us that, while the service did not employ specialist mental health nurses, shifts could be covered with bank or agency nursing staff.
- It was reported on the directorate's risk register on 26 January 2009 that the provision of on-site psychological and psychiatric, multidisciplinary support for children was unavailable. Staff working on Great Western Ward reported that, while there was a good relationship with the local CAMHS nursing team, there remained no on-site psychiatric provision. The provision of CAMHS

services was supported by a third-party provider; an update on the risk register dated 19 August 2014 reported that "Constructive on-going discussions with commissioners to sort out acute CAMHS cover [continues]". It is acknowledged that the availability of CAMHS provision is a national issue however we noted that the trust were liaising with third party providers in an attempt to resolve the matter.

- Patients and parents provided the oncology team with feedback that they found waiting in paediatric A&E with an immuno-compromised child distressing. As a result, the patient pathway from paediatric A&E to Grand Union Ward was developed collaboratively with the paediatric A&E team, the general paediatric team and the POSCU team. The pathway ensured that paediatric oncology patients who attended A&E out of hours were streamlined into a cubicle (whenever possible) and admitted to Grand Union Ward as soon as possible.
- Based on feedback that patients felt that there were delays in receiving care, the nursing team successfully provided a rolling training programme across the ward to ensure that staff were trained to support patients who need Portacath access.
- In response to patient and parent feedback, the oncology team developed an oncology information pack which was shared with patients when they were initially diagnosed.
- Play specialists were available each week day and provided a service to children accessing clinical services in inpatients, outpatients, ambulatory care, PICU and A&E.
- The play service developed guidelines including 'Invasive procedures and psychological comfort guidelines for children' and 'Restrictive physical intervention and therapeutic holding guideline for children and young people'.
- Children admitted to hospital for prolonged periods of time were supported to continue their education. Westminster City Council funded the Chelsea Community Hospital School, of which one location was sited next to Great Western Ward at St Mary's Hospital. The service was equipped to support children from reception age through to those completing their A-levels. Children undertaking examinations were able to do so while they continued to receive care in the hospital setting.
- Medical staff from a range of clinical settings raised concerns that there was limited access to neurophysiology services within paediatrics and neonatology. The directorate risk register listed this as an area of risk and had been first reported on 1 January 2006. An update to the risk register in June 2014 indicated that the provision of neurophysiology support would worsen following a reduction in the neurophysiology workforce, further impacting on the timely reporting of neonates and children referred for neurophysiology opinions. There was no clear plan detailing how the risk was to be managed and resolved.
- The epilepsy clinical nurse specialist provided training and support to schools, nurseries and after-school clubs where children may have epilepsy and who may require emergency treatment.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). A dedicated member of staff within each of the clinical areas, including the deputy divisional nurse, reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the whole team to improve the patient experience within the department.
- Information was readily available for patients who wished to make a complaint, but who may have needed support to do so.
- Overall, the ratio of complaints lodged against the department versus the number of admissions and attendances was low (0.04%). There was evidence that complaints were shared with members of the team so lessons could be learnt. Trends arising from complaints were discussed as part of the clinical governance system within the department.
- Following a patient complaint in which the parents considered that the level of post-operative care instructions to be insufficient, actions were taken to resolve the issue. Post-operative instructions were now explained by the surgeon responsible for the child, as well as written information also being made available to parents/carers; this guidance was in line with national standards.
- Feedback from the allergy service Patient Reported Experience Measure from 2013 identified an issue with patients being able to access secondary and tertiary

allergy services in a timely way. Community-based services were now provided and provisional feedback has demonstrated an improvement in the integration of allergy services within the local community.

Are services for children and young people well-led?

Good

Day-to-day leadership of the service was strong within the division which, although newly created, had a vision which was in line with the trust's wider transformation programme and revised clinical strategy.

There was a risk register for the directorate and risk management issues were discussed at directorate meetings. Although risks had been identified, there was not always a robust action plan to resolve issues, with some risks being present on the register for five or more years.

Morale within some clinical areas had experienced peaks and troughs and this was attributed to high staff turnover, high vacancy rates and a lack of sustained, robust leadership at ward level. We were pleased to find that many of these issues had been, or were in the process of being resolved; however, it was too early for us to fully measure the impact of these changes.

While our inspection focused on acute services, it is important for us to acknowledge the clinical research and academic study that was being undertaken by the various neonatal, children's and young people's healthcare professionals. It was clear that, while we have rated this service as requiring improvement, staff working across this division were committed to enhancing the health and wellbeing of children on an international scale.

Vision and strategy for this service

- The department had considered a range of developments to further enhance the provision of services for neonates, children and young people in the future and a range of business cases were in progress to do so.
- There was an active emphasis on the implementation and sustained compliance with the standards set out in the Department of Health's National Service Framework: Children, Young People and Maternity Services, which was now in its final year of a 10-year programme.
- Staff across the various clinical areas were able to describe the vision for children's services at Imperial College Healthcare NHS Trust.
- Staff spoke positively about the impact that 'Connecting Care for Children' was having on the welfare of children who used the services.
- There was a focus on clinical research within child health, including allergies, childhood infection and intensive care.
- The vision of the service was in line with the trust's wider clinical strategy and service transformation plans. It was noted that neonatology services would continue to be provided on two sites, albeit with a transfer of the NICU to the St Mary's campus and the special care baby unit moving to Queen Charlotte's. Some clinicians had hoped that the service would be solely provided on one campus in the future but this was not to be the case according to the clinical strategy.

Governance, risk management and quality measurement

- Governance meetings took place and there was discussion regarding incidents and complaints.
- Risks associated with the provision of services were logged on the divisional risk register. While there was evidence that risks were discussed and updates applied to the register, we noted that some risks (seven in total) had existed for five or more years with little or no progress being made to resolve the issues.
- A range of dashboards were used by the various clinical services to help monitor the overall quality of services being provided to neonates, children and young people.

Leadership of service

- Although fairly new, leadership at ward level was strong. New matrons had been appointed to the Winnicott Baby Unit and Great Western Ward shortly prior to the inspection. A new matron had been appointed to the PICU, although was not in post at the time of the inspection.
- While there had been an effort to amalgamate the Winnicott Baby Unit and the NICU located at Queen Charlotte's into one complete service, there remained a degree of separation among the nursing staff. There was no formal rotation of nursing staff and so it was difficult to consider that both units were operating as one seamless service.

- Ward matrons reported that having supernumerary status allowed them the time to carry out the full leadership role.
- Staff told us that they felt well-supported by their matron.
- A small number of staff raised some frustrations about communication among leaders above the grade of matron, with poor information flow between the board and the ward.
- At the time of the inspection, children's and young people's services did not have a named non-executive board member representing the service at board level.

Culture within the service

- The staff we talked with were proud to work at the trust and felt it was a centre of excellence.
- There was a culture of openness and staff felt able to report concerns.
- The service had an open and friendly approach with team working among the clinical specialities being reported as strong and effective.
- However, we found that morale among the nursing teams was varied. Staff on Great Western Ward had reported that staffing difficulties and high staff turnover during 2013 had had a negative impact on the team's morale. It is important to note, however, that staff further reported that the introduction of new nursing staff and nursing leadership had been beneficial, with many staff reporting a renewed enthusiasm for their jobs as a result.

Public and staff engagement

- Patient feedback was widely displayed throughout the various departments.
- There was a range of systems to seek the engagement of members of the public including parent groups.
- The diabetes parent user group was reported as being an active group with regular meetings taking place, providing patients and parents/carers an opportunity to seek support from peers and to influence the provision of the service.
- Paediatric intensive care hosted parent feedback forums three times per year with minutes of the meetings being circulated to the wider team so feedback could be used to shape future improvements within the service.
- The neuro-disability team had introduced a Down's syndrome community-based clinic and parent group which provided parents/carers an opportunity to seek peer support and to learn about the syndrome.
- The trust facilitated a young person's user group; meeting throughout the year, the group were offered the opportunity to provide feedback on their experiences of using hospital services so services can be improved and shaped for the future.

Innovation, improvement and sustainability

- The paediatric physiotherapy department had trialled an indoor climbing experience for children with motor disorders.
- Business plans had been submitted to extend inpatient paediatric dietetic and occupational therapy services to facilitate seven-day working.
- The NICU was trialling a 'real-time' standalone training terminal to enable staff working in the Winnicott Baby Unit to troubleshoot common problems with equipment and to provide training on the safe use of medical devices.
- Children's services had access to a dedicated simulation training suite adjacent to the PICU for twice-weekly multi-professional simulation and teaching.
- The Connecting Care for Children programme was designed to help the local health economy achieve fully integrated child health provision by bringing together specialist expertise and community support directly into primary care. This included specialist outreach services provided by a team including paediatricians and providers of primary and secondary care. Outreach services included GP-based child health outreach clinic, face-to-face education and learning, email and telephone paediatrician support to primary care providers.
- Engagement in the Itchy, Sneezy, Wheezy programme to manage children with allergies attempted to reduce hospital admissions. As part of this project, a Patient Reported Experience Measure was developed by the team which was awarded the Barry Kay Allied Health Professional Award for best Allied Health research project.
- Development of the youth worker service within the A&E and acute trauma centre was an initiative aimed at improving the outcomes for young people aged 11 to 24 years affected by gang-related violence, including gang-related sexual exploitation.

Services for children and young people

- The Winnicott Baby Unit introduced the use of headphones to the unit so that parents were encouraged to be present for ward rounds. Since the introduction of the headphones in April 2014, the number of times a parent/carer had been asked to leave the unit during ward rounds or handovers had decreased by 70%.
- The infectious disease department at St Mary's Hospital were currently engaged in 21 different research studies involving collaborative, multi-centre or independent approaches.

End of life care

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

Information about the service

The St Mary's Hospital specialist palliative care team (SPCT) included a palliative care consultant and three clinical nurse specialists. There was also a medical palliative care lead and a nursing team leader.

They were part of a specialist palliative care team that covered Imperial College Healthcare NHS Trust's three acute hospital sites: St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital. They shared policies, practices, documentation and held joint multidisciplinary team meetings.

The St Mary's Hospital SPCT had been involved with 471 patients and with approximately 514 of deaths that occurred in the hospital in 2013/14. The team's input ranged from providing advice and support to ward staff on the management of palliative care for patients through to directly assessing and monitoring end of life patients.

The team visited patients on a range of wards including elderly care, respiratory, stroke and surgical. They liaised with ward staff, patients' families and community services with the aim of ensuring that patients' palliative care was delivered efficiently and in accordance with patients' wishes.

Summary of findings

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the majority of the organisational indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The specialist palliative care team (SPCT) were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

End of life care

Are end of life care services safe?

Requires Improvement

There is an inconsistent approach to the completion of DNR CPR forms. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. There was no formal action plan in response to the National Care of the Dying Audit, which found the trust did not achieve the majority of the indicators in this audit.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The SPCT were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

Incidents

- There had been no incidents, Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or incidents requiring investigation that could be attributed to the SPCT.
- Staff were aware of how to report an incident or raise a concern.
- Incidents were reviewed and discussed every two weeks at the multidisciplinary SPCT meeting to identify and share learning.

Cleanliness, infection control and hygiene

- The mortuary was visibly clean and well-ventilated, records demonstrated that it was cleaned daily. There was appropriate hand washing facilities.
- In the mortuary we observed a sharps bin which was sealed and safe.

Medicines

- We were told there were nurse prescribers in the SPCT. The records of patients receiving palliative care or who were being seen by the SPCT on a number of medical wards showed that arrangements were in place for medicines to be provided if patient conditions deteriorated and they required medicine to relieve symptoms. Prescriptions were written up in anticipation and therefore could be given in a timely manner.
- Medicines were available on the wards.
- The medical lead for the SPCT told us they were aware there had been issues that related to the prescribing of opioids within the hospital. These issues included conversation of dosage when the drug was administered via different methods, such as injection or syringe drivers. To mitigate this risk the SPCT produced an opioid conversion chart. This was credit-card sized and converted differing opioid doses to enhance patient safety. Feedback from the medical staff we spoke with were positive about its effectiveness.
- In response to the National Care of the Dying Audit for Hospitals 2013, the trust were trialling a system in relation to prescribing medication delivered via syringe drivers. This included the use of 'syringe driver prescription' stickers, which were pre-printed and aimed to make the identification of medications delivered via this method easy to identify. The pilot was being audited at the time of our inspection.

Environment and equipment

- Staff told us that syringe drivers used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner.
- There were specific facilities available in the mortuary to store bodies' long term. Staff told us that, these facilities were sufficient to meet demands.
- There was a well-maintained chapel but we noted the multi-faith room had not been maintained. There were stains on the lino at the entrance, drink stains on the window sills and we observed a drink splatter on one of the walls in this room. Walls and carpet were faded and there was an unpleasant odour and some chairs had fabric which was frayed and broken. We received conflicting information about who was responsible for the maintenance of these rooms.

Records

- Some patients receiving end of life care had been identified as 'not for resuscitation'. Patients had the appropriate DNA CPR form in their file so that staff were aware of what action to take in the event of cardiac or

respiratory function ceasing. The form identifies those patients who would not want resuscitation to be attempted in the event of an arrest and who competently refuse this treatment option.
- Of the seven available DNA CPR forms we reviewed on three wards where patients were receiving end of life care, four had been completed correctly and fully.
- Three DNA CPR forms had not been fully completed. We found an example where the form indicated that a patient had not been consulted, although it stated they had capacity, and another where relatives had not been consulted where the patient's case notes stated they lacked capacity.
- Another DNA CPR form stated the patient had capacity. It had been signed by the doctor but consultation with the patient or their family had not been recorded. A case note entry, dated the following day, stated that the patient agreed with the DNA CPR. The word 'NOT' had then been crossed out and dated with the following day's date leading to confusion as to whether the patient agreed with this decision. We spoke to the ward sister regarding this who said they would report it to the medical team.
- In case notes we found that discussions with patients had taken place, however, these were not documented on the relevant DNA CPR form and consequently were lost.
- We were told that all patients who had requested DNA CPR had a sticker indicating this on their case notes to avoid inappropriate care being delivered. However; the hospital had run out of these stickers at the time of our visit and therefore there was a risk in the case of an emergency inappropriate care would be provided.
- The end of life care plans we looked at had all been completed and updated appropriately.
- The mortuary log was maintained and weekly report shared with the patients' affairs team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The SPCT involved family members in decisions that related to a patient's care and treatment.
- Independent mental capacity advocates attended SPCT multidisciplinary meetings and contributed to discussions about treatment and discharge destinations, best interests and informal decisions.
- In all notes we looked at patients' capacity to consent was recorded.

Safeguarding

- Staff had attended safeguarding training.
- We were given examples by medical and nursing leads for the SPCT which demonstrated they had raised and discussed concerns about potential abuse and vulnerability in multidisciplinary team meetings. Cases had been referred to the hospital safeguarding lead. This included issues of financial abuse, concerns about patients' children, suicidal and elderly patients. They were able to easily locate the safeguarding referral form on the trust's intranet.

Mandatory training

- Staff were required to attend a three-day training course that covered mandatory training every three years. There were also other courses completed annually. Topics included infection prevention and control, fire safety, information governance and mental health and capacity.
- Attendance was monitored and recorded centrally within the trust. If staff had not attended, managers were contacted. Attendance was reviewed in annual appraisals and objectives could not be judged as 'met' unless staff had fulfilled this requirement.
- Mortuary staff trained porters in the trust's procedures for transporting bodies to the mortuary and the use of equipment.

Assessing and responding to patient risk

- Ward staff told us that the SPCT were visible on the wards and supported the management of deteriorating patients. They were also available by phone for advice and verbal referrals.
- Nurses told us that deteriorating patients would also be identified by nurses and highlighted to the doctors. These patients would have a multidisciplinary review which would involve the SPCT.
- Junior doctors told us they found the SPCT helpful and gave good advice about anticipatory prescriptions and pain management. All senior house officers had been given opioid conversion cards to aid conversion of oral to ventral doses.
- Nurses we asked told us that they had contact numbers and were able to contact the SPCT out of hours should this be needed.
- The results of the National Care of the Dying Audit 2012/13 showed that 75 % of patients were identified for end of life care when they were dying. This was better than

End of life care

the England average of 61%. The trust scored better than the national average for those patients who had been assessed within their last 24 hours, with 94 % compared to the England average of 82%.

- There were informal arrangements such as direct contact by ward staff to the SPCT to refer patients for end of life care or seek advice. There is no electronic flagging to know how many patients were receiving end of life care.
- There was a system for grading the level of input required from the SPCT.

Nursing staffing

- There had not been an assessment to determine nurse staffing in the SPCT, current staffing levels were historical.
- There were a total of 7.8 whole time equivalent (WTE) clinical nurse specialists in the trust's SPCT. Three were based at St Mary's Hospital. They were rotated annually across the sites to promote the trust-wide approach to palliative care.

Medical staffing

- There was a palliative care consultant based at the hospital and a medical lead within the SPCT that covered all three sites. This was in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds.
- There was an out-of-hours rota shared by the four consultants which ensured staff had access to the SPCT at all times.

Major incident awareness and training

The medical lead for the SPCT told us they had completed the trust's major incident awareness training last year and had contributed to the major incident team's planning process.

Are end of life care services effective?

Good

The Liverpool Care Pathway for end of life care had been withdrawn and replaced with a new end of life care pathway framework that had been approved by the trust's end of life steering group and professional practice committee. Ward staff were trained and confident in the use of this pathway.

The National Care of the Dying Audit for Hospitals 2013 had made specific recommendations. While these were being addressed there was no formal action plan which documented the action that were to be taken to address the issues raised and timescales for completion of these actions. Pain relief was appropriately managed.

All members of the SPCT had participated in an annual appraisal in the last 12 months. Ward staff from all of the wards we visited had attending training in end of life care. There were examples of multidisciplinary working and an on-call rota to ensure a member of the end of life team was available seven days a week.

Evidence-based care and treatment

- SPCT withdrew the Liverpool Care Pathway in July 2013 which was as soon as the announcement regarding its withdrawal was issued by the Department of Health.
- A new end of life care pathway was subsequently produced by the SPCT and had been agreed through the end of life steering group which was chaired by the trust's director of nursing. This was rolled out across the hospital wards. It included a principles document and a multidisciplinary decision document. We were told this had been ratified by the professional practice committee and was due for imminent sign-off by the quality and safety executive committee.
- Ward staff told us that the SPCT had visited wards specifically to familiarise staff with the principles and use of the new care pathway documentation.
- The SPCT medical lead demonstrated annually to the trust's clinical quality assurance manager that the service was compliant with National Institute for Health and Care Excellence (NICE) guidance. Evidence seen during our inspection demonstrated compliance with relevant NICE guidance.
- The end of life care strategy was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults and the Department of Health's National End of Life Care Strategy.

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Pain relief

- We found that pain relief medication had been assessed by medical staff and given as appropriate. We found that advice about pain management was being given to ward staff by the SPCT. Patients' notes demonstrated that pain was being managed appropriately.
- Ward staff told us they were aware of who to call for help and advice and how to contact the on-call consultant.
- Junior doctors told us they found the SPCT helpful and gave good advice about anticipatory prescriptions and pain management. All senior house officers had been given opioid conversion cards to aid conversion of oral to ventral doses.
- The trust's results from the National Care of the Dying Audit showed that, at the time of the patient's death, there was documented evidence that 'use when required' medication had been prescribed for 43 % of patients; this is worse than the England average of 51%.
- There was an end of life care pathway which included pain management; the case notes for end of life patients we looked at included this documentation.
- Syringe drivers were used to deliver continuous analgesia to assist with effective pain management.
- The National Care of the Dying Audit for Hospitals 2013, found that the trust achieved the key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at the end of life.

Nutrition and hydration

- The National Care of the Dying Audit for Hospitals 2013, found that 66% of patients had a review of their nutritional requirements. This was better than the England average; while 77% of patients' hydration requirements had been reviewed, which was better that the England average of 59%.
- Nutrition and hydration needs were included in end of life care pathway documentation.
- Speech and language therapy assessments had been completed for palliative care patients.

Patient outcomes

- The SPCT participated in the National Care of the Dying Audit for Hospitals and received outcomes from this in May 2014. Actions were being taken on its key recommendations. These included auditing syringe driver use, having a board member with responsibility for end of life care and reviewing protocols for DNA CPR. We were told that action was being taken to address these recommendations but we were not provided with evidence of an action plan or which recommendations had been implemented
- The SPCT lead told us that a formal action plan in response to the National Care of the Dying Audit had been delayed because the trust wanted to produce a more comprehensive improvement plan for palliative care services. They had recently commissioned an independent service review that was carried out by Macmillan. The preliminary draft findings were received by the trust the week prior to our visit. It was the trust's intention to formulate its strategy and improvement plans on the basis of these reviews. We were told by the director of nursing that any actions from the CQC report would also be incorporated. The timescale for completion of this piece of work was based on receiving the CQC report.
- The National Care of the Dying Audit for Hospitals 2013 found that the trust had achieved better than the England average for seven out of ten clinical key performance indicators and scored worse for one indicator.

Competent staff

- All SPCT staff had participated in an annual appraisal. Training attendance was reviewed in annual appraisals and objectives could not be judged as 'met' unless staff had fulfilled their training requirements.
- SPCT staff told us they saw part of their role as always being available to ward staff to give advice and share expertise. Ward staff told us they felt more competent as a result of this support.
- Staff told us the SPCT had carried out training on using the new end of life care pathway documentation on the wards. Other ward staff told us they had received additional end of life training. For example, through attendance on the postgraduate end of life care module or the four-day course run by the trust. We were told they felt supported by the hospital to do this which enabled them to provide support for junior nurses and healthcare support workers.
- On one ward we visited, the sample of training records we looked at showed that six of 14 staff had attended palliative care training and 10 of 14 breaking bad news training. We also spoke with the healthcare support workers who were able to tell us about the new end of life care pathway documentation.

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- The mortuary's anatomical technology pathologist told us they had provided training to the porters in the transportation of bodies between the ward and mortuary and in storage of bodies.
- Junior doctors told us they felt well supported and that end of life training modules had been included in their teaching sessions.

Multidisciplinary working

- Regular SPCT multidisciplinary team meetings were held and attended by a range of staff including nursing, medical and others from all three hospital sites that provided palliative care within the trust.
- Members of the SPCT also attended multidisciplinary discussion of cases, board rounds and ward rounds to provide clinical input for palliative care patients and to identify other patients who may benefit from the SPCT being involved in their care.
- SPCT members maintained relationships with external teams who provided palliative care such as the local hospice's multidisciplinary team by regularly attending meetings with them. They were also in contact with community health teams and attended the local authority end of life steering group meetings and meetings with local clinical commissioning groups.
- The SPCT liaised with carers and care homes and the lead dementia nurse for the trust. Care planning for patients was addressed within this wider support network. For example, mental capacity issues, treatment options and discharge planning which was the responsibility of the care of the elderly and medical teams.
- The end of life steering group met monthly and had representative from across the hospital, including junior doctors, allied healthcare professions, nurses, discharge teams, chaplains and governance teams. Its focus was on service improvement.

Seven-day services

- The SPCT provided a clinical nurse specialist service Monday to Friday between 8am and 5pm and medical cover was available on site Monday to Friday between 8am and 8pm.
- There was a palliative care consultant on-call rota out of hours. We were told that an average of three to six calls were received daily at the weekend through the on-call system, these were mostly for advice about pain relief.
- Ward staff had the contact details of the on-call service displayed in nursing offices. Ward staff told us they felt supported by this service.
- The bereavement officer was available Monday to Friday 09.00 to 5pm.
- There were arrangements for relatives to visit the mortuary and to allow bodies to be released out of hours and during the weekend.
- Chaplains were available at evenings and weekends.

Are end of life care services caring?

Good

Ward staff demonstrated they understood the need for care and compassion when caring for end of life and palliative care patients. Mortuary staff and porters were aware of the need for sensitivity and compassion in working with people.

The SPCT supported people's wishes and preferences for how they wished to be treated and cared for and acted as advocates for patients and their relatives to assist in ensuring their specific needs were met. Written information was available to assist patients and their relatives understand their care in a range of languages and formats. Patients and their relatives were involved in decisions about their care and treatment.

Compassionate care

- Ward staff demonstrated the need for care and compassion when caring for end of life and palliative care patients. Staff spoke to relatives separately if needed as well as together.
- We observed that staff were caring and compassionate in their interactions with patients and their relatives.
- The trust did not achieve its National Care if the Dying Audit organisational KPI for clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient
- Mortuary staff described to us the compassion and consideration they gave to relatives of the deceased. This included speaking to them about what to expect when they came to view their relative in the mortuary viewing area. They also described to us how they would sit with relatives if this was needed.

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- The SPCT told us about the need to work with heightened emotions, sensitively and the importance of working with compassion at what was a difficult time for people.
- Porters demonstrated that they were aware of the need to maintain the individual's dignity when transporting a body between the ward and mortuary.

Patient understanding and involvement

- Patient notes demonstrated that patients' and their relatives' views were taken in to consideration when their care and treatment was being planned. For example, we observed that during ward rounds patient's views were sought.
- The SPCT had a policy of always supporting patients' choice of preferred place of care and preferred place of death, although community resources meant this was not always achievable. The team did not provide us with data to demonstrate how many patients were able to die in the place of their choice.
- As well as promoting family/carers involvement in patients' care, independent mental capacity advocates attended the SPCT multidisciplinary team meetings, to assist and support patients make informed decisions about their care.
- We noted that patients' wishes were documented on the SPCT multidisciplinary form for each patient and in case notes by the ward.
- Information leaflets were available on a range of topics including funeral arrangements and funding, benefits; these were available in the bereavement office.

Emotional support

- The clinical nurse specialists were all trained in psychology. They demonstrated the need to support patients, staff and relatives emotionally.
- The trust's end of life strategy stated that psychological support should be offered to people in the last days of life, however, no evidence was provided to demonstrate that this was achieved.
- SPCT multidisciplinary meetings discussed patients' emotional and psychological needs to ensure these were met.
- There was a counselling service available for oncology patients and their relatives and staff knew how to access this service.
- There was a staff counselling service available and staff we spoke with were aware of this service and how to access it.

Are end of life care services responsive?

Good

Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

Action had been taken in response to complaints relating to end of life care to reduce the risk of a similar complaint being received. Arrangements were in place to provide interpreter services for most people; however, there were isolated examples of these arrangements not being effective.

Service planning and delivery to meet the needs of local people

- Ward staff told us the SPCT was responsive to people's needs and accessible to wards who contacted them for support. We were told that the team's capacity ensured that they were never in a position where they had to prioritise who they saw.
- The SPCT nurse lead had recently completed an audit to assess the team's response to referrals. This showed that, from the time the SPCT were contacted to the time they had first contact with a patient or member of staff, dependent on the level of need, there was a trust average of 2.3 hours and a 2.4 rate at St Mary's Hospital demonstrating they were able to respond in a timely manner.
- To inform the level of intervention the SPCT provided to individuals they used a 1-4 grading system with one being offering advice to four, the team directly assessing and monitoring a patient. An audit undertaken in 2013/14 by the SPCT found that around 86% of referrals were graded as a 3 or 4, requiring direct involvement of the SPCT.
- The hospital was able to offer relatives reasonably priced accommodation in a block of flats nearby. The trust's shuttle bus service ran between the trust's hospitals and was available to people staying there.
- There were quiet rooms available on wards for holding sensitive conversations and for breaking bad news.

However, we found these rooms to be bare, sparse and had multiple uses, such as a meeting room and break room, with faded paintwork and bright, uncomfortable lighting.

- The patient affairs office had recently moved location to a smaller and less convenient space. For example, the room where people were seen by patient affairs was now accessed through the patient affairs office space. People waiting to meet with patient affairs now waited in the hospital corridor.
- Mortuary staff told us they had adequate fridge space. There were also other mortuaries within the trust they could use as a resource and a private company it was possible to outsource to if required.
- When a patient died, the hospital's information system had a facility to cancel their future appointments, avoiding relatives receiving hospital appointments for the deceased.
- The mortuary back gate, where undertakers and ambulances entered, had a large wooden panel missing. We were told that, although this had been reported five weeks ago, it had not been repaired.

Access and flow

- The National Care of the Dying Audit for Hospitals 2013, found that the trust did not achieve the performance indicator that patients had access to specialist care in the last hours of life.
- The trust's discharge team worked with the SPCT to support people's preferred place of care and preferred place of death. The team were involved in 95% of the hospital's fast-track referrals for discharge. The trust aim to obtain funding for rapid discharge with four hours and a placement found within 24 hours. However, we were given examples where access to home equipment or hospice placements had been difficult and resulted in delays outside the hospital's control..
- We also found examples where a patient's condition had rapidly deteriorated and a clinical decision had been made to not move the patient from hospital to avoid them dying in transit.
- The trust had a policy not to move patients receiving palliative care between wards at night. We were not provided with information to demonstrate that end of life patients were not moved after 10pm.

Meeting people's individual needs

- We were told that the SPCT rarely had contact with patients with a learning disability but if did, they would immediately contacted the person's community support network and family to obtain an up-to-date information regarding the individual's preferences and needs.
- People's individual preferences were noted in the SPCT's hospital multidisciplinary meeting record. This included their spiritual preferences, goals, social/family involvement and whether the patient had signed a DNA CPR form.
- In the last 12 months the team had received 471 referrals for their involvement in patient's end of life care. The SPCT retrospectively measured the level of involvement they had with each patient, using a four point tool. One being advice provided to four directly assessing and monitoring by the team. The team's 2013/14 annual report demonstrated that 86% of referrals were graded as three or four; however, it was unclear what evidence had been used to develop this tool.
- We were told that all bodies were transported from the wards to mortuary in an enclosed electric vehicle to maintain the deceased dignity. The SPCT told us that they saw part of their role as advocating for patients and their relatives on wards to ensure their needs were met. For example discussing with staff patient's requests to be moved into a single room. We were told that patients receiving end of life care would be accommodated in these when it was appropriate and rooms were available. We found that side rooms were available to patients receiving end of life care when we visited the wards.
- There were no visiting restrictions for end of life patients and we found that relatives were able to stay overnight when the patient was accommodated in a single room.
- There was a telephone interpreting service available and also an internal interpreting resource provided by bilingual health professionals employed by the trust. These arrangements met the majority of patient's needs however if necessary languages not covered by these sources would be outsourced.
- We noted one example on Manvers Ward where it had been documented in the patient's records and that the multidisciplinary team were aware that they could not speak English but the interpreting services had not been contacted. In response the team contacted the

grandson to ask basic assessment questions which he could not answer. It was noted that they planned to wait until the family visited to complete this assessment as they would be able to translate.

- The majority of patient's religious needs were met. The chaplaincy team who covered the majority of faiths attended the SPCT multidisciplinary team meetings and were aware of patient's who may wish to be supported by a member of the chaplaincy team. Posters and newsletters were also displayed on wards informing patients and their family about the availability of chaplaincy and about multi-faith services.
- The National Care of the Dying Audit for Hospitals 2013found that 39 % of patients had a spiritual needs assessment at the trust; this was similar to the England average.
- Mortuary viewing facilities were subtly lit and well-maintained and allowed relatives privacy.

Learning from complaints and concerns

- We were told that the SPCT had not received any complaints in the last year. Trust-wide, 4% of complaints related to patients receiving end of life care, the majority of these complaints related to poor communication and decisions regarding care and treatment. To reduce the risk of similar complaints being made the SPCT had delivered presentations on the issues faced by patients and relatives at the end of life to ward staff. However, there was no evidence to demonstrate that this action had been effective in preventing similar complaints being received.
- We were provided with examples of where the SPCT had liaised with wards when patients' relatives were unhappy with aspects of care. We were told that the SPCT's intervention was a supportive role for both relatives and staff when there were heightened emotions and difficult conversations about palliative care.

Are end of life care services well-led?

Good

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. There was an annual audit programme and the service contributed to national data sets. There was no formal action plan in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the majority of the organisational indicators in this audit. However, the majority of the clinical indicators in this audit were met.

Staff stated action had been taken and some of this was evidenced during the course of our inspection, however, this had been taken in an ad hoc manner and not against an agreed action plan and not reported through a governance structure.

There was limited evidence of how the view of patients and their relatives were obtained and how this feedback was acted on in a timely fashion.

Vision and strategy for this service

- The end of life care strategy developed in 2014 by the end of life steering group was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, and the Department of Health's National End of Life Care Strategy.
- In response to the National Care of the Dying Audit, that found there was no executive lead for end of life. The director of nursing was identified as the executive lead for end of life care and chaired the end of life steering group from May 2014.
- The end of life steering group met monthly and had representative from across the hospital, including junior doctors, allied healthcare professions, nurses and chaplains.

Governance, risk management and quality measurement

- The end of life steering group reported to the executive committee through the director of nursing who was also the chair of the group.
- There was an annual audit programme and audits completed this year included syringe driver sticker audit, SPCT response times to referrals and hospice waiting times. Planned audits for later this year included Pro Re Nata (PRN, or as required) drugs administration, fast-track discharge and syringe driver set-up times. Some action plans had been developed following audits to address shortfalls.

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- Audit results were presented at the monthly cancer directorate morbidity and mortality meetings. It was unclear how learning from audits was shared with other directorates in the hospital.
- The SPCT participated in the London Cancer Alliance (West and South London group) work programme including the palliative care and the psychological work stream, which aimed to share learning, practice and service improvements.
- The National Care of the Dying Audit for Hospitals 2013 found that the trust had not achieved six of the seven of the organisational key performance indicators (KPIs) and made nine key recommendations for the trust. There was no action plan detailing the delivery of these key recommendations. We found during our inspection that action had been taken to address some recommendations but had not been reported through formal governance arrangements.

Leadership of service

- The SPCT had a medical lead supported by a consultant based at each hospital site. The team also had a clinical nurse specialist team leader, with clinical nurse specialists based at each hospital site.
- The SPCT team leader and medical lead regularly visited all three sites and were aware of issues relating to their service.
- There were some systems in place to ensure a consistency of approach by all staff caring for patients at the end of their life. For example, all ward staff we spoke with were aware of the new end of life care pathway documentation.

Culture within the service

- The SPCT leadership team told us they nurtured a culture of helpfulness, accessibility and openness. Ward staff told us they found the SPCT members to be accessible, helpful and approachable. We were also told they fulfilled an educational and advisory role whenever they were called on.
- The SPCT aimed to achieve a culture that had the same attitudes and values, culture and practice across all three hospitals. They held joint meetings and shared pathways, processes and documentation. They had also introduced an annual staff rotation between the hospitals for clinical nurse specialists.

Public and staff engagement

- The patient experience committee fed into the oncology patient experience group. Minutes showed that meetings were held every two months and patients were represented alongside trust leads and matrons.
- We were told by the SPCT medical lead that they had faced difficulty getting feedback from people who had come in to contact with their service due to the sensitive nature of death for people's relatives and carers. In 2011/12 the team tried to implement a patient questionnaire without any success. The team had recently approached a clinical psychologist to explore how feedback could be obtained.
- The clinical psychologist found that relatives reported that they were too exhausted following a bereavement to give feedback about the service. In response, the service had recently completed a piece of work with information governance and patient affairs. This will involve the patient affairs team obtaining consent from relatives to send them a questionnaire six weeks after the death of their relative, asking for feedback on their experience of the service. As this initiative had only recently been introduced we were unable to assess it effectiveness or if concerns raised by relatives were addressed.

Innovation, improvement and sustainability

- To make improvements to the service participated in the National Council for Palliative Care's minimum data set collection. This information compared the service with other palliative care services and fed in to the trust's service review of palliative care services.
- Work had commenced in the development of a Commissioning for Quality and Innovation (CQUIN) framework that aimed to encourage healthcare providers to demonstrate quality improvements and innovation in relation to advanced care planning for end of life patients. One of the SPCT consultants spent one day a week focusing on developing and implementing a baseline audit. To support this work the hospital had commenced recruitment for a clinical nurse specialist on a one-year contract.

Outpatients and diagnostic imaging

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

Information about the service

The main outpatients department is located in a three-storey building and has 36 consulting rooms. The outpatients department sees around 50,000 patients per year. The general outpatients department includes a variety of specialisms such as rheumatology and anti-coagulation therapy, gastroenterology, dermatology, neurology, urology and diabetes. There is also a phlebotomy service based in the department.

We inspected the general outpatients and radiology departments. We spoke with 17 patients and four family members or carers. On the day of our visit, six clinics had been cancelled so that a regular clinical meeting could take place. These clinics were dermatology, oncology, breast, upper gastrointestinal, cardiology and orthopaedic. In addition, we spoke with 19 members of staff including managers, doctors, nurses, administrators and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

The hospital had not increased capacity to respond to the gradual increase in outpatient attendances. Patients were waiting longer to be given an initial appointment and also experienced waits in clinic. The hospital was not meeting its target of sending out appointment letters to patients within 10 working days of receiving the GP's referral letter. On average, appointment letters were being sent to patients between five and six weeks after the GP's referral letter had been received. Some patients were either not receiving their appointment letters or received this after the date of their appointment.

Doctors consistently turned up late for clinics without explanation. There was a lack of process in place to monitor performance and identify improvements required. Staff felt supported by their local clinical managers but considered that senior managers were unaware of how the department operated. Staff met with their local managers to discuss performance and concerns on a regular, informal basis only.

There were enough nursing and medical staff in the department and patients were treated with compassion, dignity and respect. Patients were positive about the care they received.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Staff reported adverse clinical incidents appropriately. Learning took place from the outcomes of any investigations. The department was visibly clean and staff adhered to trust infection control procedures.

The majority of patient records were available to support consultations in clinics. There were enough nursing and medical staff in the department to ensure appropriate care was provided. The majority of staff had completed mandatory training, including safeguarding. Medicines were not always stored securely. In three of the six treatment rooms, which were not locked, we found medication cabinets unlocked.

Incidents

- The outpatient department reported no Never Events between April 2013 and August 2014. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff had access to the trust's online incident reporting form and had completed training in how to report incidents. Staff said they had used the reporting form previously.
- Senior staff showed us reports of incidents and the changes that had occurred to prevent similar incidents occurring in the future. For example, following an incident where a child was allowed to attend an adult clinic, procedures were put in place to make sure children did not come in to contact with any adult patients.

Cleanliness, infection control and hygiene

- Clinical and non-clinical areas, such as the waiting areas, were visibly clean and tidy. There were cleaning schedules for the department, including daily cleaning of consultation rooms. We saw that checklists had been completed to confirm that areas had been cleaned.
- There were policies and procedures to reduce the risk of cross-infection. Staff were aware of the trust's aseptic non-touch technique guidance which aimed to reduce the risk of infection. We observed that in the phlebotomy area staff used disposable tourniquets to reduce infection risks.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients. 'Bare below the elbow' policies were adhered to by staff in the clinical areas where examinations were taking place.
- Personal protective equipment such as gloves, aprons, were available for staff use. We observed staff using this equipment correctly when preparing for a biopsy.
- We saw that weekly hand hygiene audits were undertaken by the outpatients matron, when non-compliance was identified, feedback was provided to the individual staff members.
- We were shown a copy of the department's decontamination process which set out the specific actions that needed to be taken in each specialist area to reduce infection risk, for example, these included ensuring that all rigid nasal endoscopes, used in ear, nose and throat procedures, were sterilised centrally and not cleaned in the department which did not have specialist decontamination equipment.
- There were 'sharps' bins in all consultation rooms and we noted that none of these bins were more than half full, which reduced the risk of needle-stick injury.

Environment and equipment

- The outpatient areas were accessible to all patients, including those in wheelchairs, as there was a lift to access the first and second floors.
- There was sufficient seating in all clinics, including chairs in the waiting rooms that were suitable for people who had difficulty sitting down and getting up.
- The ground floor of the department had a café, dispensing chemist and patient transport desk all in the same area. Therefore, once a patient had been seen in clinic they were able to wait in comfort for their transport and obtain any medication that had been prescribed.
- We were told by staff that there was always a 'floor walker' on duty between the two ground floor entrances to the clinic to assist patients as necessary. We observed that the floor walker was greeting and supporting patients as they arrived at the clinic.

Outpatients and diagnostic imaging

- There was an electronic display board on the ground floor that informed patients of the location of their clinic.
- Equipment was appropriately checked and was visibly clean. Staff told us that there was adequate equipment available in all outpatient areas.
- We noted that the resuscitation equipment in the clinic had been checked daily and had been regularly maintained.

Medicines

- Staff we spoke with were not aware of the hospital's policy on the safe storage of medicines.
- Medicines were not always stored securely. In three of the six unlocked treatment rooms, we found medication cabinets unlocked.
- In one treatment room on the first floor we found an unlocked fridge with out-of-date skin test patches, skin creams and eye drops in it. We informed the matron who immediately put a note on the fridge that the medication should no longer be used.
- Staff told us that regular medicine audits were carried out by an external pharmacy company. But they were unable to provide us with copies of the findings of these audits.

Records

- Patient records were stored securely in the medical records department which was located on the ground floor of the department. These records were provided to clinics in paper form with some diagnostic test results such as x-rays, blood tests and computerised tomography (CT) scans being provided electronically.
- Staff told us that it was very rare for them not to be able to locate a patient record or for patients to use temporary records that did not include their history. We noted that all 16 medical records for one of the clinics we visited were available and no patient was due to be seen using a temporary record.
- The medical records team told us that, on the day of our inspection, none of the notes in any of the clinics were temporary. Managers told us that the availability of medical notes was audited regularly and that between 95% and 97% of full notes were available over the last 12 months.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for consent to procedures appropriately. They told us that staff always explained any procedure before carrying it out.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Safeguarding

- The department had up-to-date policies and procedures for safeguarding children and adults. The name of the adult and children's safeguarding leads in the trust and their contact details were readily available should staff need advice or guidance.
- The outpatients matron told us the department had not had any safeguarding issues or referrals in the last 12 months. However, the matron was able to demonstrate that the last safeguarding incident had been managed appropriately and in line with trust policies and procedures.
- Staff were clear about what the action they should take should they suspect that a patient was at risk or the subject of abuse.
- We noted that there was safeguarding information displayed on the walls of the clinic for staff and the public.

Mandatory training

- The trust's training records for the department showed that 83% of staff had completed their mandatory training. Mandatory training covered areas such as, basic life support, conflict resolution, moving and handling, infection control, safeguarding, information governance and improving communication.
- Mandatory training was provided either face-to-face or online, depending on the topic. We were told that cover was provided to allow staff to attend training when required. For example, staff told us that they had attended basic life support training and they knew how to use these skills in practice.

Assessing and responding to patient risk

- Staff told us that all patients who attend the clinic were seen when they arrived in the department by the 'floor walker' who would identify any patients who were unwell or at risk, and appropriate action would be taken.

Outpatients and diagnostic imaging

- Staff told us that, where appropriate, patients could be admitted directly onto specialist wards from the department.

Nursing staffing

- The department had undertaken a staffing skills mix review to identify the skills staff needed. The department had an establishment of six registered nurses and 16 outpatient care assistants, which provided appropriate staffing in the department for the clinics scheduled.
- There were no staff vacancies at the time of our inspection. Many staff had been working in the department for long periods of time and were experienced in delivering the service and understood the department's procedures. For example, staff acted as patient advocates on behalf of patients and asked doctors to clarify points about treatment if they thought the patient had not understood.
- The department always had a nurse in charge on duty who had responsibility for resolving any staffing issues that occurred. We reviewed the number of qualified nurses and outpatient care assistants. We found the outpatients departments were adequately staffed based on the needs of the patients who attend. For example, there were six full-time nurses to cover five outpatient clinic areas; this allowed the extra nurse to cover sickness, leave and training absences.
- The matron and nurse in charge of outpatients were supernumerary and not included in the department's staffing numbers; they were able to supervise and assist staff as necessary.
- Each clinic had a nurse who was responsible for making sure the patient's notes were complete, undertaking any initial procedures, such as weighing the patient and supporting the patient during the consultation, acting as a chaperone if needed.
- In the afternoon falls clinic, we noted that the specialist nurse practitioner was undertaking both the reception and the general nursing duties as there was no receptionist or nurse assigned to the clinic. This resulted in her having less time available to undertake her consultations with patients.

Medical staffing

- Staff told us that every clinic was consultant-led. We found that all the clinics on the day of our inspection had a consultant present, although they did not see all patients but were available to provide support and advice to middle grade and junior doctors.
- Staff told us there was no rota identifying which middle and junior grade medical staff were expected to attend clinic to support the consultant. Some clinics had three or four additional junior doctors while others had none. In clinics where the consultant did not have support from middle or junior doctors, patients often have to wait more than an hour to see the consultant.
- There was insufficient medical staff in some of the clinics to meet the increasing demand for appointments. We were told by staff and managers that the ear, nose and throat, and neurology clinics in particular, required additional medical staff to ensure patients were seen in a timely manner.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We observed that clinical practice was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines. Patients were satisfied with the treatment they receive in the department. Not all patients were able to access specialist pain treatment as there was only one pain clinic in the trust and this had a long waiting list.

There was a delay with GP letters being sent after a patient had been seen in outpatients. The outpatients department provided clinics Monday to Friday 9am to 5pm.

Evidence-based care and treatment

- We were told that national policies, such as NICE guidelines, were followed where appropriate. For example, the care pathway for patients with diabetes was based on national guidelines.
- Clinical staff demonstrated knowledge of the NICE guidelines relevant to their specialist areas.

Pain relief

- Patients told us that staff had spoken to them about pain control and explained who they should contact to access pain relief.

Outpatients and diagnostic imaging

- The trust had a special pain clinic run but this had a long waiting list, resulting in patients not always being able to access specialist pain treatment and support.
- One patient told us how he had been referred to the specialist pain control clinic run by the trust.

Patient outcomes

- Staff told us that diagnostic test results were available promptly to support consultations. The radiology department manager told us that the department was well-staffed and able to provide reports electronically within the trust's timescales of six weeks for non-urgent cases, ensuring the commencement of treatment was not delayed.
- The department undertook its own satisfaction survey using the information collected from public terminals in the department. In June 2014, 83% of patients said they would recommend the department to friends and family, and 90% in July 2014. However, in May 2014 only 29% responded they would recommend the department to others. Staff said that the poor performance in May 2014 was due to the introduction of a new IT system which had caused major delays in clinics. Staff told us that most of the issues with the new IT system had been resolved.

Competent staff

- Staff were competent and knowledgeable about their specialist areas.
- All staff had participated in annual appraisals in the last 12 months. During their appraisal they were asked to identify how they would like to develop in the future and this feedback was used to inform individual development plans.
- All newly appointed staff in the department completed an induction programme which included mandatory training as well as an overview of trust's practices and procedures.

Multidisciplinary working

- We saw examples of multidisciplinary team working, for example, in the falls clinic we noted doctors, clinical nurse specialists, and physiotherapists working as an effective team to support patients.
- The trust aimed to inform the patient's GP in writing of the outcome of their consultation and any ongoing treatment that was required within five working days to ensure appropriate care and treatment was provided. During our inspection we found that this target was not being met and GP letters were frequently delayed for up to 10 working days.
- Staff we spoke with, including the medical secretaries, who were responsible for sending the GP letters once written by the patient's consultant, were clear about the process for preparing and sending these letters. Although, staff gave a differing range of timescales for these letters to be sent, ranging from five, seven and 10 working days. The trust's target was five working days.
- Staff and managers were unable to confirm how the department was performing against the trust's five working day target for send GP letters and could not provide us with evidence to demonstrate this target was being met as this information was not collected.
- Patients' discharge letters we looked at during our inspection demonstrated that these were being sent out between eight and 10 working days after the clinics had taken place. Therefore the trust's five working day target was consistently being breached.

Seven-day services

- The outpatients service did not provide a seven-day service. All outpatient clinics were provided Monday to Friday between 9am and 5pm.
- We were told that, occasionally, Saturday morning clinics had been organised to address waiting list issues. This was not a routine arrangement and there were no Saturday clinics planned at the time of our inspection.

Are outpatient and diagnostic imaging services caring?

Good

Patients were positive about the care they received. Staff treated patients with care and compassion, and gave them the time and space they needed. Patients did not always find it easy to contact secretaries for specialist clinics or the central booking office if they had a query about their appointment.

Compassionate care

- Patients were treated with compassion, dignity and respect. We observed reception staff being polite and taking time to explain things to patients and their relatives.

Outpatients and diagnostic imaging

- Doctors, nurses and healthcare assistants spoke to patients in a dignified way; they greeted them, introduced themselves by name, apologised if there had been a delay when escorting the person into the consulting room.
- Most patients told us that their experience in the department was positive. One person said, “the staff are fast, efficient, caring and companionate”; another said, “the receptionist is very caring, friendly and approachable”.
- Patient consultations took place in private rooms and we noted that sensitive information was never discussed in public areas. Staff told us that, if necessary, they would use a quiet room to discuss confidential matters.

Patient understanding and involvement

- Patients stated they felt that they were involved in their care. For example, they said they had been told what side effects medicines might have and were provided with a choice of medicines.
- There was a range of written information available for patients in the outpatient waiting areas. Some of these leaflets had been produced by the trust and others had been produced by external agencies such as Royal Colleges. Written information was available in different languages on request.
- Patients with queries about the date or time of their appointment were given a central telephone number to contact which aimed to effectively resolve these issues. However, patients said they sometimes had experienced issues contacting specific medical secretaries and the central booking office. These issues included long waiting times for the telephone to be answered and getting through to the correct person.
- We saw patients’ families or carers could accompany them into their consultation, providing the opportunity for a second person to hear what the doctor told the patient and clarify issues later if needed.

Emotional support

- Staff told us they would support patients who had received bad news by taking them to a quiet room and giving them the time to talk about their feelings.
- One patient said, “they are very supportive, I prefer to visit this hospital rather than Ealing”.

Are outpatient and diagnostic imaging services responsive?

Inadequate

The hospital had not responded to the gradual increase in clinic attendances. The number of clinics had not increased in the last two years despite an increase in patients. Patients were waiting longer for an initial appointment and also waiting longer in clinic. Doctors consistently arrived late for clinics without explanation.

There was no process to monitor performance and identify improvements required. The hospital was not meeting its target for sending out appointment letters to patients within 10 working days of receiving the GPs referral letter. Some patients were not receiving their appointment letters or did so after the date of their appointment.

Service planning and delivery to meet the needs of local people

- Most staff told us that there had been a gradual increase in number of patients attending the majority of clinics. Many staff felt that this increase had not been effectively managed and, as a result, patients were waiting longer for an initial appointment and longer in clinics to see the doctor.
- Staff told us that patients were experiencing longer waiting times in most clinics, particularly in the ear, nose and throat, and neurology clinics, due to clinics being over-booked.
- We noted that no additional clinics had been organised to deal with the increased number of referrals. Staff told us that this was because of the limited number of doctors available to provide these clinics.
- The managers were unable to provide evidence to show how this increasing demand for outpatient services was being managed effectively or how they monitored performance.
- Managers told us that there was no system for ensuring that the number of doctors and specialist nurse practitioners matched the needs of the patients in any particular clinic. This resulted in longer waits for initial appointments and over-booking of clinics, leading to longer waiting times.

Outpatients and diagnostic imaging

Access and flow

- Most patients who attended the outpatients department were referred by their GP to the hospital. Other patients were referred from other hospitals or by other departments in the trust. All referrals for outpatient appointments were registered by the central booking team who allocated appointments and sent out appointment letters.
- We were told that the trust's target was to provide the patient with an appointment within 10 working days of receiving their GP's referral letter. Staff told us that, on average, appointment letters were being sent to patients between five and six weeks after the GP referral letter had been received. The trust were unable to provide us with any information to demonstrate that the department's performance in this area was monitored.
- Information provided by the trust showed that the average waiting times to see a specialist for a first appointment, for non-urgent matters was nine weeks for most clinics. However, for urology, chronic obstructive pulmonary disorder and gastroenterology, the waiting time was up to 13 weeks. Staff told us that these delays were due to a shortage of available clinic appointments.
- During our inspection on 3 September 2014 we found that the central booking team were starting to process GP referral letters that had arrived on the 27 August 2014, which would result in a breach of the five-day target.
- There was a 'hot' ear, nose and throat clinic which saw patients at very short notice, for example, people who had sustained an injury, on the same day of referral. These patients were usually referred by the A&E or their GP for specialist treatment.
- Staff told us that, if clinics were delayed, information on the expected waiting times was displayed on a whiteboard in each of the clinics. In one clinic we found that patients had been waiting for more than 40 minutes past their appointment time but the whiteboard did not indicate any delays.
- Patients told us that waiting times in clinic varied between 20 minutes and three-and-a-half hours. The trust were unable to provide us with information on waiting times in out patients as this information was not collected centrally and not monitored.
- The hospital performed worse than the England average for patients not attending appointments. For the financial year 2013/14, 11% of patients did not attend their outpatient appointment compared to the national average of 7%.
- Data showed that 11% of patients failed to attend their appointment. Some staff told us that the reason some patients did not attend was due to appointment letters not being sent out in a timely manner, therefore arriving after the appointment date. We were told that some patients reported that they had not received their appointment letter.
- The hospital cancelled 10% of the appointments which is worse than the England average of 6%. Most staff we spoke with, including managers were not aware of the hospital's performance in relation to cancellation of appointments. Those staff who were aware of the issue could not provide evidence to demonstrate that the underlying causes for this issue had been identified or that there were plans to improve performance.
- The hospital had a dedicated urgent cancer referral team who ensured that all cancer referrals were managed effectively and patients were able to see a consultant within the two-week target.
- Only one of the six clinics we observed on the day of our inspection had all the doctors present before the planned clinic start time. Staff told us that this was not an unusual occurrence and doctors were regularly late for clinics. Doctors' lateness was reported as caused by being delayed in meetings, theatre or on ward rounds. However, as they did not tell the clinic of these delays, staff could not inform patients.
- We were told that most specialties allocated all new patients a 20-minute appointment, while existing patients had 10 minutes. However, we observed that these times were consistently being overrun. This resulted in waiting times of over an hour for some patients. Staff told us that most clinics usually overran and that the longest delays were in ear, nose and throat, and dermatology.
- While information relating to the time patients arrived and left the clinic was collected by the receptionist, the time the patient was called in for their consultation was not recorded. Therefore, it was not possible for the department to monitor or accurately report patients' waiting times or to demonstrate that capacity did not meet demand.

Outpatients and diagnostic imaging

Meeting people's individual needs

- Staff told us that they had access to a translation service for those patients who did not speak English as their first language.
- All clinics had been fitted with induction loops to support people with hearing needs.
- We observed that a patient who arrived in the department in a wheelchair was identified by the 'floor walker' as needing support. They were taken to the clinic receptionist who took over responsibility for their needs. Staff ensured patients spent as little time in the clinic by ensuring they saw the doctor when they were next available.

Learning from complaints and concerns

- Information on how to make a complaint was easily available in the waiting areas.
- We were told that informal complaints were managed by the outpatient matron or nurse in charge and resolved if possible at this stage. If they were unable to resolve the complaint satisfactorily, the patient or relative would be directed to the Patient Advice and Liaison Service (PALS) who would help them to make a formal complaint.
- The staff in PALS told us that the main issue patients raised was the lack of communication about appointments. In particular, the fact that patients had not received their appointment letters and were then told that they had been recorded as a non-attendance, which resulted in another round of referrals and appointments.

Are outpatient and diagnostic imaging services well-led?

Inadequate

There was no departmental vision underpinned by detailed, realistic objectives and plans to inform the development of the service. The trust's vision and values were not understood or fully supported by all staff in the department. Some staff told us that it was unclear how changes at trust level affected them in their role. There was no identified individual or group with overall responsibility for the governance of the outpatient department Some quality and risk issues were not managed effectively.

Staff felt supported by their local clinical managers but considered that senior managers were unaware of how the department operated and the issues they faced on a day to day basis. Staff met with their local managers to discuss performance and concerns on a regular, informal basis. However, managers did not arrange formal, regular and minuted staff meetings at which issues could be escalated and information disseminated to all staff. There was a lack of performance information around key areas, such as timing of initial appointment letters being sent out, and waiting times in clinic.

Vision and strategy for this service

- There was no written vision for the department or plans of how this vision would be achieved.
- The trust's vision and values were not understood or fully supported by all staff in the department. Some staff told us that it was unclear how changes at trust level affected them in their role.
- Staff told us that there had been a number of trust-wide briefing sessions about the general future direction of the trust, which most staff had attended. But there had not been any meetings about future developments in their own department.

Governance, risk management and quality measurement

- There was no identified individual or group who had overall responsibility for the governance of the outpatients department. Responsibility was shared between staff in the clinical specialties and the outpatient management team. This resulted in some quality and risk issues not being managed effectively. For example, it was unclear who was responsible for addressing the issues that resulted in some doctors being persistently late for clinic.
- There was a lack of performance information relating to areas such as management of appointment letters, waiting times in clinics and communication with GPs following an outpatient consultation.
- Non-clinical managers did not demonstrate that they had knowledge and understanding of the performance in their areas of responsibility – for example, if the correct staff were in the right clinic.
- Staff were not provided with information regarding the clinics' performance and were unaware of the key performance indicators set for their clinics.

- There were no regular department meetings at which the staff from outpatients, central booking and medical secretaries met to discuss performance and other issues of common concern.

Leadership of service

- The outpatient departments were dispersed within the structure of the hospital management. Many of the clinics were coordinated by outpatient services while others were managed by the clinical specialities, resulting in staff not being clear who their senior leaders were.
- Staff told us that they felt able to discuss a range of issues with their line manager and felt able to contribute to the running of the department.
- Staff stated that the senior management team were not visible and did not understand staff's operational issues.
- Most staff told us that they did not feel supported by senior managers.

Culture within the service

- Staff were patient-focused and aimed to provide a good service for patients.
- Staff said the department had an open culture in which they were encouraged by their line managers to raise and report concerns.
- We observed that staff worked well as a team and they spoke about supporting each other and helping out as required to ensure clinics ran effectively.

Public and staff engagement

- Patients attending outpatients clinics were able to provide feedback by using touch-screens available in waiting areas. This feedback was analysed and shared among staff and displayed in the department for patients to see.
- Although patient feedback was collected and analysed in terms of the numbers of people who answered positively to questions, there was no detailed assessment of public satisfaction which would identify areas for improvement. For example, there was no information about what issues made people unhappy with the service.
- Staff met with their local managers to discuss performance and concerns on a regular, informal basis. However, managers did not arrange formal, regular and minuted staff meetings at which issues could be escalated and information disseminated to all staff.

Innovation, improvement and sustainability

- Patients attending clinics were able to use self-check-in terminals to book into clinics, which reduced the time spent waiting at the reception desk. To assist patients with this process and provide them with support there was a 'floor walker' on duty at all times. During our inspection we were not provided with any evidence of examples of quality improvement programmes or action plans to address identified issues.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The hospital must:

- Increase the number of cases submitted to the audit programme for the World Health Organization (WHO) surgical safety checklist to increase compliance with the 'Five steps to safer surgery'.
- Develop and implement systems and processes to reduce the rate of patients who do not attend their outpatient appointment or surgical procedure.
- Review the level of anaesthetic consultant support and/or on-call availability to ensure it is in line with national recommended practice.
- Review the arrangement for medicines storage and ensure medicine management protocols are adhered to.
- Ensure all staff are up to date with their mandatory training.
- Ensure all equipment is suitably maintained and checked by an appropriate person.
- Ensure adequate isolation facilities are provided to minimise risk of cross-contamination.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.
- Review the provision of the paediatric intensive care environment to ensure it meets national standards.
- Review the provision of services on Grand Union Ward to ensure the environment is fit for purpose.

Action the hospital SHOULD take to improve

The hospital should:

- Improve the handover area for ambulances to preserve patient dignity and confidentiality.
- Ensure that there is a single source of up-to-date guidelines for A&E staff.
- Seek ways of improving patient flow, including analysing the rate of re-attendances within seven days.
- Improve links with primary care services to help keep people out of A&E.
- Ensure that all patients who undergo non-urgent emergency surgery are not left without food and fluids for excessively long periods.
- Review the literature available to patients to ensure it is available in languages other than English in order to reflect diversity of the local community.
- Ensure same-sex accommodation on Witherow Ward to ensure patients' privacy and dignity are maintained.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Develop a standardised approach to mortality review which includes reporting to the divisional boards and to the executive committee.
- Review patients' readmission and length of stay rates to identify issues which might lead to worse-than-average results.
- Review the arrangements for monitoring compliance with statutory and mandatory training to ensure there is a consistency with local and trust-wide records.
- Review the double-checking process for medication to ensure that staff are compliant with trust policies and procedures.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Review the provision of adolescent services and facilities to ensure the current provision is able to meet the needs of patients.
- Ensure that there is sufficient capacity to accommodate parents/carers while their child receives intensive care support.
- Ensure that the children and young people's service has representation at board level.

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 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **The provider did not have suitable arrangements to protect patients against the risk of unsafe equipment** • An anaesthetic machine had been out of order for six days. • An examination lamp head in one cubicle was significantly dented with resultant sharp edges. There was no light bulb so the equipment was unusable. • There was a number of items of broken equipment, held together with tape, for example a drip stand and a patient monitor in one cubicle. • The brake on one of the patient trolleys did not work. • There were insufficient wheelchairs which led to patients missing their appointments, for example for radiology. • The floor in the resuscitation area was lifting in the gap between door and floor. • The psychiatric holding room had two movable chairs rather than seating fixed to the floor. **Regulation 16 (1) (a) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.**